



COMPARATIVE ANALYSIS OF SENIOR CARE POLICIES IN SELECTED EU COUNTRIES

Lenka LACHYTOVÁ and Kristína DEMČAKOVÁ MIHALOVÁ¹

The issue of care for older adults is gaining importance in the context of population ageing in Europe. Demographic projections of the European Union indicate a continuous rise in the share of older persons, affecting health and social care systems, fiscal sustainability, and the quality of life of the ageing generation. This paper conducts a comparative analysis of current trends in long-term care in four European Union countries - Malta, Italy, Sweden, and Spain, which record the highest life expectancy at birth among their populations. The aim is to identify common features of successful models and assess the potential to transfer those elements to other contexts. The findings underscore the importance of community-based care, strong support for informal caregivers, and investment in prevention and healthy ageing. These results provide inspiration for policy development in other countries, including Slovakia, where an integrated and functional framework for long-term care is lacking.

Key words: long-term; care; comparison; demographic ageing; European Union.

1 INTRODUCTION

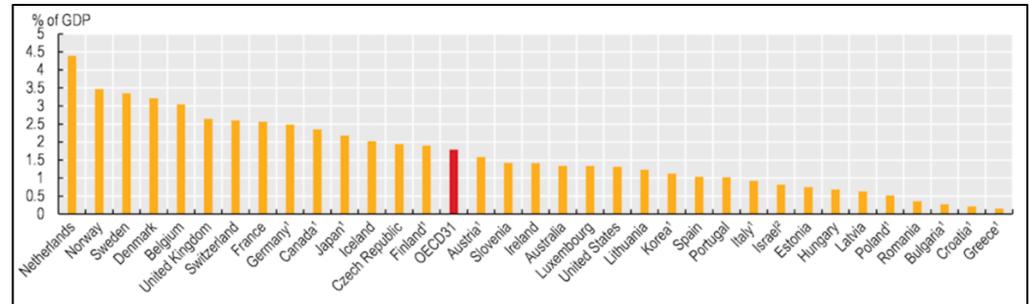
Demographic development in the European Union countries define population ageing as the increasing share of people of retirement age within the overall population structure. In the 21st century, population ageing has become a significant demographic trend, shaped by economic development and advances in medicine. The growth rate of people in the post-productive age group surpasses that of other age cohorts, which constitutes a fundamental challenge for social and health care systems. It is projected that the share of individuals aged 65 and over across European regions will increase from 16% in 2010 to 27.8% by 2050. This trend is associated with a rising number of older adults

¹ Lenka LACHYTOVÁ is Associate professor of social work at the Faculty of Public Administration, Pavol Jozef Šafárik University in Košice, Department of Social Studies, Slovakia. Kristína DEMČAKOVÁ MIHALOVÁ is PhD candidate at the Faculty of Public Administration of Pavol Jozef Šafárik University in Košice. Contact: kristina.mihalova@student.upjs.sk.

experiencing deteriorating health and functional limitations, thereby requiring long-term care (LTC) (Van Eenoo et al. 2016).

European countries face growing fiscal pressure as demographic ageing increases financial demands for pensions, health care, and long-term care (Eble et al. 2025). Although EU member states, in line with the principle of subsidiarity, retain the authority to shape their own models of social policy, European Union institutions, particularly the European Parliament and the Council of the European Union, actively contribute to fostering transnational cooperation (Díaz-Tendero and Ruano 2024). In practice, however, persistent shortcomings remain in the availability and quality of services for older adults across individual countries, despite their progressive development at the international level (Monteiro, Martins and Schoeller 2022). Figure 1 illustrates the share of long-term care expenditure as a percentage of gross domestic product (GDP) in EU and OECD countries.

FIGURE 1: SHARE OF LONG-TERM CARE EXPENDITURE IN THE GROSS DOMESTIC PRODUCT OF COUNTRIES



Source: OECD (2023).

The experience of advanced countries demonstrates that investments in elderly care, which in some cases exceed 4% of GDP—as in the Netherlands—can mitigate the negative consequences of demographic ageing (Asadzadeh et al. 2022). On average, European Union countries allocate 1.7% of their GDP to long-term care (LTC), although there are significant differences in investment levels among them. Higher shares of expenditure indicate structured and publicly funded systems in which formalised care prevails over informal, for instance, family-based models of care. Such a substantial share of public spending on LTC in some countries reflects more comprehensive and sustainable systems capable of alleviating the negative impacts of demographic ageing (OECD 2023).

The European care strategy builds on an analytical assessment of the current state of LTC systems in EU countries and points to the fact that approximately one-third of households requiring home care services do not utilise them due to financial inaccessibility. This aligns with OECD’s cross-country assessment indicating that OOP expenses for LTC frequently absorb a very large share of older people’s income, especially among those with severe needs and low resources (OECD 2024a). At the same time, nearly half of persons aged over 65 who depend on the assistance of another person do not actually receive such support. According to projections, by 2050 approximately 38.1 million people will require LTC, representing an increase of 23.5% compared with 2019 (European Commission 2022b). Regardless of whether resources are channelled through public or private providers, most analyses show a strong correlation between the level of public investment in LTC and the extent to which the needs of dependent persons are met (Díaz-Tendero and Ruano 2024).

Long-term care already represents one of the fastest-growing components of

health expenditure, particularly in higher-income European countries. This trend is driven by population ageing, technological progress, and rising labour costs in a resource-intensive sector. Since most LTC expenses are concentrated in the final years of life, higher life expectancy implies a further increase in total expenditure that is not fully balanced by longer healthy life years. These growing costs may burden both public budgets and households, especially where fiscal consolidation limits public spending, thereby increasing inequalities in access to quality care (Eble et al. 2025).

The European Pillar of Social Rights, under Principle 18, guarantees that “Everyone has the right to affordable long-term care services of good quality, in particular home care and community-based services.” These LTC services should be accessible to all, regardless of socio-economic status or insurance coverage. Furthermore, it is essential that such services meet high-quality standards and reflect the dynamics of recent developmental trends (European Commission 2022a).

The objective of this paper is to compare models of elderly care in the European context, focusing on Malta, Italy, Spain, and Sweden, which, according to Eurostat, record the highest values of life expectancy at birth among older populations. Demographic changes affecting all European countries present a major challenge for public policymakers. The health and social care systems of these states will have to respond to the increasing number of people with LTC needs by ensuring accessible and high-quality care, while at the same time protecting individuals and households from excessive financial burdens (Lussi et al. 2024). Comparing selected approaches to care is key to understanding how different social, health, and political arrangements influence the quality and sustainability of care for the ageing population. Identifying and contrasting these models makes it possible to define strategies that may be applied or adapted in other EU member states.

2 LIFE EXPECTANCY AS AN INDICATOR OF THE QUALITY AND EFFECTIVENESS OF CARE POLICIES

One of the indicators of the quality and effectiveness of health and social care systems is the demographic measure of life expectancy at birth in individual European Union countries. Table 1 provides an overview of life expectancy across EU member states by age, with particular attention paid to those countries that achieve the highest values of this indicator within the Union. According to Eurostat statistics for 2023, life expectancy at birth in the European Union reached 81.5 years, representing an increase of 0.9 years compared with 2022 and 0.2 years compared with the pre-pandemic level of 2019. In 15 member states, life expectancy exceeded the European average, with the highest levels recorded in Spain (84.0 years), Italy (83.8 years), and Malta (83.6 years). Among European regions, the Spanish region Comunidad de Madrid achieved the highest life expectancy at 86.1 years. Conversely, the lowest average life expectancy was recorded in Bulgaria (75.8 years), Latvia (75.9 years), and Romania (76.6 years) (Eurostat 2024). Countries achieving the highest life expectancy face particularly intense challenges in ensuring high-quality and sustainable care for older adults and may thus contribute to identifying effective solutions in the context of the shared European challenge of population ageing.

TABLE 1: AVERAGE LIFE EXPECTANCY IN SELECTED EU COUNTRIES BY AGE

Country	2019	2020	2021	2022	2023	2024
France	83.0	82.3	82.4	82.3	83.0	83.1
Luxembourg	82.7	82.2	82.7	83.0	83.4	83.5
Malta	82.7	82.1	82.3	82.4	83.4	83.3
Italy	83.6	82.3	82.7	82.8	83.5	84.1
Spain	84.0	82.3	83.3	83.2	84.0	84.0
Sweden	83.2	82.4	83.1	83.1	83.4	84.1

Source: Author's calculations based on Eurostat data (2025a).

These differences in life expectancy at birth across countries result from multiple factors, including the quality of health care, the effectiveness of social policies, economic stability, and the availability of support services for the older population. Countries with longer average life expectancy typically possess more comprehensive health and social care systems that emphasise prevention, early intervention, and high-quality services for older adults. Conversely, in states with lower average life expectancy, elderly care tends to be less developed, which is reflected in higher mortality rates and lower quality of life in old age (Eurostat 2024).

Health and social service systems are characterised by significant variability, reflecting the specific conditions of individual countries. They are primarily determined by the nature of the welfare state, the model of social policy, and the method of health care financing. The growing proportion of older adults in society requires strategic adjustments in health and social care, as well as the implementation of comprehensive and sustainable long-term solutions that reflect the rapidly changing needs of an ageing population (Hromková 2013).

The effectiveness of social care systems for older persons is conditioned by the principles of accessibility, sustainability, and cooperative financing, which are embedded in strategic and policy frameworks at both the national and international levels.

3 METHODOLOGY

This paper focuses on the analysis and comparison of elderly care policies and plans, with the aim of identifying opportunities for improvement based on international experience. The research was conducted as a comparative study employing a mixed-methods approach, combining quantitative analysis of statistical indicators with qualitative content analysis of strategic documents, academic sources, and analytical databases. Within the comparative framework, policies and strategies of four European countries were selected which, according to the latest Eurostat data (2024), achieved the highest levels of life expectancy at birth among EU member states. Emphasis was placed on the practical application of these strategies and their impact on the quality of life of older adults. The selection of documents was guided by the criteria of relevance and currency, with preference given to materials published between 2021 and 2025, due to their timeliness and accessibility. The study's findings provide a basis for optimising existing elderly care strategies, with particular attention to their sustainability and effectiveness.

3.1 Study design

The research is guided by three principal research questions:

1. What are the differences in the structure, financing, and organisation of elderly care systems in the observed countries?
2. What common characteristics can be identified in successful care models within the European context?
3. Which elements of these models are applicable to the conditions of Slovakia?

3.2 Context

Country selection was based on life expectancy at birth according to Eurostat (2024) data. The analysis included Sweden, Spain, Italy, and Malta, which represent diverse models of elderly care (the Nordic universalist model, the Mediterranean family-based model, a regionally fragmented model, and a centralised model). This approach enabled the application of the Most Different Systems Design (MDS), which allows for the comparison of countries with distinct care models but a shared challenge - demographic ageing.

3.3 Data analysis

The quantitative component was based on data from Eurostat, the OECD, the WHO, and European Commission databases. The following indicators were analysed: the proportion of the population aged 65 and above (%), life expectancy at birth, expected healthy life years (HLY) at age 65, LTC expenditure as a percentage of GDP, and the institutionalisation rate (percentage of older adults in residential facilities). In addition to descriptive analysis, basic statistical measures (mean, median, minimum, maximum, and standard deviation) were employed, enabling a more comprehensive picture of the differences among the studied countries. The qualitative component focused on the analysis of legislative and strategic documents in the selected countries, with particular attention to the Swedish Social Services Act, the Italian reform Legge Delega of 2023, the Spanish Law No. 39/2006 on the Promotion of Personal Autonomy, and the Maltese National Strategy for Active Ageing 2023–2030. Data processing combined descriptive statistics (quantitative part) with content and thematic analysis (qualitative part). The quantitative analysis enabled the comparison of key performance indicators of the systems, while the qualitative analysis revealed structural and policy differences among care models. The comparative analysis concentrated on identifying similarities and differences between countries and on highlighting so-called “good practices” that may serve as inspiration for Slovakia. Research validity was supported through source triangulation—combining statistical data, legislative frameworks, and secondary academic literature. The timeframe of 2020–2025 made it possible to capture the most recent trends in elderly care and enhanced the explanatory value of the results.

4 RESULTS

4.1 Sweden

Similar to most countries worldwide, Sweden is experiencing an increase in the proportion of older citizens within its overall population structure. At present, Sweden is implementing several initiatives aimed at anticipating and meeting the needs of this demographic group. In order to address demographic challenges effectively, without undermining the quality of social security, it will be necessary to extend the working lives of the population (Swedish Institute 2024).

The core principle of elderly care in Sweden is to enable older adults to live independent lives, with health and social care forming an integral part of Swedish social policy aimed at safeguarding quality of life.

Out of Sweden's current population of 10.5 million, people aged 65 and over represent approximately 20% of the demographic structure. By 2040, this share is projected to reach 23%, reflecting the continuing trend of population ageing and the growing demands on health and social care systems. Sweden ranks among the countries with the highest life expectancy at birth globally, reaching 81.58 years for men and nearly 84.9 years for women. More than 5% of the population is aged 80 or above (Eurostat 2024). Sweden is also among the countries with the highest LTC expenditure relative to gross domestic product, at approximately 3.5% of GDP (OECD 2023). Funding is predominantly public, drawn from municipal budgets and complemented by state transfers (Swedish Institute 2024).

The Swedish model strongly favours non-institutional, community-based care, primarily through the development of home care services, assisted mobility, and specialised housing. Residential care is reserved for those with a high degree of dependency, and the institutionalisation rate is among the lowest in Europe. A key feature of the system is decentralisation, whereby municipalities hold direct responsibility for service provision. Entitlement to municipal support in Sweden is regarded as an individual right of the citizen, and municipalities are not only responsible for social services but also provide selected health services. The system is regulated by the Social Services Act, which broadly defines the municipal obligation to provide support, while leaving the specifics of services to local discretion. Section 1 of the Act highlights the crucial role of social services as an integral component of Swedish social policy. This approach contrasts with the universalist nature of the social insurance system and state benefits, which are structured on the basis of general criteria (Konečný 2022).

Key challenges include rising demand for services combined with shortages of qualified personnel. While decentralisation allows for flexibility, it also creates disparities in quality and access among citizens. A solution lies in stronger coordination between municipalities and the state. Further challenges include an ageing workforce and the need to strengthen community capacities. From a fiscal perspective, pressure is exerted on the pension, health, and LTC systems (Hinrichs 2021; European Commission 2022b). Sweden thus represents an example of a universal, publicly funded model of LTC that is highly decentralised and focused on promoting independent living among older adults, distinguishing it from Mediterranean and centralised models. The strength of the Swedish system lies in the integration of social and health services, strong municipal autonomy, and guaranteed access to care. Nevertheless, fiscal challenges and regional inequalities call for further modernisation of the system and

reinforcement of its infrastructure.

4.2 Italy

Italy, like many advanced economies, faces increasingly complex social challenges stemming from demographic change, which has significantly transformed life expectancy and the population's age structure. Older adults (65+) now represent 24.1% of the total population. As noted by Dicorato and Mazza (2025), Italy's demographic dynamics are strongly shaped by pronounced territorial disparities. The publicly funded care system is regionally fragmented, with substantial variations in the scope and quality of services across regions (Brugiavini, Carrino and Pasini 2023). The Italian care system is characterised by a regional public model based on decentralisation of competences (García-Pereiro 2018). Since 2001, regional governments have held extensive authority in the planning, financing, and provision of health and social services (Poscia et al. 2017). Coordination of care is achieved through national and regional health plans, while service delivery takes place at the local level. Due to decentralisation, the organisation of the system, financing mechanisms, and access conditions fall primarily within the competences of regional governments. This governance model leads to substantial disparities in the availability and quality of services across regions. At the same time, the private LTC market remains underdeveloped (European Commission 2021). A key milestone was the adoption of the 2001 constitutional reform, which further expanded the powers of regional governments and reinforced their responsibilities, thereby transforming the Italian health care system into a model of a "regionally" organised national health service (Poscia et al. 2017).

Long-term care is financed through general taxation combined with patient co-payments. However, a considerable proportion of costs is borne directly by older adults or their families, especially when relying on informal or private services (European Commission 2021). The private insurance sector for LTC is weak and insufficiently developed. The Italian model is marked by the strong role of the family and a high prevalence of informal care, often based on family ties and supported by an informal labour market dominated by unskilled caregivers operating within the shadow economy. In practice, it is common for older persons to combine publicly funded services, private care, and informal family support in order to meet their care needs as cited in Brugiavini, Carrino and Pasini (2023).

The main challenges of the Italian elderly care model include regional inequality in service provision, insufficient integration of health and social care, and the heavy burden placed on families. Approximately 83.8% of care recipients rely on informal support, while only 34.7% use formal care services. In response, Italy adopted Law No. 33/2023 (Legge Delega), which represents a reform of social and health care systems with the goal of improving the quality of life of the older population. The legislation focuses on strengthening coordination, integrating service provision, and supporting active ageing. The reform encompasses the reorganisation of existing measures and the introduction of new initiatives to enhance the autonomy and independence of older adults (Brugiavini, Carrino and Pasini 2023). The Italian model reflects a high degree of decentralisation and family solidarity, in sharp contrast to the Nordic universalist model. While fragmentation reduces system efficiency, the 2023 reform represents an important step towards greater coordination and integration of care. A common feature with other countries is the ongoing search for effective forms of integrating health and social care.

4.3 Spain

From a demographic perspective, Spain has undergone a transformation in recent decades that has significantly reshaped its population structure. A notable shift has occurred from the “baby-boom” period, characterised by high fertility rates and a predominance of younger cohorts, to the current trend of an ageing society. Spain belongs to the so-called “long-lived societies,” with the share of people aged 65+ surpassing 20% in 2024 (Pérez Fructuoso et al. 2025). The Spanish system is organised as a community-based, multi-level model founded on decentralisation. Its key legal instrument is Law No. 39/2006 on the Promotion of Personal Autonomy and Care for Dependent Persons, which enshrines the right to care and expands existing services. Service implementation lies with the 17 autonomous regions (European Commission 2021; Díaz-Tendero and Ruano 2024). Each region independently sets its own health plans and manages resources, while financing is provided by the central government through budgetary transfers (Lasmarías et al. 2023). The Spanish LTC model, as part of the broader Mediterranean social care framework, retains a multi-level governance structure characteristic of other areas of public policy. Regional governments play a decisive role in service delivery and management, while the central government defines the regulatory framework and basic standards. Increasingly, private actors are becoming involved in the infrastructure of health and social care provision (Díaz-Tendero and Ruano 2024). LTC in Spain is financed through a mix of public expenditure and private contributions, with informal care, primarily provided by families, largely covered by citizens themselves. System contributions can also be used to support informal caregiving in cases where formal services are unavailable. Overall, the LTC sector is predominantly family-oriented, with the family remaining the main source of social care (Kraus et al. 2010).

Spain has a low institutionalisation rate and prioritises ageing in place. Services include home assistance, day centres, rehabilitation, telemonitoring, and residential facilities, the latter of which expanded following the adoption of Law No. 39/2006. Private providers also play a significant role. Nevertheless, families remain the primary source of care—up to 83% of dependent persons rely on informal support (Díaz-Tendero and Ruano 2024). Spain faces several challenges, including regional disparities in service quality, the heavy burden placed on family caregivers, and a shrinking pool of potential caregivers due to demographic shifts. The COVID-19 pandemic exposed systemic shortcomings, prompting the launch of a Shock Plan financed in part by the Next Generation EU initiative. Key priorities of this plan include deinstitutionalisation, strengthening community-based care, and developing a new national legal framework (European Commission 2021). The Spanish model exemplifies the Mediterranean approach to elderly care, grounded in family and community support, decentralised governance, and low institutionalisation. Yet the challenges posed by population ageing, regional inequalities, and gender disparities call for continued reforms to ensure more accessible and sustainable care. The Spanish model shares similarities with the Italian system in its strong reliance on family support and regional decentralisation, while its emphasis on strengthening community-based care aligns with trends seen in the Nordic universalist approach.

4.4 Malta

The Maltese islands have a well-developed health care system, which has significantly contributed to increased life expectancy at birth and improvements in the overall health status of the population. Over the next three decades, the number of people aged 80 and above is expected to triple. This demographic shift will have a profound impact on several areas of public policy, particularly in acute and long-term care (LTC). The Ministry for Active Ageing (2022), in its National Strategic Policy for Active Ageing 2023–2030, anticipates multidimensional challenges closely linked to cultural norms, value frameworks, and societal expectations in Malta. The Maltese elderly care model is highly centralised, with no regional differences in organisation or service availability. All key decisions fall under the competence of the Ministry for Active Ageing, while local councils function as coordination centres for community-based services. Services are delivered through a mix of public and private providers with an increasing emphasis on home-based services. Financing of LTC is secured through mandatory social security contributions directed into a consolidated state fund. Residents of public facilities contribute between 60% and 80% of their pension income towards the costs of care, while a minimum disposable income (€1,397.62 annually) must be safeguarded. Services such as HomeHelp are provided for a symbolic fee, supporting ageing in place (European Commission 2021). Malta's policy framework favours ageing in place and has expanded home- and community-based services; however, the institutionalisation rate remains comparatively high among the countries analysed. The government supports these preferences through investment in home and community-based services, including HomeHelp, day care, respite care, and night care. Residential placement typically occurs only when ageing in place is no longer sustainable. The government facilitates this preference by providing financial support either for family-based caregiving or for the employment of formal caregivers on a full-time or part-time basis. The number of private facilities has increased in recent years, but waiting times for admission to public facilities remain a challenge (Ministry for Active Ageing 2022).

A major milestone in the enhancement of Malta's LTC system was the adoption of national minimum standards for LTC facilities in 2015. These standards improved the quality of life for older residents in institutional settings, despite their advanced physical and cognitive decline (Formosa 2019). The policy domain of ageing is governed by the National Strategic Policy for Active Ageing, which recognises that LTC facilities may risk prioritising collective needs over individual preferences, potentially limiting privacy, choice of leisure activities, dietary habits, and the scheduling of health care services. In response, the strategy proposes three key recommendations:

1. To promote LTC provision in ways that respect the autonomy of older adults.
2. To establish mechanisms that enhance the decision-making autonomy of older persons, including access to relevant health, legal, and community services.
3. To implement measurable national minimum standards in LTC and establish the legislative framework necessary for their enforcement and monitoring (Formosa 2019).

The Maltese model is characterised by centralised governance, a strong emphasis on home-based care, and extensive family support. The absence of regional disparities and the legislative guarantee of equal access provide the system with a stable foundation. Nevertheless, the growing demands of an ageing population

require additional investment in community-based services, deinstitutionalisation, and further quality enhancement. Cross-country comparison reveals that institutional arrangements strongly influence both expenditure and service accessibility. While Sweden’s decentralised system achieves a balance between local autonomy and service equity, Italy’s regional fragmentation leads to pronounced territorial disparities. Spain’s mixed governance model, despite lower overall expenditure, shows relatively efficient outcomes in community-based care. Malta, in contrast, maintains universal coverage through a centralised scheme, but with limited flexibility for local adaptation. These findings indicate that governance structure, rather than expenditure level alone, determines LTC outcomes. Reiners (2025) similarly emphasises that the quality of public administration and the effectiveness of governance structures are key conditions for implementing complex social policies. This helps to explain why Nordic countries, supported by strong administrative capacity and coherent coordination between government levels, tend to achieve more consistent and equitable outcomes in long-term care compared with Southern or Central European systems.

4.5 Comparison of Selected Approaches to Care in the European Context

Every society is shaped by distinct expectations and cultural models regarding the balance between the state and family institutions in the provision of care for older adults. In designing supportive structures, it is essential to take these diverse socio-cultural traditions into account. Research conducted by the OECD highlights substantial regional differences—while in Southern European countries older adults tend to prefer care provided within the family, in Northern European states care delivered through formal social and health care services is more strongly favoured (Pérez Fructuoso et al. 2025). These differences are also reflected in the core indicators of elderly care systems across countries. Table 2 presents a comparative overview of key aspects of long-term care (LTC) systems, underscoring both similarities and differences between Malta, Italy, Spain, and Sweden.

TABLE 2: KEY INDICATORS OF LONG-TERM CARE SYSTEMS IN SELECTED EU COUNTRIES

Country	Long-term care expenditure (% of GDP)	The dominant model of care	Share of home-based care	Degree of institutionalisation	Policy focus
Malta	1.5% (2022)	Centralised, institutional model	Low	High	Investments in institutions and residential facilities, development of home-based care
Italy	0.84% (2024)	Mediterranean, family-based model	High	Low	Informal care, family support
Spain	0.94% (2023)	Fragmented regional system	Moderate	Moderate	Reform of the system and promotion of community-based care
Sweden	3.07% (2023)	Universalist, community-based model	High	Low	Ageing in place, community-based services, public financing

Source: Author’s calculations based on OECD (2023); Gubert and Perobelli (2024); Costa-Font et al. (2023) ; Eurostat (2025b).

The organisational structure of long-term care (LTC) services across European countries is diverse; however, this diversity does not preclude the existence of several fundamental common features observable across most states. In general, nearly all countries recognise the subjective right of individuals meeting the legally defined criteria to access services, provide some form of publicly secured care regardless of the specific eligibility conditions, and offer a comparable range of services—particularly in the areas of home-based and residential care, as well as specialised support services. Furthermore, they employ dependency assessment mechanisms that serve as the basis for the development of individualised care plans (Díaz-Tendero and Ruano 2024). A more detailed view of the analysed countries through selected indicators of quality and sustainability of care systems is presented in Table 3. The table summarises key statistical indicators concerning the quality and sustainability of elderly care systems. These indicators allow not only an assessment of the volume of invested resources but also of their efficiency, reflected in the achieved health and social outcomes.

TABLE 3: COMPARISON OF SELECTED INDICATORS OF CARE FOR OLDER ADULTS

Country	Share of the population aged 65+ (%)	Life expectancy at birth (years)	Healthy life years at age 65 (years)	Expenditure on long-term care (% of GDP)	Institutionalisation rate 65+ (%)
Sweden	20.9	84.1	13.9	3.07	4.2
Italy	25.1	84.1	10.8	0.84	0.8
Spain	21.6	84.0	10.3	0.94	2.2
Malta	20.5	83.3	12.5	1.5	7.6

Source: Author's calculations based on Eurostat (2025b); UNECE (2025); Eurostat (2023); OECD (2023); European Commission (2022c).

The quantitative analysis revealed several differences among the countries under review. The results show that Italy has the highest proportion of older adults (25.1%), while Malta records the lowest (20.5%). Sweden stands out in terms of healthy life years (13.9 years) and also reports the highest expenditure on long-term care (LTC) (3.07% of GDP). In contrast, Spain and Italy allocate significantly less to LTC (0.94% and 0.84% of GDP, respectively). Differences are also evident in the institutionalisation rate, which is highest in Malta (7.6%), reflecting a stronger reliance on residential services, whereas in the Mediterranean context, home- and family-based care predominates. To provide a clearer understanding of cross-country differences, basic statistical characteristics of selected indicators were calculated. Table 4 presents the mean, median, minimum, maximum, and standard deviation of the analysed variables.

TABLE 4: SUMMARY STATISTICAL INDICATORS

Indicator	Mean	Median	Minimum	Maximum	Standard deviation
Share of the population aged 65+ (%)	22.0	21.3	20.5	25.1	1.9
Life expectancy at birth (years)	83.9	84.1	83.3	84.1	0.4
Healthy life years at age 65 (years)	11.9	11.7	10.3	13.9	1.4
Expenditure on long-term care (% of GDP)	1.6	1.2	0.84	3.07	0.9
Institutionalisation rate 65+ (%)	3.7	3.2	0.8	7.6	2.6

Source: Author's calculations based on Eurostat (2025b); UNECE (2025); Eurostat (2023); OECD (2023); European Commission (2022c).

Table 4 summarises the basic statistical indicators of the analysed variables. The average proportion of seniors aged 65+ in the examined countries is 22%, with a gap of more than five percentage points between the minimum and maximum values. The low standard deviation (1.9) confirms modest cross-country variation. Life expectancy at birth is relatively homogeneous across all countries (83.3–84.1 years). Healthy life years (HLY) at age 65 average 11.9 years, although with a higher standard deviation (1.4) and a range spanning from 10.3 in Spain to 13.9 in Sweden. This indicator therefore highlights inter-country differences in the quality of life in older age, which are primarily associated with the level of prevention, health care, and support for active ageing. The most pronounced disparities emerged in the institutionalisation rate of older persons, which ranges from 0.8% in Italy to 7.6% in Malta, with an average of 3.7%. The high standard deviation (2.6) illustrates the divergent approaches to the placement of seniors in residential facilities.

To complement the descriptive findings, a brief statistical comparison of the indicators presented in Table 4 helps clarify the relationship between financial inputs and care outcomes. Countries with higher public expenditure on long-term care, such as Sweden, where spending exceeds 3% of GDP, tend to report the lowest institutionalisation rates (around 3–4 %) and a higher proportion of community-based services. In contrast, countries with lower expenditure, such as Italy or Spain (around 1% of GDP), display higher institutionalisation rates and greater reliance on family or informal care. Malta, representing a centralised model, falls between these two extremes. These patterns suggest a broadly inverse relationship between the level of public LTC spending and the degree of institutionalisation. This statistical observation supports the interpretation that not only the amount but also the allocation and governance of expenditure significantly shape the accessibility and structure of care provision across welfare regimes. Similar tendencies have been highlighted in comparative analyses by Kraus et al. (2010) and in the OECD (2023) report on long-term care, both of which underline that decentralised and community-oriented financing arrangements generally yield more sustainable and equitable care outcomes.

Based on the comparative analysis of elderly care systems in Sweden, Italy, Spain, and Malta, several common trends can be identified, alongside specific differences linked to the historical, cultural, and institutional development of each country.

1. Differences in the structure, financing, and organisation of care systems (Research Question 1):

Sweden represents a universal decentralised model, characterised by the strong role of municipalities and the integration of social and health care services. Financing is predominantly public, with the institutionalisation rate among the lowest in the EU. Italy operates on the basis of a regionally fragmented model, where the scope and quality of care depend on the economic capacity of individual regions. A strong reliance on family-based care is complemented by an underdeveloped formal system, which undermines equality of access. Spain applies a decentralised community-based model in which autonomous regions play a central role. The family remains the primary provider of care, combined with a low institutionalisation rate. By contrast, Malta represents a centralised model without regional disparities, placing emphasis on home-based care and equal access guaranteed by legislation. Financing is mixed, combining mandatory social contributions, pensioner co-payments, and state subsidies.

2. Common Features of Successful Care Models (Research Question 2):

Despite national differences, several shared trends can be identified. All four

countries emphasise the preference for home-based and community-based care over institutional care, with institutionalisation regarded as a measure of last resort. A crucial element is the gradual process of deinstitutionalisation, supported by legislative reforms (e.g., the Italian Legge Delega reform of 2023 or Spain's Shock Action Plans). Another common feature is the growing emphasis on autonomy and the active participation of older persons in decisions concerning the type of care they receive, alongside the sustainability of system financing. These features indicate that successful models must combine legislative flexibility, adequate public funding, and mechanisms that strengthen family-based care.

3. Applicability of Elements to the Slovak Context (Research Question 3):

From the perspective of knowledge transfer, several inspiring elements can be identified for Slovakia. Although international experience offers a number of tested and innovative solutions that could be applied in the Slovak context, their implementation has in the past encountered tangible practical limitations. These constraints persist despite several national-level initiatives, including the adoption of the Strategy for Long-Term Social and Health Care in the Slovak Republic in 2021, which formally reflects modern principles of integrated care, community-based ageing, and the concept of "ageing in place." Nevertheless, it has not yet resulted in fundamental reforms that would establish a functional and legally anchored model of integrated care (Ministerstvo práce, sociálnych vecí a rodiny SR a Ministerstvo zdravotníctva SR 2021). While these policy documents declare the need for systemic change, they remain largely at the level of programmatic visions. The Slovak system continues to be characterised by the duality of health and social care, which operate as separate and only minimally interconnected systems—whether in terms of legislation, financing, or the day-to-day coordination of services (OECD 2024b). This situation leads to fragmentation, duplication of competences, and deepening inequalities in citizens' access to care.

From the Swedish model, Slovakia can draw lessons from the integration of health and social care, which eliminates service duplication and reduces the administrative burden on care recipients. The Italian experience highlights the risks of excessive decentralisation, while also offering valuable insights into flexible planning at the regional level, which could be particularly beneficial in areas with a higher share of the ageing population. Spain provides inspiration through the systemic anchoring of the right to care and the development of community-based services co-financed by European funds, which could strengthen efforts toward deinstitutionalisation. The Maltese model illustrates the benefits of a centralised system that guarantees equal access for all citizens, thereby reducing regional inequalities. However, such a model requires substantial public investment, which represents a major challenge in the Slovak context.

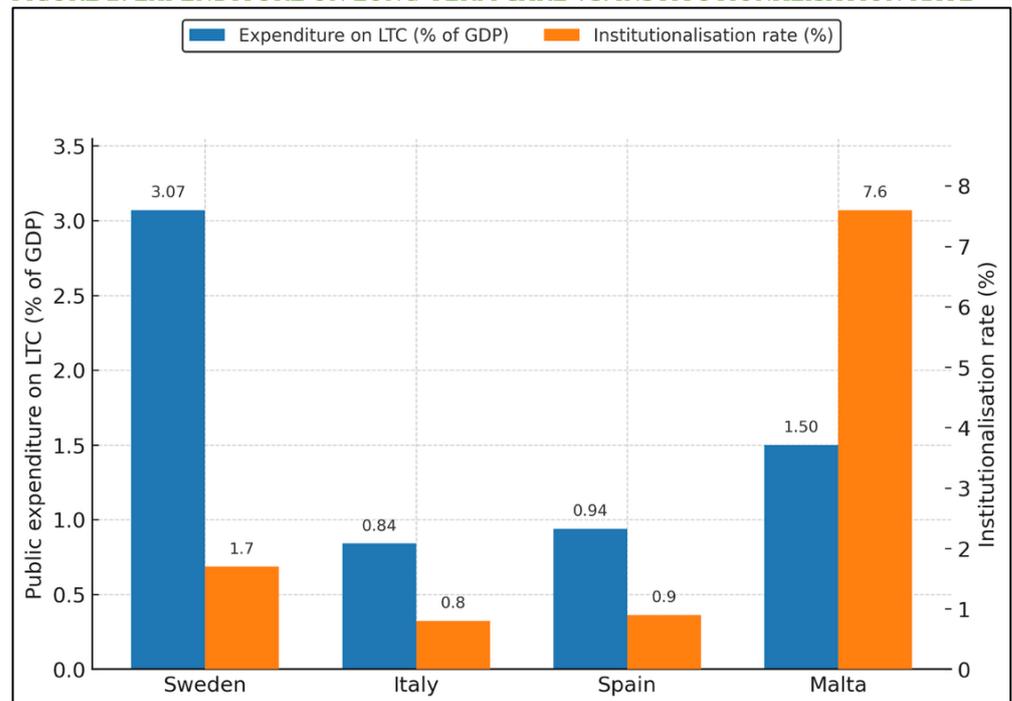
The discussion of the Slovak case confirms that implementation barriers are not only institutional but also territorial. Hornek and Maškařinec (2025) highlight that small municipal size and limited administrative capacity constrain the delivery of public services in Czechia. A similar challenge can be observed in Slovakia, where many municipalities lack the organisational and financial resources to expand community-based long-term care. These local-level constraints further complicate the practical transfer of decentralised LTC models into the Slovak context.

The overall applicability of foreign elements is constrained by Slovakia's cultural and institutional specificities. Unless Slovakia establishes a clear legislative basis

for integrating health and social care and ensures long-term financial stability, these objectives will remain aspirational. The findings of this research also highlight the strong cultural embeddedness of care, which limits the direct transferability of foreign models.

Although some differences in the organisational models of long-term care can be partially attributed to the demographic and health indicators specific to each country, a significant share of these differences arises from the distinct foundations of welfare state models and the associated diversity of care policies. This aspect helps to explain why Nordic countries systematically assume primary responsibility for the provision of formal care services, while in Southern and Eastern European countries this responsibility is more heavily delegated to the family. Consequently, in these regions, greater emphasis is placed on informal (non-professional) care, which is typically compensated through economic transfers rather than through an extensive system of publicly provided services (Díaz-Tendero and Ruano 2024). The following figure compares the relationship between the level of public expenditure allocated to long-term care in the observed countries (as a percentage of GDP) and the institutionalisation rate of elderly care in these countries.

FIGURE 2: EXPENDITURE ON LONG-TERM CARE VS. INSTITUTIONALISATION RATE



Source: Author’s calculations based on OECD (2023); Eurostat (2023).

The data presented in the figure indicate that Sweden contributes the highest share of public expenditure to long-term care (LTC) among the countries under review (3.07% of GDP), combined with a medium institutionalisation rate and a strong orientation toward community-based care. This model illustrates that higher levels of public investment enable the development of a balanced system that integrates institutional and community-based care. By contrast, Italy and Spain allocate a relatively low share of resources (0.84% and 0.94% of GDP), which is reflected in their low institutionalisation rates. These countries are characterised by the strong role of the family and informal caregivers, while institutional infrastructure is distributed unevenly across regions (OECD 2023).

Malta represents a model with intermediate expenditure levels (1.5% of GDP)

but the highest institutionalisation rate (7.6%), indicating the predominance of traditional residential care. This centralised approach ensures equal access to care for all citizens but simultaneously generates a high dependency on institutional capacity. The results highlight that higher investment in LTC does not automatically lead to higher institutionalisation rates. What proves decisive is the way financial resources are allocated between formal and community-based care, as well as the extent of engagement of family and informal caregivers.

Countries such as Sweden, the Netherlands, and Belgium not only allocate the largest volume of public resources to LTC but also achieve the highest levels of availability and coverage of services. In contrast, in states such as Poland or Bulgaria, where public spending in this sector is significantly lower, service coverage remains considerably more limited. This trend corresponds to the typology of countries that apply strongly state-regulated models of social care, where public expenditure ranges from around 2% of GDP (e.g., France, Belgium, Finland) up to 3.5% of GDP (the Netherlands, Sweden, Denmark). In sharper contrast stand countries such as Spain, Portugal, and several Eastern European states, which allocate less than 1% of GDP to LTC (Joseba 2022). Current approaches to elderly care increasingly reflect an institutional shift within public administration, particularly in the form of decentralisation of social policies toward lower levels of governance. An effective ageing policy cannot be conceived exclusively at the central level; greater potential is demonstrated by multi-level approaches that align national objectives with regional and local initiatives. Such arrangements also allow for better adaptation of interventions to the specific needs and conditions of individual communities, thereby enhancing the effectiveness and targeting of public services (Barbosa et al. 2016).

At present, the structure of LTC provision is evolving more dynamically, primarily due to the demographic shifts across European countries. Among the growing trends in this sector are privatisation and commercialisation. In many countries, the share of private providers is increasing, while that of public providers is declining. Furthermore, the international dimension of the LTC market is expected to expand, as both the workforce and service providers increasingly operate across multiple markets. These changes, particularly the growing demand for LTC, may significantly affect long-term fiscal sustainability. In addition to an expansion in the volume of services, price increases are likely, which could hinder access for vulnerable groups. Such developments may generate a greater need for government support, leading to higher levels of public expenditure. The degree of public support is therefore crucial in ensuring equitable access to quality long-term care services (European Commission 2022a).

5 CONCLUSION

Population ageing ranks among the most significant demographic shifts of the 21st century, fundamentally shaping the conditions for the formulation of social and health policies. As the proportion of older adults within the population increases, so does the need for a sustainable long-term care (LTC) system, one capable of addressing the evolving needs of the population, reflecting principles of social justice, and safeguarding dignity in old age.

The issue of providing LTC for older adults has acquired growing strategic importance within public policies across the European landscape. Although organisational models, levels of public expenditure, and the extent of state

involvement vary among countries, the analysis highlights the existence of common systemic elements. These include the combination of cash and in-kind support, assessment of care dependency, and the increasing orientation toward community-based and home care services.

Marked cross-country differences stem primarily from diverse welfare state traditions, which determine the extent of public provision, as well as from efforts to promote deinstitutionalisation and to strengthen the autonomy of older persons within active ageing policies. Nordic countries exemplify systematically managed models in this regard, whereas Southern and Eastern European states continue to emphasise family-based and informal care.

The results of the comparative analysis reveal that systems of elderly care range from highly decentralised (Sweden, Italy, Spain) to strongly centralised (Malta). Financing is predominantly public, yet the share of private expenditure and informal support rises significantly in Mediterranean countries. Successful models share common features: emphasis on community-based care, prevention, and the promotion of independence among older adults. For Slovakia, particularly inspiring are the integrative components of the Swedish and Maltese models (linking social and health care, and legislated quality standards), as well as Italian and Spanish experiences with addressing regional disparities and reinforcing family care. These findings align with the conclusions of European Commission (2022b), which stresses the need for accessible, high-quality, and sustainable LTC for all EU citizens. While international models offer several promising solutions, their transfer into the Slovak context encounters significant implementation barriers, as confirmed by past attempts at application.

The compared countries demonstrate that there is no universal solution. Nonetheless, successful models converge in the integration of services, prioritisation of community-based care, and legislative guarantees of quality. For Slovakia, this underscores the necessity of strengthening community services, adopting unified quality standards, and supporting families, which remain the primary providers of care. In the broader European context, these findings point to the essential need for coordination among member states and the sharing of best practices, since demographic ageing constitutes a common challenge that transcends national borders.

In summary, the comparative findings highlight that effective LTC systems depend less on total expenditure levels and more on institutional design and governance capacity. Future research may extend the analysis to include countries such as the Netherlands or France, where policy innovations in ageing and community-based care provide valuable lessons for Central and Eastern Europe.

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PRIMERJALNA ANALIZA POLITIKE OSKRBE STAREJŠIH V IZBRANIH DRŽAVAH EU

Vprašanje oskrbe starejših odraslih postaja v kontekstu staranja prebivalstva v Evropi vse pomembnejše. Demografske projekcije Evropske unije kažejo na nenehno naraščanje deleža starejših, kar vpliva na zdravstvene in socialne sisteme, fiskalno vzdržnost in kakovost življenja starajoče se generacije. Članek ponuja primerjalno analizo trenutnih trendov dolgotrajne oskrbe v štirih državah Evropske unije - Malti, Italiji, Švedski in Španiji, ki beležijo najvišjo pričakovano življenjsko dobo ob rojstvu med svojim prebivalstvom. Cilj članka je opredeliti skupne značilnosti uspešnih modelov in oceniti potencial za prenos teh elementov v druge države. Ugotovitve poudarjajo pomen oskrbe v skupnosti, močne podpore neformalnim negovalcem ter naložb v preventivo in zdravo staranje. Rezultati so

navdih za razvoj politik v drugih državah, vključno s Slovaško, kjer primanjkuje integriranega in funkcionalnega okvira za dolgotrajno oskrbo.

Ključne besede: dolgotrajna oskrba; primerjalna analiza; staranje prebivalstva; Evropska unija.