



CONVENCIÓN
EUROPEA DE LA DEPENDENCIA

LA ATENCIÓN A LAS PERSONAS EN SITUACIÓN DE DEPENDENCIA EN EUROPA

SITUACIÓN ACTUAL
Y PROPUESTAS DE FUTURO



EUROPEAN
CONVENTION ON LONG-TERM CARE

ATTENDANCE FOR PEOPLE IN NEED OF LONG-TERM CARE IN EUROPE

CURRENT SITUATION
AND PROPOSALS FOR THE FUTURE

MADRID 2026



ECONOMÍA Y SALUD
FUNDACIÓN

PANEL III Financing and Taxation

Co-payment and beneficiary contribution

What share of cost do care recipients bear, on what basis and with what effect on access and inequality?

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Four structural models of co-payment

Capped user fees

Sweden · Denmark · Finland

Care itself is free or subject to a statutory ceiling.
Rent and food are billed separately, uncapped.

Open-ended partial insurance

Germany

A fixed insurance benefit; every euro above it is self-pay, regardless of income or assets. The only system in the sample with no income test and no overall cap.

Capped, means-tested contribution

Netherlands

Two-tier eigen bijdrage, income- and asset-tested, but with a statutory maximum (2026: €3,062/month, incl. accommodation).

Fragmented, income-adjusted systems

Spain · Italy · France

National entitlements or benefits are combined with decentralised implementation, producing substantial variation in user contributions, service availability and effective access within each country.

Four structural models of co-payment

Capped user fees (Sweden, Denmark, Finland)

Care is either free or subject to statutory financial protection. The public system largely carries the risk of increasing care costs, while beneficiaries remain responsible for some housing, food and personal expenses.

- **Denmark:** core care services largely free, residents pay separately for accommodation, food and personal expenses.
- **Sweden:** low absolute care-fee ceiling (240 €/month), rent, food, medicines, consumables and other living expenses are generally charged separately (medicines: separate national high-cost protection); protected minimum amount 2026: 644 €/month
- **Finland:** income-related charge with a protected personal allowance: up to 85% of net income in long-term 24-hour service housing, family care and institutional care; minimum allowance 2026: €195 (service housing) / €131 (institutional) per month

Four structural models of co-payment

Capped Income- and Asset-Related Contribution (Netherlands)

The beneficiary's contribution is adjusted to financial capacity and living arrangements but remains subject to a statutory maximum.

Access to long-term care is based on assessed care needs. Beneficiaries pay a personal contribution calculated according to:

- income,
- assets,
- household composition,
- age,
- living and care arrangements.

The maximum contribution is 3,062 Euro per month (2026; covers both care and accommodation).

Four structural models of co-payment

Open-ended partial insurance (Germany)

Germany provides universal long-term care insurance, but the insurance covers only part of the actual cost of care (Teilkasko-Principle).

There is no statutory ceiling on the beneficiary's total remaining care costs.

Four structural models of co-payment

Regionally fragmented and income-adjusted systems (Spain, Italy, France)

National entitlements or benefits are combined with decentralised implementation, producing substantial variation in user contributions, service availability and effective access within each country.

Spain

- The national SAAD system (Sistema de Autonomía y Atención a la Dependencia) establishes a general entitlement based on assessed dependency. The autonomous communities implement and administer the system.
- Beneficiaries contribute through regional co-payment arrangements.
- Contributions are related to financial capacity.

Four structural models of co-payment

France

- The principal long-term care benefit is the Allocation personnalisée d'autonomie, APA.
- The beneficiary's income determines the level of personal contribution (national scale); care-home accommodation costs: means-tested ASH as secondary safety net.
- The départements administer and finance a substantial part of the system.

Italy

- Universal flat-rate cash benefit for people meeting the relevant disability and dependency conditions.
- 2025-2026 pilot (Prestazione Universale): means-tested supplement of €850/month for people aged 80+ with very severe care needs and ISEE $\leq$ €6,000, earmarked for regular care work.
- The national cash benefit is not linked to income or assets, it is not systematically adjusted to the intensity or actual cost of care.
- Its use is generally not restricted to formal or quality-assured services.
- Publicly funded services are organised through regions and municipalities.

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Effect on access and inequality

Higher co-payments increase the risk of financial barriers

- Germany shows the highest resident burden in the sample; however, second social net ensures access

Income-tested and capped systems provide stronger financial protection

- Nordic countries and the Netherlands limit individual exposure to care costs
- Lower risk of care-related poverty

Decentralised systems can create territorial inequalities

- Regional variation affects user contributions and effective access
- Different levels of protection within the same country

Deep Dive GERMANY

The only system in the sample with no income test and no overall cap — and the fastest-rising resident co-payment

A fixed insurance benefit, an open-ended resident bill

Since 1995, German long-term care insurance (SGB XI) has been a partial (“Teilkasko”) insurance: it pays a fixed, care-grade-based ceiling: €2,096/month at most for residential care in 2026 (care-grade 5). **Everything above that like the facility-wide care co-payment (EEE), accommodation, food and investment costs is paid by the resident, regardless of income or assets.**

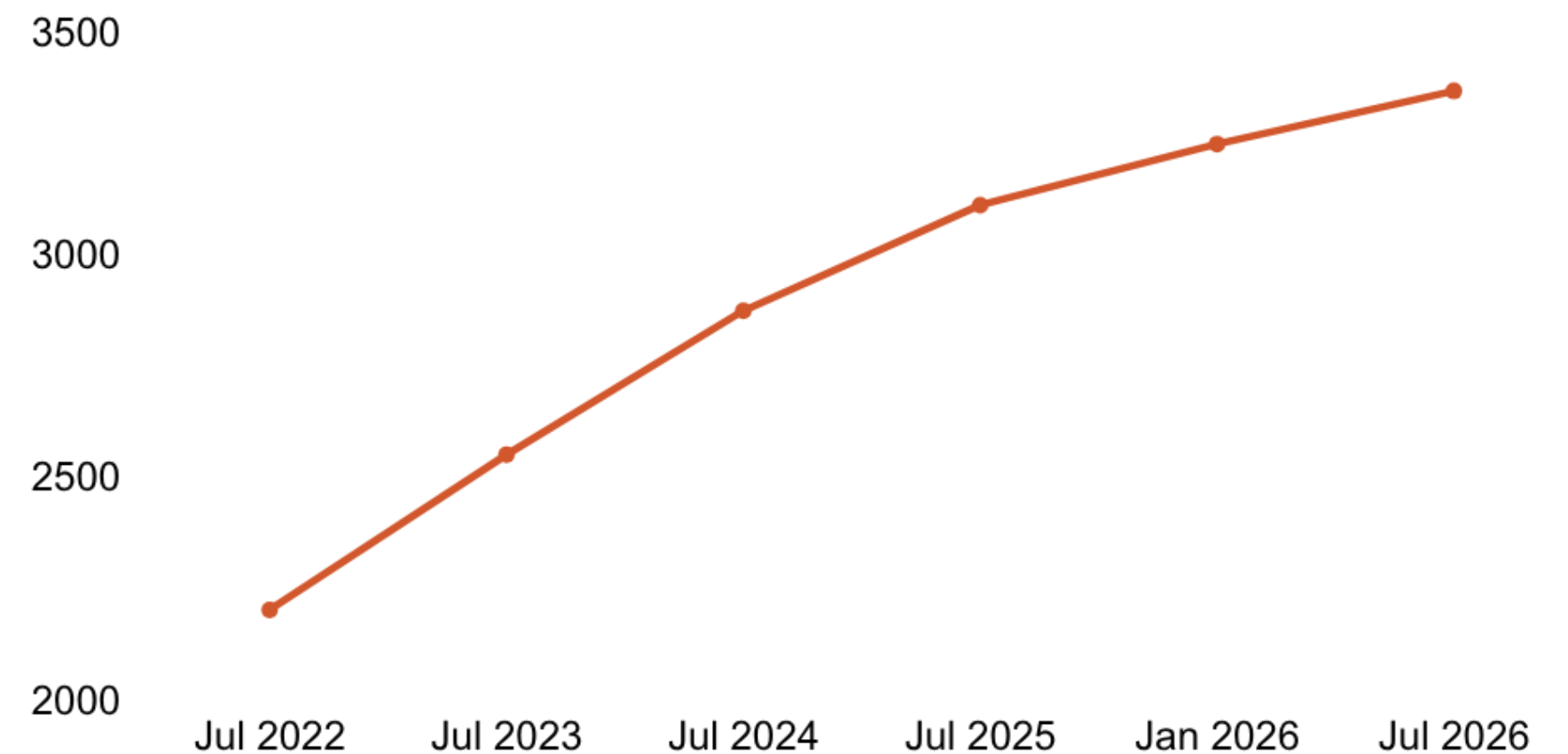
€ 2,096

max. statutory monthly
ceiling, residential care

~1 in 3

residents also draw means-
tested social assistance
(Hilfe zur Pflege)

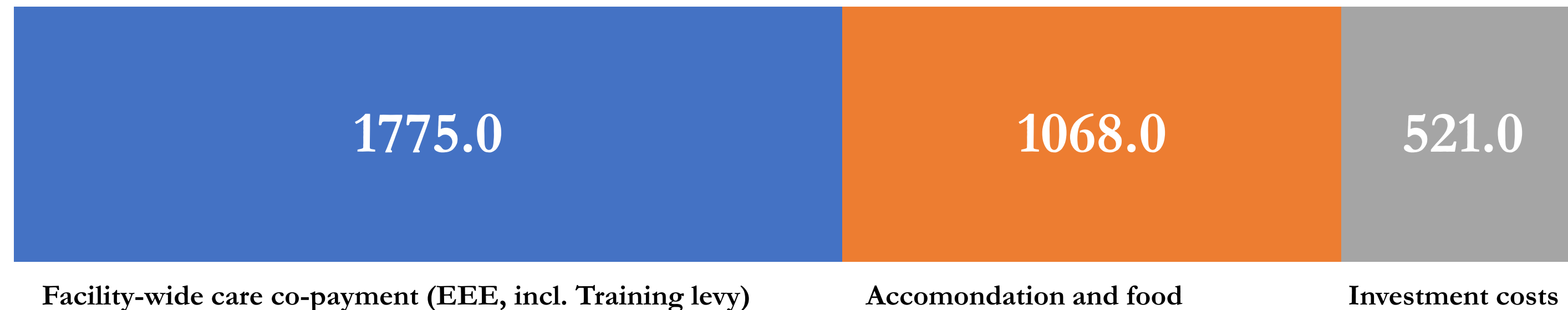
Average resident co-payment, Germany (EUR/month)



+8–9% year-on-year — driven by wage (tariff), training-levy and investment-cost increases passed through to residents.

Where the €3.364 goes

Composition of the average co-payment, 2026 (EUR/month)



Regional spread: Bremen €3.761/month · Saxony-Anhalt €2.891/month

Out-of-pocket care costs incurred by households

Care Services	Mean monthly cost (€)	Median monthly cost (€)
Home care service	277	100
Day care service	397	212
Short-term care	677	318
Total	469	200

Source: WidO 2026

Since 2017, reimbursement rates for home care providers have increased by 38% nationwide, whereas long-term care insurance benefits for home care have risen by only 5%. Consequently, out-of-pocket expenses for home care recipients have increased by more than 50% within just five years.

5 measures to secure care in the future

Design opportunities, economic viability, workforce security

Making long-term care fit for the future: Five priorities for a sustainable and high-quality care system

1. **Ensure access:** No matter the financial system, the right to wish and choose the form of care must not be denied by co-payments

2. **Strengthen competitiveness:** Encourage quality, efficiency, and innovation through fair competition of the providers.
3. **Ensure economic stability:** provide reliable financing and reduce excessive bureaucracy, create stable conditions for investment and growth.
4. **Secure workforce:** use the pillars of educating new care workers, keeping existing ones in the job, bringing international workforce and providing attractive working conditions.
5. **Enable innovation:** give providers greater flexibility to develop and implement innovative solutions



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GRACIAS THANK YOU

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Key sources

- ESPAN / European Commission (2026), Long-term care settings for older people
- vdek (2025/2026), Finanzielle Eigenbeteiligung in der vollstationären Pflege
- OECD Health Statistics 2025 / Health at a Glance 2025
- National tax authorities: BMF (DE), impots.gouv.fr (FR), Agenzia delle Entrate (IT), Belastingdienst (NL), HMRC (UK), Skatteverket (SE), AEAT (ES), Skattestyrelsen (DK), Vero (FI)
- Benefit and contribution authorities: CAK (NL), DHSC (UK), Socialstyrelsen (SE), INPS (IT), CNSA (FR)