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Building 'Implicit Partnerships'? Financial Long Term Care Entitlements in Europe

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Abstract

The public funding of long-term care (LTC) programs to support the frail elderly is still underdeveloped compared to other areas of social protection for old age. In Europe, any moves to broaden entitlements to LTC are impeded by increasing demand for care coinciding with constrained public finances. We examine a set of conditions that facilitate modifications to the financial entitlement to LTC and elaborate the concept of 'implicit partnerships': an implicit (or 'silent') agreement, encompassing the financial co-participation of public funders and the time and/or financial resources of users and their families. We argue that the successful building of 'implicit partnerships' opens the door to potential reform of financial entitlements, either through 'user partnerships' relying on users' co-payments, or 'caregiver partnerships' relying on informal care provision. We examine entitlements over time in seven European countries; the EU-5, the Netherlands and Sweden. Furthermore, we show that public attitudes towards financing and provision of LTC support the country specific financial entitlements and the type of implicit partnership we identify.

Keywords: implicit partnership, partial insurance, cost sharing, long-term care, financial sustainability, family, Europe.

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Table of Contents

Introduction **1**

Reform and long-term care coverage **4**

Defining implicit partnership types **6**

Implicit caregiver and user partnerships: the evidence **9**

Public preferences for long-term care provision and financing **16**

Conclusion **19**

References **21**

Building 'Implicit Partnerships'? Financial Long Term Care Entitlements in 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.[1] Currently, increasing demand due to demographic and social changes – population ageing and reduced availability of informal care support – place strain on the provision of LTC services and has led to questioning of the financial sustainability of LTC. Financial coverage for LTC is far less developed and more recently formalised into social security legislation, compared to other policy areas. Support is often provided subject to means and needs tests, which has given rise to concerns over catastrophic care costs faced by certain users. It is fair to say that LTC currently stands at the forefront of health care and social protection debates in Europe, in particular given the fiscal austerity experienced in several countries in recent years (OECD, 2011).

The definition of entitlements to LTC services or support has proven to be a difficult and lengthy process in many European countries. The understanding

[1] Need for LTC is commonly discussed in terms of ADLs, "Activities of Daily Living", and IADLs, "Instrumental Activities of Daily Living".

of the conditions under which reform may take place is at its infancy. While in some countries reforms to expand LTC financing have moved beyond the 'public debate stage', or even governmental commission, the scope of such reforms has often narrowed substantially during its implementation, if not failing completely (Riedel and Kraus, 2011; Costa-Font, 2010b). In some cases, the entitlement has been significantly watered down after implementation, such as the Spanish reduction in LTC support of 25% amidst the economic downturn in 2012 (Costa-Font et al., 2016a). An essential constraint to the expansion of public LTC coverage[2] has been ensuring, jointly, short-term cost-containment and longer-term financial sustainability, in addition to securing public support. Existing research has not given much attention to the conditions that pave the way for LTC reform, and in particular coverage expansion that is financially sustainable.

This paper adds to the literature by introducing the concept of 'implicit partnerships' (IPs) as a way of understanding the program design mechanisms behind the expansion or sustaining of public LTC coverage. We discuss its definition below in more detail, but briefly 'implicit partnerships' can be understood as implicit financial agreements whereby reform arrangements involve the co-participation in the financing of LTC of different public stakeholders (central, regional or local), in addition to, or conditional on, contributions of private stakeholders such as users, relatives or the community. The latter contribution can be in the form of time devoted to informal care (and

[2] 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.

hence not to producing rents from employment) or money, such as users' fees or cost sharing (co-payments or deductible) to pay for personal care.

We contribute as follows: first, 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, and can be seen as a facilitating condition for European LTC reform. Second, we report evidence suggesting that attitudes towards care is 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, which represent the different welfare state regimes in Europe. 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 European Social Survey 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 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, generally at home; and 'implicit caregiver partnerships' where the policy focus is on incentivising and supporting informal care provision through cash-for-care schemes or higher reliance on cash benefits as a means to sustaining or expanding coverage of LTC financing. We further find that the type of IP in each the countries of 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'. Section three provides the main features of reform in the selected European countries, linking to the types of IP previously defined. Section four reports and discusses the quantitative evidence of public opinion data and discusses the relation with the typologies of IP in each of the countries. Section five provides a concluding discussion.

Reform and long-term care coverage

Welfare reforms, taking place in the current era of permanent austerity, usually either preserve the status quo, or encompass the retrenchment of public financing or the production of welfare services (Pierson, 2001). There is an 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 and coverage of services. Accordingly, in the case of LTC, the main constraint to expanding the coverage is financial sustainability (OECD, 2011). This is the case insofar as universal coverage, involving some form of entitlement, is very costly (Lave, 1985). 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 demographic and labour market change and the loosening of family ties (Costa-Font, 2010a). Finally, 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 developing needs for LTC services in the future, and hence taking it into account when making electoral choices. This behavioural aspect includes some degree of denial of potential future health problems or frailty, and a disinterest in reform related to insuring against these types of risks (Frank, 2012). This also influences the perception of the relative 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 revenue towards LTC, and possibly accepts future tax increases.

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

On the other hand, one of the most important motivations for reform lies in the inefficiencies an underdeveloped or underfunded LTC system brings. Indeed, limited health and long-term care integration and lack of LTC services affect the efficiency of health services. Similarly, the contrasting entitlements between health and long-term care and poorly funded and managed LTC has huge spill-over costs onto health care, for example due to prolonged hospitalisation

(Costa-Font et al., 2016). The integration issue can both constrain LTC reform – if it is allowed to eat into health spending without too much issue – or, serve as an impetus for reform – where it is clear that underfunding of LTC leads to inefficient use of resources in the health service (Costa-Font et al., 2016b).

The expansion of LTC entitlements does occur even given the constraints discussed above. We argue that these constrains alone do not necessarily impede reform, if coverage is expanded alongside the introduction of cost sharing schemes, forming implicit partnerships. Such 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. Nevertheless, coverage expansion has relied on the key characteristics of an implicit partnership: the involvement of the individual and the family in the responsibility for financing, provision, and the organisation of care.

Defining implicit partnership types

A set of conditions or characteristics are here defined and we argue that these, taken together, suggest that what we see can be usefully defined as an implicit partnership (IP) facilitating LTC coverage reform. Unlike explicit partnerships where involved stakeholders have some say, in the case of implicit partnerships this is by far not the case (e.g., in all European countries families are providing the bulk of care, also in so-called 'universalist' systems). This is the partial nature of LTC coverage (or what it is sometimes referred as the 'mixed economy of care'): the private (meaning family and not commercial) component participates either as co-financing or co-producing, importantly, however, without a clear 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.

The implicit partnership concept is particularly useful for understanding public financing of LTC when it is contrasted with alternative funding models such as 'explicit (financial) partnership' models prevalent, for example, in the US. 'Explicit partnerships' can contract an expansion of individuals' contributions to newly funded care costs with the guarantee that the public sector will cover the remaining costs, and have been debated in many countries (see for example Wanless and Forder (2006) on England, and Doty et al. (2015) on France). Benefits include clarity of the relative responsibility of the citizen and the state in relation to the financing of LTC and potentially opens up for a stronger role of private insurance (and increased supply of insurance products). In the US the LTC Partnership program is such that Medicaid funds LTC costs above and beyond the coverage of private long-term care insurance that tends to be equivalent to the beneficiaries' assets (Bergquist et al., 2015). The long-term care partnership (LTCP) program 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 LTSS. This formal partnership was designed with the purpose to reduce cost for the state by ensuring that individuals where better insured.

In Europe, the explicit partnership approach has never moved beyond the debate stage. For example, the Wanless report (see Wanless and Forder, 2006) argued that the best approach for England would be a partnership model, including a role for private insurance. The later Dilnot commission produced recommendations designed to produce a status quo in English LTC that facilitated partnerships with private insurance to cover the, under the Dilnot proposal, clearly defined, private share of LTC expenditure (Dilnot, 2011).

Similarly, in France under previous leadership an explicit public/private partnership in LTC was debated. In recent years, 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).

The first condition supporting the IP hypothesis is the 'partial universalism' of public LTC coverage across Europe. In both residual (means tested access to care) and universal systems, either families or users themselves are expected to contribute time or money towards the financing of any care needed. We define IPs 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 support and political will to make the financing 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 child care, and into caregiving. The reliance on family care can be explained by a number of factors: needs tested formal care tends to only address substantial needs; quality of formal services is often perceived to be low; accessibility of alternative sources of support can be an issue; and traditionally 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 health care services. Research has found that most users and caregivers[3] have a preference

[3] Nonetheless, there is some evidence suggesting negative impacts of caregiving on carers (Smith et al., 2014).

for 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, 2015).

Implicit caregiver and user partnerships: the evidence

This section traces the broad reform trajectories and compares the LTC systems of 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 were generally considerably lower (below 10%) and where reliance on family care and a heavier reliance on other health services was common, found 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).

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 et al., 2010). In later years Sweden has however experimented extensively with privatised provision of care and choice for users, as well as increased levels of co-payments (Blomqvist, 2004). Similarly, the Netherlands has a universal LTC system established as early as the 1960s. Care is, however,

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. As of 2015, a major LTC reform is taking place with the purpose of containing expenditure, in which a shift from residential to non-residential care is an integral aspect (Maarse and Jeurissen, 2016).

In contrast, Italy and Spain represent the other extreme in terms of expenditure and public involvement, characterised by low expenditure and care largely provided informally by family, friends and relatives, complemented by predominantly publicly funded institutional care (Costa-Font, 2010b). In Spain the 2007 Dependency Bill reform expanded public coverage universally, subject to a needs test, with in-kind formal care provision, as well as a caregiving allowance. The central and regional government funds two thirds of expenditure and users the remainder (Costa-Font et al, 2016). This LTC system design mimicked the German scheme instigated in 1994 (see Rothgang, 2010). However, in 2012, as part of widespread budget cuts, the LTC subsidy was slashed between 15-25% (Costa-Font et al., 2016).

Germany and England represent the middle ground in terms of public resources spent on LTC; with a significant share supporting informal carers. The devolution of the British political system has, however, resulted in diverging LTC systems: the Scottish system provides free home care and subsidies for nursing home care, whereas in England strict means testing is applied for all services (Comas-Herrera et al., 2010). The extension of means testing to some form of universal entitlement has been much debated in England, where catastrophic costs are faced by middle income households in

case of substantial and prolonged care needs.[4] The German system on the other hand offers a universal entitlement channelled through social insurance funds. A needs test restricts access, and the benefit levels have been criticised for being insufficient. Means tested social assistance plays a substantial role for people who are not able to meet the required co-payments (Rothgang, 2010).

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). 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. Total 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

[4] 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).

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	1.91 (1)	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+tel ecare)	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+D P/PB) 7.19% (inst+home)	Decentralised	Means-tested co-payments up to 100% of cost.

Note: 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.

order to be comparable and to avoid double counting users. These play a substantial role in many of the systems, for example in England, where universal disability benefits such as attendance allowance and disability living allowance cover over 27% of the population aged 65 and above. There are similar cash benefits in Italy (the IDA) which cover 12% of the elderly population, with the important distinction that 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', each month after care payments. In all the systems except for Italy 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 the countries. A noteworthy recent trend is cash-for-care schemes, which allow the user to purchase, or informally source, the care package desired. Cash-for-care schemes are also seen as 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). 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 outlines the cash-for-care schemes of the countries in our sample.

The German approach universally 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 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). In Sweden, cash payments play a smaller role and are generally focused on young disabled rather than on the elderly with care needs (Sundström et al., 2002).

Table 2.
Overview of LTC cash for care schemes and their role as part of LTC financing.

	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	Cash or in kind services	11	level 1: €215 level 2: €420 level 3: €675	Family
France	l'allocation personnalisée d'autonomie (APA)	Foundation of LTC policy	Cash for care	7.8 (on population 60+)	Average amount: €494/month	Mixed/State
Italy	Indennità di accompagna-mento	Core position within implicit LTC policy	Cash	10	Flat-rate payment, 2009: €472	Family
Spain	Sistema para al autonomía y la atención a la dependencia (SAAD)	Foundation of LTC policy	Cash or in kind services	3.3	200-500 euro per month	Family /Mixed
Netherlands	Attendance allowance	Flexibility of established LTC policy	Cash or in kind services	1.4	Average budget, 2006: €11,500/year	State/ professionals
Sweden	Decentralised attendance allowance	Flexibility of established LTC policy	Cash	0.1	487/month	State/ professionals
UK	Individual budgets	Flexibility of established LTC policy	Cash	0.5	Depending on need	Mixed/State

Sources: ANCIEN study country reports and OECD Health data and documentation.

The review of the seven systems illustrates how implicit partnerships have 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 cheaper 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 have to date not led to reform (Tediosi and Gabriele, 2010). Spain also operates a system of co-payments accounting for 25 per cent of community care and 75 per cent of residential care spending (Costa-Font and Patxot, 2005). We view these familistic LTC systems as implicit *caregiver* partnerships, given that the main approach to 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 can be seen as a response to the limited benefits and income related means test structure of the APA rather than driven by a demand for private insurance per se, or an explicit partnership structure (Doty et al., 2015; Da Roit and Le Bihan, 2010). France hence forms another example of an implicit *user* partnership given its substantial reliance on co-payments and remaining focus on formal care. Similarly, Germany has a particularly high proportion of co-payments (see 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 in particular 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 and over held a (mainly) indemnity policy (OECD, 2011).

Public preferences for long-term care provision and financing

The previous section provided some evidence on the association between European coverage reforms and the characteristics of 'implicit partnerships', although with noteworthy cross-country variation. Given that in addition to financial constraints, one can argue that there are social constraints to LTC reform, we here consider the alignment of preferences of the public with the state LTC financing and provision structures. 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.

In Table 3 attitudes in relation to three facets of the LTC system are reported: the role of family care; the role of public finance and provision; and the role of private financing. Particularly in relation to the role of family responsibility, there are marked cross-country differences. For example, the variation between the lowest rate of support for the care by relatives (even if it represents a sacrifice for the carer), found among the Swedish respondents (7.3%), and the substantial support for such care (52%) amongst Italian respondents is striking. This suggests 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. The latter explains why in countries like Sweden, we tend to observe an "implicit user partnership" whilst in a country like Italy one would instead expect to identify an "implicit caregiver partnership".

There is much less variation in the views on the role of the state in the financing and provision of services. Generally speaking, 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, similarly appear to be system specific. Individual 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 overwhelmingly benefited older individuals. The views on user payments hence seems to match up well with the mainly 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 dive into public preferences illustrated how the idea of implicit partnerships and the two types, user and caregiver partnerships, seems to match, or be supported by the public in the respective countries.

Table 3.
Attitudes to financing and provision of LTC – % agreeing with statements

		France	Germany	Italy	Netherlands	Spain	UK	Sweden	Average
Family responsibility	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%
Role of public finance and provision	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%
Role of private financing	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%

Note: 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.

Conclusion

This paper has set out to examine one potential explanation for LTC coverage expansion (or maintenance) in Europe, namely, the development of what we have conceptualised as 'implicit partnerships'. These 'silent agreements' encompass a partial extension of public LTC coverage, shared between caregivers, users and the state. The advantage of this strategy with respect to explicit partnerships 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 caregiver partnership' or an 'implicit user partnership'. The former is denoted by subsidies to incentivize and support informal, or family, provision of LTC, and the latter by the subsidy of in-kind services provided externally by market or public services, subject to means testing and with a significant cost sharing element to ensure fiscal sustainability and counteract moral hazard.

Drawing on both institutional analysis of LTC system developments and quantitative analysis of European survey data, we have documented evidence indicating that countries that have expanded coverage have done so by introducing or changing pre-existing cost sharing schemes and hence 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 implicit partnerships when restricting funding, while maintaining at least theoretical coverage, through changes to needs or means tests, such as in Sweden and England. Whether one or the other partnership type develops seems to have depended to a certain extent on path dependency of reform as well as on the

national context and the attitudes towards informal care versus in-kind services, i.e. the level of familism (Costa-Font, 2010a, Saraceno and Keck, 2010). These considerations might in turn have slowed down the expansion of public LTC coverage, compared to other social services.

When setting the idea of implicit partnerships in the broader reform debate, it is worth noting that the reform and expansion of public long-term care funding and coverage is not without problems. The modification of the LTC entitlement, such as a move from means tested to universal access, may have equity impacts. Hence, the effect of new entitlement design on access to care by those at the bottom of the income distribution should be carefully considered in designing new implicit partnerships.

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