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# Funding system of LTC in the Netherlands

Aad Koster

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# Funding system of LTC in the Netherlands I

1. Care-& nursing homes are public funded by ‘The long term care act’ (WLZ). Care-offices runned by insurance companies pay the providers.
2. Every citizen above 18 pays WLZ-premium.
3. 2024: 18.6 billion for 130.000 places.
4. In 10 years the amount of for-profit homes grew from 96 to 500 with ± 15.000 places.
5. public:0%, private not-for-profit:88%, private for-profit:12%.
6. In not-for-profit homes you pay per month between 205 and 2954 euro depending on income.
7. In for-profit homes care is payed by WLZ, housing and services payed by the resident.

# Funding system of LTC in the Netherlands II

1. Nursing & care at home is public funded by ‘Health Insurance Act’ (ZVW). Insurance companies pay the providers.
2. Every citizen and employer pays ZVW-premium.
3. 2024: 3.3 billion euro.
4. Domestic help, transport, daycare, accompaniment, wheelchairs etc. is public funded by ‘Social Support Act’ (WMO). Municipalities take care of the WMO.
5. There are 4569 registered home care organisations. Public: 0%, private not-for-profit 10% (but they deliver ±80% of the budget), for-profit 90%.
6. Every client has to pay a small financial contribution.

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# Private - for profit and not for profit

- Government policy:
- 1 ‘as much self as possible’: more informal care by family, neighbourhood, volunteers, reablement
- 2 ‘as much at home as possible’: more appropiate housing, facilities in neighbourhood, care at home
- 3 ‘as much digital as possible’: more technology
- Growing amount of for-profit homes and for-profit ‘care and support at home’-organisations.
- More citizen initiatives.
- More coöperation between elderly care-organisations, organisations for well-being and citizen initiatives.

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# Funding system of LTC in FRANCE

Didier Sapy

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# Funding system of LTC in France

3 sources of funding : client, national public funds (called « social security ») and local public funds

- Care homes :

→Clients = 54%

→National = 32%

→Local = 14%

- Home care :

→National = 100%

- Other home support :

→ No data available (in progress)

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# Public and private providers

- Care Homes :

→Public = 50%

→Not-for-profit = 30%

→For-profit = 20%

- Home Care :

→Public = 33%

→Not-for-profit = 50%

→For-profit = 17%

# Private - for profit and not for profit

- Situation

→ Financial losses, labour shortage, lack of trust (Orpea case)

- Trends

→ Raising costs for the clients only, waiting for a new deal

→ Higher demand on quality of care and quality of work

- Future

→ Attractiveness, reputation as provider of good care and as employer

→ Person-centered and home-like organizations

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# Funding system of LTC in Sweden

Maria Mannerholm

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# Funding system of LTC in Sweden
# LTC expenditure 3.2- 3.3 % of GDP

- Municipal/Local taxes.
  85- 90 % of LTC cost covered by local taxes

- National Government Grants/ State Funding
  10- 12 % of LTC spending

- User Fees/ Out-of- Pocket Payments
  4- 6 % of LTC financing.
  Income- related fees.
  Ceiling on what care recipient can be charged.

- No Private LTC insurance

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# Social Service Act

- Ensures provision based on needs not means.
- Core values

  Dignity

  Self determination

  Individualisation

  Freedom of choice

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# Services provided

- Nursing and care home
- Serviced apartment
- Senior housing
- Respite care/ short term care
- Home care services. Keyless.
- Personal security alarm
- Day- centre activities
- Transport services
- Assistive devices
- Janitor service

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# Providers of services and care

- Voucher system.
  Individual choice

- Municipal providers
- Private providers
- Non for profit providers

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# Future trends

- Rapidly aging population.
  1 in 4 Swedes 65+ in 2040

- Rising costs of care.
  health improvements can reduce care needs.

- Shift toward
  home-based
  preventive
  technology- assisted care

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# Challenges

- Sustainability of financing
  Balance between
  service level
  fees
  tax base

- Workforce shortages and skills

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# Way forward

- Focus on Aging- in- Place
- New models of care. Integrated health/ social care. Mobile in home care.
- Increased investment in prevention
- Boost and stabilize LTC workforce capacity

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# Funding system of LTC in ITALY

Elena Weber

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# Funding system of LTC in Italy

In italy there are 21 different systems, one per each region, and really in one region there are 2 different ones.

Concerning the region I am coming from, Friuli Venezia Giulia, the system is based on a mix between public and private fundings.

The public funding is supported by our region (Friuli Venezia Giulia) and it is not going directly to the person, it is going directly to the hosting care services.

The biggest part is paid by the individual (private funding) directly, again, to the hosting care services.


# Differences between LTC hosting self and not self indipendent persons

- For self indipendent persons: 23 LTC residential services
- For not self indipendent persons: 143 LTC residential services

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# Waiting list

- medium number of days in waiting list: 91

- going from 151 days in Gorizia province to 101 in Pordenone province

- from 77 in Udine province to 75 in Trieste province

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# Cost per day in 2024

- medium cost per day: eur 84,14
- minimum cost per day: eur 52,30
- maximum cost per day: eur 135,54

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# Future challenges

- new 40 LTC residential services to be established in our region in the next 20 years

Public-private-partnership to be activate in LTC residential services so to be able to support the reduction our region is going to define in LTC residential services

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# Funding system of LTC in Czech Republic

Ing. Věra Husáková, MBA

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# Funding system of LTC in Czech Republic

**LTC system** is divided between **social and health care sector:**

- **Social care sector – nursing homes, homes for people with dementia, community-based and field services etc.**
- **Health care sector – Long-term care hospitals, Home health care etc.**

**Main financial streams for social sector:**

- **Care allowance** – state benefit for individuals, 4 levels (880 – 27 000 CZK / month), mandatory public expenditure.
- **Client co-payments** – regulated fees for accommodation & meals.
- **Operating subsidies** for registered social services – state budget + regional co-funding (+ municipalities).
- **Additional client contributions** – in facilities outside the regional funding network, where operating subsidies are not provided, part of the care costs is covered directly by the client or family.
- **Health insurance payments** – for nursing care within LTC facilities (contractual basis).

No unified LTC financing framework – fragmented responsibilities.

# Public and private providers CZ SOCIAL

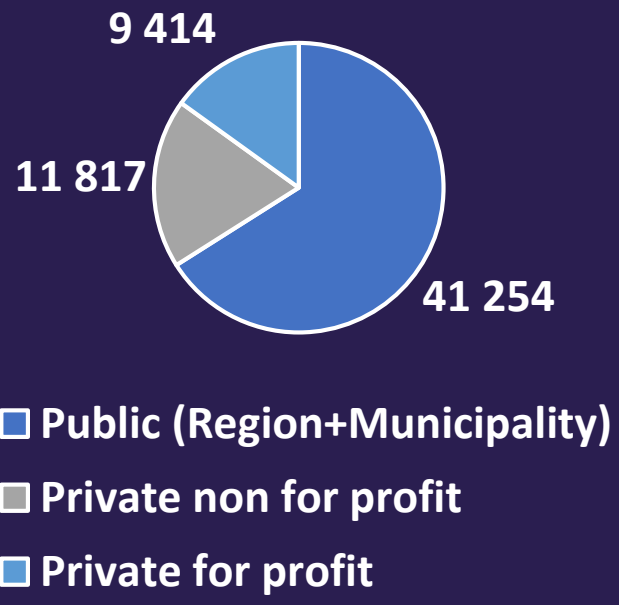
**Number of facilities**
937

- **Nursing homes**
  521
- **Homes for people with dementia**
  416

**Capacity of beds**
62 485

**Share of beds in public ownership**
66 %

**Market Structure by Type of Provider (Number of Beds)**




**Source:** MPSV Statistical Yearbook 2024; internal analysis Vera Husáková)

## Environment

- Regulation defined by Act 108/2006 Coll. and Decree 505/2006 Coll.
- Quality standards are monitored by the Social Services Inspection of Ministry (MPSV).
- No defined national capacity planning or personnel standards → strong regional differences.

# Private - for profit and not for profit

## Support

- Public providers (regional, municipal) are included in regional LTC networks and regularly funded through state and regional subsidies.
- Private providers (for-profit & non-profit) operate under the same legal framework – Act No. 108/2006 Coll. – but 90% of beds are without investment grants or systemic inclusion in regional planning.

## Trends

- Rapid growth of private capacity over the past 10 years (esp. dementia care).
- Expansion driven by demographic demand and insufficient public supply.
- Focus on quality, innovation and digitalisation (telecare, AI).

## Future

- Ageing population and rising demand for care capacity – around +15,000 additional LTC beds needed by 2035.
- Integration of social and health funding supported by legislative reform (2025–2030).
- Greater involvement of insurance and public-private partnerships.
- Workforce stability and attractiveness of care professions remain key challenges.
- Transparent and equal conditions for cooperation between public and private providers.

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# Funding system of LTC in AUSTRIA

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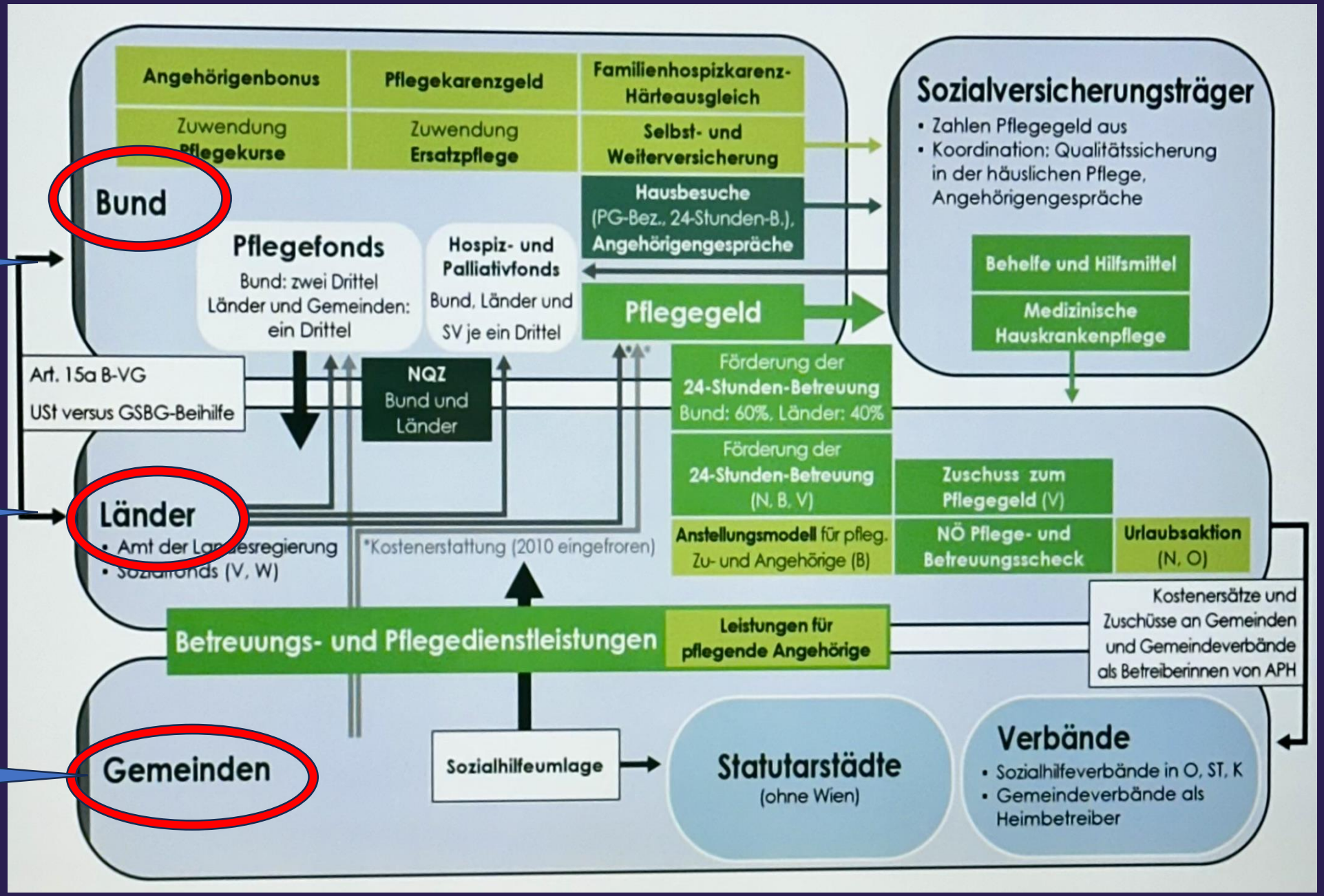
financial supporting

- people in need for care
- Caregivers (informal)
- regional authorities

legally responsible & financial supporting

- structural quality
- process quality
- result quality

financial supporting

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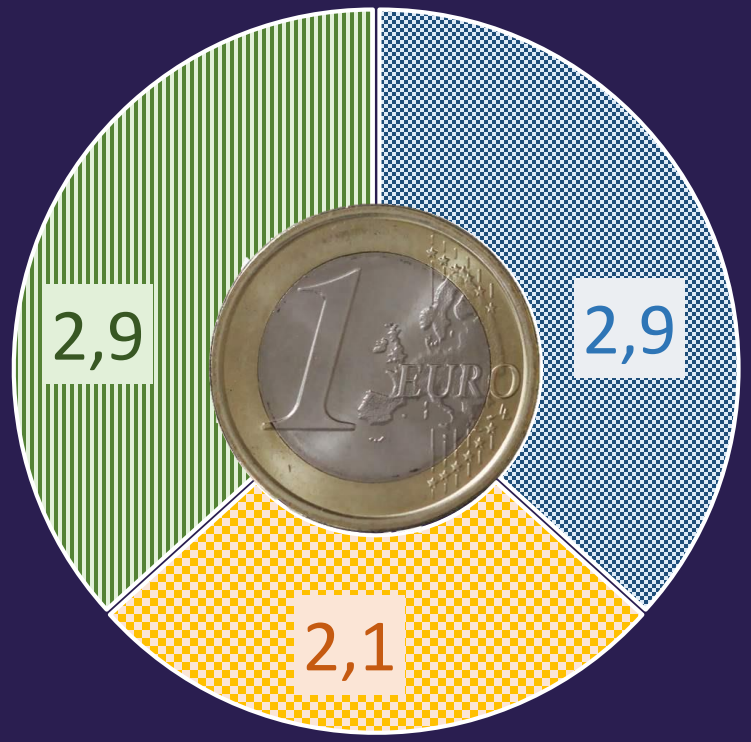
# Source of Funds

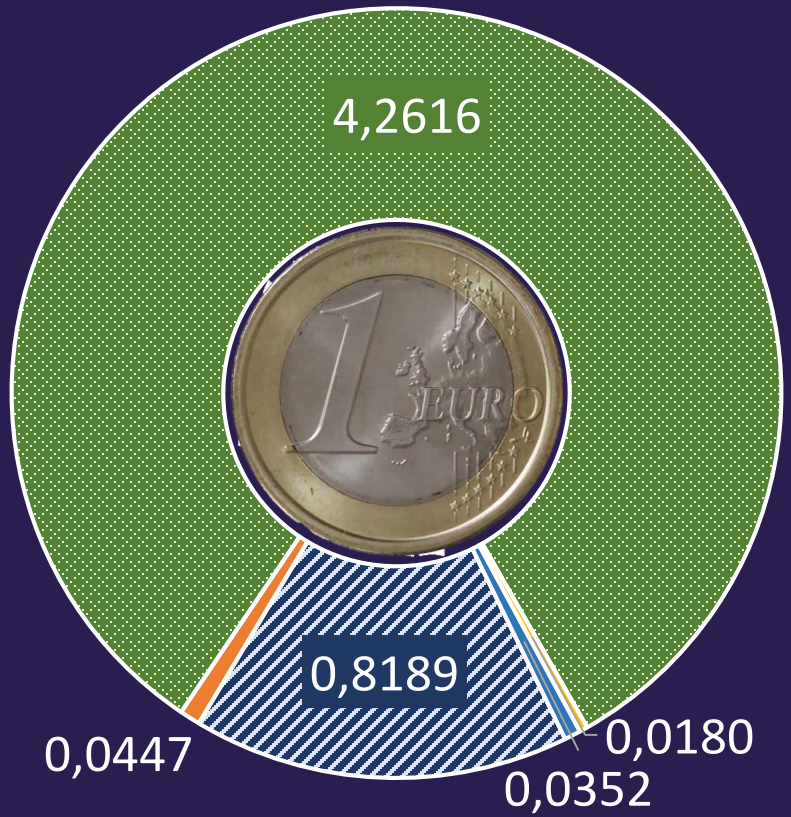
(Bundesrechnungshof – Federal Audit Service)




- 37% Federal Government
- 37% Private Persons
- 26% Regional Governments & Municipalities

# Use of Funds

(Statistik Austria)

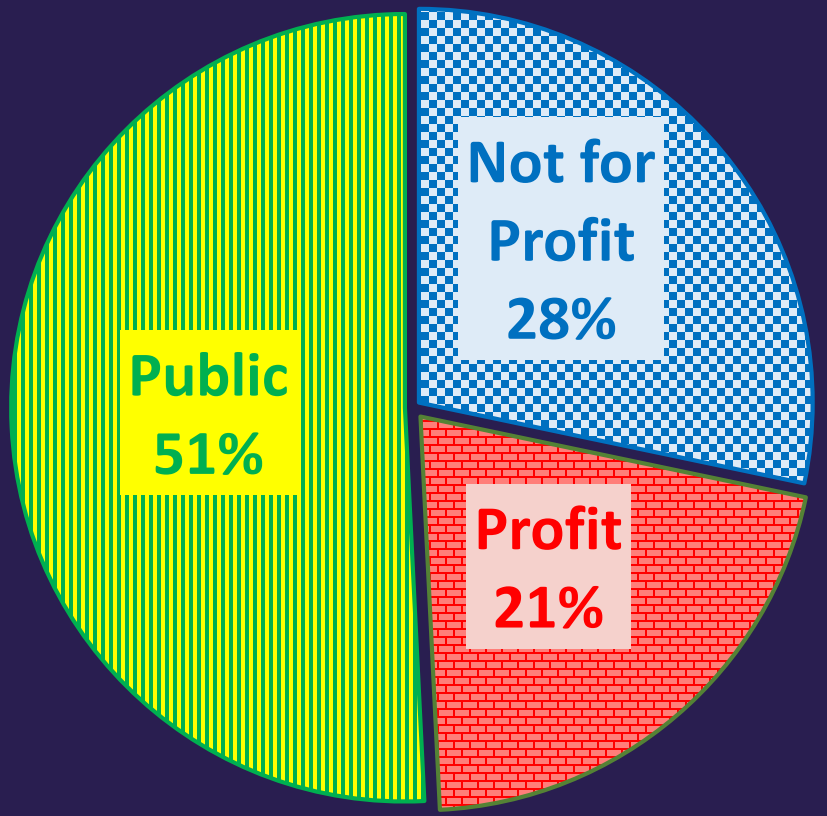



- 15,8 % Mobile Services
- 0,9 % Daily Care Services
- 82,3 % Nursing Homes
- 0,3 % Alternative Living Settings
- 0,7 % Case & Caremanagement

# NURSING HOMES in AUSTRIA regarding PROVIDERS

Source: Statistic Austria, Annual Nursing Service Report

| | nursing homes | places | average places |
|---|---|---|---|
| Not for Profit | 376 | 22.980 | 61 |
| Profit | 296 | 16.999 | 57 |
| Public | 405 | 41.255 | 102 |
| Total | 1.077 | 81.234 | 75 |



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# Private - for profit and not for profit

➢ **SITUATION**

- according to the regional legislation different types of tariff systems
- regional laws + national laws regulates the service content

⇒ No distinction is made between providers, but providers make distinctions for non-regulated services

⇒ no nationwide pay system - equal pay for equal work is not guaranteed

⇒ Bundespflegegeldgesetz- uniform federal subsidies - 7 care levels

⇒ no nationwide uniform standards for staffing requirements

➢ **TRENDS**

- more and more regional governments prefer NPO sector
- public budget restrictions on each level

➢ **FUTURE**

- no cost-covering tariffs
- the gap between service provision - entitlement to benefits and service financing is widening
- Concentration of providers in the care sector
- Urban-rural gap in performance due to staff and financial shortages
- Need for a holistic view of needs and requirements
- overall economic analysis and evaluation of the care sector in the context of other services such as education, health, public transport, security
- Increasing efficiency in service provision while maintaining contemporary quality - the question of core tasks

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# Funding system of LTC in PORTUGAL

Antonio Gouveia

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# Funding system of LTC in Portugal

Portugal offers a mix of public, non-profit (social), informal (family) and private funding for long-term care:

**- Social Security / Public Social Services**

*Residential care* (nursing homes / elderly care homes / "lares residenciais") for temporary or permanent stays. Users typically pay a "contribution" based on income

*Home help services* ("apoio domiciliário"), for people who are dependent and cannot carry out activities of daily living without help

*Solidarity Supplement for the Elderly (Complemento Solidário para Idosos): for low-income seniors aged 66+ (and meeting residency requirements). It's a monthly cash benefit*

# Funding system of LTC in Portugal

- National Network of Integrated Long-Term Care (RNCCI)

*The Rede Nacional de Cuidados Continuados Integrados is a public network that combines health and social care services, including beds for long-term and palliative care, rehab, residential/inpatient maintenance, etc.*

*The State contributes via budgets, sometimes co-financed by different ministries (Health; Labour, Solidarity & Social Security) depending on the type of service.*

# Funding system of LTC in Portugal

- Third-Sector / Non-Profit Providers

A large share of LTC services are delivered by non-profit / social economy institutions (charities, religious organizations, associations) under agreements or contracts with the State. These providers often receive public funding or subsidies to provide services

# Public and private providers

**Public / Government Support**

- Portugal has public social services and safety nets, so for people with limited resources, there may be subsidies or assistance. The cost someone actually pays can depend on their income, assets, and what benefits they qualify for
- There are also “moderation fees” in the public health system, and sometimes people are exempted
- Waiting lists or low capacity may limit access to public or subsidised care in certain areas
- Additional costs may include: specialised equipment, home modifications, transport, medical supplies, in-home medical visits, etc., which may or may not be covered.

# Public and private providers

## Private Providers

For **basic residential care** in a non-luxury facility, a safe estimate could be around **€1,400-€2,300/month** in many places (higher in Lisbon and in high-amenity homes).

If you need more intensive nursing, medical support, or luxury, the cost could be double ( until 4,600€ )

If staying at home with visiting carers / home care, hourly rates can add up quickly, especially for 24-hour or near-24-hour care.

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# Funding system of LTC in Scotland

Karen Hedge, Scottish Care

WWW.EAN.CARE

# Funding system of LTC in Scotland

**Funding system is complex**

**Care / Nursing Homes**

Route 1 - Independently Funded Person

Route 2 - Care contributions (Personal 292 euros Nursing 131 euros)

Route  3 - Assessed contribution 25,300 - 42,000 euros

Route 4 - Assessed contribution with top up

Route 5 - Fully funded supported person

**Homecare**

Assessed need. Mix of private and state funded

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# Sector composition

- C. 86% of care homes are independent sector

- Number of care homes is decreasing, but the number of  care home places is increasing
- Many not-for-profits have closed. Private homes rely on self-funders or additional charges to be sustainable
- Workforce increased by 17%

- 55% homecare delivered by independent sector
- Number of homecare providers is increasing
- Workforce decreased slightly by 1.3%

# Private - for profit and not for profit

- Immigration

Changes to legislation risk staff continuity and access / attractiveness to new staff

- Financing

Short-termism decision-making

Cabinet Secretary intervention dowloading

National Care Service - Ethical Commissioning

- Future

Prevention agenda

Digital Front Door

Data and AI

Scottish Election

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# Funding system of LTC in ICELAND

Sigurjón Norberg Kjærnested

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# Funding system of LTC in Iceland

- Third sector service providers are contracted by the state to provide LTC
  - Our entity SFV handles negotiations for the providers
- The state pays with individuals contributing a maximum of about 30%, heavily depended on income
- Monthly cost to state per person of 11.000 EUR
- Total cost between 4-5% of Iceland's total budget
- Very strong political and public support for funding
- Special payments:
  - Small providers
  - Based on a measure of care intensity
  - Special spaces
- Housing payments / rent a huge issue

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# Public and private providers

- All providers are non profit
- 85% third sector; 5% public; 5% private
- Key issues:
  - Building more nursing homes
  - Housing payments
  - Health insurance rights
  - Younger people in nursing homes
  - Special solutions

# Private - for profit and not for profit

- Situation
  - World class care being provided
- Trends and challenges
  - Rapidly agaeing population
  - Shortages of healtcare workers
  - Housing a challenge
- Future
  - Welfare tech
  - New class of healthcare worke – education
  - Resident rights

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# Key takeaways

- A great track record of success for the third sector
- Challenges relating to staffing and housing
- Solutions will involve strengthening resident rights, more education of the workforce and massive implementation of welfare tech

# Funding in Social Services – Italy

The Italian socio-healthcare system, though formally national, is effectively composed of 21–22 regional systems, with significant autonomy in governance and delivery. This ensures responsiveness to local needs but also produces deep territorial inequalities, fragmentation of responsibilities, and uneven access to care. The current reform path—anchored in Law 33/2023 and subsequent decrees seeks to reorganize the system by strengthening community health services and integrating social and healthcare pathways. However, critical concerns remain: limited resources, weak enforcement mechanisms, and the risk that reforms may reinforce regional disparities instead of reducing them, unless accompanied by stronger national coordination and sustainable financing.

Health care facilities address all ages while elderly in specific are cared for in the mixed and social care homes. Denominations vary among the regions but generally speaking in Italy, elderly care facilities can be categorized into: Residenze Sanitarie Assistenziali (RSA) for non-self-sufficient elderly, Case di Riposo for elderly who are more independent, and Centri diurni for day care. RSA provide mixed services including both health care and social care. There are trends moving towards enlarging services to the territory, home care, assisted independent living, social housing ecc.

Data sources for the number of elderly care facilities including the split of public/private facilities, general/specialized facilities and the regions are difficult statistic to obtain. The data is highly fragmented due to the complexity of the Italian context. Considering all the differences I estimate a 60 beds average capacity of te facilities.

ISTAT Reports are the main source for all the studies: ISTAT regularly publishes comprehensive data on elderly care facilities in Italy, including the number of beds and their distribution across public and private sectors.
For example, the 2021 report indicates around 414,000 beds in residential care facilities, with significant regional variations.
The latest official ISTAT data reports about 267,000 over 65 years old elderly in care facilities. I consider that this is a reliable starting point for tracking the number of LTC patients. These reports often include the breakdown of beds by general and specialized care.
Please find attached the latest report.
https://www.istat.it/comunicato-stampa/le-strutture-residenziali-socio-assistenziali-e-socio-sanitarie-anno-2021/

There might be around 7,000 residential care facilities for the elderly in Italy.
The market is roughly 75% private players and 25% public (decreasing) .
Of the private facilities, a significant portion is operated by non-profit organizations.

Regional Breakdown:
Northern Regions: Regions like Lombardy and Veneto have higher bed availability, with Lombardy offering tens of thousands of beds. The North-East regions, overall, have about 31 beds per 1,000 elderly residents, reflecting better infrastructure and resource allocation.

Southern Regions: In contrast, southern regions such as Calabria and Sicily struggle with fewer beds, averaging around 5-6 beds per 1,000 elderly residents. This indicates a shortage of facilities and more limited access to care compared to the North.
Around 75% of these facilities are privately operated. Among these, estimated 3400-3500 private facilities have been accredited, meaning they meet the quality standards necessary to receive public funding through Italy's national healthcare system (Servizio Sanitario Nazionale - SSN).

Among private facilities, approximately 70 % big private players + 20 % religious foundations+ 10 random private ex ipab family owned bussinesses ecc
There are mainly the facilities that specialize in conditions like Alzheimer's and dementia, There are also some (yet few) disabled, psychiatric, nutrition disorders facilities but in this care there are regulated and mainly financed by the public health insurance (often commissioned to private providers). The rest are general elderly care facilities.

The average revenue per bed ranges between €2,500 and €3,500 , depending on the region and level of care provided.

The demand is high and growing, particularly for non-self-sufficient elderly. The aging population drives this demand, and waiting lists are common in many regions.

Approximately 300,000 elderly are currently housed in residential nursing homes across Italy. There are no official data but there might be 50,000-70,000 elderly are on waiting lists across Italy, varying by region. The waiting time can range from 3 to 18-24 months , depending on the region and type of facility.
The demand is expected to increase due to the aging population and increased life expectancy. Drivers include the lack of adequate home care and increasing non-self-sufficiency among the elderly. But the wealth of the elderly is decreesing.

Facilities are concentrated in northern Italy , especially in regions like Lombardy, Veneto, Toscana and Emilia-Romagna. Southern regions are less equipped, with fewer facilities per capita. The facilities in rural areas tend to be smaller and have fewer beds compared to urban facilities.

## Residential Elderly Care Services Admission and Financing Systems

The process typically involves:
1. Application submission (via local health authority or directly to the facility),
2. Health and social assessment to determine eligibility (UVG),
3. Placement on a waiting list based on priority and availability,
4. Admission.

Public funding for elderly care facilities (RSA) in Italy is primarily allocated through a mix of national, regional, and municipal contributions, with significant involvement from the Servizio Sanitario Nazionale (SSN). Here's how the funding is generally divided:
1. National Healthcare System (SSN) Contributions:
The SSN funds the healthcare services provided in RSAs, including medical care, nursing services, rehabilitation, and other health-related services. These costs are covered for both public and accredited private facilities, ensuring that healthcare remains free for the residents.

The SSN's role is crucial in guaranteeing that healthcare services in RSAs, whether public or accredited private, are accessible to all residents, irrespective of their financial situation.

2. Regional Funding:

Italy's regions have autonomy over their healthcare systems, so each region allocates funding according to its own budget and priorities. This leads to regional disparities in the availability and quality of elderly care services.

Regional governments contribute to both the healthcare and non-healthcare aspects of RSA funding, such as co-financing services that are not fully covered by the SSN. These may include certain social care services and part of the accommodation costs.

3. Municipal Contributions:

Municipalities play a significant role in funding hospitality services (accommodation, meals, laundry, etc.) for residents who cannot afford to pay these costs. Municipal social services evaluate the financial situation of residents (often using the Isee socio-sanitario, a specific income assessment tool) and may subsidize part or all of these expenses.

The extent of municipal support varies widely depending on local budgets and policies, leading to further disparities between different areas of the country.

4. Co-Payment by Residents:

While healthcare services are covered by the SSN, residents are generally responsible for paying for their hospitality services. The cost can vary depending on the region, the level of care required, and whether the facility is public, accredited, or entirely private.

In cases where residents or their families cannot afford these costs, municipal contributions may cover some or all of the expenses. However, this support is means-tested and not universally available.

5. Public-Private Partnerships:

Many RSAs operate through public-private partnerships, where private facilities receive accreditation and funding from the public sector in exchange for providing services under the regional healthcare system. These facilities must meet specific quality standards to be eligible for public funding, ensuring that they provide a level of care equivalent to that offered by public facilities.

6. Allocation Based on Needs:

Funding is often allocated based on the assessed needs of the elderly population in each region. This means that regions with higher concentrations of elderly people or higher demand for care services may receive more substantial funding allocations from the SSN and regional governments.

Conclusion:

The public funding for elderly care facilities in Italy is divided among the national, regional, and municipal levels, with significant involvement from the SSN for healthcare services. Regions and municipalities contribute to non-medical costs, particularly for those who cannot afford to pay. However, regional disparities and reliance on private funding continue to pose challenges for equitable access to care across the country

Public facilities usually have a centralized process through local health authorities, while private facilities often manage applications directly. Concession facilities may follow a hybrid model. Criteria include health condition, level of dependency, social factors (e.g., lack of family support), and financial situation (ISEE).

In Italy, the cost of staying in a Residenza Sanitaria Assistenziale (RSA) varies significantly depending on whether the facility is public, private, or private with public funding (accredited).

The fees are split into two main components: quota alberghiera (hospitality costs) and quota sanitaria (healthcare costs).
Payment schemes consist of a combination of public funding, out-of-pocket contributions, and insurance. In public and accredited facilities, patients pay a portion of the cost based on income and dependency level, with the rest covered by the regional health system or municipality.
The costs of staying in a Residenza Sanitaria Assistenziale (RSA) in Italy vary significantly based on the region, the type of facility (public, private, or private with public funding), and the specific care needs of the resident.
Public RSAs or accredited private RSAs partially funded by the Servizio Sanitario Nazionale (SSN) tend to have lower fees. In these facilities, the SSN covers the healthcare costs, but residents or their families are responsible for the hospitality costs (accommodation, meals, etc.). The average daily cost in these facilities is around €112.60, with regional variations. For example, in Basilicata, costs can be as low as €82.08 per day, while in regions like Valle d'Aosta, costs can rise to €167.50 per day.
Private RSAs that do not have agreements with the SSN can be more expensive, as residents must cover the full cost of both care and accommodation. The total monthly costs in these facilities can range from approximately €1,500 to over €3,500 per month, depending on the region and level of care required.

Total Cost Structure:
Quota Alberghiera (Hospitality Costs): This portion of the fee covers accommodation, meals, laundry, and other non-healthcare-related services. It is typically paid by the resident or their family.
Quota Sanitaria (Healthcare Costs): This portion covers medical and nursing care, rehabilitation, and other health-related services. If the RSA is accredited, these costs are covered by the Servizio Sanitario Nazionale (SSN), meaning the resident or their family does not pay for these services directly.

Public and Private Accredited RSA Costs:
In public RSAs and accredited private RSAs, the SSN funds the healthcare costs, but residents are responsible for the hospitality costs. The division of the fee typically looks like this:
Quota Sanitaria: Fully covered by the SSN, usually amounting to around 50-60% of the total cost.
Quota Alberghiera: This portion, which covers living expenses, is the responsibility of the resident or their family. It can range from €1,000 to €2,500 per month, depending on the region and the level of care provided.

Private RSA Costs:
In private RSAs without public funding, the resident or their family must cover both the hospitality and healthcare costs. This results in significantly higher monthly fees, typically ranging from €1,500 to over €3,500 per month, depending on the quality of the facility and the level of care required.
Costs Based on Levels of Non-Self-Sufficiency:
Low to Moderate Non-Self-Sufficiency: Residents who require basic assistance with daily activities may have lower costs, as their healthcare needs are minimal. In accredited RSAs, the total monthly cost may be closer to €1,500, with a larger portion being covered by the resident or their family.
High Non-Self-Sufficiency: For residents who are fully non-self-sufficient and require intensive medical and nursing care, the total costs can be significantly higher. In such cases, the healthcare

costs covered by the SSN may be substantial, but the hospitality costs still often range between €2,000 to €3,000 per month.

Municipal and Regional Support:
For low-income residents, municipalities may provide financial assistance to cover the hospitality costs, particularly in public and accredited RSAs. The amount of support varies by region and is based on the resident's financial situation, assessed through tools like the ISEE socio-sanitario.

Regional Variations:
Lombardy: Known for having a well-developed RSA network, the costs in public and accredited facilities are on the higher side, but the division between hospitality and healthcare costs remains consistent with national averages.
Southern Regions: In areas like Calabria or Sicily, the availability of publicly funded RSAs is lower, and private facilities may charge higher fees, with less financial support available from local governments.
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Application Procedure for **Civil Disability Assessment and What an Elderly Person Can Obtain**
In Italy, the application for civil disability assessment is a process that allows the permanent reduction in work capacity to be assessed, or, for those under 18 years old or over 65 years old, the difficulty in performing daily activities. This process can lead to the recognition of economic and welfare benefits.

Involved Institutions:
- INPS (National Social Security Institute): It is the body that manages civil disability applications, coordinates medical examinations, and pays the economic benefits.
- ASL (Local Health Authority): Collaborates with INPS in the medical evaluation through its medical commissions.
- CAF and Patronages: Provide assistance to citizens in submitting applications and managing appeals.

**What an Elderly Person Recognized as Civilly Disabled Can Obtain:**
1. Civil Disability Allowance: If disability is recognized with a percentage between 74% and 99%, the elderly person can receive an assistance allowance of about €313.91 per month (updated amount for 2024). This benefit is granted in the presence of income limits.
2. Inability Pension: If disability is 100%, the elderly person can receive a disability pension of about €313.91 per month, also subject to income limits.
3. Accompanying Allowance: If the elderly person is recognized as totally disabled and unable to walk without assistance or requires continuous care, they can receive the accompanying allowance, amounting to about **€560** per month (updated amount for 2024). This benefit is not tied to income limits.
4. Other Benefits: Other benefits may be recognized, such as exemptions from healthcare fees, subsidies for medical devices, and assistance for home adaptation.

**Amount of Benefits (2024):**
- Civil Disability Allowance: Approximately €314 per month.
- Inability Pension: Approximately €314 per month.
- Accompanying Allowance: Approximately **€560** per month.

These amounts may be updated annually based on ISTAT adjustments.

The Italian system for the recognition of civil disability offers various forms of economic and healthcare assistance for elderly individuals who, based on medical assessment, are recognized as disabled. The procedures are mainly managed by INPS in collaboration with the ASLs, and the benefits are intended to improve the quality of life of elderly individuals with disabilities or those who are non-self-sufficient.

**ASSESMENT ON THE care levels, which reflect the intensity of services provided**

**In Piedmont,** a person interested in obtaining a contracted bed (accessing a practically public bed even if provided by a private facility) submits a request for a multidimensional assessment to the Geriatric Assessment Unit (UVG) in the Health District of the Local Health Authority (ASL) of residence at the territorially competent services:

- Front Desk / Single Access Point
- Managing Body of Social and Welfare Services and/or Health District

It is necessary to present the following documents to the UVG:

- "Request for evaluation" completed and signed in all parts
- Referral from the General Practitioner
- "Health Information Form"
- Proof of application for the ISEE model
- Copy of the single substitute declaration (DSU)

Procedure:

Within 90 days from the date of receipt of the request, the UVG performs the health and social evaluation using the "Geriatric File," determines the non-self-sufficiency, and defines the Individual Project agreed upon with the person concerned and their family. The person is recognized as "non-self-sufficient" with a health assessment score of 5 or higher.

Types of Interventions:

The individual projects can lead to different types of interventions.

Regarding Residential Care:

Placement in an Assisted Living Facility (RSA) meets the health and care needs of non-self-sufficient elderly people over 65 years old who cannot be cared for at home.

Following the multidimensional assessment by the UVG, services are provided based on the type of individual project and the specific needs of the person.

The care levels, which reflect the intensity of services provided, are:

- HigH-Increased
- High
- Medium-High
- Medium
- Medium-Low
- Low

Some RSAs have a Alzheimer Unit (FOLLOWS UVA ASSESMENT) dedicated to people with moderate-severe dementia and severe behavioral disorders for a period typically ranging from 60 to 180 days.

The non-self-sufficient elderly person and their family can choose among RSAs authorized and accredited by the Healthcare System.

Rates

The fee is determined by the Rate Plan, which indicates the total fee (including taxes) for the care level and divides the costs as follows:

- 50% (healthcare share) is covered by the Local Health Authority (ASL) of residence, which takes responsibility for the elderly person, even when the RSA is in the territory of a different ASL than that of residence.
- 50% (social share) is borne by the elderly person. If, based on the social assessment, the person is found to have insufficient income to pay the required share, the Municipality/Managing Body of social and welfare services steps in to cover or fully take on the amount.

The rates, applied uniformly throughout the regional territory, are established by Regional Council Resolution (D.G.R.) 85-6287 of 02/08/2013.

RSAs can offer additional services, identified by D.G.R. 85-6287 of 02/08/2013, for all residents or for certain modules of the facility (for residents able to cover the social share) for an additional fee.

Waiting Lists:
The Geriatric Assessment Unit sends the outcome of the assessment to the home of the person concerned, indicating:
- The type of individual project
- The distinct scores of the health and social assessment
- The priority level, distinguished as follows:
  - Urgent (score of 24 or higher) with admission within 90 days of the assessment
  - Non-urgent with admission within one year of the assessment
  - Deferrable where no admission timeframe is provided

The price of residential elderly care is partially regulated: prices are regulated in public and accredited facilities. The cost is split into two parts: social quota (hotel cost) and health care quota. The health care quota is covered by the regional health system, while the social quota is partially covered based on income.

The market is highly fragmented, with many small and medium-sized operators. However, there is an ongoing trend toward consolidation, particularly among for-profit and non-profit organizations that manage multiple facilities.

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https://www.liucbs.it/osservatori/osservatorio-settoriale-sulle-rsa/

https://www.uneba.org/wp-content/uploads/2023/08/confronto-sistemi-sanitari.pdf

https://ilbolive.unipd.it/it/news/indagine-sulle-rsa-business-che-fa-perdere-vista

Sanità24: Another valuable resource for understanding the distribution of public vs. private facilities is Sanità24, which often summarizes ISTAT data with additional insights into regional disparities. https://www.sanita24.ilsole24ore.com/pdf2010/Editrice/ILSOLE24ORE/QUOTIDIANO_SANITA/Online/_Oggetti_Correlati/Documenti/2023/11/14/RSA_ISTAT.pdf?uuid=AFoXKHcB

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# Funding in Social Services – Romania

(The figures and data presented in this document refer to available statistics and official sources from the period 2021–2024. They should therefore be considered as indicative and approximate, providing an overall picture of the elderly care sector rather than precise, up-to-date numbers. Variations may occur due to changes in regulation, financing, local implementation, or the informal and unauthorized market, which remains difficult to quantify.)

The Long-Term Care (LTC) market in Romania is currently experiencing a growth phase, primarily driven by new private initiatives. As mentioned during various calls, the market is significantly undersized compared to the actual needs of the population, indicating that further expansion is inevitable.

The Romanian government has previously launched several funding programs and incentives to develop elderly care facilitie. However, these initiatives have had limited tangible impact, with many projects being stalled or facing issues in terms of efficiency and effectiveness. The goal remains to improve service quality and increase the availability of beds, with a reform designed to address these priorities. However, the current state of public funding and incentives is marked by uncertainties, partly due to the country's economic challenges and evident budgetary difficulties.

**Social Assistance System Reform**: a reform of the sector is imminent, aimed at strengthening the quality standards of services. However, specific details of this reform have yet to be made public or precisely defined.

At present, government measures for the creation of new community centers for non-self-sufficient elderly lack tangible substance. Existing initiatives are broad in scope and focus primarily on promoting social inclusion through EU funds and other public financing, without specific actions dedicated to nursing homes.

**EU Funds for Social Inclusion**: Part of the EU structural funds has been allocated to cohesion and social inclusion projects, without specifying funds exclusively dedicated to developing residential care facilities for the elderly. Romania will receive a total of 31.5 billion euros from cohesion funds for the 2021-2027 period, of which 7.3 billion euros will come from ESF+ to promote job creation, reduce poverty, and implement inclusive policies. Of this amount, 3.5 billion euros will be used to modernize the Romanian public employment service, develop social entrepreneurship, and support capacity-building for social partners and civil society organizations.

**Public-Private Partnerships (PPP)**: Public-private partnerships (PPPs) in Romania have struggled to gain systematic traction, mainly due to institutional and regulatory issues. Recently, the government has taken steps to improve the situation by establishing the Public Investment and Management Unit (PIMU) within the Ministry of Finance. This entity is tasked with drafting policies, strategies, and recommendations to enhance the preparation and implementation of PPP projects. More information on PPP projects and investment program updates can be found on the official website of the Romanian Ministry of Finance.

In Romania, there are no facilities that are exclusively dedicated to the care of elderly people affected by various forms of dementia. These patients are generally cared for in regular elderly care facilities, sometimes in dedicated departments. Despite the claims of specialization in facility descriptions, even where such dedicated departments exist, they are not designed or organized in line with the Western standards commonly implemented elsewhere.

Given the current trends and patient demographics, there is a high demand everywhere for specialized beds and facilities that include purpose-designed indoor and outdoor spaces, as well as specialized personnel with the right training and support for comprehensive care. Unfortunately, the costs associated with development and management are high, making such services niche but likely to have market potential.

Due to the increasing prevalence of dementia, it is inevitable that all elderly care facilities in Romania will face and need to manage patients with Alzheimer's or other types of dementia. Therefore, it is crucial to consider the specific needs of these patients during the design and operational planning of any care facility.

The elderly care sector in Romania is predominantly oriented towards **social care**, with a total of **33,031 beds** available nationwide. Of these, **3,431 beds** fall under the category of mixed health and social care, largely concentrated in public facilities (3,255 beds), while the number of dedicated palliative care beds remains extremely limited.

In terms of market size, official statistics indicate **33,031 authorized beds**, divided between **7,072 in public facilities (21.5%)** and **25,959 in private facilities (78.5%)**. However, it is important to note the existence of an unauthorized market that remains difficult to quantify but significantly affects the real capacity of the system. The overall number of facilities amounts to **751**, of which **120 are public (16%)** and **631 are private (84%)**. Public facilities tend to be larger, with an average of **around 60 beds per structure**, compared to **41 beds in private ones**.

This configuration illustrates a system where **private entities play a leading role**, responding to the growing demand for diversified and more personalized elderly care solutions. Among private providers, **60% of extended social care beneficiaries are served by private entities**. Within this segment, **80% are non-profit organizations** and **20% are for-profit providers**, while the public sector covers the remaining **40%**.

A geographical analysis reveals strong disparities in the distribution of facilities and bed capacity. For example, **Bacău County** stands out with **20.8 beds per 1,000 elderly residents**, while **Argeș County** lags behind with only **6.7 beds per 1,000 elderly residents**, reflecting uneven resource allocation, facility development, and demographic density.

The counties with the highest concentration of elderly care facilities include **București** (92 facilities, 4,689 beds), **Ilfov**(62 facilities, 2,600 beds), **Timiș** (52 facilities, 1,974 beds), **Cluj** (50 facilities, 2,091 beds), and **Bacău** (42 facilities, 2,083 beds). Other notable areas are **Constanța** (35 facilities, 1,549 beds), **Bihor** (34 facilities, 1,059 beds), **Mureș** (27 facilities, 1,134 beds), **Arad** (25 facilities, 722 beds), and **Sibiu** (20 facilities, 1,036 beds).

When analyzing the ranking by bed capacity, the same counties dominate: **București** leads with **4,689 beds**, followed by **Ilfov** (2,600), **Cluj** (2,091), **Bacău** (2,083), **Timiș** (1,974), and **Constanța** (1,549). Interestingly, **Dolj** (1,281 beds in 16 facilities) and **Sibiu** (1,036 beds in 20 facilities) emerge as counties with relatively high bed capacity despite a smaller number of facilities, suggesting larger average facility sizes.

Overall, this analysis highlights the **strong regional differences** in elderly care infrastructure in Romania. **București and Ilfov**, as the capital and its surrounding area, concentrate the largest share of facilities and beds, while developed urban counties such as **Cluj, Timiș, and Bacău** also show solid infrastructures. At the same time, counties like **Dolj and Sibiu**demonstrate how fewer but

larger facilities can elevate total bed capacity. This distribution underscores the interplay between urbanization, economic development, and care provision capacity.

**Costs and Financing of Nursing Homes in Romania**

The development of Romania's nursing home network reflects less the actual demographic need for care and more the **socio-economic development of individual counties**. In practice, the complexity of organizations, the range of services offered, and the fees applied in the private sector follow closely the economic growth and spending capacity of each region.

The **average monthly fee per bed** in Romania varies widely, ranging from **€300 to €1,200**, depending on the type of facility, ownership model, and level of care provided.

In the **public sector**, costs and tariffs are not standardized nationally, as each facility operates under the rules of the local public authority. Funding is shared between public subsidies and family contributions, with tariffs reduced thanks to public financing. A relevant example is the **Cajal facility in Bucharest**: the average cost per patient is around **7,000 RON (€1,400)**, yet the tariffs set by the public authority vary by degree of non-self-sufficiency—**3,000 RON (€600)**, **2,400 RON (€480)**, or **1,800 RON (€360)**. The remainder is covered by public funds. Residents are required to contribute up to **60% of their monthly income**, and if this does not meet the tariff, family members are legally obliged (up to the third degree) to make up the difference. If no family exists or if family members have insufficient income, the municipality covers the costs, recognizing the person as a social case.

In the **private sector**, fees are determined strictly on the basis of operational costs. Non-profit providers set tariffs after considering any third-party funding, while for-profit entities also add a profit margin. The pricing is therefore linked not only to the degree of dependence of the residents but also to the **comfort level, infrastructure, and service complexity**of the facility. Nationally, the highest rates are concentrated in major cities, where demand is high and economic capacity stronger. In large urban centers, medium-sized quality homes typically charge between **€800 and €1,000**, while better-structured facilities may demand between **€1,600 and €1,800**, and in exceptional cases even up to **€2,000**. Conversely, some facilities—often operating at the margins of legality—offer much lower rates.

The **current national average fee** is estimated around **€1,200**, a figure driven upward by increases in labor costs and utilities. Fee differentiation tends to reflect comfort and accommodation type more than clinical dependency. For example, in many facilities the tariffs are structured as follows:

- **Single room**: €800–900 (low care), €1,000 (medium care), €1,200+ (high care)
- **Multiple room**: €520–600 (low care), €800–900 (medium care), €1,000–1,100 (high care)

Private groups such as **Affinity in Bucharest** (three facilities) publish transparent packages ranging from **€880 to €1,200**, depending on location, room type, and health status. Lower-cost facilities, such as Stejarul Home, advertise more modest rates but still adjust based on dependency.

Alongside fees, residents may receive **public disability benefits**, managed by the **National Agency for Payments and Social Inspection (ANPIS)**. The process involves a socio-psycho-medical evaluation by **SECPAH** and **CEPAH**, which issues a disability certificate and an individualized rehabilitation and integration plan. Depending on classification, beneficiaries receive allowances of **529 RON (€106)** for severe disabilities and **350 RON (€70)** for moderate disabilities, plus a

complementary budget of **199 RON (€40)**, **146 RON (€29)**, or **80 RON (€16)**, depending on severity.

Those with severe disabilities may also receive an **attendant allowance**, equivalent to the net salary of a beginner social assistant in the public sector. As of February 2023, this is **1,898 RON (€380)**, with the option to hire a personal assistant at a gross salary of **3,000 RON (€600)**. Under Article 77 of Law 263/2010, invalidity pensioners with a first-degree classification receive an attendant allowance equal to **80% of a pension point**, amounting to **1,626 RON (€325)** as of January 2024. In total, a person with severe disability may receive approximately **€526 per month** (allowance + complementary budget + attendant allowance). In non-profit facilities, this can be supplemented by a **€200 public subsidy**. However, in **public nursing homes**, all disability allowances are suspended upon admission.

The **organization and financing of public nursing homes** are regulated by **Law 17/2000**. Responsibility lies with local authorities, who may provide services directly or through contracts with other providers. Funding follows the principle of subsidiarity: first from own revenues, then from local budgets, and finally from allocations from the state budget, including at least **10% of the minimum cost standards** set by government decree. For 2022, **Decision 1253/2022** established cost standards:

- €17,068/year for dependent elderly (grades IA–IC, 0.56 staff/beneficiary)
- €11,692/year for semi-dependent (grades IIA–IIC, 0.33 staff/beneficiary)
- €8,806/year for non-dependent (grades IIIA–IIIB, 0.2 staff/beneficiary)
- €7,565/year for home care (grades IA–IC, 20h/week, €7.27/hour)
- €5,673/year for home care (grades IIA–IIC, 10–20h/week)
- €3,782/year for home care (grade IIIA, <10h/week)
- €5,505/year for daycare and recovery centers.

On average, the **net monthly salary in Romania** is approximately **€1,046**, while the **average pension** is around **€463**. Against this background, the Ministry of Labor notes that fees can vary from **€202/month per beneficiary in public nursing homes** to **€1,010 or more in private ones**, depending on dependency level and quality standards.

In **public facilities**, contributions are calculated according to the resident's income and the ability of legally obligated relatives, in line with **Law 292/2011** and **Law 17/2000**. Residents may contribute up to **60% of their income**, but not more than the official maintenance cost, while relatives contribute if their income exceeds the guaranteed minimum wage. If neither the elderly person nor their relatives can contribute, the costs are covered by local or county budgets.

In both **public and private settings**, the service contract specifies the level of contribution and identifies the individuals legally responsible for payment. The final amount is personalized after a full **socio-medical and geriatric evaluation**, ensuring that the contribution reflects both the needs and the financial capacity of the resident and their family.

**Rates for Single, Double, and Triple Rooms**

Among mid- to high-level facilities, there are fewer and fewer four-bed rooms, with the majority of beds found in double or, at most, triple rooms. For the evolving nursing home landscape in Romania, double rooms are considered a satisfactory and above-average arrangement. Single rooms are often non-existent in some facilities, or relatively few in number, and are generally reserved for premium facilities. There is no consistent median rate for single rooms, but they typically might

cost as much as about 20% more than double rooms, and 25% more than triple rooms. Currently, to estimate absolute values, one can consider the average for double rooms as a baseline, then adjust accordingly for single and triple rooms.

Rates are influenced by various factors, which I have already indicated: market conditions, geographic location, socio-economic context, the distinction between rural and urban areas—which is diminished in cases of proximity to major cities—facility standards, structural characteristics, and the quality and complexity of services offered.

**Costs of Additional Services**

The definition of optional service packages beyond the base rates is a strategic commercial decision by each individual facility. Depending on their approach, facilities may offer several pay-per-need or continuous services. Many mid-level facilities tend to opt for an "all-inclusive" pricing approach. In higher-level facilities, with more complex and higher-quality services, the commercial and care approach changes, leading to more detailed and itemized pricing. Especially in facilities with monthly rates far above the market average, a base rate is often communicated, which then significantly increases with the activation of additional services, which are often essential and necessary for the resident's specific needs. These facilities frequently partner with external providers to deliver these services.

**Additional services may include**:

1. **Specialized Medical Consultations**: Neurology, psychiatry, dermatology, ophthalmology, medical diagnostic tests, pharmacological and non-pharmacological therapies, etc.
2. **Mental Health and Psychological Support**: Periodic consultations and therapeutic support.
3. **Rehabilitation and Kinesiotherapy**: Approximately 200 euros per month for five weekly sessions.
4. **Incontinence Management, Including Supply of Absorbent Materials**: Approximately 100 euros per month.
5. **Dressing and Pressure Ulcer Prophylaxis**: Approximately 160 euros per month.
6. **Materials for Special Feeding Needs and Stoma Care**: Approximately 80 euros per month.
7. **Hygiene and Prophylaxis**: Including personalized hygiene packages for immobile patients, with costs ranging between 160 and 180 euros per month.
8. **Hospital Bed and Oxygen Therapy**
9. **Private Ambulance Transport Service**: In Bucharest, approximately 50-70 euros per trip.
10. **Accompaniment for Hospital Visits**: Support for patients during visits for exams or analyses.
11. **Beauty and Comfort Services**: Manicure, pedicure, etc.
12. **Leisure Activities**: Such as excursions.
13. **Administrative Assistance for Paperwork**