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**Working Paper**

## Long-term care policies in practice: A European perspective

Bruegel Working Paper, No. 21/2024

**Provided in Cooperation with:**

Bruegel, Brussels

*Suggested Citation:* Hougaard Jensen, Svend Erik; Pinkus, David; Ruer, Nina (2024) : Long-term care policies in practice: A European perspective, Bruegel Working Paper, No. 21/2024, Bruegel, Brussels

This Version is available at:

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# LONG-TERM CARE POLICIES IN PRACTICE: A EUROPEAN PERSPECTIVE

SVEND E. HOUGAARD JENSEN, DAVID PINKUS AND NINA RUER

This paper offers a comprehensive study of the long-term care (LTC) systems in Germany, France, Slovenia, Italy and Denmark. In many EU countries, the demand for LTC services already exceeds supply. Without major reforms, this ‘care gap’ is likely to widen further because of population ageing. This paper highlights a number of recent reforms to reduce this care gap by affecting the demand for and supply of long-term care services. We find that most measures to increase the supply of formal LTC services focus on workforce attractiveness. By examining recent policy efforts and reforms, we aim to understand in which direction LTC policy is going, and to showcase measures to prepare for the future increase in demand for care.

**Keywords:** Long-term care, population ageing, health system reform, Europe  
**JEL codes:** H51, I18, J11, J14

*We thank Axel Boersch-Supan, Elsa Perdrix, Cristiano Gori and participants in a BB-Future workshop in Madrid, 11-12 September 2024, for helpful comments and discussion. Funded by the European Union as part of the BB-Future project that has received funding from the European Union's HORIZON Research and Innovation Actions under grant agreement No. 101093849. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Research Executive Agency. Neither the European Union nor the granting authority can be held responsible for them.*

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**Recommended citation:**

Hougaard Jensen, S., D. Pinkus and N. Ruer (2024) ‘Long-term care policies in practice: a European perspective’, *Working Paper 21/2024*, Bruegel

## 1 Introduction

Long-term care (LTC) is an essential component of social welfare systems, designed to support individuals who are unable to perform basic daily activities independently because of age, disability or chronic illness (WHO, 2022). It is widely accepted that the large wave of retirements into the 2030s will be followed by a surge in elderly people needing formal and/or informal LTC<sup>1</sup>. This ‘care wave’ will impact not only the generation of baby boomers (BB), usually defined as people born between 1946 and 1964, who will need care, but also their children who are expected to provide the care<sup>2</sup>. In several countries, demand for LTC services already exceeds their supply and this ‘care gap’ is likely to worsen with the projected surge in demand for LTC services resulting from population ageing (Belmonte *et al*, 2023).

Several European Union countries have already taken measures to address this gap. This paper offers a comprehensive analysis of LTC reform efforts since 2015 in Germany, France, Slovenia, Italy and Denmark. We assess if such reforms address the supply or demand side of LTC services. Since the total demand for care is fundamentally shaped by health needs, policymakers can influence the overall demand through healthcare system reforms. However, because these reforms relate more to the healthcare sector and not specifically to LTC, they fall outside the scope of this paper. Table 1 provides definitions for the types of care and carers we cover in this paper.

We define the *total demand for care* as the sum of demand for formal and informal care services. The total demand for care is largely driven by the health and physical needs of the population.

The *demand for formal care* is the demand for formal LTC services by those who are eligible under the country-specific eligibility criteria. Policymakers can directly affect the demand for formal LTC services by reforming entitlements and eligibility for benefits. Hence, our evaluation of demand-side efforts focuses on reforms to entitlements and eligibility.

The *demand for informal care* is the difference between the total demand for care and the supply of formal LTC services. The demand for informal care stems from formal care being unavailable, too expensive or insufficient in terms of coverage to satisfy all care needs. To simplify the framework, we assume that informal care demand stems only from unmet needs in the formal care system. Therefore, we abstract from the fact that societal norms and expectations (such as the expectation that family members should care for the elderly) and personal preferences can drive the demand for informal care. For example, some patients prefer care from family members. In this paper, we aim to classify

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<sup>1</sup> In this paper, we distinguish between formal and informal caregivers. Formal caregivers are paid employees trained as care workers and working for service providers which provide care in a formal setting, such as a nursing home or an assisted living facility. Informal carers are defined as people providing any help to older family members, friends and people in their social network in a non-formal setting. They are usually not professionally trained.

<sup>2</sup> This paper reprises several themes and contains insights from the Horizon Europe project ‘BB-Future’. See the project website at <https://www.mea-share.eu/bb-future/> for a deeper discussion of the care gap, its origins and implications.

policy efforts according to their effects on the supply of and demand for care, and do not investigate the drivers of demand for formal and informal care.

In the short-term, reducing the demand for formal LTC services can be done by reducing benefits or making the eligibility criteria stricter. However, there is an obvious risk of reducing welfare for ill citizens by reducing their entitlement to services when such services are needed. Assuming the total demand for care remains constant, efforts to reduce the coverage of formal care are likely to increase the demand for informal care. Policymakers can therefore influence the demand for informal care indirectly by reforming formal LTC systems. Total demand for care can also be reduced by promoting healthy ageing, which reduces the number of people requiring care. Meanwhile, medical advancements such as robotics can ease the physical strain on caregivers and thus help prevent work-related injuries, while also improving caregivers' productivity.

Our aim is not to evaluate the success of the described policy interventions or to prescribe specific solutions for LTC policy reform. Rather, we seek to take stock of strategies adopted by different countries in tackling LTC challenges and to understand in which direction LTC policy in the EU has developed in the last decade. While many LTC systems in the EU face common challenges, national LTC systems vary considerably and there is no one size that fits all. Nevertheless, LTC systems with similar structures can learn from each other.

We find that most of the recent policy efforts in the countries under study have focused on increasing the supply of care services, both in the formal LTC setting and informal care, rather than reducing demand. In the formal-care sector, measures to increase the attractiveness of working in LTC are the most prevalent. Such efforts include increasing wages and reducing the administrative burden on LTC workers, enabling them to spend more time with patients. Some countries have also increased subsidies for training and have facilitated the immigration of prospective care workers from non-EU countries. All countries under study have increased investment in LTC infrastructure. Efforts to increase the supply of informal care indicate awareness that formal LTC systems are struggling to meet demand. Most countries in our sample have expanded opportunities for informal carers to take short-term breaks from caregiving.

There has been less effort to affect the demand for formal long-term care<sup>3</sup>. Where efforts have been made, such as in Slovenia and Germany, the focus is on increasing coverage of LTC benefits, effectively increasing the demand for formal LTC services. If such measures are not met with corresponding undertakings to increase the supply of formal LTC, they will increase the formal care gap. Nevertheless, the reluctance to limit coverage or services of formal LTC systems indicates that governments are attempting to solve the issue from the supply side.

An interesting fact emerges regarding the scale of formal LTC systems. In countries with more developed LTC systems – proxied by spending on health LTC – including Germany, France and

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<sup>3</sup> We do not discuss general healthcare reforms that obviously can reduce the need for LTC in the long-term.

Denmark, there is a strong focus on addressing care-workforce shortages by improving working conditions, raising wages and attracting more professionals into the sector. In contrast, the countries with less-developed LTC systems have aimed for more fundamental reforms to their care systems. Slovenia is establishing a comprehensive LTC system for the first time, while Italy is aspiring to a large-scale reform but the implementation is lacking thus far. Countries thus follow different strategies to improve the efficiency of LTC systems, influenced by their historical contexts. Germany and Denmark, further along in the reform process, have been able to focus more on the care gap itself due to earlier awareness of demographic pressures and stronger political commitments.

We demonstrate that measures aimed at increasing wages in the LTC sector, while appearing significant at first glance, are unlikely to bridge the substantial initial wage gap between this sector and others. As a result, these measures may not significantly enhance the sector's attractiveness. Since the LTC workforce is predominantly female, simply raising wages may fall short of encouraging longer working hours, particularly given the challenges posed to work-life balance by evening, night and weekend shifts. To sustain the LTC workforce, policies supporting families, such as flexible childcare options, will be crucial. The persistent labour shortages in the LTC sector, combined with low wages and relatively low public spending as a percentage of GDP, call into question whether LTC truly holds priority in policy agendas.

Section 2 seeks to identify some common challenges in the LTC sectors across European countries. After a presentation in section 3 of the structure of LTC systems in Europe, section 4 proceeds outlines different approaches to address these challenges. Section 5 shows how the five countries have taken onboard the process of reforming their LTC sectors in recent years. Section 6 extracts some takeaways from recent reform efforts to reduce the care gap.

**Table 1: Definitions of main terms**

Activities of daily living (ADL)	Basic activities necessary for daily life. They represent the skills required to manage one's basic physical needs. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating (WHO, 2022).
Instrumental activities of daily living (IADL)	Include more complex activities related to the ability to live independently in the community. This would include activities such as managing finances and medications, food preparation, housekeeping and laundry (WHO, 2022).
Formal carers	Formal caregivers are paid employees trained as a care worker from a service provider who provides care in a formal setting, such as a nursing home or an assisted living facility (WHO, 2022). It also refers to paid care services provided by a healthcare institution (including at home).
Personal care	Refers to support with limitations in ADL, such as bathing or showering, dressing, eating, getting into and out of bed or chairs, using the toilet and walking short distances (WHO, 2022).

Informal carers	Individuals who provide care services to others in a non-formal setting (mostly at home). They are usually not professionally trained and members of the family. The definitions of informal carers differ significantly across countries <sup>4</sup> .
Home care	Refers to long-term care delivered in the private home of the care recipient. It is most appropriate for cases with lower levels of dependency (European Commission, 2024).
Institutional care	Is delivered in a specialised institution in which the care recipient lives. It is most appropriate for cases with relatively high degrees of dependency with high care needs (European Commission, 2024).
Nursing home	Nursing homes have qualified nurses on-site around the clock to provide medical care as needed.
Residential home	Residential homes provide 24-hour personal care and support for people who need help with daily tasks, but do not need nursing care.
Respite care	Refers to different types of interventions providing temporary ease for informal carers from the burden of care. The most common types of respite care are: day-care services, in-home respite and institutional care in LTC facilities (Rocard and Llana-Nozal, 2022).

Source: Bruegel.

## 2 Drivers of LTC reform

While each country has a unique LTC sector with specific issues, there is a degree of similarity in the challenges they face. Understanding these overarching issues can help policymakers develop effective strategies to ensure the sustainability and effectiveness of LTC services across Europe.

### 2.1 Demographic change

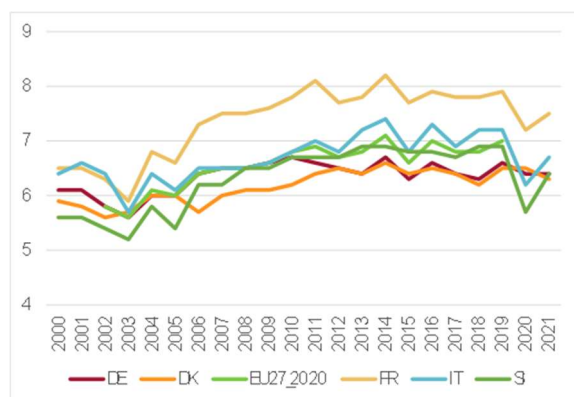
One of the most pressing challenges facing LTC systems in Europe is the demographic shift towards older populations. Advances in healthcare and improved living conditions have led to increased life expectancies at old age (Figure 1), while birth rates have been falling in most EU countries, resulting in a higher proportion of elderly individuals in the EU. Although longer lives are a testament to progress and are fundamentally positive, they pose challenges to pension and LTC systems. The increasing share of elderly in the EU population is projected to be driven by a rapid increase in the very old (Pinkus and Ruer, 2024). As can be seen in Figure 2, the share of the population aged 85 years and older relative to the total population is projected to increase to 6 percent by 2050 and almost 8 percent by 2070 for the EU as a whole, according to Eurostat projections<sup>5</sup>. This demographic trend will increase

<sup>4</sup> It is important to underline that each country can have its own definition of informal carer. OECD (2022) for example showed that most legal or *ad-hoc* definitions of informal carers focus on the close bond to the person in need of care (eg in Belgium, Canada, Finland, France, Italy, Portugal, Spain and the US, but not in Australia, England, Germany).

<sup>5</sup> As the baseline projections in the Ageing Report are based on a general 'no-policy-change' assumption, they illustrate what the future is likely to look like if current policies remain unchanged. The projections of course bring a certain degree of uncertainty as the results are strongly influenced by the underlying assumptions.

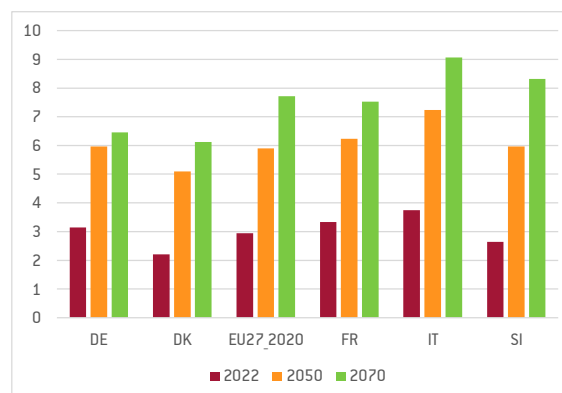
pressure on LTC systems, as more people will require long-term support due to age-related conditions and chronic illnesses, and will require care for a longer period (Belmonte *et al*, 2023).

**Figure 1: Life expectancy at 85 (years)**



Source: Bruegel.

**Figure 2: Share of 85+ in total population (%)**

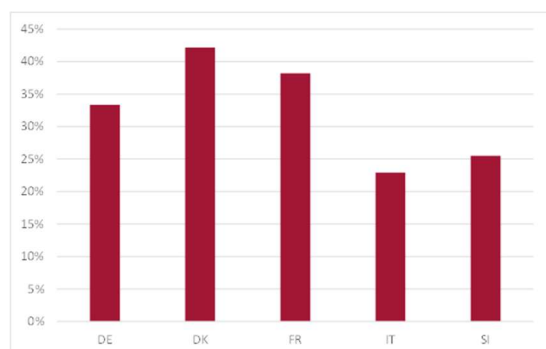


While care needs are projected to increase, a large share of people in need of LTC do not receive adequate care in numerous EU countries already today (Pinkus *et al*, 2023). In Denmark for example, 42 percent of people with limitations in daily activities reported unmet care needs<sup>6</sup> (Figure 3). Furthermore, the prevalence of dementia increases rapidly with ageing. Countries that have high shares of very elderly people now generally have greater proportions of people with dementia (OECD, 2023b). The proportion of the population aged over 60 that have dementia is expected to grow to over 8 percent in many EU countries by 2040 because of population ageing (Figure 4). This issue has a significant gender aspect, as women generally live longer, demand more LTC services<sup>7</sup> and also experience higher rates of dementia than men in every age group, with the disparity widening in older age groups (OECD, 2018).

<sup>6</sup> We acknowledge that self-reported 'unmet care needs' is a subjective measure, with perceptions of what constitutes 'met' and 'unmet' care varying across countries. For a more objective comparison, indicators such as the frequency of baths per week, diversity of available food and access to social activities would be needed to better capture cross-country differences.

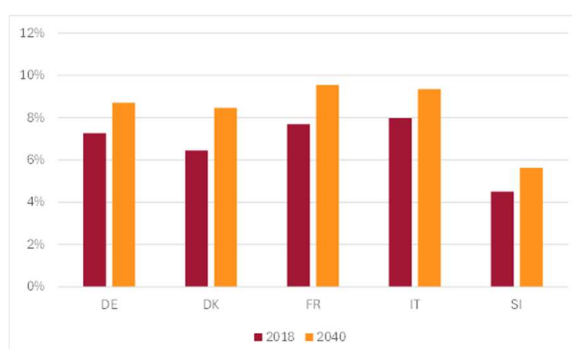
<sup>7</sup> Belmonte *et al* (2023) showed that 32 percent of women over 65 need LTC services, compared to just 19 percent for men.

**Figure 3: Unmet needs among people with limitations in activities of daily living**



Source: Bruegel based on SHARE wave 6.

**Figure 4: Estimated prevalence of dementia among people aged 60 and over**



Source: Bruegel based on OECD (2018).

## 2.2 LTC workforce shortages

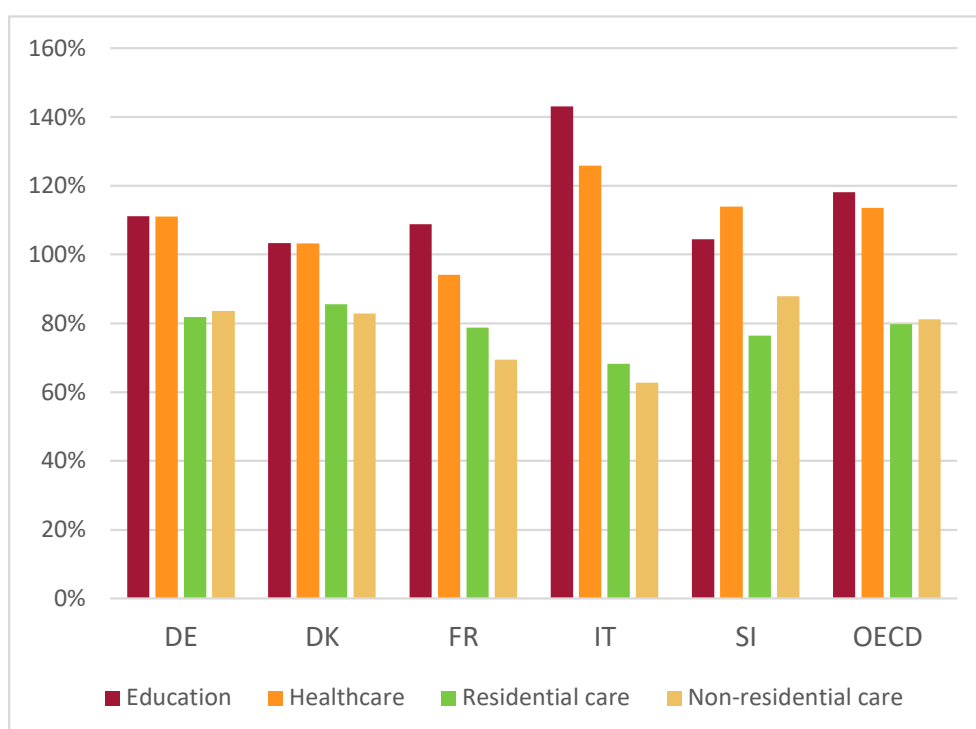
On the supply side, the LTC sector faces a critical shortage of qualified care workers, a problem exacerbated by high turnover rates and unattractive working conditions (OECD, 2023a). In 2021, nurses and healthcare assistants were among the top shortage occupations in 18 and 11 EU countries, respectively (McGrath, 2021). The demanding nature of care work, coupled with relatively low wages and limited career advancement opportunities, makes it difficult to attract and retain staff (OECD, 2023a). The low wages in the sector reflect this reality. Across OECD countries in 2018, jobs in residential and non-residential care paid, on average, 80 percent and 81 percent of the economy-wide gross average hourly wage, respectively (Figure 5). In contrast, workers in the healthcare and education sectors earned 114 percent and 118 percent of the economy-wide average. The predominance of personal care workers, including nursing assistants, partially accounts for the lower wages observed in LTC (OECD, 2023a).

Labour shortages are particularly present in rural areas and regions with ageing populations, where the demand for LTC services is highest (WHO, 2010). In Denmark, LTC institutions are also dealing with high turnover rates (Gørtz *et al*, 2023). According to Local Government Denmark<sup>8</sup> (KL, 2021), if current enrolment levels remain unchanged, there will be a shortfall of 16,000 social and nursing assistants in Denmark by 2030.

<sup>8</sup> Local Government Denmark, KL, is the association and interest organisation for the 98 Danish municipalities.



**Figure 5: Percentage of the economy-wide gross average hourly wage, 2018**

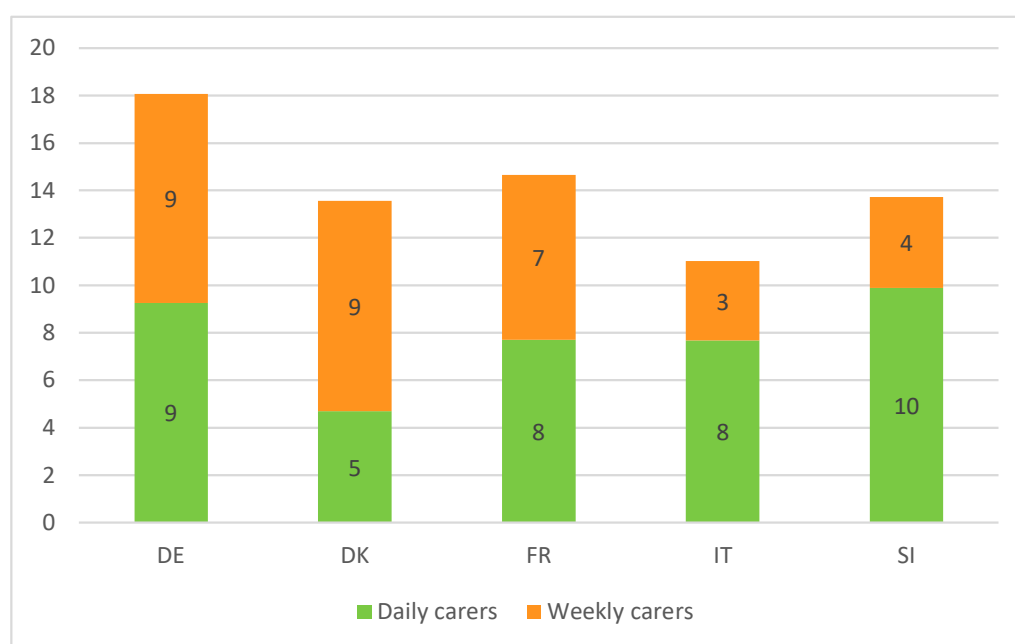


Source: Bruegel based on OECD (2023a). Notes: These sectoral averages account for all workers within these sectors, including those not classified as LTC workers, such as doctors, cooks and accountants.

## 2.3 Reliance on informal carers

Informal carers, primarily family members, are often relied on to fill the gap left by the shortage of professional care workers. Rocard and Llena-Nozal (2022) reported that, on average, 60 percent of older adults across OECD countries receiving care rely solely on informal care. Additionally, about 14 percent of individuals aged over 50 provide informal care on a daily or weekly basis across these countries. In Germany, this figure exceeds 18 percent, while in Italy it stands at just 11 percent (Figure 6). This places a significant emotional and financial burden on families and can lead to caregiver burnout and stress. Many informal carers juggle caregiving responsibilities with employment, resulting in lost income and reduced job security.

**Figure 6: Share of informal carers among the population aged 50+, 2019 (or nearest year), %**



Source: Bruegel based on OECD (2023b).

Furthermore, the past and current reliance on informal care provided by family members is unlikely to be sustainable in the future for four reasons<sup>9</sup>. First, childlessness is becoming more common, alongside a general decline in fertility rates, reducing the pool of potential caregivers (Wenger *et al*, 2000). Second, informal care is predominantly provided by women, who are increasingly participating in the workforce, thereby limiting their availability for caregiving (Haberkern *et al*, 2015). Third, as children tend to live farther from their parents than in the past, providing care becomes more challenging (Steinbach *et al*, 2020). Lastly, an increased prevalence of patchwork families with divorced parents and stepchildren will impact the pattern of caregiving. Informal care can be understood as a bargaining process inside the family to agree if informal care will be provided, who will provide it, and what compensation parents will pay to children. Changing relationships inside the family will impact this bargaining process, with biological children, for instance, approximately four times more likely to provide both financial and time-based support compared to stepchildren (Pezzin *et al*, 2008).

## 2.4 Lack of social recognition of care workers

Social recognition refers to the acknowledgment of a worker's contributions to society, and may be expressed through gratitude, social status or adequate remuneration (OECD, 2023a). The COVID-19 pandemic highlighted long-standing challenges and poor working conditions in LTC sectors. Despite being more in the spotlight during the pandemic, LTC workers have continued to face tough working environments and still receive little social recognition (OECD, 2023a). The OECD (2023a) notably highlighted that LTC workers themselves feel recognised by the care recipients and their families, but

<sup>9</sup> For a more detailed discussion see <https://www.mea-share.eu/bb-future/>.

much less so by their managers, policymakers and the wider community. For instance, in France, the poor working conditions of LTC workers and other healthcare professionals have been highlighted over the past few years. Since late 2022, the group 'Angry Self-Employed Nurses' (*Infirmiers libéraux en colère*) has organised several protests to draw attention to their exclusion from recent legislation aimed at improving conditions in the healthcare sector and to demand better working conditions<sup>10</sup>.

Increasing social recognition is particularly important in view of gender equality because women stand to benefit most. Across all studied countries, women make up over 80 percent of the LTC workforce, yet they remain underrepresented in senior positions (OECD, 2023a).

## **2.5 Financial sustainability of formal LTC systems**

The rising cost of providing formal LTC poses a significant challenge to the financial sustainability of public LTC systems. The Commission's 2024 Ageing Report (European Commission, 2024) shows that age-related expenditures (including pensions, healthcare, long-term care and education expenditures) are a significant part of government spending in all EU countries. Aggregate EU age-related expenditure stood at 24.4 percent of GDP in 2022 and is projected to rise by 1.2 percentage points of GDP in the EU by 2070. Healthcare and long-term care spending are projected to increase in almost all EU countries over the next decades. Long-term care expenditure is the category among the age-related expenditures set to increase the most. These estimates may be conservative, as they are based on an extension of current cross-country differences in LTC provision. Countries that currently rely heavily on informal care, which is generally less costly for the public sector, may find this model unsustainable in the face of long-term structural trends, such as declining fertility rates and increasing female labour market participation.

Since 2017, public LTC expenditure has risen and is projected to increase by a further 0.9 percentage points of GDP, from 1.7 percent in 2022 to 2.6 percent by 2070, therefore outpacing the growth of spending on public pensions<sup>11</sup>. Rising expenditures will mostly be driven by increased demand for services and technological change driving healthcare costs upwards. The increasing need for LTC funding comes at a time when public finances are already strained in numerous EU countries. Furthermore, in many countries, the reliance on out-of-pocket payments and private insurance exacerbates inequalities in access to care, with wealthier individuals able to afford better services than those with fewer resources, and in some cases the latter not being able to afford the required services at all (Baeten *et al*, 2018). For example, women face higher poverty rates after paying for LTC, even

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<sup>10</sup> In France, a significant portion of LTC workers are assistant nurses, professional caregivers and non-qualified caregivers, rather than nurses. As a result, many of them were not included in this collective. Their working conditions and wages are generally even lower than those of nurses.

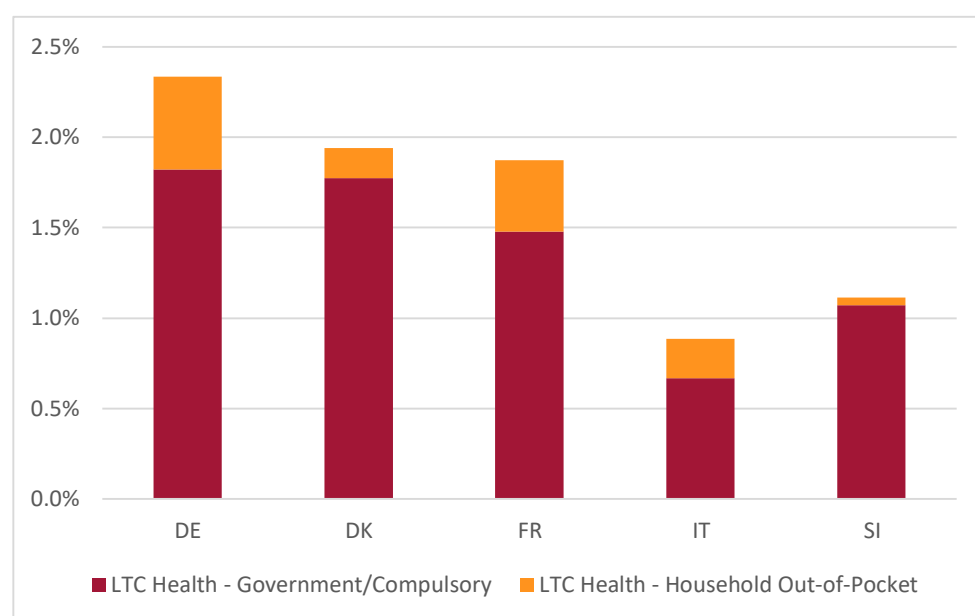
<sup>11</sup> The European Commission (2024) predicted that average public pension spending in the EU will rise from 11.4 percent of GDP in 2022 to 12.1 percent by 2045, and then decline to 11.8 percent of GDP by 2070 (weighted by GDP). After 2045, the Commission expects ageing trends to be mitigated by three factors: first, reduced pension spending per pensioner; second, a slower increase in the number of new pensioners compared to the growth of the population aged 65 and over; and third, trends in the labour market.

with public benefits and services, compared to the average poverty rates among older people (OECD, 2024).

Figure 7 shows the expenditure on health LTC in the countries under study. Out-of-pocket payments represent above 20 percent of total LTC health expenditure in Germany, France and Italy while they are lower than 10 percent in Denmark. Furthermore, Denmark, Germany and France spend a much higher share of GDP on LTC health than Italy and Slovenia.

Within countries, inequalities in access to care also arise from regional disparities in funding and resources. Variations in local budgets and administrative capacity mean that some regions are better equipped to provide comprehensive LTC services than others, creating disparities in the quality and availability of care.

**Figure 7: Long-term care financing in % of GDP, 2022**



Source: Bruegel based on OECD Health Expenditure and financing. Note: The distinction between health-related LTC expenditure (ie assistance with ADL) and those that come under the social (ie help with IADL) is difficult. See Table 1 for definitions. The social component of LTC is less frequently reported by countries than the medical one and is especially high for Germany and Denmark.

### 3 Structure of long-term care systems in Europe

#### 3.1 Common elements of LTC systems

Eligibility for formal LTC services and support typically depends on a needs-based assessment, evaluating an individual's ability to perform activities of daily living (ADL) such as bathing, dressing and feeding. This assessment involves healthcare professionals who determine the level of care required.

The types of care provided under LTC systems generally fall into three broad categories: in-home services, nursing homes and residential care. In-home services include personal care, nursing and household assistance, enabling individuals to remain in their own homes. Nursing homes have qualified nurses on-site around the clock to provide medical care as needed, whereas residential homes help people with personal care and support them to engage in physical activity.

Finally, informal care, mostly provided by family members or friends, plays a crucial role across Europe. Informal care may represent up to 80 percent of total care time in the EU (European Commission, 2021b). Over the last few years, several countries have tried to better recognise this important role informal carers play, and some have introduced various allowances and benefits to alleviate the financial and emotional burden on caregivers.

#### 3.2 LTC systems differ substantially across countries

While all LTC systems under study share some broad structural similarities, each country's LTC system has unique features and distinct levels of benefits, eligibility criteria and processes, and the ways in which benefits can be used by recipients. For example, cash-for-care schemes are a major part of LTC systems in Germany, France, Italy and Slovenia, but not in Denmark<sup>12</sup>. Table two provides an overview of cash-for-care schemes in the countries under study except Denmark.

Germany's system, established in 1995 under its public long-term care insurance scheme (LTCL, *Pflegeversicherung*), offers beneficiaries the option to choose between cash benefits, in-kind services or a combination of both (Geyer *et al*, 2023). The scheme includes five levels of care needs, each corresponding to a specific range of benefits, thereby ensuring that support is adapted to the severity of each individual's condition. Similarly, France introduced the *Allocation Personnalisée d'Autonomie* (APA) in 2002, a means-tested benefit targeting those aged 60 and above who require significant assistance with daily activities and can be received for care at home or in a nursing home. The benefit amount depends on the level of dependency and is adjusted based on the recipient's income. The idea of this system is to ensure that those with the greatest need and least financial means receive the most substantial support. Germany's LTCL also offers several additional financial benefits, such as

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<sup>12</sup> For a more detailed overview of the long-term care systems refer to Gruber *et al* (2023), with specific chapters on Germany, Denmark and Italy provided by Geyer *et al* (2023), Brugiavini *et al* (2023) and Gørtz *et al* (2023).

financial support for nursing equipment, such as special beds, and grants for home modifications to meet nursing care needs.

**Table 2. Cash for care (CfC) schemes in selected European countries**

Country	Scheme (year of introduction)	Eligibility criteria	Means-tested benefit	Assessment tool	Nature of benefit	Benefit levels and benefit rates (max/min in € per month)	Funding
Italy	Indennità di accompagnamento (IA) (1980)	No age limit, Needs tested	No	Nationwide standardised assessment (100% disability and need of continuous care)	Detached from in-kind services delivery, Free use	Unique level (€531)	National funding
Germany	Pflegegeld (1995)	No age limit, Needs tested	No	Nationwide standardised assessment based on six criteria	Choice between CfC, in-kind services or a mix, Free use	Five levels of care needs (€125-€2005) <sup>(1)</sup>	National funding
France	Allocation Personnalisée d'Autonomie (APA) (2002)	Age: 60+, Needs tested	Yes	A unique grid: the AGGIR grid (six levels of dependency)	CfC allocated to finance a care plan defined by professionals. Benefit paid to individual or care professional directly.	Four levels of care needs, Income-related reduction of benefit (€762-€1955)	Mainly local funding, partly funded by government budget and taxes through CNSA.
Slovenia Slovenia	New Long-Term Care Act (ZD0sk-1)	Needs tested	No	Nationwide standardised assessment based on eight criteria	Cash benefit, care services	Five levels of care needs (€89-€491)	National funding

Source: Bruegel. Notes: (1) Users can choose between cash, service provision or a mix of the two. Only the cash option is considered as CfC. Levels of care needs refer to the CfC option only.

In contrast to Germany, Italy's *Indennità di Accompagnamento* (IA) programme, which dates back to 1980, provides a flat-rate cash allowance to individuals with severe disabilities (100 percent disabled), regardless of their age. Unlike the systems in Germany and France, the IA does not require beneficiaries to justify how they use the funds, offering maximum flexibility Brugiavini *et al* (2023). However, this lack of oversight has led to widespread use of these funds for services in the informal labour market and thus to the extensive use of informal care, often provided by migrant workers under irregular contracts, creating challenges in ensuring the quality and regulation of care (Jessoula *et al*, 2018). The issue of long-term care notably gained importance in the public debate in Italy in the beginning of the 2000s with the appearance of the new carer profile of the *badante* – a migrant woman often working irregularly in the informal labour market (Da Roit *et al*, 2007). The significant presence of

immigrant workers is consistently estimated to be around 800,000 in Italy (Pavolini *et al*, 2016; Pasquinelli and Rusmini, 2013)<sup>13</sup>.

Slovenia, which underwent a significant reform of its LTC system in 2023, previously had a fragmented system without a unified legislative framework. The reform introduced a more cohesive approach, combining cash benefits with in-kind services and establishing a standardised needs assessment process. This change aimed to address previous inconsistencies in governance and service provision. Since 2018, both the volatile political situation (with five health ministers between 2018-2021) and the COVID-19 pandemic delayed the implementation of long-awaited reforms. The need to comprehensively regulate LTC within a social insurance framework had been discussed in Slovenia since 2006, when the health ministry presented the first legislative proposal. LTC services in Slovenia before 2023 included benefits in kind (healthcare and social care services in residential care, community, and home care) and cash benefits. There was however no standard model of needs assessment. Eligibility was determined by a team of experts (general practitioner, nurse, social worker) for residential care or by an individual expert (eg social worker) for home care. Similarly, cash benefits were granted upon application and approval by an expert team.

In most countries, eligibility for these cash-for-care schemes is assessed through standardised procedures with criteria defined at the national level. In Germany, medical service assessors evaluate applicants in their home environments to determine the necessity and severity of care. This evaluation is based on a standardised nationwide procedure involving six criteria: mobility, cognitive and communication skills, behaviour and psychological problems, self-care, coping with disease and treatment, and the organisation of daily life and social contacts (for more information on this assessment see Geyer *et al*, 2023). Slovenia's new system also evaluates long-term care needs using these six criteria, along with the ability to function outside the home environment and perform household activities. In France, the departmental APA social team utilises the AGGIR grid for assessment (see Table 2).

In Italy, eligibility for IA benefits requires the recognition of full incapacity based on a medical examination. Although the definition of incapacity is rather broad it includes blindness, deafness, physical or mental disabilities as well as other forms of handicap. However, unlike most other countries, there are no explicit guidelines for the assessment and evaluation of such outcomes, leading to some regional disparity. Also operating at the national level is the National Fund for the Loss of Autonomy (FNNA, *Fondo Nazionale Non Autosufficienza*), with the aim of providing essential support to individuals experiencing a loss of autonomy. Resources from the fund are distributed to regions, which then implement tailored care programmes. Regions can then choose to complement the national resources with a Regional Fund for the loss of autonomy (FRNA, *Fondo Regionale per la Non Autosufficienza*). These regional LTC programmes have different legal bases and thus different eligibility rules. Brugiavini *et al* (2017) documented substantial variation across regions in eligibility

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<sup>13</sup> Whereas in 2016 the number of formal long-term care (LTC) workers was estimated to be approximately 260,000, with about 83.5 percent being women (European Commission, 2021a).

rules for LTC support, partially because of the absence of a single definition of disability in the clinical literature. Brugiavini *et al* (2017) also related different eligibility rules to different levels of available financing.

Denmark has a different model entirely – there is no cash-for-care scheme. However, according to the Social Service Law<sup>14</sup> of 1998, elderly residents who can no longer live independently are eligible for various forms of care, including home-based care, sheltered housing and nursing home accommodation (Gørtz *et al*, 2023). There are no co-payments from the users for home-based care services, including cleaning and personal care. Eligibility for LTC is based solely on needs assessment by the municipalities, aiming for free and equal access regardless of income, wealth, age or household situation.

The Danish LTC system has five main elements: preventative measures, rehabilitation, home help, homes for the elderly and other support services. Preventative measures include home visits and activity offers that address the functional, psychological, medical and social needs of elderly individuals. The separate priority of preventive care is a distinctive feature of the Danish system compared to the other countries under study. For instance, the municipality must offer preventive home visits at ages 75 and 80, as well as to individuals aged 65-79 who belong to special risk groups. Rehabilitation services, part of home help, aim to make the elderly autonomous and independent. These services are provided free of charge by the municipality. When elderly individuals need an alternative living arrangement for health reasons, housing options include nursing homes, sheltered housing, elderly care homes, senior citizen residences and private care accommodation. All countries have some type, if not several types, of homecare, nursing homes and residential care facilities for elderly. Appendix 1 provides detailed information on the different housing services offered to the elderly in each country.

In addition to these core elements, the Danish LTC system offers various other support measures, including subsidised food services at home and in nursing homes.

Most of the countries under study recognise the crucial role of informal carers in their LTC systems and offer either flexible working arrangements or additional support services to assist them. For instance, Germany offers training courses, pension contributions, respite care and care leave. Denmark allows municipalities to employ informal carers under specific conditions, reflecting a broader trend of integrating informal care into formal support structures. Moreover, respite and flexible care leave options are available for working-age relatives involved in caregiving. Relative can also apply for care allowances in order to look after a close relative or friend who is dying and who wishes to die at home. Carer relatives are entitled to leave from work during this period.

In Slovenia, an insured person, even before the 2023 LTC reform, could take seven working days of paid leave to care for an ill co-resident family member. For a child of up to seven years who is either

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<sup>14</sup> Lov om social service, Bekendtgørelse om plejehjem og beskyttede boliger.



mentally or physically disabled the allowance is up to 15 days. In France, there was – until recently – no real ‘care for the carer’ policy. Provisions such as respite care or care leave have only been available since 2015. Before 2015, the only paid leave was a specific leave scheme for parents of disabled children (*Congé de présence parentale*). Italy, like Germany, has a quite generous care-leave system, in place since 1992, offering both short-term leave for urgent cases and longer leave provisions. Care leave is granted to public and private employees caring for severely disabled relatives and children, based on the ‘sole carer’ principle (Law No 183/2010), which restricts care leave to one worker per household for a severely disabled person. Appendix 2 provides more details on the different kinds of care leave each country offers.

### 3.3 Financing of LTC systems

Financing mechanisms for LTC also differ significantly across these countries. Germany’s LTCL operates on a pay-as-you-go basis, funded by income-related contributions shared equally between employers and employees, with additional contributions required from childless individuals. However, the Long-Term Care Support and Relief Act of 2023 introduced changes under which contribution rates now vary based on the number of children, and the employee’s share decreases with an increasing number of children. Anyone living in Germany is obliged to take up LTCL, either in the statutory or private LTCL system<sup>15</sup>. In Italy, LTC funding comes from general taxation, administered by the National Institute of Social Security (INPS).

France’s APA, meanwhile, is financed by a combination of local government funds and the National Solidarity Fund for Autonomy (*Caisse nationale de solidarité pour l'autonomie*, CNSA)<sup>16</sup>. The CNSA itself is financed by employers’ contributions (0.3 percent of total wages) in return for the abolition of one day of public holidays, plus 0.15 percent of the *Contribution Sociale Généralisée* (CSG, a tax on income which finances social security), and the transfer of credits for frail elderly and disabled people from the social security fund.

Denmark’s system is funded through a mix of national and local taxes, with significant decentralisation in the allocation of resources. Regions are responsible for specialised healthcare (hospitals, private GPs and specialists on public agreements) and municipalities are responsible for a broad range of welfare services including home-based healthcare, elderly care, social care, rehabilitation, prevention and health promotion. Municipalities allocate resources, funded by national government contributions, local taxes and equalisation money from other municipalities. Denmark’s LTC system is indeed highly decentralised, but over the last 15 years there has been a move towards centralisation. In 2007 there was notably a major structural reform to merge 14 counties and 275 municipalities into five regions and 98 municipalities.

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<sup>15</sup> There is no difference regarding benefits between statutory and private LTCL.

<sup>16</sup> Following the European heatwave of August 2003, France implemented in June 2004 a law on solidarity for the autonomy of the elderly and disabled by creating a day of solidarity and the CNSA.

Finally, Slovenia's pre-2023 system relied heavily on a fragmented mix of public and private funding, a situation the recent reforms sought to address.

#### **4 Different approaches to address these challenges**

Having reviewed the LTC systems in the five countries under study, it becomes clear that LTC systems differ considerably in the EU. Nevertheless, they face similar challenges as described in section 2. Therefore, policymakers in all countries need to ask the same question: how can the care gap be closed?

The care gap results from demand for LTC exceeding the supply of LTC. The problem can be tackled from two angles: reducing demand for care and/or increasing the supply of care.

In the short-term, reducing the demand for formal LTC services can be done by reducing benefits or making eligibility criteria stricter. However, there is an obvious risk of reducing welfare for ill citizens by reducing their entitlement to services when such services are needed. If the total demand for care is constant, efforts to reduce the coverage of formal care are likely to increase the demand for informal care.

In this analysis, we also include efforts to prevent LTC needs in old-age as a demand measure. As in the long-term, this will be the most effective way to reduce the demand for LTC.

Recent reform efforts have focused on increasing the supply of care rather than reducing demand. It is important to distinguish between the formal and informal sectors. Policymakers can take measures to directly increase the supply of formal LTC services by expanding the workforce, investing in new infrastructure and investing to increase the efficiency of existing services and infrastructure. While setting standards can be useful, eg minimum staffing levels in care homes, they should go hand-in-hand with measures to actually deliver them, eg subsidising training for new nurses. Measures to increase the hours worked by existing staff (intensive margin) and to attract new staff to the sector (extensive margin) are targeted at increasing the supply of formal care.

Increasing the supply of informal care alleviates the pressure on formal LTC systems. The supply of informal care can be increased by reducing the burden on informal carers, making it more likely that individuals choose to care for those in need. Such measures include reducing the financial burden on carers, eg through paid care leave, and also initiatives to alleviate the care weight, for example respite care.

However, when reforming LTC systems some trade-offs need to be kept in mind from an economic point of view. All else being equal, making the formal care sector more attractive entails fewer workers in other sectors that might be more productive. Increasing subsidies for informal care can have negative effects on the labour force as people choose to care instead of entering the formal labour

market. This could be especially pronounced for women, increasing gender inequality. Expanding formal LTC benefits enlarges the formal care gap, if supply is not increased accordingly at the same time, but might still be desirable from a health and welfare perspective. More services and benefits can also negatively impact financial sustainability.

The general equilibrium effects of the coming care wave remain largely unexplored, but understanding the interactions between LTC reforms and the rest of the economy will be crucial to strike the right balance<sup>17</sup>. In the next section, we describe a series of recent LTC reform efforts in the context of closing the care gap.

## 5 Recent LTC reforms

We have grouped recent reforms in the LTC sector into four categories: i) measures to improve LTC workforce attractiveness, ii) measures targeted at informal carers, iii) actions targeting those in need of care, and iv) actions taken with respect to the financing of LTC services. Table 3 gives an overview of the main reform efforts in these four groups.

**Table 3: LTC reforms, selected EU countries**

Country	LTC workforce attractiveness	Informal carers	Benefits for people in need	Financing
Germany	<ul style="list-style-type: none"> <li>• Creation of a legal basis to improve wage conditions for care workers;</li> <li>• Unified training programme for nursing with no school fees;</li> <li>• Uniform national minimum staffing ratios with financial penalties for non-fulfilment, and national minimum wage</li> <li>• More responsibilities for nursing staff;</li> <li>• New rules and dedicated agency for non-EU qualified care workers;</li> <li>• Employers can hire foreign workers for short-term employment.</li> </ul>	<ul style="list-style-type: none"> <li>• Longer duration of respite care and abolition of pre-care period for respite care;</li> <li>• Care support allowance not granted just once per care case but annually.</li> </ul>	<ul style="list-style-type: none"> <li>• Several expansions of cash and in-kind benefits for home and ambulatory care;</li> <li>• Social long-term care insurance with a prevention mandate;</li> <li>• Subsidy scheme for care-related personal contributions in inpatient care;</li> <li>• Municipal care through nursing care funds and local advice expansion;</li> <li>• Five care-grades based on physical, mental, and psychological disabilities;</li> <li>• Additional funds for home renovations for older people's needs;</li> <li>• Higher benefits for dementia patients.</li> </ul>	<ul style="list-style-type: none"> <li>• Several increases in contribution rate, especially for those without children;</li> <li>• New long-term care fund to secure financial support after 2035.</li> </ul>

<sup>17</sup> For ongoing research on this question see the BB-Future research project (<https://www.me-share.eu/bb-future/>).

France	<ul style="list-style-type: none"> <li>Higher wages for qualified workers;</li> <li>Investments of more than €2 billion in renovating and digitalisation of care homes</li> </ul>	<ul style="list-style-type: none"> <li>Respite care;</li> <li>Paid leave for informal carers;</li> <li>Pension credits;</li> <li>Professional certification for informal caregivers.</li> </ul>	<ul style="list-style-type: none"> <li>New aids to improve loss-of-autonomy prevention;</li> <li>Measures to fight against isolation of the elderly and to favour care at home.</li> </ul>	<ul style="list-style-type: none"> <li>Fifth branch of social security;</li> <li>Transfer of social debt.</li> </ul>
Slovenia		<ul style="list-style-type: none"> <li>Partial payment for lost income;</li> <li>Social insurance.</li> </ul>	<ul style="list-style-type: none"> <li>New assessment tool and newly defined care categories;</li> <li>E-care services;</li> </ul>	<ul style="list-style-type: none"> <li>Compulsory LTC insurance;</li> <li>state budget increase;</li> </ul>
Italy			<ul style="list-style-type: none"> <li>Building and refurbishing facilities for people with severe disabilities and dependent older individuals;</li> <li>Single access points;</li> <li>Simplified assessment to define someone in need;</li> <li>Temporary new benefit.</li> </ul>	<ul style="list-style-type: none"> <li>Increase in <i>Fondo Nazionale Non Autosufficienza</i> (FNNA).</li> </ul>
Denmark	<ul style="list-style-type: none"> <li>Salary increases and bonuses to promote full-time employment;</li> <li>1,000 residence and work permits for non-EU social and healthcare workers.</li> </ul>		<ul style="list-style-type: none"> <li>Resilience commission;</li> <li>Holistic care;</li> <li>Permanent teams;</li> <li>Local care home.</li> </ul>	<ul style="list-style-type: none"> <li>Adjustment of municipal co-funding.</li> </ul>

Source: Bruegel.

## 5.1 LTC workforce attractiveness

This set of measures focuses on increasing the supply of formal LTC services to close the care gap. Challenging working conditions in the LTC sector are now widely recognised in Europe. To address this, some countries have introduced measures targeting both the intensive (retaining existing staff) and extensive margins (aimed at recruiting new staff) to make working in the LTC sector more attractive. On the intensive margin, measures focus on improving job quality and organisational adjustments. On the extensive margin, examples include improving recruitment processes, prioritising LTC workers in visa and work permit applications and providing better training programmes (eg Germany and Denmark). Pay increases can address both margins, as higher salaries can incentivise current workers to work longer hours (intensive margin) and attract new individuals to the profession (extensive margin).

Germany has put in place several reforms since 2015, including the *Pflegeberufereformgesetz* in 2017, which modernised care training by integrating various nursing disciplines into a single generalist training course. Moreover, school fees were abolished and financing of nursing training standardised through state funds to ensure consistent quality across the country. By standardising nursing training and removing financial barriers, Germany aims to increase the supply of skilled workers in the LTC sector, thereby directly addressing the care gap.

Additionally, the *Pflegepersonal-Stärkungsgesetz (PpSG)* of 2018 improved working conditions and staffing levels in nursing care. This law introduced minimum nursing staff levels with, for example, a maximum of 2.5 patients per nurse in ICU and 10 patients per nurse during a day shift in geriatric care. If a hospital does not comply with the prescribed minimum staffing levels, it faces a reduction in its financial resources. At the same time, some 13,000 additional nurse positions in geriatric care were created and financed by statutory health insurance funds. These positions had to be filled by trained nurses and were distributed according to the number of residents in care facilities. If this failed within four months, a nurse in training could also be hired, showcasing the urgency of the shortages. This initiative helped to increase the supply of care services by ensuring adequate staffing levels, which reduces the strain on existing staff and improves care quality, potentially reducing the demand for additional services through better preventive care. Such an initiative is only successful if staff are available to fill the positions.

The 2018 act further aimed to encourage hospitals to hire new nursing students. For example, the first year of training in paediatric nursing, nursing and nursing assistant training was only partially reimbursed by the funding bodies. To create more incentives for hospitals to train in nursing, the training is now fully refinanced from the first year of training. Data from the Federal Statistical Office (Destatis) indicates that, as of December 31, 2020, nearly 486,100 people were employed in hospital nursing care in Germany, compared to 437,800 at the end of 2018. Although the increase in staffing cannot be directly attributed to this law, over 48,300 positions were created in just two years. In contrast, only 25,700 positions were created between 2011 and 2017.

Furthermore, €100 million annually from the nursing insurance fund between 2019 and 2030 will be provided to improve the compatibility of care, family and work for care workers, for example childcare facilities open at irregular times. Up to 50 percent of the amount spent by the nursing facility on a measure can be repaid from national funding. Another focus is on reducing administrative burdens on nursing staff, with the nursing insurance financially supporting digitalisation by care establishments.

The *Pflegelöhneverbesserungsgesetz* of 2019 created a legal basis to improve wage conditions for care workers. Improving wage conditions aims to both retain current staff and attract new workers, thus increasing the supply of care workers and helping to close the care gap. Specific minimum wages for care workers with different qualification levels were introduced and a periodical review of minimum wages in the care sector by an expert commission was put into law. From the beginning of 2022 up to mid-2024, minimum wages for nursing assistants increased by approximately 21 percent, for qualified nursing assistants by 23 percent, and for nursing professionals by 25 percent. By the end of 2026 the minimum wages will be increased by a further 3.8 percent, 5.2 percent and 5.1 percent, respectively. By taking measures to increase wages in the LTC sector, Germany continues working on making the LTC sector more attractive.

Also, under the *Gesetz zur Weiterentwicklung des Gesundheitsversorgung* of 2021, care institutions can since September 2022 only claim reimbursement from the care insurance fund if they pay their

staff according to levels similar to collective agreements in the region. In the same year, nursing staff were given more responsibility, allowing them to prescribe equipment and request home-care services independently. Finally, at the end of 2023, the German government passed the Nursing Studies Strengthening Act (*PfIStudStG*). According to this law, nursing students will in the future receive appropriate remuneration for the entire duration of their studies.

In France, the COVID-19 crisis prompted the health ministry to initiate the *Ségur de la santé* (French Ministry of Health, 2020) in May 2020, a national consultation aimed at improving care organisation and remuneration. This led to significant investments in healthcare infrastructure and significant salary increases for health workers (€8.2 billion per year allocated to increasing their wages). An increase of €183 per month went to all public and private not-for-profit non-medical carers in residential homes, nursing homes and staff in social and medico-social establishments (and €160 per month for the private for-profit sector), amounting to 1.5 million professionals.

Among the investments, around €2 billion has been invested in digital infrastructure, including €600 million for digital infrastructure in nursing homes. These investments will enable the creation of an online health and care portal including shared health and care records, a shared messaging system and records and information relative to hospital discharge, ultimately aiming at easing the administrative burden on care workers. Reducing the administrative burden helps to close the care gap by making services more efficient and allowing skilled care staff to spend more time caring for patients. Furthermore, €1.5 billion has been allocated over four years to invest in the transformation, renovation works, and digital upgrading of care and nursing homes.

In Denmark, a new agreement on wages and working conditions in March 2024 was secured through a collective bargaining agreement. The primary goal of this agreement is to increase the number of professionals in health and elder care, especially by encouraging more full-time employment. Currently, nearly half of the nurses in Denmark work part-time, and a third are reluctant to take evening, night and weekend shifts. To address these issues, the agreement includes a combination of higher wages and bonuses for working at irregular times (nights, weekends). The increase in base wage is higher for those who work a minimum number of irregular shifts. Full-time nurses are offered a monthly salary increase of 6,200 DKK (about €830) if they work at least 40 irregular shifts (odd times) per year or a 4,400 DKK (€590) increase without such shifts. The extra payment for evening, night and weekend shifts (*Særydelsesbetalingen*) rose by 5 percent from April 2024. Additionally, a duty bonus (*vagttilæg*) was introduced for nurses with a minimum of 300 hours of evening, night and weekend shifts: 6,667 DKK (about €890) per year starting in 2024 and 12,252 DKK (about €1643) per year from 2026. The government aims to encourage at least 85 percent of nurses to take on irregular shifts and work full-time by 2026. By encouraging full-time employment and providing incentives for irregular shifts, Denmark aims to maximise the usage of the existing workforce, thereby increasing the effective supply of care services.

Slovenia, as part of its national Recovery and Resilience Plan, will support the training of additional nurses specialising in chronic disease care and geriatric patient treatment.

## **5.2 Attracting non-EU workers**

In several European countries, there has been a push to reduce the care gap by facilitating immigration for care-sector workers. These initiatives aim to reduce the formal care gap by increasing supply through the attraction of new skilled personnel. For instance, to address the need for skilled workers, Germany established in 2019 the German Agency for Skilled Workers in Health and Nursing Professions (*Deutsche Fachkräfteagentur für Gesundheits- und Pflegeberufe*, DeFa). It is a state-run company designed to speed up immigration procedures for qualified nursing staff recruited from abroad by private recruitment agencies, hospitals and nursing homes. Germany already had some specific legal labour migration channels for care workers, and with the 2023 Skilled Immigration Act since March 2024 new employment and recognition rules apply. A notable change relevant to the care sector is the possibility for all third-country nationals with less than three years of regulated nursing training to work in the health and care sector. The prerequisite for this is that such individuals either have relevant vocational training in nursing in Germany or a foreign nursing qualification that is recognised in Germany. Furthermore, nursing and care assistants from third countries who have completed their training in Germany can apply for a residence permit for jobseekers. Further changes include relaxed regulations for the EU Blue Card, making it easier to attract skilled workers with recognised qualifications.

In Denmark, starting 1 July 2024, social and healthcare workers have been included in the Positive List for Skilled Workers, with 1,000 residence and work permits available. The Positive List schemes for skilled workers and highly educated workers allow non-EU applicants to apply for residence and work permits in professions experiencing labour shortages.

In contrast, Italy has not implemented significant measures to improve the working conditions and social recognition of LTC professionals, lagging behind other European countries in this regard.

## **5.3 LTC and informal carers**

Increasing the supply of informal care has also been a focus of recent reforms. Such efforts ease the pressure on formal LTC systems.

In Germany, the 2023 *Pflegeunterstützungs- und -entlastungsgesetz* (PUEG) abolished the requirement for a six-month pre-care period before the use of respite care, making use of respite care easier. The maximum duration of respite care has been increased from six to eight weeks and the budget for hourly respite care by close relatives (or formal carers) will be adjusted to double the monthly care allowance rate. From 2024, the ten-day care support allowance can be claimed annually per care case, instead of just once per care case. This means that, from 2024, the care support allowance can be claimed for up to ten working days per calendar year per person in need of care.

In France, the 2015 Act on Adapting Society to an Ageing Population marked a significant step in recognising informal caregivers, offering respite care and occasional financial assistance for APA beneficiaries when their caregiver is hospitalised. In addition, the family support leave became leave for informal caregivers, allowing employees to temporarily stop working without pay to take care of a person in need. In October 2019, the French government introduced a comprehensive national strategy to support informal carers, called *Agir pour les aidants 2020-2022*. With a budget of €400 million over three years, including €105 million specifically for respite care, this initiative was the result of extensive consultations with caregivers, representative organisations and various stakeholders. Notably, the previously unpaid leave for informal carers was replaced by a paid leave (*allocation journalière proche aidant, AJPA*). This benefit allows carers to take a three-month break, with 22 paid days per month, totalling up to 66 days per year. Previously, informal carers could claim this benefit only once in their career. However, in October 2024 it was been decided that from January 2025, carers will be able to claim the allowance for up to four separate care cases, providing a maximum of 264 days of paid leave over their working lifetimes.

In October 2023, the government launched a follow-up strategy for 2023-2027. New measures proposed include the creation of a form of insurance for caregivers (*Assurance vieillesse des aidants, AVA*) and access for informal caregivers to certification for acquired experience (*Validation des Acquis de l'Expérience, VAE*). The AVA, part of France's 2023 pension reform, ensures the continuity of pension rights for those who stop or reduce their professional activity to care for a child, or an ill or disabled person (optional free insurance). The VAE procedure allows individuals to have their professional experience validated to obtain professional certification, regardless of their age, education level or status. Applicants must have at least one year's practical personal experience in the field of care before they can begin the process of obtaining the VAE towards a professional carer qualification. These measures aim to provide financial compensation and support, helping to alleviate the burden on informal carers.

In Italy, since 2020, informal carers who have at least one year of experience in providing care can earn a professional certificate by completing a minimum of 64 hours of free training and passing a final examination. This initiative aims to incentivise training programmes and improve the quality of care provided. By providing the opportunity to earn a professional certificate, Italy and France are aiming to directly increase the number of formal caregivers. The skills acquired through informal care can thus help to close the gap in formal care.

In Slovenia, the introduction of a compulsory LTC insurance system in 2023 includes new rights to family caregivers, such as partial payment for lost income, inclusion in mandatory social insurance, respite care (max 21 days) and training and professional advice.



## 5.4 Reforming LTC benefits

Reforms expanding formal LTC services directly increase the demand for formal LTC. This can widen the formal care gap if the services to meet these new entitlements are not made available. However, reforms can still be desirable and justified from a health and welfare perspective. Another way to impact the LTC services patients receive is to make service delivery more efficient. Examples include measures to allow care workers to spend more time with patients and simplification of assessment procedures.

Germany expanded its LTC system through a series of reforms between 2015 and 2017, known as the Long-term Care Strengthening Acts (*Pflegestärkungsgesetz I, II, III*, or PSG I, II and III). These reforms expanded benefits for care recipients and introduced a new definition and assessment procedure for determining care needs, which now includes mental and psychological conditions. With PSG I, the cash benefits increased by 4 percent and funds for household renovation measures – for example the installation of barrier-free showers – were increased to up to €4,000 per measure, so that people in need of care can stay in their familiar environment for longer.

With PSG II, the previous three care levels were replaced by five more-tailored care levels, and mental and psychological conditions were given more consideration to better account for the increasing number of people suffering from dementia. The number of recipients (mostly for home care) within statutory LTCI increased by more than 20 percent from 2.7 million in 2016 to 3.3 million in 2017.

Finally, with PSG III, the relationship between care and integration assistance was clarified. When the same services are provided by different providers, social welfare offices and nursing care funds should agree regularly how the services should be provided in relation to the person entitled to the service and how providers should reimburse each other for the costs. Moreover, PSG III is intended to improve the nursing-care situation at the local level. Municipalities are granted a right of initiative to set up new care centres to advise those seeking help. This regulation deprives the nursing insurance company of any say in whether and where a care centre is required, even though it has to pay for the care centres.

Then, in 2023, Germany adopted the *Pflegeunterstützungs- und -entlastungsgesetz* (PUEG), which includes a 5 percent increase in both the care allowance and in-kind care benefits, starting in January 2024.

In France, in April 2024, a new law, *Bâtir la société du bien-vieillir et de l'autonomie*, was proposed. It includes measures to combat the isolation of the elderly in care facilities, such as daily visiting rights from anyone they consent to without a requirement to give the facility prior notification and the right to pets. It also includes regulations for nursing homes (EHPAD), the creation of a departmental public service on autonomy for the elderly, and a conference on autonomy every three years.

Denmark's 2024 elderly reform emphasises a holistic approach to care, allowing the elderly to customise their care services based on their preferences and needs. This person-centred approach

aims to improve satisfaction and outcomes for care recipients. Another important part of this is to reduce the time care workers spend on administrative and management tasks, in favour of more time with patients. Additionally, a supervisory reform will replace the current system of 98 municipal and state-level inspecting authorities with a unified, inter-municipal supervision model. This new approach will ensure that all necessary inspections for an institution are conducted on a single day each year, addressing issues with overlapping and conflicting oversight. The reform will also remove several requirements and regulations from municipalities, including annual quality standards, supervision policies, dignity policies and a requirement to offer preventive home visits to those over 70. Starting in 2025, municipalities will be allowed to set up municipally-owned care homes, known as local care homes<sup>18</sup>. These will be different to existing municipal nursing homes or private nursing homes. Furthermore, the government also wants private companies to play a role in more areas than today and this reform thus opens elderly care to private sector bids. Currently, private companies can provide practical help such as cleaning and personal care, but in the future, they will also be responsible for retraining and rehabilitation.

In Italy, interest in the issue of dependency has been growing for the last three years. For instance, the first draft (January 2021) of the Italian National Recovery and Resilience Plan (NRRP) did not include any reforms related to the LTC sector. This omission led to the creation of the Pact for a New Welfare on Non-Self-Sufficiency (*Patto per un Nuovo Welfare sulla Non Autosufficienza*), which unites over 60 associations involved in assisting and protecting non-self-sufficient elderly people. These associations lobbied for the inclusion of a reform for the assistance of the non-self-sufficient elderly in the NRRP. As a result of their intense lobbying, this reform was included in the final NRRP presented at the end of April 2021. The LTC reforms in the NRRP are to be introduced in two steps: first, through enabling legislative decrees, followed by implementation decrees. Two key laws are involved:

1. Enabling Law No. 227/2021 reformed the disability assessment system in line with the Convention on the Rights of Persons with Disabilities (CRPD) and the European Disability Strategy. It seeks to remove inefficiencies and red tape, provides a common definition of disability at the national level and creates a multidimensional assessment approach.
2. Delegation Law No. 33/2023 allows the government to pass legislative decrees to promote dignity, independence, social inclusion, active ageing and the prevention of frailty and disability among the elderly.

Implementation Decree 29 is a legislative act that puts into effect the provisions of Delegated Law No. 33/2023 by detailing its practical application. Despite inclusion of many proposals from the social pact in the Delegated Law No.33, Implementation Decree 29 of 2024 has been seen as disappointing because it did not plan changes for the three main measures described in the Delegation Law: new integrated system, home care, allowances. For instance, the Delegation Law No. 33 proposed a new

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<sup>18</sup> Local nursing homes will operate as businesses with the following characteristics: (i) they will be owned by municipalities, (ii) managed independently as private operational units under the oversight of their respective boards of directors, which will be accountable for their finances and operations, and (iii) required to offer citizens the opportunity to purchase additional services beyond basic assistance.

universal benefit as part of the reform of the accompanying allowance. However, the implementation decree leaves the existing allowance unchanged but adds additional resources by introducing a temporary intervention for the period 2025-2026, providing an extra €850 per user per month. This benefit is limited to a small group of individuals.

The main innovation in the implementation decree is the simplification of the assessment process for elderly care interventions, reducing the current five to six evaluations to just two: one by the state and one by the regions. The state will implement the Unified Multidimensional Assessment (*Valutazione Multidimensionale Unificata*, Vamu), consolidating existing assessments for national benefits (accompanying allowance, Law 104/92, civil invalidity). Regions and municipalities have their own evaluation units (*Unità di Valutazione Multidimensionale*, UVM) but will draw on information from the Vamu (whereas before there was no information sharing). This second evaluation is aimed at defining the personal Integrated Care Plan (*Progetto Assistenziale Individualizzato*, PAI) and determining the services available to the elderly and their caregivers, including home, semi-residential or residential care.

Slovenia's 2023 Long-Term Care Act introduced comprehensive LTC insurance covering a range of care services, including institutional care, home care and cash benefits. This act aims to reduce inequalities in access to care through a universal approach and includes a new assessment tool to evaluate LTC needs based on eight criteria. The provision of care services is based on a personal plan, which is the act's fundamental starting point. The act introduces one-stop shops at the regional offices of the Health Insurance Institute of Slovenia (HIIS), where potential LTC users can receive information and apply for services. Moreover, the law introduces the right to e-care services and financing for it. As part of its National Recovery and Resilience Plan, Slovenia has invested in broadening nursing skills and expanding the responsibilities of primary care doctors. It will also create a network of regional coverage with palliative mobile teams.

## 5.5 Financing

The expansion of services and investment described above raises the question of how countries plan to finance such efforts. Germany has incrementally increased contribution rates for LTC insurance, with recent reforms introducing different contribution rates based on the number of children an insured person has. The contribution payment amount started in 1995 at 1.7 percent of gross income and was at 4 percent as of July 2023 for those with no children, 3.4 percent for those with one child and a 0.25 percent reduction for each additional child up to five. Since 2015, 0.1 percentage points of the contribution rate flows into a newly created long-term care fund (in the form of a special asset managed by the German Federal Bank) to additionally finance the expected growing burden of long-term care from 2035 onwards.

Germany also made several efforts to reduce the financial burden on care recipients and their relatives. Between 2018 and 2020, the average total private contributions for LTC services per individual in care increased by nearly €200 per month, primarily due to a rise in the number of

beneficiaries and increased benefits, and the efforts to enhance wages and working conditions in the sector (Gerlinger, 2020). Furthermore, since January 2020, children are only required to contribute to their parents' nursing home costs if they earn €100,000 or more per year before tax. This amount applies to each child individually and is unrelated to their household incomes. Under the previous regulation, only children with a net monthly income of up to €1,800 were exempt from supporting their parents. Another new reform passed in 2021 was the Health Care Development Act (GVWG). Part of this reform was to protect those in need of care from rising care costs, with nursing care insurance paying a surcharge for care in a nursing home that increases over time (5 percent of the care-related personal contribution, in the second year 25 percent, in the third year 45 percent and thereafter 70 percent). These surcharges increased to from 5 percent to 15 percent for the first year, 25 percent to 30 percent for the second year, 45 percent to 50 percent for the third year, and 70 percent to 75 percent for care exceeding 36 months with the *Pflegeunterstützungs- und -entlastungsgesetz* (PUEG) of 2023.

In France, the 2019 Libault report recommended a renovation plan for care facilities, especially public ones, with a budget of €3 billion over 10 years and a 25 percent increase in staff for nursing homes by 2024. The proposed financing involved reallocating the social debt repayment contribution in 2024, which was then anticipated as the date for social debt extinction. This report and the pandemic led to the Organic Law and also the Law of 7 August 2020 on social debt and autonomy. The former allows the transfer of €136 billion in debt to the *Caisse d'Amortissement de la Dette Sociale* (CADES)<sup>19</sup>, and the latter created the fifth branch – the autonomy branch – of social security system<sup>20</sup>. The Organic Law concerning social debt highlighted that the COVID-19 health crisis significantly impacted social finances through a considerable reduction in the wage bill, which is the main basis for calculating social contributions. Additionally, the crisis led to increased expenditures, such as paying bonuses to staff of public health institutions, including elderly care homes, and raising the daily sickness allowances for individuals who needed to care for their children. To ensure the sustainability of the social protection system in view of the increased expenditure, it was decided to extend the repayment deadline for social debt to the end of 2033.

After 15 years of discussion, the French government recognised ageing as a new branch for social insurance in 2020, the autonomy branch, in addition to the first four (family, sickness, work-related accidents/illnesses and retirement)<sup>21</sup>. The main change was making the National Solidarity Fund for Autonomy (CNSA) responsible for managing this fifth branch of the French social security system. The main services provided by the autonomy branch are the provision of APA, PCH and the disabled adults' allowance (AAH) and the disabled children's education allowance (AEEH) paid to disabled people. This branch also contributes to the financing of informal caregiver leave. However, the WHO (2022) pointed

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<sup>19</sup> CADES was created in 1996 to 'pay off' the debts of the general social security system. Its purpose is to pay off the social security debt over a limited period, to avoid burdening future generations.

<sup>20</sup> From January 2024, a proportion of the *contribution sociale généralisée* (CSG) – 0.15 points, or €2.3 billion euros – currently used to pay back the social security debt will be allocated to this branch.

<sup>21</sup> The idea of the creation of a fifth branch dates back to 2007 with the Gisserot report (Gisserot and Grass, 2007), which predicted that the doubling of the population aged over 85 could lead to a 25 percent increase in the number of dependent individuals by 2020 and proposed potential funding avenues. In February 2011, then French President Nicolas Sarkozy started a national debate on dependency.

out that the creation of the fifth branch does not modify the structural weaknesses of LTC funding in France, and does not help to reduce regional inequalities in financing LTC.

In Denmark, a reform in 2016 adjusted the funding mechanisms for municipalities, focusing on prevention and health promotion. Municipal co-payment of hospital admission was introduced in the 2007 reform to incentivise municipalities to enhance prevention and health promotion. The initial general co-funding was criticised for being too broad, as municipalities had limited influence. It was therefore decided in 2016 to place a cap on municipal payments and the payment model was changed to include age differentiation, focusing on age groups that municipalities can influence most easily (0–2, 65–79, and 80+ years) through prevention and rehabilitation services. More recently, as part of the 2024 elderly reform, an additional annual investment of one billion DKK will be made to raise the quality of elderly care in Denmark by 2027.

Further demonstrating Italy's growing interest in LTC, the 2022 budget law (Law No. 234/2021) gradually increased the National Fund for the Loss of Autonomy (*Fondo nazionale Non Autosufficienza*, FNNA) from 2022 to 2025, adding €100 million in 2022, €200 million in 2023, €250 million in 2024 and €300 million in 2025. These increases build on the €560 million already allocated to the fund for the 2019–2021 period. This fund was established in 2006 to support disabled and seriously ill people requiring continuous home care. Regions must create regional dependency plans to access the fund. The increase in the amount in the fund was partly due to the introduction of Essential Levels of Social Benefits (*livelli essenziali delle prestazioni sociali*, LEPS), ensuring nationwide services, activities and integrated provisions to improve quality of life, equal opportunities and non-discrimination. The budget law also established single access points (*Punti Unici di Accesso*, PUA) within community health centres (*Case della comunità*) to provide dependent elderly people and their caregivers with information and administrative support.

Finally, Slovenia's new LTC insurance, introduced as part of the 2023 Long-Term Care Act, is financed through compulsory contributions and state budget funds. The contribution rate is set at 1 percent for employees, employers and pensioners from net pensions, and 2 percent in some specific cases, such as for self-employed persons or individuals working in agricultural activities. On top of this, €190 million annually will come from the state budget.

## **6 Takeaways from recent reform efforts to reduce the care gap**

Our analysis of LTC reform measures since 2015 in Germany, France, Slovenia, Italy and Denmark highlights the diverse approaches European countries have taken to address the care gap. In this section, we cluster initiatives into different groups to identify patterns of LTC reforms across countries, and to highlight some limitations.

Measures to address the supply of LTC are much more prevalent than actions impacting demand. Most measures to increase supply focus on workforce attractiveness. Overall, these measures directly

impact the attractiveness of the sector by attracting more people or by retaining the current staff, and also indirectly impact the social recognition of LTC workers, thereby impacting the supply side of the care gap.

**Wages.** Measures increasing wages are the most popular tool to increase the attractiveness of the LTC sector for current and prospective workers. Germany and France have implemented increases in wages for the LTC workforce to retain current staff and to attract new workers, thereby impacting both the intensive and extensive margins. In Germany, the introduction of minimum staffing levels also aims to reduce the strain on existing staff and increase staff numbers to ensure adequate quality of care. Denmark more specifically used bonuses and increases in wages to encourage full-time employment and provide incentives to work irregular shifts.

However, these wage increases may fall short of fully addressing the challenges in the sector. For instance, in Germany, the minimum wage across all sectors is set to rise by 30.5 percent between early 2022 and 2025, while minimum wages for LTC workers will see increases ranging from 28.2 percent to 33.1 percent. This suggests that the sector-specific increases, though significant, are relatively similar to overall wage growth.

**Table 4: Minimum hourly wage overall**

January 1, 2022	€9.82
July 1, 2022	€10.45
October 1, 2022	€12
January 1, 2024	€12.41
January 1, 2025	€12.82
Total % change	30.5%

**Table 5: Minimum hourly wage LTC sector**

Unskilled workers	from 01.05.2022	€12.55
	01.05.24 to 30.06.25	€15.50
	01.07.25 to 30.06.26	€16.10
	Total % change	28.2%
Skilled workers, carers	from 01.05.2022	€13.20
	01.05.24 to 30.06.25	€16.50
	01.07.25 to 30.06.26	€17.35
	Total % change	31.4%
Skilled workers with additional qualifications, qualified carers	from 01.05.2022	€15.40
	01.05.24 to 30.06.25	€19.50
	01.07.25 to 30.06.26	€20.50
	Total % change	33.1%

Source: Destatis.

In France and Denmark, wage increases have targeted the broader healthcare sector; among LTC workers nurses in particular have benefited. However, as highlighted by OECD (2023a), much of the LTC workforce comprises personal care workers, who are excluded from these wage adjustments. This limitation underscores the need to better recognise and value the contributions of less-skilled workers to effectively address the unique challenges faced by the LTC workforce.

In France, the increase in wages offered to those who work in LTC represented an increase of about 5 percent of net wages, depending on the activity, and only covered parts of the workforce (DREES, 2024). In Denmark, the wage rise is structured with a 5.81 percent increase in 2024 followed by a 2.99 percent increase in 2025 for all healthcare workers; nurses can have an extra increase if they work irregular shifts. As shown by Figure 5, before these increases, average wages in 2018 in most residential and non-residential care jobs were approximately 20 percent lower than the average in the economy. These factors call into question if the reforms make the LTC sector significantly more attractive relative to other sectors. Therefore, further incentives are direly needed to attract workers.

**Training and attraction of foreign workers.** Another set of popular measures aims to attract new workers to the sector by promoting training and lowering barriers to entry. Slovenia will financially support training programmes using Recovery and Resilience Facility<sup>22</sup> (RRF) funds. Germany standardised nursing training and started several programmes to subsidise training. Additionally, both Germany and Denmark have introduced various measures to attract prospective care workers from non-EU countries, making it more appealing for these individuals to emigrate and work in the care sector. Germany also eased conditions to stay in the country for immigrants who trained to become care workers in Germany.

This approach helps fill local shortages by facilitating the immigration of skilled non-EU workers. However, this cannot be a long-term solution. There is clearly the risk of further straining the already fragile health systems in the countries of origin of non-EU workers, potentially compromising their capacity to provide adequate healthcare to their own populations.

**Reducing the administrative burden.** By reducing administrative burdens, care workers can dedicate more time to direct patient care, thus reducing the need for additional staffing. Slovenia, Germany and France have invested in digitalisation to ease the administrative load on formal LTC workers. Meanwhile, Denmark and Italy have reduced bureaucratic requirements. For example, Denmark has removed several regulations for municipalities, including those concerning annual quality standards, supervision policies and mandatory preventive home visits for individuals over 70.

Another set of measures to increase the supply of formal LTC goes beyond the workforce and relates to the organisation of services, as well as investment in infrastructure.

**Changes to the governance of formal care.** The countries under study have implemented several measures aiming to improve the efficiency of LTC systems and service delivery, hoping to affect the supply of services. In Germany and Denmark, recent reforms have allowed municipalities to establish care centres, shifting responsibilities from central to local governments. In Slovenia and Italy, on the other hand, we can observe a shift from decentralised authorities to centralised government. Italy reduced the number of examinations necessary in the assessment procedure, now involving only one regional authority and one central government authority instead of six different institutions.

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<sup>22</sup> The RRF is part of the NextGenerationEU initiative, the EU's post-COVID-19 pandemic economic recovery plan.

Furthermore, the central government is taking a leading role in developing standards and models for community health centres, while community care policy has historically been very decentralised in the country (Cinelli and Fattore, 2024). Slovenia has only recently defined national criteria for the assessment of LTC needs, similar to those used in Germany.

**Investment in infrastructure.** All countries under study recently increased investment in LTC infrastructure to increase supply. In Germany and France, resources were made available for the refurbishment of individuals' homes or existing care facilities, and for the building of new care and healthcare facilities. France's *Ségur de la Santé* initiative outlines a comprehensive investment push in digital healthcare, focusing on the deployment of digital patient records, expanding telemedicine but also the development of artificial intelligence to support professionals. Denmark, on the other hand, has established regional health clusters to consolidate LTC services and concentrate expertise, potentially reducing the need for additional staffing. Italy and Slovenia have planned investments in LTC infrastructure using resources from the RRF.

**Informal care.** Recognising that informal care is a demanding activity that is essential to alleviate pressures on formal care systems, several countries have introduced measures to support informal carers.

France and Slovenia have introduced respite care and France has also introduced paid care leave for informal carers. Care leave also exists in Germany, Denmark and Italy. In Germany, France and Denmark this includes pension contribution subsidies for time spent caring outside of maternity leave and childcare. Respite care also exists in Denmark and Germany, and Germany decided recently to expand respite care by increasing the duration and by making it more accessible. In its landmark LTC reform, Slovenia introduced partial income replacement for carers, although based on the national minimum wage and not on the carer's previous employment. Therefore, paid leave for care and different forms of financial support are widely utilised measures to support informal carers. By offering the opportunity to earn a professional certificate, Italy and France aim to increase the number of formal caregivers. The skills acquired through informal care can help bridge the gap in formal care.

Financial subsidies can thus reduce the opportunity cost for informal carers and provide, at least in the short term, relief for formal care systems. However, one needs to be mindful of the potential adverse effects on labour supply, particularly for women, if more people choose to provide informal care. Nevertheless, this risk might be exaggerated. In Japan, for instance, despite having one of the highest old-age population shares in the world, there is a considerably higher female labour supply than in the US or the EU (Pinkus and Ruer, 2024). It should also be borne in mind that even though informal caregivers might get some training, they often lack the skills to provide proper care, which can result in suboptimal or even harmful outcomes for care recipients.

Efforts to address the *demand* for formal LTC services have been less prevalent.



**Expansion of LTC benefits.** Germany has significantly expanded the conditions covered by formal LTC services, including recognising psychological and mental conditions, resulting in a 20 percent increase in LTC recipients from 2016 to 2017. Similarly, Slovenia's creation of LTC insurance comes with a new assessment tool based on eight criteria similar to those used in Germany, likely increasing the number of people eligible for formal care services.

Expanding LTC benefits can widen the care gap, but it may still be desirable from a health and welfare perspective. It makes thus sense that rather than reducing demand, policymakers have focused on increasing supply. Furthermore, more people accessing LTC services can also serve as a preventative measure, reducing future demand for care as people age. Such efforts are therefore highly relevant, and it should be highlighted that prevention is already a major part of Denmark's LTC system.

## 7 Conclusion

In this paper, we take stock of recent long-term care reforms in five EU countries: Germany, France, Italy, Slovenia and Denmark. We find that recent efforts to reduce the care gap, ie the difference between demand for and supply of long-term care services, has focused firmly on increasing the supply of LTC services. Governments in the countries under study have not reduced LTC entitlements or toughened eligibility criteria. On the contrary, we see a tendency to increase benefits.

Reforms to increase the supply of formal LTC services have mainly focused on two aspects. First, governments have sought to make the LTC sector more attractive for workers by raising wages, reducing the administrative tasks of care workers and other efforts to improve working conditions. Germany has also instituted minimum staffing levels to encourage training and hiring, as well as expanded subsidies for training. Second, all governments have invested in refurbishing existing care infrastructure and the construction of new infrastructure.

Governments are also recognising that formal care systems alone will not be able to shoulder the incoming care wave. Thus, steps have been taken to support informal carers. Such measures include more financial support for informal carers and increased opportunities to take short-term breaks from caring responsibilities.

We also see that the scale and level of ambition of reforms differ between countries. Countries with more developed LTC systems – proxied by spending on health LTC – ie Germany, France and Denmark, have taken measures to directly close the care gap. There is a strong focus on addressing care workforce shortages by improving working conditions, raising wages and attracting more professionals to the sector. In contrast, the countries with less developed LTC systems have aimed for more fundamental reforms to their care systems. Slovenia is establishing a comprehensive LTC system for the first time, while Italy is aspiring to a large-scale reform. However, implementation in Italy has been slow, likely due to LTC not being a top policy priority. This is reflected in Italy's public LTC spending, which remains below 0.7 percent of GDP despite the country's advanced stage in the ageing process.

Italy is not unique in this regard. Examination of recent LTC reforms raises the question of whether LTC is really a policy priority.

The measures taken to increase wages in the sector, while appearing significant at first glance, might not make the LTC sector considerably more attractive than other sectors. In Germany, the sectoral LTC minimum wage has broadly evolved in line with the general minimum wage, while in the other countries the increases are unlikely to make up for the significant initial wage gap between the LTC sector and other sectors.

Low wages can be explained by, for example, the lower levels of education or the higher proportion of women in the sector. For instance, even though the majority of LTC workers are female, a gender pay gap of 7.6 percent has been found among LTC workers in similar jobs and with similar characteristics (OECD, 2023a). Despite long-standing labour shortages in the LTC sector, wages remain strikingly low. In theory, excess demand for workers should drive wages up to attract more labour and balance the market through higher service costs. However, low wages and worker shortages persist.

Several factors could explain why wages do not increase more. First, LTC workers often have limited bargaining power in the labour market. Second, various mismatches exist, including geographic disparities between rural and urban areas, timing mismatches between worker availability and the moment where carers are most needed, and skill gaps. Third, the sector suffers from public underfunding (OECD, 2023a). These issues contribute to the persistence of low wages in the LTC sector, even as political attention has been directed at workforce shortages. In many cases, the needs of the ageing population appear to be overshadowed by other public spending priorities.

Low wages make it hard to attract more workers, but working conditions also play an important role. The high proportion of migrant workers in the field can explain poor working conditions, as does the overrepresentation of women in the workforce, as both of these groups generally suffer from worse working conditions. Women not only dominate the LTC sector but are also disproportionately likely to require care in old age and face a greater risk of poverty. Given that the LTC workforce is predominantly female, simply raising wages may not sufficiently incentivise longer working hours, particularly given the challenges for work-life balance of evening, night and weekend shifts.

Therefore, policies that support families, such as flexible childcare, will be important in sustaining the LTC workforce. Germany's initiatives to improve compatibility between care work and family responsibilities —for instance, by offering childcare facilities with flexible hours —serve as promising models. Beyond this, addressing stereotypes and gender biases is critical. Women are often perceived as 'natural' caregivers. Therefore, it is important to not only fight gender discrimination in the labour market but also gender norms and stereotypes more generally, in order to reshape the distribution of care responsibilities. Expanding hiring efforts to include more men could help address workforce shortages and alleviate outdated gender norms.

Given the persistence of shortages of LTC workers across EU economies, governments should explore all options to make the sector more efficient. Investment in robotics could alleviate the physical and administrative burdens on caregivers, boost productivity and make the sector more appealing. Lee *et al* (2024) found that in Japanese nursing homes, the use of robots was associated with improved care quality – demonstrated by reduced restraint use and pressure ulcers – and increased productivity, alongside higher employment and retention rates among workers. However, the use of and investment in robotics in the care sector still remains low in Europe.

Policy options are also needed to ensure fiscal sustainability. It would be beneficial to explore innovative private contribution options and pre-funding mechanisms. The introduction of Slovenia's LTC insurance or Germany's LTC fund could provide useful avenues for the future. Improving the targeting of LTC benefits can also promote adequacy. In all countries except Italy, public benefits are targeted to those with greater needs. Finally, promoting healthy ageing and productivity improvements could help contain costs (OECD, 2024).

The incoming care wave will have major consequences for all European economies. To design effective policies, further research on the effects of LTC reforms on the broader economy is needed. Future research should investigate the effectiveness of different policies that increase formal and informal care supply. Women in particular could be negatively affected if the reliance on informal care is not reduced, or if the distribution of care responsibilities does not change. Another interesting avenue for research is to understand the complex relationship between formal and informal care, taking into account personal preferences and cultural factors. How reforms to formal care systems will impact informal caregiving will be crucial to design efficient policies.

## References

- Baeten, R., S. Spasova, B. Vanhercke and S. Coster (2018) *Inequalities in access to healthcare. A study of national policies*, European Social Policy Network (ESPN), European Commission
- Belmonte, M., S. Grubanov-Boskovic, F. Natale, A. Conte, A. Belanger and P. Sabourin (2023) *Demographic microsimulation of long-term care needs in the European Union*, Publications Office of the European Union
- Brugiavini, A., L. Carrino and G. Pasini (2023) 'Long-term care in Italy', in J. Gruber, K. McGarry, and C. Hanzel (eds) *Long-term Care around the World*, National Bureau of Economic Research
- Brunel, M., J. Latourelle and M. Zakri (2019) 'Un senior à domicile sur cinq aidé régulièrement pour les tâches du quotidien', *Études et résultats* 1103(6)
- Christiansen, T. and K. Vrangbæk (2018) 'The Danish Long-Term Care System', *Health Policy*
- Cinelli, G. and G. Fattore (2024) 'The 2022 community-based integrated care reform in Italy: From desiderata to implementation', *Health Policy* 139: 104943
- D'Alfonso, A. (2024) 'Italy's National Recovery and Resilience Plan: Latest state of play', *Briefing*, European Parliamentary Research Service
- Da Roit, B., B. Le Bihan and A. Österle (2007) 'Long-term care policies in Italy, Austria, and France: variations in cash-for-care schemes', *Social Policy & Administration* 41(6): 653-671
- DREES (2024) 'Les salaires dans les établissements de santé', in Direction de la recherche, des études, de l'évaluation et des statistiques, *Les établissements de santé en 2022*, Édition 2024
- European Commission (2021a) *Long-term care report – Trends, challenges, and opportunities in an ageing society*, Volume II, Country profiles, Publications Office of the European Union
- European Commission (2021b) *Study on exploring the incidence and costs of informal long-term care in the EU*, Publications Office of the European Union
- European Commission (2024) *The 2024 Ageing Report. Economic and Budgetary Projections for the EU Member States (2022-2070)*, Publications Office of the European Union
- Geyer, J., A.H. Börsch-Supan, P. Haan and E. Perdrix (2023) 'Long-term care in Germany', in J. Gruber, K. McGarry, and C. Hanzel (eds) *Long-term Care around the World*, National Bureau of Economic Research
- Gerlinger, T. (2020) 'Long-term care insurance in Germany: Facing a paradigm shift in financing?' *ESPN Flash Report* 2020/63, European Social Policy Network (ESPN), European Commission

- Gisserot, H. and E. Grass (2007) *Perspectives financières de la dépendance des personnes âgées à l'horizon 2025: prévisions et marges de choix*, Paris: Cour des comptes
- Gørtz, M., B.J. Christensen, and N.D. Gupta (2023) 'Long-term care in Denmark', in J. Gruber, K. McGarry, and C. Hanzel (eds) *Long-term Care around the World*, National Bureau of Economic Research
- Gruber, J., K.M. McGarry and C. Hanzel (2023) *Long-term care around the world*, National Bureau of Economic Research
- Haberkern, K., T. Schmid and M. Szydlik (2015) 'Gender differences in intergenerational care in European welfare states', *Ageing & Society* 35(2): 298-320
- Jessoula, M., E. Pavolini, M. Raitano and M. Natili (2018) *ESPN Thematic Report on Challenges in Long-Term Care—Italy*, European Commission
- KL (2021) 'Udbud af og efterspørgsel efter udvalgte velfærdsuddannelser – 2021', Local Government of Denmark, available at <https://www.kl.dk/media/0dymcnd3/udbud-og-efterspørgsel-efter-udvalgte-velfaerdsuddannelser-2021.pdf>
- Lee, Y.S., T. Iizuka and K. Eggleston (2024) 'Robots and Labor in Nursing Homes', *NBER Working Paper* No. w33116, National Bureau of Economic Research
- McGrath, J. (2021) *Report on labour shortages and surpluses*, Publications Office of the European Union
- OECD (2018) *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, Organisation for Economic Co-operation and Development
- OECD (2023a) *Beyond Applause? Improving Working Conditions in Long-Term Care*, Organisation for Economic Co-operation and Development
- OECD (2023b) *Health at a Glance 2023: OECD Indicators*, Organisation for Economic Co-operation and Development
- OECD (2024) *Is Care Affordable for Older People?* OECD Health Policy Studies, Organisation for Economic Co-operation and Development
- Pezzin, L.E., R.A. Pollak and B.S. Schone (2008) 'Parental marital disruption, family type, and transfers to disabled elderly parents', *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 63(6): S349-S358
- Pinkus, D., S.E. Hougaard Jensen and A. Börsch-Supan (2023) 'The Care Wave and the Future of the Baby Boomers and their Children', available at <https://www.mea-share.eu/bb-future/>

Pinkus, D. and N. Ruer (2024) 'Beyond retirement: a closer look at the very old', *Analysis*, 30 April, Bruegel, available at <https://www.bruegel.org/analysis/beyond-retirement-closer-look-very-old>

Pavolini, E., C. Ranci and G. Lamura (2016) 'Long-term care in Italy', in B. Greve (ed) *Long-term Care for the Elderly in Europe*, Routledge

Rocard, E. and A. Llana-Nozal (2022) 'Supporting informal carers of older people: Policies to leave no carer behind', *OECD Health Working Papers* No. 140, Organisation for Economic Co-operation and Development

Steinbach, A., K. Mahne, D. Klaus and K. Hank (2020) 'Stability and Change in Intergenerational Family Relations Across Two Decades: Findings From the German Ageing Survey, 1996–2014', *The Journals of Gerontology: Series B* 75(4): 89-906

Wenger, G.C., A. Scott and N. Patterson (2000) 'How important is parenthood? Childlessness and support in old age in England', *Ageing & Society* 20(2): 161-182

WHO (2010) *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*, World Health Organisation

WHO (2022) *Rebuilding for sustainability and resilience: strengthening the integrated delivery of long-term care in the European Region*, WHO Regional Office for Europe, World Health Organisation

WHO (2024) 'Long-term care financing: lessons for low- and middle-income settings', *Brief 3*, How countries finance long-term care, World Health Organisation

## Appendix 1: More detail on residential and home care services

The German LTCI offers respite care, with a stand-in caregiver is provided for up to six weeks a year if the primary caregiver is unavailable due to holidays or other reasons. Part-time institutional care is available, covering day and night care in a facility, with LTCI covering the costs of care, social support and medical treatment. Short-term care is also provided in appropriate facilities for those who need full-time residential care for a limited period, such as during crises in home care or following a hospital stay.

In France, medical residential facilities include residential nursing homes (EHPAD). EHPADs are for individuals over 60 who require regular care, medical supervision and assistance with daily activities. Recent reforms aim to expand the role of EHPADs as geriatric resource centres, providing services in the community and supporting older individuals living at home. Non-medical residential facilities include social residences and private care homes. Social residences are regulated and partly funded by local authorities, intended for individuals who can perform personal activities of daily living (ADL) but require assistance with instrumental ADL and recreational activities. Private care homes, on the other hand, are not regulated by local authorities, and their prices are not fixed.

Home care services in France are provided through home care nursing services (SSIAD) and home care and support services (SAAD). These are not regulated and private companies are also providing home care services. SSIADs offer medical and technical nursing services prescribed by physicians, while SAADs provide personal and social care services, assisting with both ADL and IADL. Efforts have been made to integrate these services under multipurpose structures called SPASAD, but their development has been limited.

Since 2005 each *département* has provided a local home for persons with disabilities (*Maison départementale pour les personnes handicapées*, MDPH), that assesses and determines the eligibility and level of allowances for people with disabilities, considering the degree of disability and difficulty with ADL.

Different schemes have been implemented to facilitate the relations between the different professional actors such as MAIA (method for integrated care in the sector of autonomy – *méthode d'action pour l'intégration d'aide et de soin dans le champ de l'autonomie*), the PAERPA (elderly people at risk of loss of autonomy – *personnes âgées en risque de perte d'autonomie*) and the PTA (territorial support platforms for coordination – *plateformes territoriales d'appui*).

In Italy, residential care (*Residenze Sanitarie Assistenziali*, RSA) is mostly provided through nursing homes, with admission based on needs and income levels, making co-payments a significant factor. Similar facilities exist for disabled individuals (*Centri Diurni per Disabili*, CDD). Additionally, integrated day centres (*Centri Diurni Integrati*, CDI) offer social and health care services to people over 60. The National Health Service (*Servizio Sanitario Nazionale*) guarantees home care to non-self-sufficient or frail individuals, fully funded as part of the national benefits package after a multidisciplinary

evaluation of the patient's health and social condition. Home care services are divided into integrated home care (*Assistenza Domiciliare Integrata*, ADI), managed by local health authorities (*Aziende Sanitarie Locali*, ASL), and home care service (*Servizio di Assistenza Domiciliare*, SAD), managed by municipalities. ADI includes medical, nursing, and rehabilitation treatments integrated with social-assistance services, while SAD focuses more on social support. Brugiavini *et al* (2023) found that the majority of care recipients, 55 percent (47.2 percent among those aged 85 and older), receive only informal home-based care. In contrast, only 21.3 percent (23.5 percent among the 85+ group) receive solely formal home-based care. The share of respondents receiving a combination of both informal and formal care is 15.4 percent in the 65+ sample and 20.7 percent in the 85+ sample. Lastly, the proportion of individuals receiving institutional care is slightly more than 8 percent for both age groups.

Finally, in Denmark, home care is divided into two categories: practical help (eg cleaning and laundering) and personal care (eg bathing and shaving). These services are provided free of charge by the municipality. When elderly individuals need an alternative living arrangement for health reasons, they are offered a more suitable residence based on their needs and wishes. Housing options include nursing homes (*plejehjemsboliger*), sheltered housing (*beskyttede bolige*), elderly care homes (*plejeboliger*), senior citizen residences (*almene ældreboliger*) and private care accommodation (*friplejeboliger*). After going on a waiting list, an elderly person must be offered within two months a place in a nursing home (*plejehjem*) or in elderly housing (*plejebolig*).

In Slovenia, institutional care has traditionally been well-developed, with the number of care institutions steadily increasing since 1990. Home care for the elderly includes community nursing and home help services. Community nursing is provided by community nurses based on instructions from a family physician. This service focuses on delivering medical care to patients at home or in social institutions and is fully covered by compulsory health insurance. Community nurses are employed by geographically dispersed healthcare centres across Slovenia.

Home help services are available to individuals whose physical and mental capacities allow them to function at home with occasional organised assistance. This includes people over 65 who, due to age-related factors, are unable to live independently. To access home help, individuals must complete a request form and submit it to their local Centre for Social Work. A social worker then visits the applicant to assess their needs and collaboratively determine the necessary services.

Home help is funded through a combination of user contributions and municipal budgets, with user fees determined based on income across 10 brackets. The local Centre for Social Work can grant full or partial exemptions from payment for long-term care services, depending on the user's financial capacity and a spending cap. Any uncovered costs for long-term care services are subsidised by the municipality or central government.



## Appendix 2: Detailed information on leave provisions

In Germany, employees are entitled to up to 10 working days of short-term care leave without prior notice. This entitlement is applying to all employees regardless of the company size. However, the statutory right to six months of care leave is restricted to employees in companies with more than 15 employees, as per the 2008 Caregiver Leave Act (PflegeZG). To help compensate for the loss of income during this leave, employees can receive an interest-free loan. For companies with more than 25 employees the Family Caregiver Leave Act (FPfZG) allows employees to work part-time (a minimum of 15 hours a week) for up to 24 months if the six months of caregiver leave were insufficient. Finally, employees are also entitled to take full-time or part-time leave to care for a close relative suffering from an incurable advanced illness under the end-of-life caregiving provision.

In France, in 2015 a reform changed the family support leave, making it 'leave for informal caregivers'. The same year, respite care and occasional financial assistance for APA beneficiaries in cases when their caregiver is hospitalised were introduced.

In Italy, care leave is granted to public and private employees caring for severely disabled relatives and children, based on the 'sole carer' principle (Law No 183/2010), which restricts care leave to one worker per household for a severely disabled person. This leave is fully remunerated and includes pension coverage (*contributi figurative*), meaning that the National Institute of Social Security contributes to the pension system during times of leave. Beneficiaries are entitled to three working days per month (at 100 percent of the last salary) even if they do not live with the care recipient, and up to two years of paid leave (at 100 percent of the last salary, with an annual cap of €56,586.00 in 2024), provided they live with the care recipient.

In Denmark, the municipality can employ informal carers for up to six months<sup>23</sup> for a close relative if specific conditions are met: i) that the alternative to care in the home is 24-hour accommodation outside the home, ii) that the need for care is equivalent to full-time work, iii) that the informal carer and the sick person agree on the caregiving relationship, and iv) that the local authority assesses that the informal carer can cope with the task. Furthermore, relatives can apply for a care allowance to look after a close relative or friend who is dying and who wishes to die at home; relative carers are entitled to leave from work during this period. The care allowance cannot exceed the relative's current income and is equivalent to 1.5 times the sickness benefit amount the relative carer would receive if ill. Multiple relatives can share caregiving duties and the care allowance, but the total amount cannot exceed 1.5 times the maximum sickness benefit. Furthermore, employees are entitled to five working days of carer's leave each calendar year, although it is not guaranteed to be paid.

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<sup>23</sup> The carer will receive a salary of DKK 26,018 (€3486) per month in 2024; however, this amount cannot be greater than what is paid by the current employer. The carer also retains the right to unemployment benefits and holiday pay.



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