



# Building ‘implicit partnerships’? Financial long-term care entitlements in Europe

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## Abstract

The design of public subsidies for long-term care (LTC) programmes to support frail, elderly individuals in Europe is subject to both tight budget constraints and increasing demand pressures for care. However, what helps overcoming the constraints that modify LTC entitlements? We provide a unifying explanation of the conditions that facilitate the modification of public financial entitlements to LTC. We build on the concept of ‘implicit partnerships’, an implicit (or ‘silent’) agreement, encompassing the financial co-participation of both public funders, and families either by both allocating time and/or financial resources to caregiving. Next, we provide suggestive evidence of policy reforms modifying public entitlements in seven European countries which can be classified as either ‘implicit user partnerships’ or ‘implicit caregiver partnerships’. Finally, we show that taxpayers attitudes mirror the specific type of implicit partnership each country has adopted. Hence, we conclude that the modification of long-term care entitlements require the formation of some type of ‘implicit partnership’.

**Keywords** Implicit partnership · User partnership · Caregiver partnership · Partial insurance · Cost sharing · Long-term care · Financial sustainability · Family · Europe

## Introduction

Long-term care (LTC) for older people refers to personal and nursing care services designed to provide support in essential aspects of daily living. A defining feature of LTC is that its typically far less subsidised than other welfare services in most European countries.<sup>1</sup> However, many European countries are experiencing rising demands for services, and in such countries unsatisfied demands are labelled as a ‘social care crises’. The origins of such demand boost include both demographic (population ageing) and social changes (reduced availability

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<sup>1</sup> Need for LTC is commonly discussed in terms of ADLs ‘Activities of Daily Living’ and IADLs ‘Instrumental Activities of Daily Living’.

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of informal care support). However, what is especially noticeable is that both demand and reform trajectories are heterogeneous across countries. Such expansion of demand is already placing a strain, although in a different degree, on the financial suitability of the provision of LTC in most European countries. Yet, only in some cases, it casts doubts about the sustainability of the system.<sup>2</sup>

It is fair to say that LTC has been at the forefront of health care and social protection debates in Europe for the last two decades in several countries (OECD 2011). This is because the financial coverage for LTC was formalised later than other social services. Although austerity policies after the Great Recession have constrained the expansion of public sector involvement, LTC reforms have been implemented in the form of public subsidies to either increase the access to nursing home and home care or, to provide care recipients and their families with the means to sort their caregiving needs using private or informal sources. Subsidies have adopted different designs; in some countries, they have been presented as conditional supports on the reception of care, such as in the Netherlands and the UK, and in others, they have been designed to be unconditional allowances transferred to the care receiver without a specific pre-defined budget, such as in Spain. However, irrespectively of the country examined, the expansion, or even the universalisation of long-term care refers to, access to care alone, and does not entail full financing of caregiving needs. Hence, most individuals still have to co-finance part of their care, except for those who fall behind income thresholds who qualify for additional means-tested support. In some Southern European countries, only a share of the population is allowed access to public subsidies, as support is means-tested. However, even in countries where support is universal, it is always subject to needs tests, which can be stringent, or moulded to be stronger over time.

The delineation of entitlements to public subsidies for LTC services has proven arduous and has resulted from a lengthy process in many European countries. This is especially the case in countries that, though at different time periods, have universalised the access to LTC such as Netherlands (which was the first country to universalise access to care in 1969), Germany (which established a social insurance scheme in 1994) and Spain (which developed a universal tax funded system in 2007). However, in characterising the models of care, one can distinguish two drivers of universalisation, namely (1) support for female labour market participation in Northern European countries and (2) support for struggling families, mainly in Southern European countries. However, the analysis of the conditions for LTC support is still at its infancy, with few exceptions (Ranci and Pavolini 2015). While in England LTC reforms have not moved beyond the ‘public debate stage’, or even governmental commissions, the scope of such reforms has often narrowed substantially during its implementation, if not failing completely (Riedel and Kraus 2011; Costa-Font 2010). In some cases, such as in Spain, the financial entitlement has been significantly reduced after its implementation amidst austerity reforms in 2012 (Costa-Font et al. 2016). When reforms have exhibited success, an essential constraint to the expansion of public LTC coverage<sup>3</sup> has been ensuring jointly, short-term cost-containment and longer-term financial sustainability, in addition to securing public support. Existing research has not given

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<sup>2</sup> For example, in 2015 in the Netherlands, the responsibility of non-residential services was shifted to a new less generous fund (WMO), the municipalities.

<sup>3</sup> We use the term coverage to denote both financial and provision-related generosity of the LTC system, for instance both the share of those with need that indeed receives public services (note that informal care is often counted as ‘unmet need’) and once a user is receiving services—what proportion of the cost is covered. The latter can be thought of as the individual intensity of provision relative to the total cost.

much attention to the conditions that open the door to the re-design of LTC subsidies in a way that they are financially sustainable. This paper tried to fill the gap by examining the conditions that allow the extension of a partial coverage which we define as an ‘implicit partnership’.

This paper adds to the literature by introducing the concept of ‘implicit partnerships’ (IPs) as a way of explaining the modification (expansion and contraction) of LTC entitlements. In a nutshell, an ‘implicit partnership’ refers to implied financial agreement involving the co-participation of public stakeholders (central, regional or local), in addition to, or conditional upon, contributions of private stakeholders such as users, relatives or the community. Contributions can be in the form of time devoted to informal care (and hence not to producing rents from employment) or monetary contributions, such as users’ fees or cost sharing (co-payments or deductible) to pay for personal care. Finally, we show that implicit partnerships are far from stable over time and, typically, require adjustments to changing circumstances (e.g. retrenchment in the Netherlands or public funding expansion in Spain). Consistently, some countries redefine their partnership terms (the ‘implicit contract’) over time.

Furthermore, we argue that the IP concept enables us to interpret the variation of LTC financial entitlements in European countries. The implicit partnership notion aligns with key values of many European welfare systems: collaboration, co-production and the importance of welfare policy in electoral politics, which we argue facilitate LTC reform. Second, we report evidence suggesting that attitudes towards care are consistent with the type of implicit partnership model observed in each country. To do so, we compare a set of countries, heterogeneous in reform trajectories. The sample includes cases of LTC coverage expansion (Germany, France and Spain), retrenchment (Netherlands and Sweden) and stability (England and Italy). We draw on academic and documentary evidence to analyse reform trajectories alongside quantitative survey data from the Eurobarometer which captures public preferences for the organisation of LTC services. The latter is important insofar as supportive public attitudes have been found to open up political, or electoral opportunities for reform (Blekesaune and Quadagno 2003).

Evidence from the set of European countries examined is consistent with the development of two forms of IPs, namely ‘implicit user partnerships’, where the policy focus is on cost sharing of formal services, mainly home care, and ‘implicit caregiver partnerships’ where the policy focus is on incentivising and supporting informal care provision through cash-for-care schemes, which entail a high reliance on cash benefits as a means of sustaining or expanding coverage of LTC financing. We further find that the type IP each country adopts in our sample tallies with domestic public opinion favouring formal relative to informal care, i.e. the level of familism (Leitner 2003).

The paper is structured as follows: the next section discusses the characteristics and challenges to LTC reform, and the following defines the concept of ‘implicit partnerships’ and its types in the selected European countries. Next section reports and discusses the quantitative evidence of public opinion data and discusses the relation with the typologies of IP in all countries selected. A final section provides a concluding discussion.

## Reform and long-term care coverage

Welfare reforms, taking place in the current era of permanent austerity, usually preserve the status quo, and encompass the retrenchment of public financing (Pierson 2001), including limits on the extension of public subsidies. There is extensive literature (see, for example, Korpi and Palme 2003) on the drivers of social protection reforms which acknowledge the fact that governments face a range of financial and social constraints when seeking to expand public funding of social services. Accordingly, in the case of LTC, the main constraint to expanding the coverage is financial sustainability (OECD 2011). This is the case when universal coverage, defines some form of entitlement, which is a significantly more costly alternative (Lave 1985).

However, this characterisation often ignores that in some areas such as long-term care, the unsatisfied demand is continuously expanding, and countries define partial entitlements where reform-increasing subsidies come together with significant user co-participation or contribution. The underdeveloped state of LTC coverage in many European countries makes financial sustainability an important concern to weigh against the increasing demand for LTC, underpinned by the loosening of family ties (Costa-Font 2010). Consistently, an emphasis on financial sustainability has led to a Europe-wide policy approach of limiting the expansion of residential care and instead favouring home-based care, including incentives for family involvement in the provision and organisation of care.

Public insurance expansion is likewise constrained by individuals' myopia with respect to the risk of needing LTC when making electoral choices. This behavioural anomaly includes some degree of denial, and a disinterest in the importance of LTC reform and the appropriate level of expenditure relative to other social expenditures (OECD 2011). Hence, ultimately the expansion of LTC entitlements becomes a political decision driven by the willingness of citizens (potential future users) to direct tax revenues towards LTC.

Another constraint to reform is the risk of moral hazard in relation to the uptake of LTC benefits. This is mainly prevalent when LTC subsidies take the form of cash benefits, as is the case in several of the countries we discuss below. The 'woodwork effect' denotes a situation where individuals who were previously eligible, but not claiming support, begin to enrol when LTC provision or payments become more attractive (Pauly 2004, Eiken et al. 2013). This is often the case with cash payments, and more specifically, when LTC users prefer informal care to receiving formal services, and would not accept services in kind, while finding cash payments acceptable (Chappell and Blandford 1991).

Similarly, another of the important motivations for reform lies in the inefficiencies of a limited health and long-term care integration. Indeed, the contrasting entitlements between health and long-term care and poorly funded LTC give rise to spillover costs onto health care, for example due to prolonged hospitalisation (Costa-Font et al. 2016, 2018).

Finally, the expansion of LTC entitlements does occur regardless of the constraints discussed above. We argue that these constraints alone do not necessarily impede reform, if coverage is expanded alongside the introduction of viable implicit partnerships. Such partnership or cost sharing can either take the form of co-payments at the point of use (the cost of which could be privately insured) and/or subsidies for families to take on caregiving in exchange for some public financial support. That is, coverage expansion is enabled by the creation of an implicit partnership: the involvement of the individual and the family in the responsibility for financing, provision and the organisation of care. The rest of the paper will elaborate on this point.

## Defining implicit partnership types

A set of conditions facilitate implicit partnership (IP) designs. These conditions are the partial nature of LTC coverage and its private (meaning family and not commercial) components: either as co-financing or co-producing care, however, importantly, without a clear ex-ante formalisation of duties and cost-bearing ex ante. IPs take the shape of a 'silent agreement' between government and society regarding the funding and provision of LTC. Consistently, Ranci and Pavolini observe that in relation to cuts to care provision, 'the introduction of specific regulations concerning the organisation of the care delivery and specific policy instruments allowed cuts in care provision without explicitly discussing the entitlement structure.' (2015: 282).

The notion of implicit partnership (IP) is particularly useful for understanding the public financing of LTC. IP are an alternative to funding models such as 'explicit (financial) partnerships', prevalent in the USA. Its origin comes from the application of the notion of implicit contracts to long-term care. A contract is implicit when it does not pre-specify the co-financing of care before the need arises (mainly because of limitations of interest representation in social policy making). However, such arrangement still exerts a similar effect as an explicit contract.<sup>4</sup> This involves using different forms of cost sharing (e.g. co-payments), but unlike explicit partnerships individuals cannot delimit the extent of public co-financing ex ante.

In contrast, an 'explicit partnership (EP)' refers to an explicit (and hence formalised) version of an IP, namely an agreement that specifies ex ante the stakeholder's contributions to newly funded care costs with the guarantee that the public sector will cover the remaining costs. Although there are no precedents of EP in Europe, some have been debated in many countries, including in the Royal Commissions for Long-Term Care Reform in England (Wanless and Forder 2006) and in France as discussed in Doty et al. (2015). In France, an explicit public/private partnership in LTC was debated; however, no progress has been made and there appears to be little political interest. Going forward, there is little prospect of an explicit coordinated strategy in France (Doty et al. 2015). Finally, in Spain, earlier drafts of the Dependency Act did consider a partnership design that included the co-participation of the private sector. In some European countries, EP was a 'theoretical' policy option, even though it did not reach such a category, and hence, it was never explicitly discussed.

The main advantages of EP designs are that they are transparent and the relative financial responsibility of the user and the state is made explicit. That is, it sets out the contribution expected from individuals in the financing of LTC. Such expected contribution can be either direct (user fee) or indirect by a possible intermediation of private insurance mechanisms. The latter is the case of the USA, in the context of Medicaid, which is the main funder of LTC in the country (Bergquist et al. 2015).<sup>5</sup> Long term care partnerships (LTCP) were designed with the purpose to reduce the uptake of Medicaid and so to meet

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<sup>4</sup> In many (even if not all) countries undergoing expansion of LTC provision, the (financial, caregiving, decision-making) involvement of families and other informal networks was openly discussed either as a necessary condition or as a desirable outcome of the reforms. However, the implicit nature of the partnership is not its discussion but that its implementation did not ex ante establish a specific level of co-participation in the financing of the services.

<sup>5</sup> Indeed, the long-term care partnership (LTCP) programme in the USA was an initiative designed to encourage middle-class individuals to purchase private long-term care insurance to cover at least the non-catastrophic costs of LTC.

comparable financial constraints that European countries face in setting out a LTC financing design. The English proposal resulting from the Dilnot commission can be defined as a form of EP, which is closer to the partnership design in the USA, but without the intervention of an insurance contract, as it defines a limit of funds 70,000£ (a private contribution) after which the NHS (just like Medicaid does with regard to the partnership design) subsidises the difference (Dilnot 2011).

The first condition supporting the IP hypothesis is the ‘partial universalism’ of public LTC coverage across Europe (Ranci and Pavolini 2015). In both residual (means-tested access to care) and universal systems, families or users are expected to contribute time and money towards the finance of any care needed. In France, for instance, beneficiaries are expected to contribute to the financing of a caregiving conditional cash allowance (APA) with a co-payment that is proportional to their income. Needs tests are employed to monitor demand in the UK, Spain and Italy where there is significant discretion in the assessment of eligibility. IPs are built around a reliance on cost sharing, predominantly through co-payments required by users, as ‘implicit user partnerships’. These rely on the willingness of users to pay at the point of use, but also significantly, a lack of public and political support to make the funding of LTC explicit, for example by creating insurance systems designed to account for co-payments. Implicit partnership arrangements also take place when relatives or members of the community deliver care themselves, instead of users paying for care. We define these as ‘implicit caregiver partnerships’. Informal carers allocate time away from other, paid or unpaid, duties such as employment, education or childcare and into caregiving. The reliance on family care can be explained by a number of factors: needs-testing may give access to formal services only to individuals with high needs; quality of formal services is often perceived to be low; accessibility of alternative sources of support can be an issue; and previous support for social care in most European countries has been irregular (Leitner 2003). Given the generally lower technical requirements of LTC provision, users’ preferences are more likely to influence the final service outcomes compared to healthcare services. Some research has found that most users and caregivers<sup>6</sup> prefer informal care over formal services (Chappell and Blandford 1991). The co-production of care services by informal caregivers is further incentivised through cash-for-care or cash benefit schemes, which have become commonplace under the ‘personalisation’ agenda (Glendinning et al. 2008). Ultimately, cash-for-care payments help keep users at home and some of the rationale for its implementation lies in that they bring significant savings, compared to subsidising community care (Da Roit and Le Bihan 2010; Roit and Le Bihan 2015).

## Implicit caregiver and user partnerships: the evidence

This section traces the broad reform trajectories and compares the formation of IPs on LTC in seven European countries: England, France, Germany, Italy, Spain, the Netherlands and Sweden. Historically, two generalised models of LTC have been discernible in Europe: a universal model (coverage above 20%) such as in Scandinavia (and the Netherlands) and a residual model where coverage was generally considerably lower (below 10%) and where

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<sup>6</sup> Nonetheless, there is some evidence suggesting negative impacts of caregiving on carers (Smith et al., 2014).

reliance on family care and a heavier reliance on other health services were common. This model is common in continental and Southern Europe. LTC models further range from highly integrated systems reliant on public provision with limited private alternatives, to systems with considerable family involvement together with a fragmented and residual public system (Lundsgaard 2005). This limits the type of IP developed in each country.

Sweden represents an 'old' LTC system, established in the 1940s, with tax-funded universal coverage and a reliance on the state as the main provider of care (Karlsson and Iversen 2010). However, in recent years Sweden has experimented extensively with privatised provision of care and choice for users, as well as increased levels of co-payments consistent with a 'user partnership' design (Blomqvist 2004). Similarly, the Netherlands has developed a universal LTC system established as early as the 1960s. Care is organised through social insurance funds and is mainly channelled towards formal nursing care or residential care homes but with users' autonomy over the organisation of care as a guiding principle. However, as of 2015, in the aftermath of the economic downturn, a major LTC reform took place with the purpose of containing expenditure and entailed a redefinition of the IP to adapt it to the new economic circumstances. Indeed, the set-up of the Social Support Act 2015 restricted the funding of the old generous insurance scheme (AWBZ), reduced the access to residential care and incepted personal budgets that are heavily scrutinised (Maarse and Jeurissen 2016). Non-residential services became the main responsibility of a less generous fund (WMO), the responsibility of which shifted to the municipalities.

The devolution of the British political system gave rise to diverging LTC systems: the Scottish system provides free home care and subsidies for nursing home care, whereas in England strict means testing is applied (Comas-Herrera and Pickard 2010). Scotland, unlike the rest of the UK, replaced the means-tested system in the rest of the UK after the implementation of the Community Care and Health (Scotland) Act abolishing all charges for personal care at home (although charges continued in place for non-personal care), and increased the flat-rate conditional cash subsidy (attendance allowance) for personal care compared to England. However, in the end, the overall entitlements were restricted by stringent needs tests and the overall costs of the reform were limited to about 0.2 per cent of Scottish GDP (Bell and Bowes 2006). In the rest of the UK, the extension of means testing to some form of universal entitlement has been heavily debated but with limited success.<sup>7</sup>

In contrast, Italy and Spain are the paradigm of caregiving IP, traditionally defined by low expenditure and care informally provided by family, friends and relatives (Costa-Font 2010). However, unlike the Netherlands, the IP partnership design was redefined in Spain to allow for further public funding. In 2007, the Dependency Act (*Sistema para el autonomía y la atención a la dependencia*, known by its Spanish acronym SAAD) expanded public coverage to universalise the access to care, subject to a needs test. SAAD allow individuals develop a care plan that involved either in-kind formal care provision or a caregiving allowance, so the system offers a choice between a user IP and a caregiver IP. This LTC system design mimicked some of the design characteristics (e.g. setting out a different subsidy by degree of dependency and type of care) of the

<sup>7</sup> The current English means-tested system implies a possible loss of up to 80% of total wealth for individuals within certain wealth segments (Dilnot 2011).



German scheme instigated in 1994 (see Rothgang 2010).<sup>8</sup> In 2011, caregiving allowances for major dependency could amount to 530€ and 300€ for the severely disabled which compare to a minimum wage of 641.40 €/month. Hence, there was a strong moral hazard incentive. Only a few months after the implementation of SAAD, about 50% of its beneficiaries were claiming caregiving allowances. The austerity reforms that took place in Spain in 2012 lead to a significant reduction of both the cash and the in-kind LTC subsidy by 25 and 15%, respectively (Costa-Font et al. 2016, 2018). Hence, consistently with the Netherlands, the IP was further redefined to adjust it to the new economic circumstances.

In Italy, the most common financial scheme has been the ‘companion allowance’ (CA), a cash allowance programme for individuals with severe disability, which provides support to 13.5% of the population and provides a cash transfer of 505€ in 2017 that compares in magnitude to the cash allowance defined in the Spanish SAAD (Pavolini et al. 2016). Again, like in Spain, the CA was affected by the austerity reforms as public funding for LTC services was slashed by 25% between 2005 and 2016 (Matteo et al. 2018). Only some regions such as Emilia Romagna topped up the CA with a means-tested cash allowance and expanded the support for home care. However, overall the system has remained cash-based over time and relies mainly on informal caregivers consistently with a caregiver IP design (Pavolini et al. 2016).

The German system on the other hand offers a universal entitlement channelled through social insurance funds and a choice of both in kinds and cash subsidies. Hence, individuals can choice between a user IP and a caregiving IP. Only a needs test restricts access to care, though the benefit levels often judged to being insufficient. In addition, means-tested social assistance plays a substantial role for people who are not able to meet the required co-payments (Rothgang 2010). However, for the majority of the population co-financing is the norm consistently with a user IP.

Finally, the French LTC system is distinct from the others in its mix of private and public care provision. The French model is based on cash payments with complementary insurance that encompasses low premiums and high uptake (Doty et al. 2015). Hence, it is an IP design, that is, it relies on shared co-financing of care, which is not explicitly defined ex ante. The fact that the main LTC scheme, the APA (Allocation Personalisee d’Autonomie), a caregiving cash allowance, is means tested has led to a demand for complementary insurance to cover the share of care not publicly funded. What sets France apart from the other countries is that there is a supply of private insurance, widely available through employment-sponsored insurance policies. Even though its share of LTC expenditure is low, private insurance covered as much as 11% of the French population in 2012 (Doty et al. 2015).

Table 1 summarises the diversity of the LTC systems surveyed. Particularly in terms of expenditure as a proportion of GDP, and the comprehensiveness of the coverage, we note marked differences. Entitlements are not the same across schemes within each country (e.g. universalism in some countries but not others). However, on the whole LTC spending is the highest in the Netherlands and Sweden (more than 3.5% of GDP) and the lowest in the Mediterranean countries. The level of coverage follows the same pattern. It should be noted that our estimates of coverage do not include cash benefits, in order to be comparable and to avoid double counting users. These play a substantial role in many of the systems, for example in England, universal disability benefits such as attendance allowance and disability living allowance cover over 27% of the population aged 65 and above. Similarly,

<sup>8</sup> However, in Spain the advocates of a Social Security-based German-style LTCI lost to those that proposed a tax-based and regionally organised LTC system social services.



**Table 1** Overview of institutional setting of the LTC systems

	Entitlement	Expenditure (% of GDP 2010)	Population coverage/65+	Financing	Cost sharing
France	Universal	1.27	12.1% (inst + home)	Decentralised (many actors—complex flows)	Income related—from 0–80% of total cost
Germany	Universal	1.44	11.3%	Mandatory social health insurance scheme	LTCI benefits are capped—user tops up, or means-tested social assistance supports
Italy	Universal	1.19	7.9% (inst + home)	Tax funded, fragmented (central, regional, local)	Substantial income-related co-payments—up to 100% of cost
Netherlands	Universal	4.1	19.6% (inst + home)	Mandatory social health insurance scheme	Co-payments by user related to income
Spain	Universal	1.11	10.2% (inst + home + telecare)	Mandatory central government	Co-payments by user related to income (up to 90% of cost) reserved amount
Sweden	Universal	3.65	16.6% (inst + home)	Decentralised	Co-payments by user related to income reserved amount
England	Means tested	1.97 (1)	11.8% (inst + home + DP/PB) 7.19% (inst + home)	Decentralised	Means-tested co-payments up to 100% of cost

Year: Expenditure from 2012. Sources: OECD Health Data 2010 (October 2010), ANCIEN study country reports. (1) Year 2010. 'Inst' refers to institutional care, 'home' refers to home care, and 'telecare' refers to telecare

cash benefits in Italy (the IDA) cover 12% of the elderly population, though they form an integral part of the public financing of care (Degavre and Nyssens 2012).

As anticipated, we find that in all of the countries examined, users are expected to share the costs of care, to varying degrees. Sweden and Spain operate systems of income-related co-payments up to thresholds defined by a 'reserved amount'. In all the systems except for Italy (except in Emilia Romagna) and England, some of the care costs are covered for all individuals, regardless of income. However, it is not uncommon that users pay a large proportion of care cost themselves, in all countries.

Policies supporting family care are common, however distinct in type, across countries. However, a noteworthy recent trend is the set up of cash-for-care schemes, which allow the user to purchase, or informally source, the care package desired. Cash-for-care (CfC) schemes are also attempts to enable people, who otherwise do not have means, to choose and control the services they need (Clarke et al. 2007; Ferguson 2007; Stevens et al. 2011; Beresford 2014).

Similar approaches to support to informal caregivers through cash benefits are the UK attendance allowance and its Swedish equivalent. The extent and trajectory of cash-for-care type schemes can be argued to illustrate the extent to which family care is seen as an essential LTC provision, and an illustration of 'implicit caregiver partnerships. Table 2 (unlike Table 1 which describes how different LTC systems are funded) outlines the cash-for-care schemes of the countries in our sample. These schemes are designed to allow individuals to either pay for family/informal care (favouring a caregiver IP) or to buy formal care (favouring a user IP). Yet, whether one option of another prevails largely depends on the country-specific values, which we pick up in the following section examining public attitudes.

The universal German approach offers a choice between formal care or cash payments as part of the national LTCI, while in the English LTC system, direct payments and personal budgets are intended to be offered to all users meeting the means test (Glendinning et al. 2008). In both systems, the cash payments can be used to fund continuous, informal caregiving, as well as one-off payments, for example, for training. Cash for care (CfC) was instituted in France in 2002 through the APA; however with strict restrictions on how the cash benefit is spent (Le Bihan and Martin 2010; Doty et al. 2015), they were only reduced in 2003 and increased in 2015 (Da Roit and Le Bihan 2019). In Sweden, cash payments play a smaller role and are generally focused on young, disabled citizens rather than the elderly with care needs (Sundström et al. 2002).

The review of the seven systems illustrates how implicit partnerships designs have been developed in different formats across Europe. Well-established systems such as Sweden and the Netherlands still face considerable, financial sustainability pressures and employ cost-sharing schemes to mediate demand for care. These systems are reverting from more expensive institutional care to more affordable community care alternatives such as home care provision, provided mainly by professional carers but also, to an increasing degree, by informal carers (Sundström et al. 2002; Maarse and Jeurissen 2016). These can be seen as implicit *user* partnerships, where responsibility for care is shifted to the user in order to maintain or expand coverage of LTC funding. In contrast, in newly established systems such as Spain and Italy, we find considerable use of cash-based caregiving allowances, relying on the family as the main caring agent, which could be seen as a strategy to transfer financial responsibility. In Italy, political debates over the financial sustainability of LTC have arisen from time to time, but has not lead to reform (Tedioli and Gabriele 2010). Spain also operates a system of co-payments accounting for 25% of community care and 75% of residential care spending (Costa-Font and Patxot 2005). We view these familial LTC systems as implicit *caregiver* partnerships, given that the main approach

**Table 2** Overview of LTC cash-for-care schemes and their role as part of LTC financing Sources: ANCIEN study country reports and OECD Health Data and documentation

Cash-for-care scheme	Initial policy setting	Cash/in-kind (service)	Percentage covered in 2011	Size of benefits	Family versus state care
Germany	Social LTCI	Foundation of LTC policy	11	level 1: €215 level 2: €420 level 3: €675	Family
France	Allocation personalisée d'autonomie (APA)	Foundation of LTC policy	7.8 (on population 60+)	Average amount: €494/month	Mixed/state
Italy	Indennità di accompagnamento	Core position within implicit LTC policy	10	Flat-rate payment, 2009: €472	Family
Spain	Sistema para al autonomía y la atención a la dependencia (SAAD)	Foundation of LTC policy	3.3	200-500 euro per month	Family/mixed
Netherlands	Attendance allowance	Flexibility of established LTC policy	1.4	Average budget, 2006: €11,500/year	State/professionals
Sweden	Decentralised attendance allowance	Flexibility of established LTC policy	0.1	487/month	State/professionals
UK	Individual budgets	Flexibility of established LTC policy	0.5	Depending on need	Mixed/state

for maintaining and expanding coverage is through incentives and support for caregivers. France is a particular case, where the focus has traditionally been on formally provided care in institutions or at home. The relatively large share of private insurance is the natural response to the limited benefits and income-related means test structure of the APA, rather than on the explicit result of a higher demand for private insurance per se, or an explicit partnership structure (Doty et al. 2015; Da Roit and Le Bihan 2010). France can be presented as another example of an implicit *user* partnership given its substantial reliance on co-payments and remaining focus on formal care. Similarly, Germany has high co-payments (Table 1), and due to capping of insurance entitlements, private co-payments and means-tested social assistance play an important role in the financing of particularly nursing home care, where around 30% of all residents receive social assistance to help cover co-payments (Rothgang 2010). Voluntary private LTC insurance plays a minor role in covering co-payments; in 2009, about 3.5% of the German population aged 40 overheld an (mainly) indemnity policy (OECD 2011).

## Public preferences for long-term care provision and financing

The previous section has documented the characteristics of ‘implicit partnerships’ across European countries. However, given that in addition to financial constraints, one can argue that there are significant social constraints to LTC reform, we examine the alignment of public preferences actual LTC entitlements. In this section, we use Eurobarometer survey data (nr. 67.3 from 2007), which provides a representative sample of peoples’ attitudes towards LTC financing and provision in the countries of our sample.

Table 3 reports evidence of attitudes in relation to the role of family care; the role of public finance and provision; and the role of private LTC financing, all being the key features that make an IP. In order to meticulously understand differences in the type of IP (user or caregiver partnership), we examine attitudes in relation to the role of family responsibility that marked cross-country differences. For example, we find a stark variation in the support for care by relatives (even when it entails a sacrifice for the carer). Indeed, while aid for family support is limited among Swedish respondents (7.3%), it reaches a level of 52% among Italian respondents. These suggest that the type of implicit partnership that can be relied on in one country is not necessarily suitable in another. Similar patterns emerge when we investigate attitudes towards children’s responsibility to help pay for their parents’ care if needed. This provides a behavioural explanation for the heterogeneity of IP across countries. While in countries like Sweden, we tend to observe an ‘implicit user partnership’, in Italy, ‘implicit caregiver partnership’ is a more commonly accepted option.

There is much less variation in the views on the role of the state in the financing and provision of services. The support for state intervention is strong. On average, 86% support the responsibility of the state to provide care to those in need and to, both financially and in terms of respite time, support informal caregivers. This is consistent with the fact that the countries examined here offer some level of support, and in the countries that have not yet had major reform, proposals attempt to overcome the reliance on means-tested care and move towards a universal entitlement with a significant cost sharing or family involvement.

Finally, the views on the role of private financing, such as private insurance, appear to be system specific. Individual and financial responsibility is not seen to stretch as far as selling or borrowing against the user’s home (house or flat). Spain is the only outlier in this category, in part explained by the housing bubble at the time of the interview, which

**Table 3** Attitudes to financing and provision of LTC—% agreeing with statements

	France (%)	Germany (%)	Italy (%)	Netherlands (%)	Spain (%)	UK (%)	Sweden (%)	Average (%)
<b>Family responsibility</b>								
Children should pay for the care of their parents if their parents' income is not sufficient	49	30	71	21	74	26	14	40
Care should be provided by close relatives of the dependent person, even if that means that they have to sacrifice their career to some extent	18	34	52	12	44	32	7	29
<b>Role of public finance and provision</b>								
Public authorities should provide appropriate home care and/or institutional care for elderly people in need	97	93	92	96	98	97	98	96
The state should pay an income to those who have to give up working or reduce their working time to care for a dependent person	88	91	87	87	95	95	86	90
From time to time, the state should pay for professional carers to take over from family carers so that family carers can take a break	92	96	88	94	96	97	97	94
<b>Role of private financing</b>								
Every individual should be obliged to contribute to an insurance scheme that will finance care if and when it is needed	79	84	57	84	73	66	58	72
If a person becomes dependent and cannot pay for care from their own income, their flat or house should be sold or borrowed against to pay for care	27	29	27	21	39	19	16	26

Question QA8: For each of the following statements regarding the care of the elderly, please tell me to what extent you agree or disagree: 'Totally agree', 'Tend to agree', 'Tend to disagree', 'Totally disagree' and 'Don't Know'. The percentage selecting categories 'Totally agree' and 'Tend to agree' have been summarised in the table and rounded. Source Eurobarometer survey 2007

overwhelmingly benefited older individuals. Therefore, the views on user payments seem to match up well with the partial co-payments systems outlined in Table 1, where certain countries employ ‘reserve income’ schemes and others combine social assistance support, where the user cannot meet co-payments.

This brief attitudinal analysis of public preferences illustrates how the idea of implicit partnerships, and its two types, namely user and caregiver partnerships, seem to match, or be supported by the public in the respective countries.

## Conclusion

This paper has set out to examine the change in the financial entitlements in Europe, and more specifically what we have conceptualised as ‘implicit partnerships (IP)’. IP’s are ‘silent agreements’ that partially modify public LTC entitlements, which are shared between caregivers, users and the state. The advantage of this strategy as opposed to explicit partnership arrangements is that it avoids a country-wide discussion centred on the potentially divisive matter of the future of the family, and the limits of public intervention in funding long-term care. We have argued that these partnerships rely predominantly on support from either the caregiver or the user. They can hence take the form of either an ‘implicit caregiving partnership’ or an ‘implicit user partnership’. The former is denoted by subsidies to incentivise and support informal care and the latter by the subsidy of in-kind services provided externally by market or public services, subject to means testing with a significant cost-sharing element to ensure fiscal sustainability and counteract moral hazard.

Drawing on both institutional analysis of LTC system developments and European survey data, we have documented evidence indicating that countries that have expanded coverage have done so by developing ‘implicit user partnerships’, or subsidising informal caregiving and hence developing ‘implicit caregiving partnerships’, or both. The same applies in the reverse situation, in which governments have relied on IPs when restricting funding by redesigning the terms of the IP, while maintaining at least their theoretical coverage, through changes to needs or means tests, such as in Sweden and England. Whether one or another partnership type develops seems to depend on the attitudes towards informal care versus in-kind services, i.e. the level of familism (Costa-Font 2010; Saraceno and Keck 2010). These considerations might in turn explain the slower expansion of public LTC coverage, compared to that of other social services.

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