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In the mid2030s, the health of the baby boomers will have deteriorated and many in these large cohorts will be in need of formal and/or informal long-term care.

This "**care wave**" will transform two generations: the baby boomers in need of care and their children who may supply care. It will have significant implications for labour supply, especially for women, saving behaviour, and therefore for productivity, economic growth and its inclusiveness.

The overarching objective of BB-Future is to understand the size and the implications of the care wave on economic and social outcomes, to appreciate the quality of this second ageing-related transformation and to develop policy recommendations for advance planning on the EU and Member State levels.

Abstract: *Population ageing has increased the demand for long-term care (LTC) throughout Europe, raising concerns about access, financing, workforce shortages, and support for family caregivers. This paper reviews thirty years of LTC reforms in France, Germany, and Spain, three neighbouring countries that adopted distinct institutional models: a fragmented means-tested system, a dedicated social LTC insurance scheme, and a decentralized rights-based system. We compare reforms affecting dependent older adults, professional care workers, and informal caregivers.*
Despite important differences in organisation and financing, the three countries have followed similar trends: expanding coverage, strengthening support for caregivers, and addressing growing labour shortages. The comparison highlights the shared challenge of balancing adequate care, workforce sustainability, and family support in ageing societies, while providing a framework for future evaluations of LTC reforms.

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Three Decades of Long Term Care Policy in Europe - Overview of the French, German, and Spanish Trajectories *

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Abstract

Population ageing has increased the demand for long-term care (LTC) throughout Europe, raising concerns about access, financing, workforce shortages, and support for family caregivers. This paper reviews thirty years of LTC reforms in France, Germany, and Spain, three neighbouring countries that adopted distinct institutional models: a fragmented means-tested system, a dedicated social LTC insurance scheme, and a decentralized rights-based system. We compare reforms affecting dependent older adults, professional care workers, and informal caregivers. Despite important differences in organisation and financing, the three countries have followed similar trends: expanding coverage, strengthening support for caregivers, and addressing growing labour shortages. The comparison highlights the shared challenge of balancing adequate care, workforce sustainability, and family support in ageing societies, while providing a framework for future evaluations of LTC reforms.

JEL Codes: I18, H55, J14

Keywords: Long-term care; professional care; informal care; population ageing; LTC system

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1 Introduction

European populations have been ageing across all Member States. One consequence of this demographic trend has been the growing number of individuals with long-term care (LTC) needs. This development has occurred to varying degrees across countries and has been addressed through different policy approaches by national governments.

Understanding the choices made by each country to address LTC needs, and the reforms implemented to ensure the sustainability of LTC systems, is crucial for at least two reasons. First, examining the history of LTC policies in Europe can help inform future policy reforms. Second, the diversity of institutional settings provides valuable opportunities to evaluate how changes in LTC benefits and organisation affect access to and use of LTC services.

In this paper, we review the policy changes that have occurred over the past thirty years in three neighbouring European countries that have adopted markedly different approaches to LTC: France, Germany, and Spain. We examine the evolution of LTC policy in a country that adopted a means-tested allowance system alongside existing social protection programmes (France), a country that introduced a dedicated national LTC insurance scheme (Germany), and a country that was a relatively late adopter of LTC policies but has substantially expanded the generosity of its system in recent years (Spain). Through this historical perspective, we highlight the major reforms that have affected three complementary dimensions of LTC: benefits for older dependent adults, support for professional care workers, and support for informal caregivers. It reflects public policy's three main challenges when referring to "LTC": support elderly adults with high care needs; insuring enough supply of formal care workers, through attractiveness, wages, working condition in this sector; supporting informal caregivers to avoid family-over burden and health deterioration of the population of caregivers.

This work complements three existing strands of literature. First, the Global Observatory of Long-Term Care provides country profiles describing LTC systems in several countries (ILTCPN, 2026). However, these profiles focus on current systems rather than their historical evolution. Furthermore, the three countries analysed in this paper do not yet have dedicated profiles in the Global Observatory of LTC. Second, the Gateway to Global Aging Data provides not only harmonised survey data on ageing but also policy explorers describing both current LTC systems and their evolution over time. These resources cover all countries with national ageing surveys, including France, Germany, and Spain (Grigoletti et al., 2023a,c,b; Grigoletti and Pasini, 2024b,a). These descriptions focus primarily on the main LTC benefit available in each country. Our contribution complements this approach by providing a comparative perspective and by incorporating broader institutional and political dimensions of LTC, including working conditions in the care sector and support for informal caregivers. Third, the OECD regularly publishes comparative overviews of LTC systems and services, seeking to ensure cross-country comparability through harmonised indicators and data sources (OECD, 2025, 2026; Llena-Nozal et al., 2025b,a). These efforts are designed primarily to support macroeconomic and comparative analyses and to document potential discontinuities in national data series. By contrast, our study focuses exclusively on the policy environment surrounding LTC, without being constrained by harmonisation requirements or methodological choices aimed at ensuring direct comparability across countries.

The paper proceeds as follows. We first present the case of France (Section 2). France has a fragmented LTC system that relies on the combination of measures embedded across several pillars of the social protection system. We review the principal policies governing access to LTC benefits for older dependent adults, as well as reforms affecting the working conditions of professional caregivers and the development of support measures for informal caregivers. We then turn to Germany (Section 3). Germany introduced its first comprehensive LTC policies during a similar period. Although its LTC system is more coherent and clearly structured than the French system, it has undergone numerous reforms over time. Germany has also implemented significant measures to improve working conditions in the care sector and has developed a broad range of policies designed to encourage and support informal caregiving. Lastly, we investigate the Spanish case (Section 4). Spain introduced a national structure for long term care almost a decade after France and Germany. Moreover, the financial crisis forced the reforms to stall in their enactment, forcing regions and autonomous communities to manage and fund increasing care needs over the decade that followed. A reinvigorated national long term care insurance system took form by the end of the 2010s and is seeing major developments in the current decade.

2 France

2.1 A Fragmented System

The French long term care system was added to an already existing welfare system. As such its components are not administered by a single entity. For instance, healthcare services, including those delivered by nurses, provided at home and in nursing homes, are funded by the national health insurance and can cover some specific needs of older disabled adults. Housing needs can be covered by allowances such as the APL *Allocation Pour le Logement* or the ASH *Allocation sociale pour l'hébergement* and support adults with low income or specific housing needs (house for handicapped adults or nursing home). In the 50's, a specific mean-tested support for housekeeping services has been created for people losing autonomy (Légifrance, 1953) and repaid through inheritance (Pour-les-personnes-agees.gouv, 2026). This is called AMD *Aide Ménagère à Domicile*. From 1997, an additional allowance specifically dedicated to older adults with loss of independence has been created, targeting, in addition of all other existing supports, the specific needs of this population (called PSD, and then APA). It includes at home services and support for financing nursing home bed. To avoid overlapping supports, the AMD evolves and is now only accessible to elderly adults not eligible to APA.
The French system is fragmented system. In addition to these support, many preventive home-care policies were introduced. Most of them came from complementary insurance (depending on insurance plan and insurers), and by pension funds. They usually target retirees aged 55 or more, and provide them with at-home assistance and house improvement in order to keep people autonomous and at home as long as possible. This program has been notably introduced for private sector employee in 2005 (CNAV, 2005) and extended to civil servants in 2012 (Légifrance, 2012b). To some extent it reduces the strain on the APA by avoiding unmet needs at earlier stages of dependence keeping people autonomous for longer. Yet, these two funds operate autonomously.
In this investigation, we focus on the benefit structure of the PSD and APA (Section 2.2).

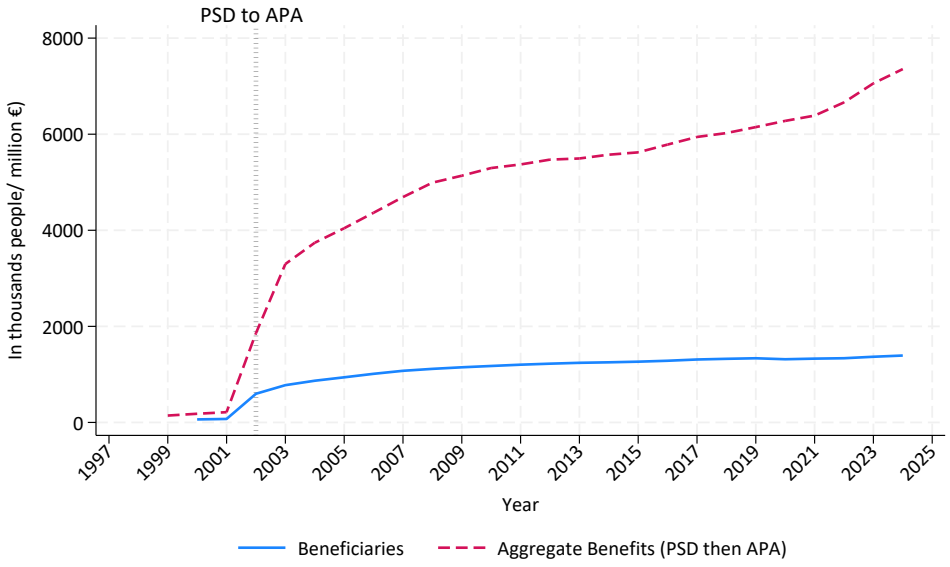
We also explain how recent years has been marked by the introduction of support for informal caregiver (Section 2.3) and support for formal caregiver, by improving their wages and introducing diploma qualifying for different degree of knowledge and expertise in caregiving practices (Section 2.4).

2.2 Benefits Structure

The French long term care system, aside from traditional health care, developed in 1997 with the introduction of the PSD *Préstation Spécifique à la Dépendance* (Légifrance, 1997) it targeted individuals aged 60 and above who faced severe limitations. The dependency assessment was managed by the councils of departments. The allowance did not reach its target, as only 112,000 beneficiaries were recorded in 1999 (Drees, 2024) representing an expenditure of 143 million euros (Drees, 2025). In 2002, most of the current benefits structure was introduced. The APA *Allocation personnalisée d'Autonomie* replaced the PSD and offered coverage to less dependent individuals, still above the age of 60 and still allocated through the conseil départemental (Légifrance, 2001). A notable change however is that the APA benefits given to dependent people were no longer to be reimbursed on their inheritance following their passing. As shown in Figure 1 the take-up of the APA was quick, leading to a rapid increase in government expenditures. The number of beneficiaries grew to nearly 600,000 and the expenditure of the APA reached nearly 2 billion euros in 2002. By 2003 the APA expenditure passed 3 billion euros, being provided to almost 800,000 people. This success appears to have been unexpected by the authorities who then passed laws to mitigate this rise in expenditures, by making benefits begin once the department notified they accepted to provide APA rather than at the time of request, by allowing the payment of caregivers and nursing homes directly by the APA rather than through the beneficiary, and by increasing the share of out of pocket expenditures associated with use of APA benefits (Légifrance, 2003). The number of beneficiaries and the share they represent in the French population then stabilized from 2005 onwards to remain between 7 and 8% of the population 60 and above. Expenditures, however continued expanding during that time. They doubled between 2002 and 2005. This is also the time, in 2004 when the National Council of Solidarity for Autonomy *Conseil National de Solidarité pour l'Autonomie* CNSA was founded and acquired the responsibility to manage APA provision at the national level (Légifrance, 2004). A law in 2012 reallocated national funding for APA from richer departments, according to their fiscal potential, towards poorer departments with an older population (Légifrance, 2012a). The Ageing Law *loi vieillesse* in 2015 made the APA thresholds more generous (Légifrance, 2015b). As seen in Figure 1, the APA aggregate expenditure stabilized a few years after its introduction, seeing constant rather than explosive growth. This held true until the beginning of the 2020s, when the system came under harsher criticism for being insufficient for the long term care crisis at hand. The project for a Law Great Age *Loi Grand Âge* was intended to restructure the system and provide it with greater funding. It was promised by all prime ministers from 2018 until 2024, after which it was no longer mentioned (Borgetto, 2025). In place of this supposed panacea, smaller, more targeted reforms occurred. In 2020, autonomy became the fifth branch of social security, turning long-term care theoretically from social aid into a right, to the same extent as health care or unemployment. This turned the CNSA into a national social security fund (Légifrance, 2021). In

2024, the Law Ageing Well *Loi bien viellir* was passed. It introduced additional norms and expectations from caregivers to ensure better treatment of dependent individuals (Légifrance, 2024b). It introduced local structure meant to help older individuals with disabilities to assess their needs and organize provision for said needs (Légifrance, 2024b). Lastly it led to the unification of the departmental services for autonomy, creating the Departmental Public Service of Autonomy *Service Public Départemental de l'Autonomie* SPDA, making access to such services easier. It was also supposed to make the parliament commit to reevaluate and agree to a program for long term care every five years, setting up the first of such plans by the end of the year. However, they failed to do so before their first deadline (Borgetto, 2025). In 2025, in the context of the social security financing of the year, the autonomy and disability benefits were restructured into two distinct channels and saw increased funding at the departmental level. The goal was to compensate for the increased costs associated with the minimum tariffs applied to home care services(Légifrance, 2025b). Looking at Figure ?? one may notice that little occurred in terms of long term care benefits, yet in Figure 1 one sees clearly the aggregate expenditures of the APA increase. A possible explanation may be that the organisational changes allowed to reach out to more people in need of care services. Alternatively, efforts oriented towards better compensating caregivers may have resulted in higher APA expenditures.

Figure 1: Beneficiaries and Yearly Expenditure on LTC Allowance in France



Note: This figure shows the evolution of expenditures and number of beneficiaries of the main long term care allowance in France: the Prestation Spécifique à la Dépendance PSD and then the Allocation personnalisée l'Autonomie APA. Due to its broader inclusion criteron, one can clearly see expenditures and number of beneficiaries increase following the switch from PSD to APA between 2001 and 2003.
Source: DREES data, Enquête Aide sociale. + INSEE data

2.3 Informal Care

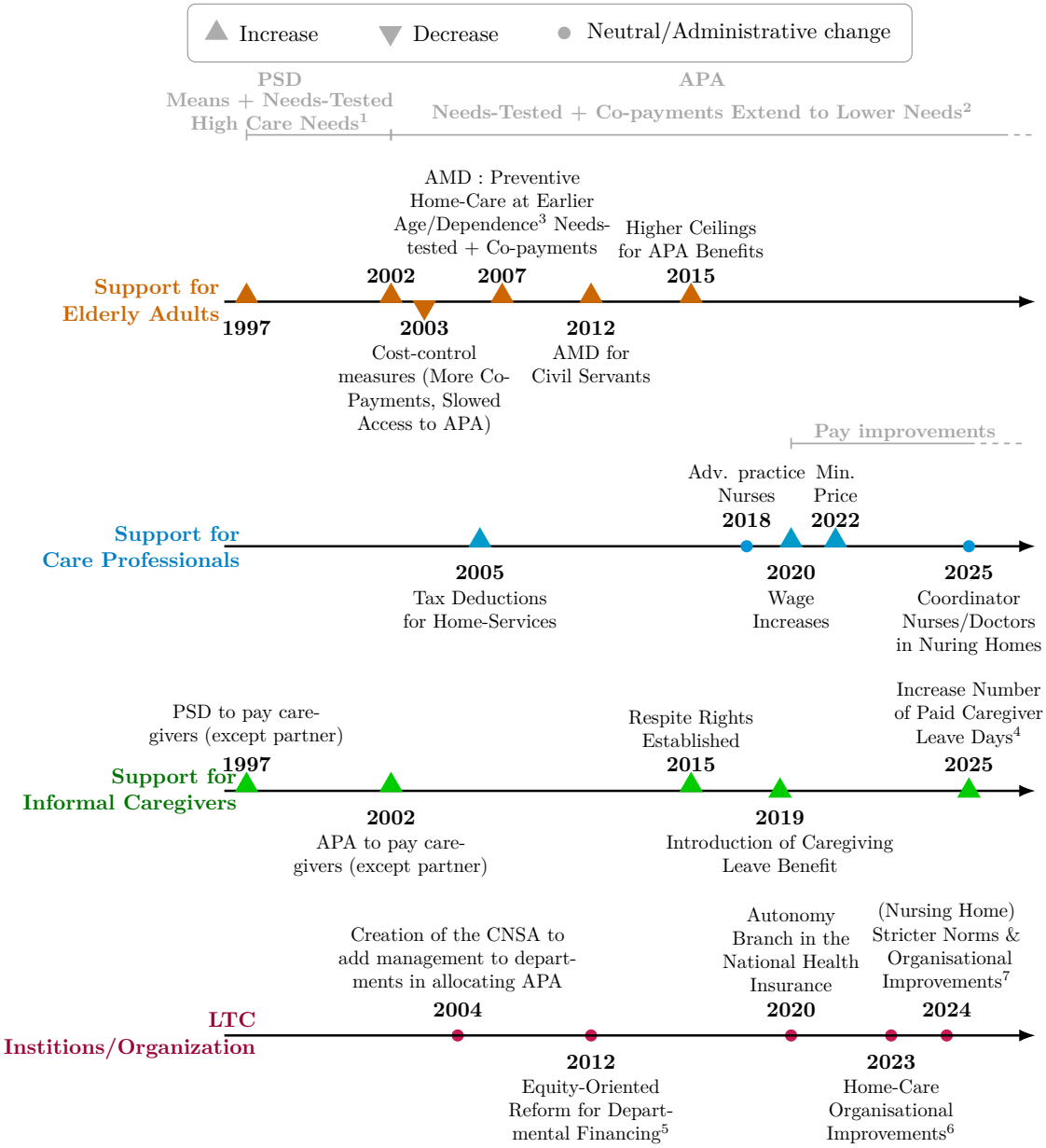
The French government implemented, in parallel with the LTC allowances, possible channels to compensate one's main informal caregiver. Except partners, they could be salaried by the PSD beneficiary, and compensated using the benefits (Légifrance, 1997). This was maintained with the introduction of the APA (Légifrance, 2001). From then, the focus was shifted from compensating informal caregivers to ensuring better care-work-life balance. In 2015, respite rights were established (Légifrance, 2015a) to allow caregivers to have time off their caregiving responsibilities temporarily, transferring them to the formal sector, notably through short stays in nursing home (Légifrance, 2016). This was followed, in 2019 by the introduction of caregiving leave benefits, allowing them to take time off work for caregiving obligation more easily. A caregiver could take up to 66 days of paid leave over their career (Légifrance, 2019). In 2025, the respite rights were expanded so caregivers could get up to 6 consecutive days of respite from the same formal caregivers. At the same time, their paid caregiving leaves were further expanded such that a caregiver could enjoy 66 days per person helped over their career for up to four dependent persons (Légifrance, 2024b, 2025a).

2.4 Policies for Professional Caregivers

The introduction of the APA increased demand for formal caregiving services without addressing the supply side. In order to incentivize easier access home-care services, and disincentivize undeclared work, France created tax deductions for at-home services in 2005 through the use of the Universal Services-Employment Checks or *Chèques Emploi-Service Universel* CESU (Légifrance, 2005). While this law was not specifically intended for long term care purposes, it made formal care more accessible for richer households. Little occurred on the supply side during before 2018. The only notable law occurring on that side being the creation of the advance practice nurse position, meant to reduce the need for doctors for some routine actions in 2018 (Légifrance, 2018). In the context of long term care, this is of particular interest in nursing homes. The covid crisis, then put the topic back at forefront of public policy. The pandemic stressed insufficient personnel and means were available to ensure decent living conditions and to meet care needs (SOS-Médecins, 2020). Additionally, France faced the *Orpéa* scandal, in which poor living conditions and treatment of vulnerable residents was revealed in the nursing homes of this prominent structure (Le-Monde, 2022). As such, since 2020, additional efforts were put on the supply-side to first improve the pay of formal caregivers through the *Ségur de santé* in 2020 (Légifrance, 2020b,a), higher minimum prices, generally indexed to inflation since 2022 (Légifrance, 2022, 2024a), and better coordination of home-based formal care services so as to make them more efficient, in 2023 (Légifrance, 2023). In 2025, the coordinator role, both for doctor and nurse was introduced. Coordinating doctors, supported by coordinating nurses, organise the nursing home personnel and the interventions of external agents. They give their opinion for admitting patients in nursing homes. They also evaluate and organise the health and care needs of dependent individuals in nursing homes (Légifrance, 2025c).

In 2027, the French presidential elections, potentially followed by legislative elections may allow the elected government to benefit from a governing majority, allowing new reforms to take place.

Timeline of long-term care policy changes in France



Funding :

- PSD and APA were/are mostly financed through department's tax revenues (housing tax until it was revoked notably) the state then provide additional funding. It does so through the CNSA since 2004
- Nurses and other health professionals (not caregivers) are financed through health insurance which itself is funded through labor and pension income taxes
- The preventive care plan is financed through pension funds.
- Tax exemptions were applied to the income tax which includes other forms of income.

Notes :

1. PSD was given according to resources, being 60 or more, and in GIR 1-3: the highest levels of care needs in France.
2. APA is given to people 60+, within the GIR 1-4, no matter their income. There is however some degree of means-testing through changing levels of co-payments.
3. This reform only applies to retirees, eligible at 55+.They get their care needs evaluated and provided to some extent. The program was renewed many times with an ending date. The last renewal was in 2023 to end in December 2026.
4. Informal caregivers can ask to be replaced by professional caregivers on a regular basis. Up to 94 days a year.
5. Changed the formula applied to allocate the state funds to departments. Having higher tax revenues per capita decrease the amount received and having more old/dependent individuals increases the amount.
6. SAD: *Service d'Aide à Domicile*: Home-based care services unified to improve coordination and access for users
7. SPDA: *Service Public Départmental de l'Autonomie*: Unified institution for people to gain information and organize their care arrangments.

3 Germany

3.1 A Unified System

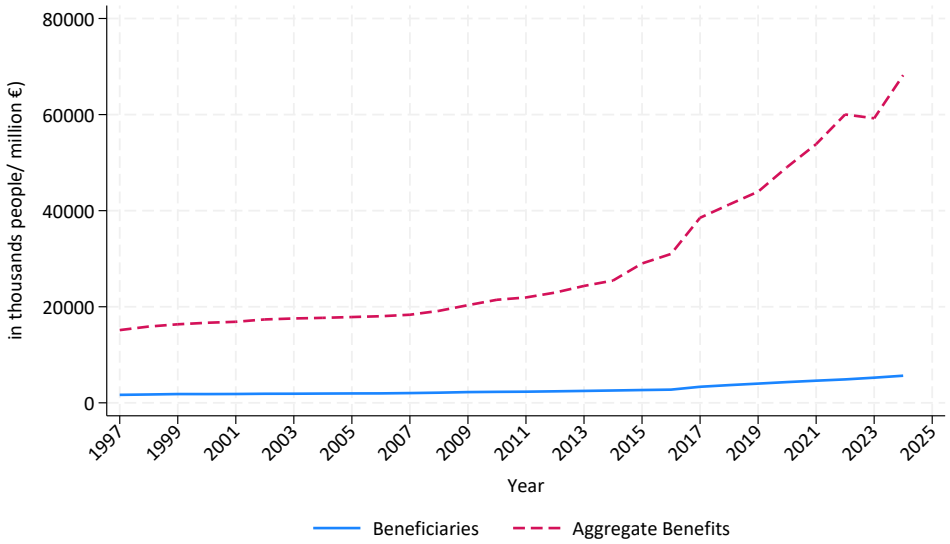
The German LTC differs greatly from the French system. When faced with an ageing population, it was decided to develop an insurance system in a similar fashion to health care. As such, workers finance the long term care system through contributions over their working life. The long term care structure such as nursing homes and service providers are then entirely funded by this Long Term Care Insure LTCi fund. For instance, pension contributions for formal and informal caregivers are paid through the fund. As such, the German expenditure captured in this investigation differ in scale compared to the French expenditures.

3.2 Benefits Structure

Germany introduced a long term care insurance system, the *Soziale Pflegeversicherung* in 1995, managed by the LTC Insurance Fund *Pflegekassen*(Bundesgesetzblatt, 1994). In its first form it determined the care needs solely on physical limitations and categorized them over three levels of disability (Bundesgesetzblatt, 1994). In doing so it partly overlooked people faced with disabilities due to cognitive conditions, notably dementia. From 2002 to 2013, to better account for potential specificities associated with cognitive decline, the government introduced multiple dementia-inclusive laws and amendments. Thus, over the period from mid 90's to mid 2000, France an Germany, while having different systems, maintain the same pattern in improving access to LTC for older population. Not much else in terms of benefits generosity occurred until after the eurozone crisis. In 2015, the first care strengthening act *Erstes Pflegestärkungsgesetz* PSG I, made benefits more generous. It also allowed better financing of short term care and of home adaptations, for up to 4,000 per improvement (Bundesministerium-für-Gesundheit, 2014). The financing of care becoming sizeable and future expenditure uncertain, the LTCi fund increased contribution and dedicated 0.1pp of contributions to a precautionary fund to face future increases in care needs (Bundesministerium-für-Gesundheit, 2014). In 2017 the second care strengthening act *Zweites Pflegestärkungsgesetz* PSG II, changed the levels of dependency used to determine the support necessary. There were now five levels instead of three, allowing better targeting when granting benefits (Bundesministerium-für-Gesundheit, 2015). The estimation of dependence level also adapted to represent limitations for doing activities rather than physical disability, allowing greater recognition of cognitive and psychiatric limitations. Lastly municipalities took a more prominent role in counselling and coordinating care. Looking at Figure 2 one can see the growth in LTC expenditures as well as the number of beneficiaries becoming more important. In fact, expenditure grew by 13% between 2014 and 2015 and 24% between 2016 and 2017, while the average growth in expenditures over the previous 15 years was 3%. Similarly, the number of beneficiaries grew by 21% in 2017 compared to 2016, and remained on a higher growth trajectory from then on at 7.7% compared to an average of 2.45% between 2000 and 2016. One might note that PSG I only resulted in increase in expenditures, by increasing benefits generosity, while PSG II increased both aggregate expenditures and the number of beneficiaries, mostly as a consequence of making benefits eligibility more inclusive. Nursing homes resident enjoyed increased co-payment from the LTCi first in 2022 (Bundesgeset-

zblatt, 2021) and then in 2024 with the care support and relief act *Pflegeunterstützungs- und -entlastungsgesetz* PUEG being passed (Bundesministerium-für-Gesundheit, 2023). As residents' stay grows longer, their share of the expenditure decrease. After these two reforms, residents staying more than three years in nursing homes covered only 25% of the costs. Contributions increased in 2023, accounting for the number of children one has to determine their contribution to the long term care insurance. Lastly benefits, following PUEG, home-based benefits grew in generosity in 2024 with inpatient care benefits following the same trajectory in 2025 (Bundesministerium-für-Gesundheit, 2023).

Figure 2: Beneficiaries and Yearly Expenditure in Germany



Note: This figure shows the evolution of the number of beneficiaries of the long term care insurance benefits in Germany since its first full year in place in 1997. One can see that expenses and membership grew in a rather stable fashion until 2015. After this date one can see that expenses more than doubled in a decade and number of beneficiaries grew alongside. This is associated with the introduction of two care strengthening acts (PSG I and II) that made the long term care insurance more inclusive and generous.
Source: German Federal Ministry of Health/*Bundesministerium für Gesundheit*
Die Finanzentwicklung der sozialen Pflegeversicherung Ist-Ergebnisse ohne Rechnungsabgrenzung
Leistungsempfänger der sozialen Pflegeversicherung am Jahresende nach Pflegegraden

3.3 Support for Informal Caregivers

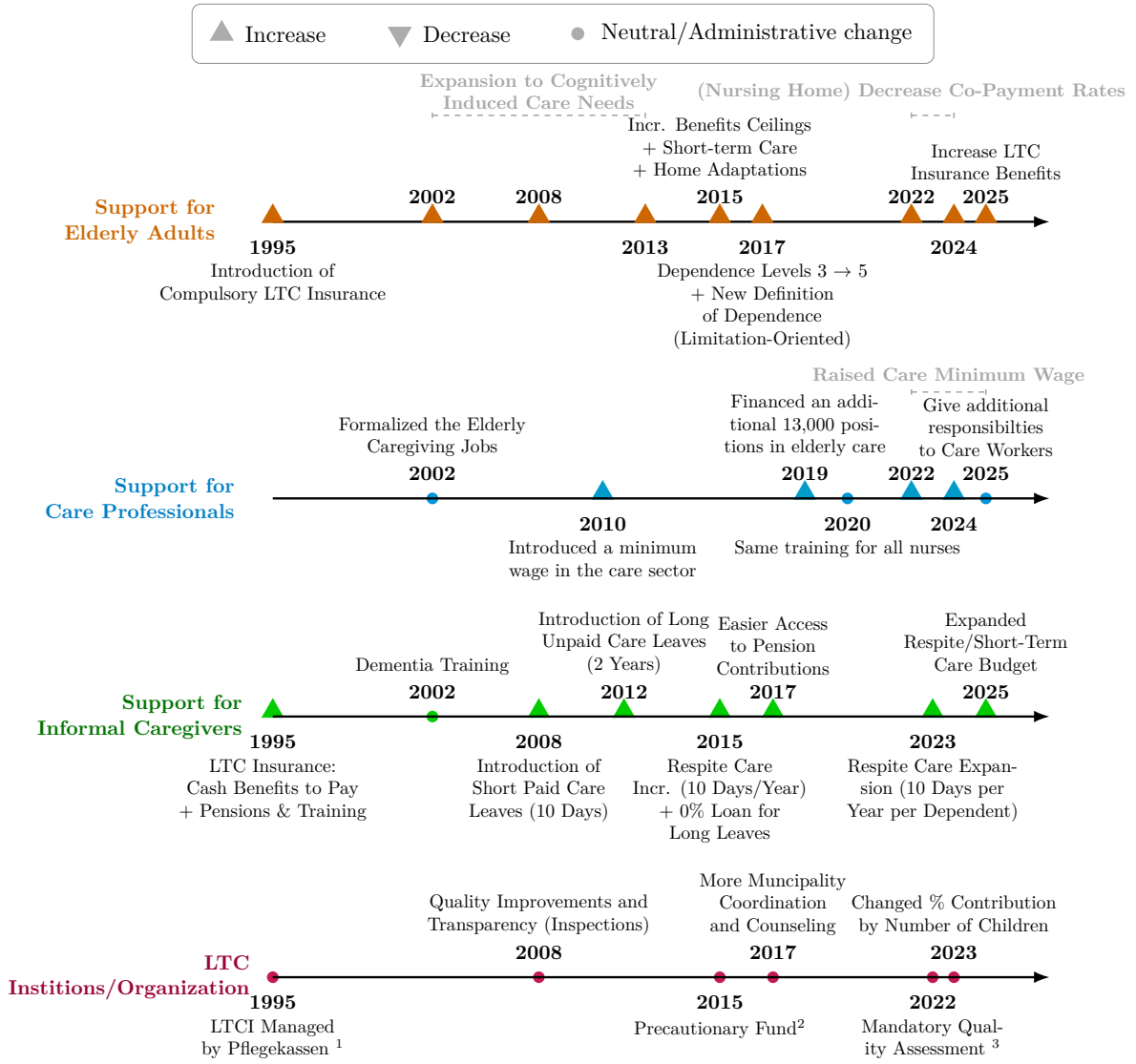
From its inception, the German long term care system included informal caregivers inside the care structure, allowing insurees to receive benefits in the form of cash to pay informal caregivers, providing training for those interested and allowing some extent of pension contribution from care provision, whenever one had no clear full-time job (Bundesministerium-der-Justiz-und-für-Verbraucherschutz, 1994a). This is a remarkable difference compared to the French system, where no incentive to rely on informal care existed at this time. From 2002 onwards informal caregivers could also receive training for providing assistance to someone suffering from a form of dementia. Important efforts were made to reconcile caregiving, family and work. In 2008, short paid

leaves were introduced so that caregivers could take ten days off specifically to provide and organize the future care needs of relatives growing dependent (Bundesministerium-der-Justiz-und-für-Verbraucherschutz, 2008). In 2012 long care leaves were introduced. Those were unpaid but allowed one to leave their jobs for up to two years to provide care to a relative(Bundesministerium-der-Justiz-und-für-Verbraucherschutz, 2011). In 2015, both forms of leave were improved. Short leaves could now be taken every year (Bundesministerium-für-Gesundheit, 2014; Bundesministerium-der-Justiz-und-für-Verbraucherschutz, 1994a) and the government offered 0% loans for people taking long care leaves (Bundesministerium-der-Justiz-und-für-Verbraucherschutz, 2015). In 2017, pension contributions for informal care were made more accessible (Bundesministerium-für-Gesundheit, 2015; Bundesministerium-der-Justiz-und-für-Verbraucherschutz, 1994a). In 2023, respite care was further extended such that an individual providing care to multiple persons could take as many 10-days leave as there are care recipient every year(Bundesministerium-für-Gesundheit, 2023). Lastly in 2025, the short-term care budget was expanded to address the generosity provided since 2023 (Bundesgesetzblatt, 1994).

3.4 Support for Care Professionals

At the time of the introduction of the German LTCi, health professionals involved were considered as being part of the wider healthcare system. In 2002, providing care professionally to older dependent individuals was further legally established with the introduction, at the federal level, of the geriatric nurse and geriatric care assistant position (Bundesgesetzblatt, 2000). These positions require specific training, ensuring comparable and quality care to dependent individuals. These quality requirements were reinforced through inspections since 2008 (Bundesministerium-der-Justiz-und-für-Verbraucherschutz, 1994b). In order to increase the caregiving workforce, and reduce turnover, a minimum wage was introduced for the care sector in 2010. Further attention is given to formal caregivers since 2019. The Nursing Staff Strengthening Act *Pflegepersonal-Stärkungsgesetz* (PpSG) brought an additional 13,000 nurse positions for inpatient care facilities (Bundesministerium-für-Gesundheit, 2018). It also provided pay improvements and better compensation for travel times when providing care in rural areas. The care minimum wage was increased in 2022 (Bundesministerium-für-Arbeit-und-Soziales, 2022) and in 2026 (Bundesministerium-für-Arbeit-und-Soziales, 2025). In 2025, a law expanded nurses competencies allowing more decisions and actions independently of doctors (Bundesministerium-für-Gesundheit, 2025).

Figure 3: Timeline of long-term care policy changes in Germany



Funding :

- The Funding for the German long-term-care insurance system relies on contributions on labor income at the national level. Länders then ensure that the care infrastructure is properly set up and manage the care contracts/employment inside their territory
- since 1995 there is a federal fund to equalize access to long-term care between länders

Notes :

1. Pflegekassen → Long Term Care Insurance Fund
2. 0.1pp of the contribution are used to maintain a fund in case care needs increase faster than expected
3. Medical Inspection Services/Association come to assess the quality of service provided by care establishments since 2008. The quality of the evaluation and independence of the evaluating entity improved particularly in 2022.

4 Spain

4.1 A Decentralized System

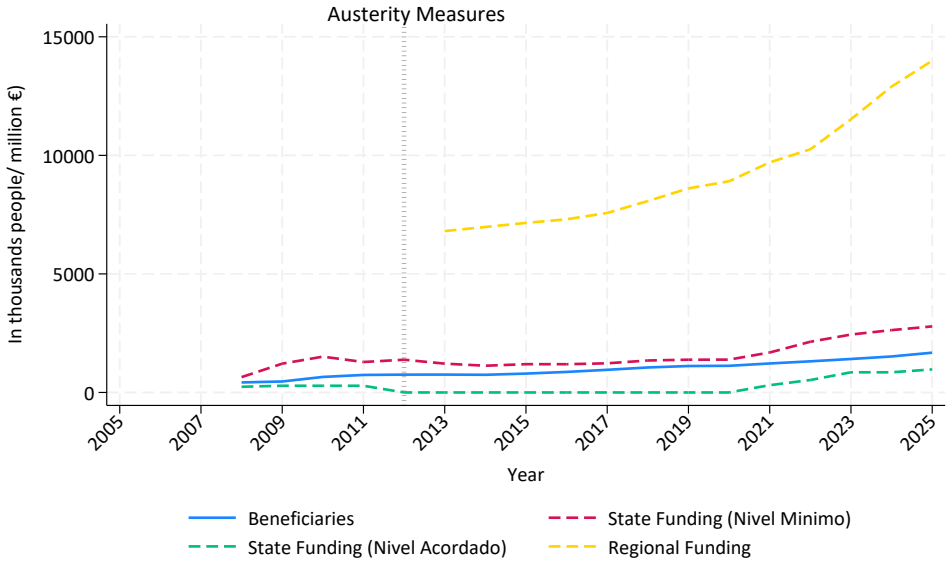
As shown in Figure 5 there were no national long term care system in Spain until 2007, time at which the Spanish National LTC system formed in 2006 began providing benefits, making them late adopters of LTC reforms compared to France and Germany. Before then, the state had initiated efforts to introduce and consolidate social services at the regional and municipal level, including long term care services such as home-help and nursing homes. These were mostly funded at the local and regional level, the funding was rather generous for the services provided to those eligible, except for nursing home costs for which co-payment rates were high (Grigoletti and Pasini, 2024b,a). Even after the introduction of the Dependency Law *Ley de Dependencia*, some of the funding originated from the regions and some initiative, such as the Services to Promote Personal Autonomy and Prevent Situations of Dependence *(Servicios de Promocion de la Autonomia Personal y Prevencion de las Situaciones de Dependencia*, managed and initiated by the regions using their own funding (Grigoletti and Pasini, 2024a) this led in 2011 to have 4 regions providing these services, and still having four other not providing it by 2014.

4.2 Benefits Structure

The central government took a major role in long term care following the introduction of the *Ley de Dependencia*, including autonomy as the fourth branch of Spanish social security (BOE, 2006). By choosing to provide benefits without developing a national long term care insurance, Spain seem to have chosen a path similar to France. One should note however that it came as a national supplement to the LTC support already provided by the Autonomous Communities *Comunidades Autonomas*. To ensure this new right, the System for Autonomy and Care for Dependency *Sistema para la Autonomia y Atencion a la Dependencia* (SAAD) was formed. The Spanish government, similarly to the German system, functioned with three levels of dependency. However, these levels result not only in different levels of generosity but also different sources of funding for benefits. The Minimum Level *Nivel Minimo* covers basic care benefits and services and is fully provided by the central government. The Supplemental Level *Nivel Acordado* includes additional benefits and services financed by the state and the autonomous communities. Laslty the additional level *Nivel Adicional* includes all additional benefits and services provided exclusively by the autonomous communities (Grigoletti and Pasini, 2024a). Moreover, the eligibility of the different dependency levels to benefits became gradually effective, with grade 3 being eligible by 2007 and grade 2 becoming progressively eligible between 2008 and 2010. Making Spain a unique setting to evaluate the impact of the level of funding on access to allowance and consequences on health maintenance.
Spain was among the countries hardest hit by the financial crisis and the ensuing eurozone debt crisis (International Monetary Fund, 2009, 2012). As such, their austerity plan included important cuts to the long term care system. For recipient of benefits, this mostly took the form of delayed access to benefits when already eligible and delayed introduction of benefits for less dependent individuals than originally planned by the 2006 law (BOE, 2012). As such, people evaluated at grade 1 or moderate dependency only became eligible to some benefits from 2015 onwards (BOE, 2006). Another notable

cut occurring at that period regards state's expenditure for long term care, both in the form of the *Nivel Minimo* stagnating and the *Nivel Acordado* being suspended altogether between 2012 and 2020, as shown in Figure 4. After the covid pandemic, as the Spanish economy seemed to have recovered from the financial crisis and received important support from the European Central Bank ECB, the long term care system experienced important reinvestment. This chain of policies was named the Shock Plan for Dependence *Plan de Choque en Dependencia*. The plan ranged far into the Spanish long term care policy, increasing the SAAD's budget through the *nivel acordado* by half a billion euros which represented a near two-fold increase compared to its initial level in 2020 (BOE, 2023) as shown in Figure 4. The plan also improved the organizational structure of the SAAD, intent on reducing waiting lists. It introduced telemedicine as a integrate tool for long term care and geared the system towards ageing in place rather than in institutions (BOE, 2023). In terms of benefits, it led to higher maximums amounts for the different dependency grades as well as the introduction of minimum amounts (BOE, 2023). This was furthered in 2026 through additional funding by the state and general increase in benefits (BOE, 2026; Ministerio-de-Derechos-Sociales-y-Agenda-2030, 2026).

Figure 4: Beneficiaries and Yearly Expenditure in Spain



Note: This figure shows the evolution of the number of beneficiaries of the long term care insurance benefits in Spain since its first full year in place in 2008. One can see that membership grew in a rather stable fashion throughout the program's existence. On the other hand the amount of benefits provided by the different entities involved in LTC faced important variations over that period. State funding saw important cut/stagnation following the GFC and Eurozone crisis with the nivel acordado being suspended and nivel minimo stagnating over that period. Both have since experienced important growth, especially since 2021. Regional funding in the other hand was measured since 2013 and seem to have taken on the expenses the state did not fund. It increased over the austerity period in Spain and contrinues expanding rapidly since 2019.
Information regarding regional funding are missing until 2013. Yet the Regions/Autonomous Communities were already the main provider of LTC in Spain
Source: Ministerio de Derechos Sociales, Consumo y Agenda 2030, Imerso "Financiacion del SAAD" Ministerio de Derechos Sociales, Consumo y Agenda 2030, Imerso "Evolucion de los principales indicadores de la gestion del SAAD"

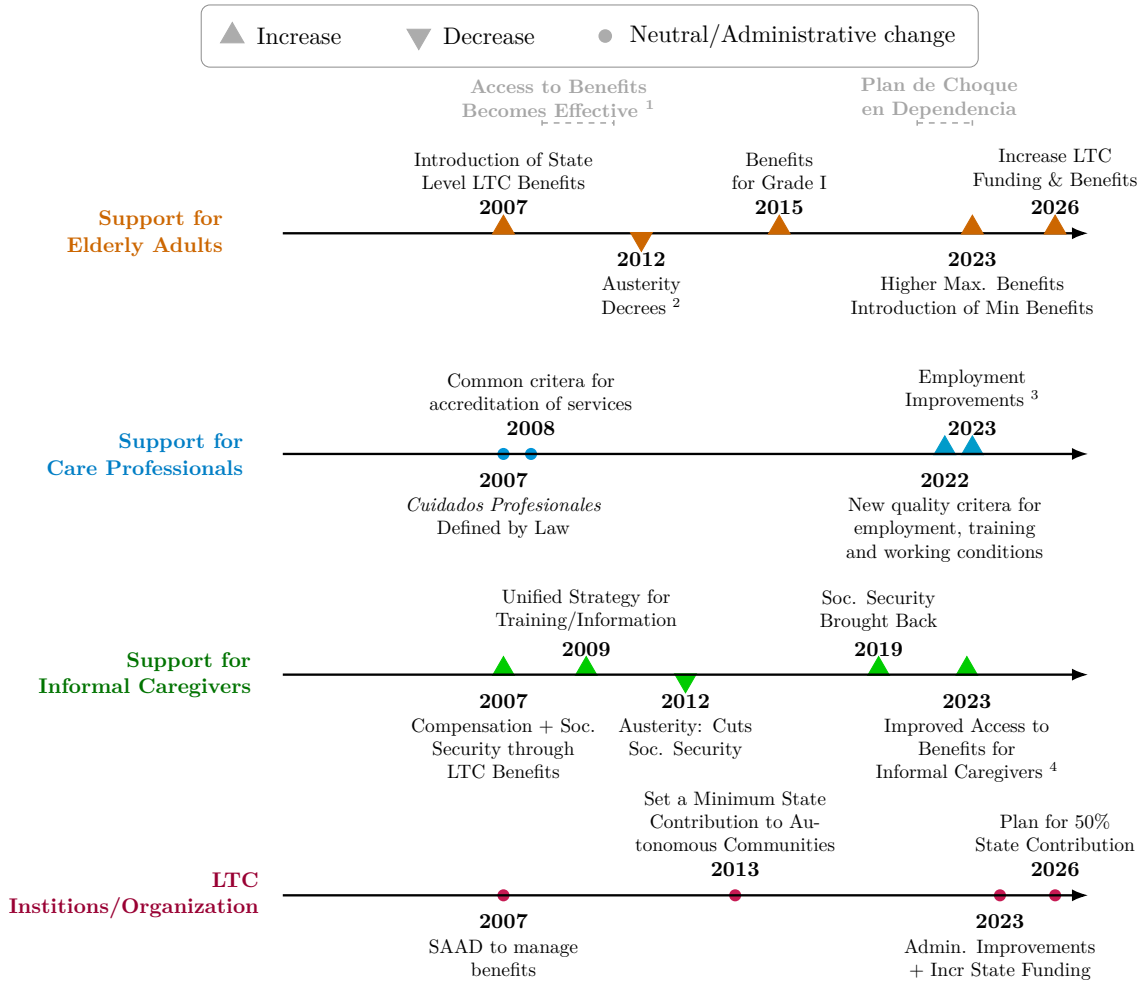
4.3 Support for Professional Caregivers

Working as a formal caregiver was defined at the national level alongside the introduction of the *Ley de Dependencia* (BOE, 2006), the criteria allowing professional care workers and institutions to benefit from the SAAD was then specified in 2008 (BOE, 2008). It functioned more as a minimum requirement applicable in all autonomous communities. Relatively little occurred at the national level in order to improve the situation of formal caregivers. This goes rather well with the stagnating minimum wages in Spain from the financial crisis until at least 2016. This changed after the pandemic. In 2021-23, the *Plan de Choque en Dependencia* included efforts to improve working conditions of care workers although no clear wage improvement commitment may be found in the plan (BOE, 2023). One might note however, that minimum wages grew over that period of time. In 2022 new criterion for training for workers and working conditions were introduced (BOE, 2022).

4.4 Support for Informal Caregivers

The *Ley de Dependencia* made room for compensating informal caregivers. The benefits could be used to pay a relative who provides important care services to the recipient (BOE, 2006). These caregivers could then receive training from the regions or municipalities with guidelines being provided by the state in 2009 (BOE, 2009). Following the financial crisis, the austerity measures made informal caregivers enjoy fewer advantages from caregiving notably regarding social security contributions they could no longer get from caregiving (BOE, 2012). In 2019 these social security contributions were brought back (BOE, 2019). The *Plan de Choque en Dependencia* also benefited informal caregivers who now had access to more benefits to get paid. Additionally, more informal caregivers could be eligible to be compensated for the care they provide to a beneficiary, particularly those without a kinship link to the care recipient (BOE, 2023).

Figure 5: Timeline of long-term care policy changes in Spain



Funding :

- The funding of the Spanish long term care system, throughout the years, is becoming centralized. Before 2007 most if not all funding came from the autonomous communities and municipalities. As the 2006 law was passed the state got involved and started to organized and fund LTC, its share is called the *nivel acordado* and is supposed to reach 50% in the coming years.

Notes :

1. Grade 3 dependencies were the first to become eligible, early in 2007. All Grade 2 dependencies then became eligible in 2009.
2. Austerity measures, regarding benefits, included notably delayed access to LTC for Grade 1 dependent people, reduced state funding in the form of the nivel acordado.
3. While the Plan de Choque did not include wage improvements, there were commitments towards improved working conditions and better training.
4. Non-kin such neighbours are now eligible to be considered as informal caregivers. It also takes less time caring for somebody to become eligible.

5 Conclusion

Over the past three decades, France, Germany, and Spain have all faced the same underlying challenge: adapting their welfare systems to a growing number of older adults with long-term care (LTC) needs. This challenge is not only a matter of support for dependency, but also insure supply and support relatives of individuals loosing their independence. Yet the three countries have pursued markedly different institutional paths. France progressively built LTC support through a fragmented set of benefits and services layered onto existing social protection programs. Germany established a dedicated social LTC insurance scheme financed through contributions and governed by a coherent national framework. Spain, a later entrant, developed a rights-based national LTC system that remains strongly intertwined with the responsibilities and financing capacities of its autonomous communities. Despite these differences, the evolution of LTC policies in all three countries reveals common concerns regarding the adequacy of benefits, the sustainability of financing, the availability of professional care workers, and the recognition of informal caregiving. This paper review historical evolution over three decades of three European LTC system: France, Germany and Spain. By doing so, it compares different policial choices and evolution, in different context. It also complement previous studies of LTC system, notably the one of the OECD, of Gateway to Global Ageing Data, and of Global Observatory of Long-term Care.

This comparison highlight three main features. First, LTC systems are not static institutions. In all three countries, reforms have gradually expanded the population recognized as needing care and increased the generosity of support. France's transition from the PSD to the APA broadened eligibility and transformed a relatively limited assistance scheme into a mass social program. Germany adjusted its LTC insurance to account for dementia and cognitive limitations. Spain experienced a more discontinuous trajectory, notably due to the austerity years. These experiences illustrate that LTC reforms often occur through incremental adjustments to eligibility criteria, benefit levels, and assessment procedures rather than through complete institutional redesign.

Second, challenges regarding the workforce required to deliver care appears to be a concern in the three countries. The difficulties of recruiting and retaining care workers have progressively moved to the forefront of the policy agenda. Germany addressed this challenge relatively early through occupational recognition, wage regulation, and workforce expansion measures. France focused more recently on wage increases, minimum service tariffs, and organisational reforms of home-care services, particularly following the COVID-19 pandemic and public concerns about care quality. Spain has devoted comparatively less attention to workforce policies at the national level, although recent reforms have strengthened training requirements and improved working conditions. The growing prominence of workforce policies reflects a broader recognition that expanding LTC entitlements is of limited value if formal care services cannot attract sufficient workers to meet demand.

Third, the historical evolution of LTC policy highlights the central role of informal caregivers. While the initial focus of LTC reforms was often on supporting dependent older adults directly, policy attention has increasingly shifted toward the families who provide substantial amounts of care. Germany is the country who incentivise and support the most informal caregivers. France moved more gradually from allowing benefits to

compensate family caregivers toward developing respite care and paid caregiving leave, with an intermediate approach, driven by the aim of supporting informal caregivers without providing incentive to leave the labour force in favour of a caregiver occupation. Spain implemented a reduced support for informal caregiver during the austerity, and recently reintroduced and strengthened the support. Across all three countries, the trajectory of reforms suggests growing awareness that the sustainability of LTC systems depends not only on formal services but also on preventing excessive burdens on family members and protecting caregivers' labour market attachment, health, and financial security.

The comparison suggests that LTC systems increasingly confront a threefold policy challenge. First, they must provide adequate support to older adults experiencing a loss of independence. Second, they must ensure a sufficient supply of formal care workers through attractive wages, working conditions, and career opportunities. Third, they must support informal caregivers in order to prevent excessive family burden and its associated health and labour market consequences. While all three countries have made progress on these dimensions, none can be considered to have fully resolved these challenges. In particular, France and Germany have not yet demonstrated that their systems can sustainably protect the population against old-age disability risks while adapting to demographic change. Across all three countries, ensuring an adequate supply of formal caregivers and strengthening support for informal caregivers emerge as major policy challenges. This highlights the need for further research to inform effective and evidence-based public policy decisions.

Finally, this historical perspective provides valuable opportunities for future research. The diversity of reforms implemented across France, Germany, and Spain creates a rich laboratory for evaluating how different policy instruments affect care utilization, health outcomes, labour supply, family caregiving arrangements, and public expenditures. The existing literature has evaluated these policies in an ex-post fashion trying to determine its policy objective and assess whether this was accomplished in France (Arrighi et al., 2015; Petite, 2006; Flipo et al., 2007; Arnault and Wittwer, 2021; Latourelle, 2019), in Germany (Rothgang, 2010; Bundesministerium-für-Gesundheit, 2017, 2020; Geyer and Korfhage, 2018; Link, 2019; Szenkurök, 2026) and in Spain (Correa Gómez et al., 2011; Peña-Longobardo et al., 2016; CostaFont and VilaplanaPrieto, 2017; Costa-Font et al., 2022, 2023; Ramírez-Pérez and Cámara, 2023). As population ageing continues across Europe, understanding the consequences of alternative LTC models will become increasingly important for policymakers seeking to reconcile access to care, fiscal sustainability, and social equity.

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