

# Chapter 1

## Reforms in Long-Term Care Policies in Europe: An Introduction

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### 1.1 Introduction

Long-term care (LTC<sup>1</sup>) is one of the most rapidly developing policy areas in Europe, where significant institutional change and innovation have taken place over the last two decades throughout the continent. In contrast to mainstream policy fields (e.g., pensions, labor market policies, and health care), where attempts to reduce public intervention has been the most common trend (Castles 2004, 2005; Korpi and Palme 2003; Pierson 2001), LTC has seen a broader scope of transformations, ranging from retrenchment and cost containment to a growth in public financing and an expansion of coverage. In many European countries, LTC policies over the last two decades have been characterized by a recognition of social rights on the one hand and yet increasing social responsibilities on the other (Morel 2006). This book is aimed at describing these general trends, identifying the factors, which explain these broad developments, highlighting both the main differences between European countries and outlining the main consequences of the various policy developments that have taken place.

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<sup>1</sup> We use here a broad definition of LTC, namely, as “a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL), such as bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom. This personal care component is frequently provided in combination with help with basic medical services such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care. LTC services can also be combined with lower-level care related to help with instrumental activities of daily living (IADL), such as help with housework, meals, shopping and transportation” (OECD 2011). This definition, however, fails to consider income scarcity, material deprivation, poverty, and housing distress, factors, which are often related to dependency.

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As outlined in greater detail below, our approach to LTC policies is characterized by an institutional perspective. In this book, LTC is seen as one of the main grounds to test the innovative capacities of European welfare systems. Contemporary welfare systems have historically failed to fully recognize the need for care as a social risk, and care as a social activity that has to be supported and promoted. For many decades, care has been mainly considered either as a private obligation or as an individual (or community-based) activity, which has to be replaced by public intervention only in very limited circumstances (lack of family ties, loneliness, poverty, very high degree of disability; Daly and Lewis 1998; Finch 1989; Leira and Saraceno 2004). Institutional changes in LTC policies in the last two decades have brought about a clearer and broader recognition of care as a basic need of citizens and as a social right in many countries. This is a paradoxical result if we consider the timing and the specific conditions under which this process has taken place. The 1990s and the last decade will be largely remembered as an historical phase characterized by welfare cuts (or attempts to do so) and a narrow reorganization of the service provision. However, the trends, which occurred in the LTC field, stand in stark contrast to this general trend within a large number of countries. Yet, how was this possible in a time of cost containment and welfare retrenchment? Furthermore, what were the main driving forces and the most prominent obstacles in this process? What social and institutional forces were activated in order to obtain, or prevent, this result? How has innovation been shaped and what were the institutional mechanisms? What has been the impact of these changes on entitlements to care, on the organization of care provision, and on the care labor market?

We also envisage that our study of the transformations that have occurred in LTC policy in various European countries can help to identify the conditions and social and political processes through which contemporary welfare systems have a chance to change in the attempt to respond to emerging new social needs in a time of strong budgetary restrictions (Bonoli 2006; Taylor-Gooby 2004). Institutional change in LTC policies is not a unidirectional process, but it has taken manifold configurations and has triggered diverse impacts in different countries. While some countries have completely redesigned the setting of their LTC policy, other countries have changed few aspects, or they have just reduced or increased the generosity of previous programs. Even the classic categorization of European countries into distinct care regimes (see below) has partially come under question as a consequence of these changes (Rauch 2007). The purpose of this research is to identify both the commonalities and the specificities of the process of change, and to provide a general interpretation of the direction taken by these changes in Europe.

The countries, which we included in our study, belong to different “welfare regimes” in Europe. Spain and Italy constitute the *Southern European* regime, France, Germany, and Austria the *Continental* regime, the United Kingdom is part of the *Anglo-Saxon* regime, and Sweden and Denmark are part of the *Scandinavian* regime. The Netherlands is a special case, characterized by a combination of Nordic and Continental patterns. The Czech Republic is also included as it belongs to the Central-Eastern European countries, which we also wished to analyze. In order to avoid a mere collection of national case studies, the analysis has consisted of

**Table 1.1** An explanatory framework for analyzing policy change

Characteristics of the LTC policy field (institutional setting and level of integration)	
Why	Old solutions vs. new needs and problems problem pressure/public policy crisis
Who	Diagnosis Mobilization of social and political actors and coalition building
How	Mechanisms of institutional change (policy reforms/incremental innovation/adaptation)
What	Outcomes/impacts on funding and coverage levels Regulation of the (formal and informal) care system Work conditions/providers

comparative research carried out by an international group of scholars who are experts in LTC policies in their respective countries. This group of scholars used a common framework for analyzing the transformations in the LTC policies in each country. This framework was based around responding to four key questions:

1. *The “why” question:* What are the causes or factors associated with the development of a specific LTC policy change?
2. *The “who” question:* Who are the coalitions of actors who push for change or stability, what are their values, interests, and resources and their internal composition?
3. *The “how” question:* What are the concrete mechanisms that allow institutional change or stability (inertia)?
4. *The “what” question:* What have been the main impacts of these changes on those with LTC needs, the (formal and informal) organization of care and the working condition of care workers?

This framework was developed by adapting existing frameworks from the academic literature. Indeed, in the literature, there are different approaches to explaining the different institutional settings for social change: from economic to cultural explanations, from political power to a neoinstitutionalist approach (Hacker 2004). Some scholars have tried to adopt multicausal explanatory models of welfare institutional settings configuration. For instance, in their studies on welfare policies in western countries, Esping-Andersen (1990) and Ferrera (2005) developed frameworks in which different explanations are considered and mixed. In order to answer our key research questions, we have adopted the explanatory scheme outlined in Table 1.1, partially based on Ferrera’s (2005) framework.

As the main focus of the book is the changes that have occurred in LTC policies, the first point is the reconstruction of LTC as a policy field. This issue is discussed in the next section of this chapter, with special focus on the institutional characteristics of this policy field. The following section (Sect. 1.3), discusses our institutionalist perspective in respect of the current literature on care regimes. Our goal is not to provide a further typology of care regimes, but to grasp from this discussion the most

important elements characterizing a care regime as an institutional setting wherein change and reforms take place. In Sect. 1.4, we develop our analytical framework for our study of institutional change in the LTC sector in Europe, starting with the “why” question. We argue that the innovation process in the LTC sector begins with a “problem pressure” or a “public policy crisis” that takes place when “old” institutional solutions no longer fit new needs and problems. As a consequence, new solutions must be adopted. Often, old and new actors with specific stakes in LTC policy start to mobilize and reciprocally interact. Through their actions, specific diagnoses and solutions are proposed and discussed. Institutional change can therefore be described as the result of a complex mechanism whereby institutional preconditions lead to the mobilization and intermediation of actors, leading in turn to coalition building. Indeed, the “agency” factor is one of the most relevant aspects that will be investigated in our research in order to answer the “who” question.

Next, we will address the “who” and “how” questions in Sects. 1.5 and 1.6, respectively. Indeed, the overall logic of institutional change can assume different shapes (Streeck and Thelen 2005), ranging from abrupt change to incremental innovation or simple adaptation in continuity with the previous situation. In order to evaluate the continuity/discontinuity of this change, we consider the outcomes, or impact of these policies in Sect. 1.7, looking at the impact of reforms and innovation on the care system, with special attention to funding and coverage level, public regulation, and the working conditions under which care is provided.

## **1.2 LTC Policies: A Traditionally Low Institutionalized Policy Field**

While it is relatively easy to define LTC activities, it is more difficult to define what exactly an LTC policy is. However, the issue is important both for theoretical and empirical reasons. As already noted by Hecló and Wildavsky (1974), more than 35 years ago, a policy is a “variable,” not a constant: the boundaries of a policy field shift over time; they are controversial and in themselves are contested among different actors. Taking a neoinstitutionalist approach (March and Olsen 1989), we expect that, once the LTC policy field has been framed in a specific country in a certain way by a series of actors and acts, unless something relevant happens (e.g., a broad change in people’s needs), the specific definition will have an impact on the way LTC policies develop: the prevailing conditions of various dimensions of LTC (such as health care, work-life balance policies) affect the way in which issues are determined, actors play in the field, rules are applied, and, mainly, solutions are proposed and adopted to avoid the onset of inertia.

LTC has historically been a less “institutionalized” policy field than other welfare policies such as health care, education, and social security. The need for care is a relatively “new social risk” compared to relatively “old social risks” such as poverty or unemployment (Ranci 2010; Taylor-Gooby 2004). LTC emerged in the public discussion only in the 1990s, when population ageing became a more widespread

and growing problem (see Chap. 2 for further details). For a long time, people whose care needs made them dependent on others were not acknowledged the basic rights of citizens (Leira and Saraceno 2004). Instead, they were considered as “dependent family members” or as social assistance recipients. As Saraceno (2008a) articulates, “entitlement to receive care was framed implicitly as an entitlement to be cared for by a female family member. It certainly did not result in a social right.” On the other hand, caring for frail older people was not only considered a moral obligation to be shared by families and society, but it was also constructed as the responsibility of women rather than men. Furthermore, responsibilities to care for older relatives do not allow for the same social entitlements such as paid leave, income support, or pension contributions that are associated with maternity leave. Finally, it is only recently that care policies in some countries have recognized not only the care problems of the dependent but also the material and psychological vulnerability of informal caregivers (Costa and Ranci 2010).

For a long time, therefore, care has been considered as an informal activity that is part of family-based reciprocal obligations, and it has not developed as a professional field characterized by standardization (Ungerson 1997). The relational nature of care as an interpersonal activity implying only a basic professional competence has meant that LTC services are not heavily formalized and has also prevented the rationalization of professional skills and services as it has occurred in the health care domain, where technical and professional skills are more widely recognized. This fact explains why, in contrast from what happened for health care rights, social care rights have been very poorly defined both in terms of service provision and quality requirements. In many countries, care services still have a vague and broad definition, ranging from social assistance to personal help. Professional care workers and care recipients have few uniform criteria that can be used to assess the real contents of care services as well as their quality. The high labor intensity of care services also explains why care is a field highly affected by cost increases and low productivity, preventing the development of a professional market-based provision of services (Baumol 1996).

The most relevant consequence of the lack of formalization of LTC services is that normative definitions and official statements about eligibility criteria do not automatically get put into practice (Leira 1992). Often, there is a great deal of uncertainty about care entitlements. First, the multiple dimensions attached to providing “care” (personal help, social interaction, support for mobility or basic everyday life activity, and so on) have made it relatively difficult to develop specific technical protocols. The needs’ assessment of the dependent is complex in itself as it encompasses multiple aspects, some of which are subject to subjective interpretation. Second, care has been perceived as a relational activity implying a specific adaptation to the needs of the recipient. Notwithstanding this, much effort has been made to provide professional care workers with standardized protocols, of which flexibility, listening capacity, sensitivity, and personal confidence are considered as valuable requirements (Malley and Fernández 2010). As care is still considered a “labor of love” (Finch and Groves 1983; Ungerson and Yeandle 2007), standardization and technical specifications have been very difficult to implement.

Further problems emerge in the organization of care services. Low productivity and high exposure to cost increases (every improvement in the efficiency would imply a significant deterioration in quality) have historically paved the way for a very low growth of private care services (Pauly 1990). Care services have been hugely based on public financing and more recently on the presence of nonprofit providers (Ascoli and Ranci 2002). Only lately new private actors (such as private insurances) have entered the field, attracted by the huge increase in demand for care and the availability of public funds (OECD 2011). In the public sector, the low qualification of care workers and the shortage of qualified providers that operate in the care sector have curbed the growth of care services. The more recent turn to the principles of “ageing in place,” stressing the convenience of care policies focused on domiciliary help rather than the supply of residential facilities, has had further implications for this aspect. On the one hand, as home care services cannot be delivered on a 24 hour basis, they need to be supplemented with additional forms of private or informal domiciliary help. On the other hand, the increasing combination of care and cash measures has been developed on the implicit assumption that an informal, semiformal, or formal caregiver is available to meet the beneficiaries’ need for care (Evers et al. 1994; Pfau-Effinger et al. 2009). Whatever is the level of standardization of professional care, therefore, a relevant part of the responsibility for care is still shared by recipients or their informal care network (if they have one; Österle 2001).

As a consequence of both the weak legal status of social rights to care and the difficulties of implementing a complete care service organization, care can be defined as a supply-conditioned right even in the most generous welfare states, “expressing the intention of government, but not necessarily establishing an entitlement to be claimed here and now. To a considerable extent, the needs of the care dependent are met outside public budgets, by nonpublic bodies or by private individuals, who by necessity or choice accept the responsibility for care provision” (Leira and Saraceno 2004, p. 26).

The gap between official statements regarding the social right to be cared for and the actual organization of the care service system constitutes a peculiar characteristic of care policy, and of the LTC policy field more specifically. Care provision must follow requirements that have been officially stated in the entitlements structure, but it also requires specific organizational conditions that are very often difficult to guarantee for the reasons outlined above. This fact can be understood in terms of Dahrendorf’s (1988) classic distinction between entitlements and provision. Entitlements are defined by Dahrendorf (1988), and also by Sen (1981), as “socially defined means of access” or “entry-tickets” (Sen 1981, p. 11). Provisions are those “things one is entitled to,” “the whole range of material or immaterial choices that may be open up by entitlements” (Sen 1981, p. 12). It is exactly in the space between what is stated about an individual’s basic entitlements to be cared for and the provision of care services on the ground that a relevant part of the problem pressures affecting LTC systems has emerged. The “care deficit” problem emerged in Europe as a critical problem in the early 1990s and it revealed not only the weak status of social rights related to care, but also the poor development of the care service infrastructure. Waiting lists; a high level of rationing, combined with the poor quality of existing

care services; a high reliance of charity or philanthropic institutions providing care; increasing costs shifted on patients and their relatives; and the lack of domiciliary help: all these aspects resulted not only in a limited expansion of the care delivery systems, but also in the weak capacity of European welfare states to better organize service provision. On the other hand, in Scandinavian (and partially Anglo-Saxon) countries where a service-led approach to LTC was already developed (Pavolini and Ranci 2008), care services showed a strong trend toward increasing costs due to low productivity and cost disease, asking for a significant reduction in their provision. In both cases, therefore, a tension between the declared level of entitlements and the actual level of provisions emerged. Also, it is mainly in that space that institutional change has occurred over the last two decades as we will see below.

### 1.3 Varieties of LTC Regimes

We limit our study of changes in LTC in Europe to the last two decades, when most of the major transformations in LTC policies have taken place. The early 1990s therefore constitute our starting point. At that time, the LTC policy field was structured differently throughout Europe. Two aspects are relevant in this perspective: the institutional setting and the level of integration of the policy domain. By the former, we refer to the *policy legacy* shaping the institutional field of LTC in each country. Policy legacy deals with the type of welfare state tradition (residual, universalistic, etc.) that was specifically dominant in the LTC policy field before reforms started. Policy legacy usually plays a big role in policy reforms due to the fact that it is one of the most influential “structuring” forces in the debate, particularly in determining which direction the reforms should take: actors used to a specific type of welfare state setting will try to apply or to adapt this traditional setting to “new” or less institutionalized policy fields (such as LTC). More specifically, the organization of care in the private or public spheres (e.g., by churches, nonprofit care institutions, care professionals hired by public authorities or by private providers) might create the basis for different perceptions and options of solutions. For instance, the spread presence in Italy of a care gray market run mostly by migrant women, independent from public policy supply, has been and is still nowadays a very relevant sociostructural phenomenon taken into consideration in the LTC policy arena. The opposite situation takes place in Scandinavian countries where there is a strong and consolidated presence of public professional care supply, which is organized and tends to be considered when discussing issues such as “freedom of choice for the dependent person.”

By the latter, we refer to the level of integration of the LTC policy field in each country. An “integrated” policy field is characterized by the existence of a recognized policy field and by joint packages and agencies of intervention. In contrast, we have a policy field structured through “loosely” connected domains. While there is some overlap in organization by different government departments, there is little integration overall, and so intervention runs through separate and parallel institutions and organizations, often with juxtaposed logics of functioning and levels of coordination.

Whether the level of integration of the policy field facilitates or does not facilitate policy change is hardly debatable. The more integrated a policy field is, the more common definitions of problems and solutions are shared by the different policy actors, and the more likely is the formation of strong policy coalitions forwarding or opposing new reforms in the public arena. On the other hand, the more fragmented the LTC policy field, the more contrasting interests shape the policy arena, and the more difficult the introduction of radical changes becomes. A certain level of integration in the LTC policy community therefore seems crucial to allow an appropriate change to this policy field.

The concept of *care regimes* can be fruitfully used to synthesize the two dimensions just considered. This concept has been proposed as a reaction to the well-known concept of “welfare regimes” of Esping-Andersen (1990), and it reflects the critics advanced by many scholars, mainly feminists (O’Connor 1993), to an analytical perspective only focused on the state and market and the relationship between these two institutions, not paying attention to the role played by the family and gender relationships in the practical provision of welfare services (Alber 1995). Therefore, new typologies of “regimes” have been developed in the attempt to incorporate the state–family nexus in the cross-national comparative analysis. In our perspective, care regimes are to be considered as institutional forms codifying peculiar social entitlements (i.e., social right to be cared in the case of need) and related forms of service provision or support (Anttonen and Sipila 1996; Bettio and Plantenga 2004; Rostgaard 2002). In the present study, the point in question is not related to the classification of specific countries, or the identification of the “right” number of clusters, in order to distinct such regimes. Rather, our use of the concept of “care regimes” is aimed at identifying the main factors explaining cross-national variations in the distribution of caring responsibility among the different actors of the care system (State, family, voluntary sector, market) in order to identify the institutional setting and the level of integration of this policy field in the different countries considered.

Care regimes have been firstly defined in relation to the extension of State responsibility to provide care in contrast with family obligations. This is the approach suggested in a seminal paper by Daly and Lewis (1998), where the authors distinguished between Scandinavian countries (where care is made available to people by the State on a universal basis) and continental countries (characterized by the privatization of care, via family or voluntary provision). Anttonen and Sipila in their well-known paper on European social care services (1996) honed this framework, adding two aspects:

1. the difference between State and family care responsibility is associated with a higher or lower activity rate of women in the labor force;
2. between the State-based model and the family-based model lies an intermediate model (a central European subsidiarity model), where responsibility for care lies with the family but the volume of social care provision is at an intermediate level.

More recently, empirical studies of national care systems and the development of comparative analysis have contributed to an attenuation of the strong contrast



between state-led regimes and family-led regimes. Still in the feminist perspective, care regimes have been identified by considering to what extent they contribute to the degendering of welfare states (Knijn and Ungerson 1997), so identifying care regimes in respect of the strength of the so-called male breadwinner/female caregiver model. In the same perspective, Bureau et al. (2007) introduced the concept of “predominate support strategy” distinguishing between public (universalistic), targeted, and family models. Analyzing home care, they found that public support can be either formal care service provision or economic support for informal caregiving. The former is predominant in countries adopting a public strategy (Sweden, the Netherlands) and the latter is predominant in family care-based countries (Germany, Italy).

In a different perspective, focused not on familialism but on the tradeoff between work and care, care regimes have been identified according to the extent to which women have the right to choose between working and caring. According to Rostgaard (2002), the main policy factor is not the distinction between in-kind service provision and cash benefits distribution, but the extension of public intervention. She identifies three models: a female care giver model (women stop working in order to provide care, public provision is mainly through cash benefits); a dual breadwinner model (extensive public provision of care, women mostly at work), and a family–work model (abundant supply of public services, an elevated compensation rates of cash benefits, and flexibility in the labor market, allow families to choose their own preferable care arrangement).

A different perspective has been developed by scholars who took into account not gender relations, or the care/work tradeoff, but the institutional setting within which public care is provided, i.e., the institutional logic according to which care services are organized and provided to the population (Bettio and Plantenga 2004; Jensen 2008). In this respect, care regimes should be considered as further developments of traditional welfare regimes, from which the new programs take the basic regulatory and institutional setting. From this perspective, three main systems have been identified: a Beveridgean approach (where LTC has been integrated within the existing public regulatory system for health and social services, based on universal principles); a social risk approach (LTC has been recently recognized as a new “incomplete” social right); and a social assistance approach (services are provided on the basis of assistance principles, and public care is considered as a means-tested, complementary solution). A similar analysis is proposed by Simonazzi (2009), who identifies care regimes on the basis of their entitlement structure. Simonazzi distinguishes a Beveridge-oriented system (care services are universally defined but are means-tested or income-related), a Bismark-oriented system (a universal scheme is aimed at avoiding social assistance), and a Mediterranean model (based on the principle of social assistance). France is considered as a mixed case between the Beveridgean and Bismarkian systems.

In a similar neoinstitutionalist perspective, Alber proposed to look at the institutional organization of social service provision. Indeed, the public intervention in this field is often characterized by a high level of vertical and horizontal subsidiarity: local public administrations, voluntary and church-related organizations each take a relevant part of the responsibility to provide care (Alber 1995). Therefore,

cross-national variations should be explained by paying attention to the institutional and organizational features of the national social services systems, with special attention paid to intergovernmental relations.

This institutionalist approach seems relevant as it is focused on both the recognition of social care as a social right and the organization of care provision. As already explained, LTC regimes are organized on two levels—entitlements and provisions—among which there are relevant gaps and tradeoffs. Care regimes identify not only different forms of care provision, but also specific forms of recognition of care as a social right. Entitlements have been established in order to select the right to access to services and provision, to limit opportunistic behaviors, to control costs and quality of services. It is highly probable that the institutional setting has been inspired by previous knowledge and experience in similar policy fields, such as care for older people, health care, and income support benefits. Thus, the new entitlements to LTC can be variously related to other rights that had previously been recognized. The entitlement structure requires that some form of public responsibility (both to cover cost and provide services or support) should be developed and institutionalized. This is exactly the focus of our research. In our perspective, therefore, care regimes are to be considered as institutional forms codifying particular social entitlements (i.e., the social right to receive care in the case of need) and related forms of service provision or support (including coverage of costs of care).

#### **1.4 The “Why” Question: Opportunities and Constraints of Long-Term Care Policy Change**

A series of factors have contributed to the path for institutional change in LTC policy. In comparative social welfare theory, this aspect is commonly considered in terms of *problem pressure*. Problems may rise from the outside as well as from the inside of the welfare state: on the one hand, social and economic transformation can create new social needs that are not adequately addressed by the existing measures, while on the other hand, inner financial or political constraints can call for a change in the previous institutional setting. Therefore, problem pressure can be considered as a window of opportunity for enlarging public intervention, but also as a new constraint requiring significant reduction in the existing public programs.

A problem pressure can be understood, according to Ferrera (2005), as an increasing gap between (emerging) social needs and the preexistent repertoire of policy measures aimed at addressing these needs. Conventional social programs can be understood as policy solutions that were found to solve previous problems: but social and/or institutional new situations can make the traditional repertoire of solutions obsolete, or inadequate. A new response is therefore needed, even though this is not always recognized. Only when this gap is recognized in the public arena, then a “public policy crisis” may be opened, and innovation has some chance of taking place. In this process, therefore, problem pressure is a necessary, though on its own insufficient, condition for institutional change and policy innovation.

Assistance for frail (older) people has historically been one of the first and most widespread forms (since the Middle Ages) of social aid through the use of shelters for the (older) poor. After World War II and until the 1980s, there were policies that we can define as “elder care” with a definition that is, however, partially different from the one adopted today for LTC. Those policies were less directed to persons with a reduced degree of functional capacity and more to older people with limited means. The typical policy instrument of traditional care policies until the 1980s was residential institutions for the poor, or lone older people, sometimes (but not necessarily) dependent, whereas nursing homes (designed for people with a mix of health and social care needs) were less diffuse.

From the 1970s, under the pressure of specific interest groups, new public programs were introduced in many European countries to address the need for care and social reintegration of adults with disabilities. Scandinavian countries also developed a generous supply of care services for older people as part of their generous approach to welfare (Anttonen and Sipilä 1996). With the relevant exception of adults with disabilities, chronic diseases, and heavy dependence were not wholly recognized as particular social risks in other European countries. Services such as nursing, long-term rehabilitation, and social care were considered as residual, mainly provided by families, voluntary organizations, public or religious institutions specialized in humanitarian help and social assistance. Until the beginning of the 1990s, only few European countries had introduced a nation-wide program recognizing LTC as a clear social right. Public programs were mainly aimed, at that time, at supporting the income, and only indirectly the care needs of dependent people: poverty, not care needs, was considered the real social risk, which people had the right to be protected against.

The 1990s were the turning point for LTC policies in many European countries. Many relevant social changes had put renewed pressure on the existing systems of LTC. The demographic structure of the population begun to change all over Europe as a consequence of the ageing process: an effect of the improvement of the material living conditions of the middle classes but also of the better quality of health care (see Chap. 2). Contrary to many pessimistic predictions, the higher number of old people has come with a reduced relative degree of morbidity and dependency, therefore increasing only moderately the number of people in need of care (Lafortune and Balestat 2007). However, if not the quantity, it was the quality of care that increasingly became significant: the higher percentage of dependent older people increased the need for *multidimensional* care, with the social and health aspects of care becoming strongly interrelated. If demographic trends only partially contributed to increasing the pressure for change, it was the transformations occurring in the social organization of care that hugely changed the situation. For many decades, the provision of care had been mainly granted by family networks in most of European countries. In 2001, Österle estimated that informal care still covered around three quarters of the total care for people with disabilities in western European countries, attributing a very secondary role to public protection. Starting from the 1990s, this (either implicit or explicit) intergenerational reciprocity system has been increasingly weakening for a number of reasons (Österle 2001; Saraceno 2008b), as outlined below.

First, the transformations in the forms of households helped to increase the demand for care, which could not be satisfied by members of the same household: the numbers of older people living alone has in fact been increasing in all European countries, while the number of those living with their children has been decreasing (see Chap. 2 for details). This was set against a progressive decrease in the potential for support from kinship networks. A first factor was the worsening of the old-age dependency ratio as a consequence of the reduction in the effect of the generation turnover. The rise of the older population, joined with the progressive reduction in the fertility rate, has reduced, and is still progressively reducing, the availability of family caregivers. A second factor, which has weakened the caregiving capacity of informal networks, is the increase in female participation in the labor market. The effects of higher female employment on informal care for older people are not clear. According to some research (Costa and Ranci 2010; Lamura et al. 2003), the increase in female employment rates does not significantly reduce caregiving activity when it is only for a few hours per week, while it has an appreciable effect on caregiving for those who require continuous assistance, making home care services or institutionalization in residential facilities necessary. Generally, while there is uncertainty over the decline in the number of informal caregivers, it is likely that the total time spent on caregiving has been constantly decreasing over the last few decades.

Therefore, the persistent increase in female participation in the labor market (especially of women aged between 40 and 60 years), and the corresponding increase in the number of dependent aged people, have conjured together to bring the dominant traditional, family-based care system close to a collapse. The organization of families and the integrity of relations between generations were put under pressure. Moreover, the presence of a dependent person in low-income families increased the risk of poverty, and the augmented use of private care services by the most dependent exposed the poorest groups in the population to further risk of poverty. In other words, a social reorganization based on dependency has been taking place in the last two decades. Dependency therefore challenged the integrity of relations between generations within families. Alternative solutions were not readily available. The traditional response to the lack of family care was the institutionalization of dependent older people in residential facilities: a solution increasingly too expensive as the quality standards of these structures improved. Such facilities were also less accepted as a viable solution, as the type of care provided can often compromise resident's independence.

The reduction in family care obligations and the subsequent increase in care requirements have together created a strong pressure on public health care systems, on the cash programs aimed at supporting the income of the dependent, and on the local assistance programs providing the dependent with residential institutions, home care, and daily services. The demand for these services increased at a time when cost containment, rather than service expansion, was the issue most at stake (Pierson 2001). The highest pressure came from the rising costs of hospitals and high-intensity caring needs, but also local assistance programs were increasingly under pressure because of the growing number of people requiring home care and daily care services. Therefore, many countries had to reduce their health care system's

operating costs and local social assistance by redirecting the rising demand for care to less expensive care options, or by reshaping the preexisting care programs.

As a consequence, a tradeoff emerged between the need to provide more and more people with care not supplied by families on the one hand, and the need to control the huge increase in public costs, mainly weighting on public health systems on the other. This problem went unresolved for many years as no suitable solution could be found. However, this was, in our view, a good condition to foster institutional change in many countries. The Nordic and Anglo-Saxon countries, which had already developed an extensive public structure of social services, had to adapt their care provision systems to the new situation. The Mediterranean and Central-Eastern countries, in contrast, could enjoy a stronger support provided by family solidarity even though the tendency of women to participate in the labor market had become very high, especially in latter countries. Continental countries were much more deeply affected by the ageing process and the weakening of family ties than other countries on the one hand; and at the same time they could not rely on an already established structure of public care services, on the other. Therefore, they had to create innovative solutions in order to find a way to get through the Scilla of enlarging entitlements and care provision and the Cariddi of cutting public expenditures.

As already stated, an increasing gap between problems and solutions does not necessarily lead to policy innovation (Ferrera 2005). However, the gap can lead to a public crisis, encouraging new actors to bring new ideas and solutions to the policy arena. Counterforces will often resist change and therefore a collective decision-making process will be required. In the field of LTC policy, the absence of the definition of “long-term care” in many countries created additional problems. In contrast, in the countries where a working definition of care for the dependent was already in use, a redefinition of the term had to take place in order to facilitate the operation of new policies. In countries where LTC was nonexistent, a new policy field had to be invented and new political and technical definition of “long-term care” had to be agreed about among the relevant policy actors.

## 1.5 The “Who Question”: The Role of Actors in LTC Policies

An analysis of LTC policies and institutional change cannot avoid the issue of *agency*: as Lundquist (1980) wrote many years ago, the policy actors are those who make policies, not contextual factors. Capano and Howlett (2009) underline the importance of agency and, in particular, of policy leadership in the event of significant changes: “radical changes develop through a complex process in which focal events, critical junctures and policy windows offer opportunities for change. Therein lies the case for the strategic role of agency; the ongoing momentum has to be taken advantage of (. . .). Policy entrepreneurs are those capable of discovering new needs and solutions, of dealing with a high degree of uncertainty, and of resolving the problem of collective coordination” (Capano and Howlett 2009, pp. 225–226). The same scholars also argue that policy leadership is not necessarily an individual mission, but a collective

**Table 1.2** The actors potentially involved in the LTC policy arena

Public actors	Private social actors
<i>National level</i>	
National governments (role of ministries of finance vs. other “welfare” ministers)	<i>Actors with direct interests in provision</i> Trade unions representing care workers
LTC ministry or the main ministry formally in charge of LTC policies (if present)	Private welfare-related enterprises (e.g., health insurance companies, etc.)
Other welfare sectors institutional actors/stakeholders (health care ministry, etc.)	The Church or other (nonprofit) delivery agencies
Top civil servants working in the LTC policy area	
<i>Subnational or supranational level</i>	
Local governments	<i>Actors with a more general interest in LTC</i> Trade unions in general
The European Union	Representatives of private economic enterprises Intellectuals/experts (economists, etc.) Carers/users’ associations Mass media

undertaking, involving different people at different institutional levels and policy stages: “to produce effective policy change, simply changing the agenda (matching new solutions to old problems or reframing the meaning of policy) is not enough: the ‘new’ solutions must pervade all policy domains, and leadership must be provided at different institutional levels and areas of policy” (Capano and Howlett 2009, p. 227).

Given the policy field analyzed, the main actors playing a role in the LTC arena can be divided into two broad categories: public and private actors (see Table 1.2). Of the public actors, there is a first set working mainly at the national level: governments (with possible internal conflicts among ministries in charge of the budget—Ministry of Finance—and welfare ministries always seeking more resources), the specific Ministry formally in charge of LTC issues (if there is one), other welfare policies actors with their own agenda and interests in LTC policies (e.g., to shift burden and costs from their own policy field to LTC), and the top bureaucracy dealing with the LTC policy area. A second set of public policy actors are those coming from local governments (given the importance of these actors in many countries for LTC policies) and from the European Union (through directives, benchmarking, etc.).

The private actors can also be divided into two broad subsets on the basis of their type of interest. We can differentiate between actors primarily interested in influencing LTC policy, because they have a direct stake in LTC provision (trade unions on behalf of workers in the sector; private enterprises providing care services; the Church; health insurers willing to open up new markets; and other, often nonprofit, delivery agencies as direct providers of services) and actors with a more general interest in the development of LTC policies (from users’ associations to experts, mass media and representatives of private economic enterprises, and again, trade unions), where the concept of development can point to possible different ideas about reform (either improving public financial support as in the case of users’ associations, or cutting down welfare costs as in the case of the representatives of private economic enterprises).

What is important about these actors is not only who they are and how they individually try to influence LTC policies, but also how they interact with each other, participating in (more or less) stable leading “coalitions” (Sabatier 1988), which will be examined in this study in terms of beliefs, interests, and resources.

## 1.6 The “How” Question: Institutional Change and LTC Policies

Institutional change, in reference to LTC policies, can be understood as change in the main institutions regulating the financing and provision of interventions in favor of persons with LTC needs. By institution, we adopt Hall and Thelen’s (2009) definition: “sets of regularized practices with rule-like quality in the sense that the actors expect the practices to be observed; and which, in some but not all cases are supported by formal sanctions. They can range from regulations backed by the force of law. . . to more informal practices that have a conventional character” (p. 9). How institutional change occurs is at the heart of a decades-long debate. Among all the possible explanations, we have focused on two: the Hall (1993) model of three orders policy change and Streeck and Thelen’s (2005) typology of institutional change.

In his seminal paper of 1993, Peter Hall described three types of policy changes, depending on the “order”/level in which these changes take place: “third-order” policy changes take place when there is a shift in the overarching goals that guide policy in a particular field; “second-order” ones are related to changes in the techniques or policy instruments used to attain those goals and the easier changes are the “first-order” ones related to the precise settings of these instruments. Somewhat differently, Streeck and Thelen (2005) adopt a typology, which underlines how along with more traditional explanations of institutional stability (which they defined “Reproduction by adaptation”) or abrupt/disruptive institutional change (“Breakdown and replacement”), often due to external shocks,<sup>2</sup> there is a chance of incremental but disruptive institutional change through “gradual transformation.” This second explanation argues that institutional change can be incremental and not necessarily abrupt. Far-reaching change can be accomplished through the accumulation of small, often seemingly insignificant adjustments: gradual transformation means institutional discontinuity caused by incremental, “creeping” change, often endogenous and in some cases produced by the very behavior an institution itself generates. Therefore, significant change can often emanate from inherent ambiguities and “gaps” that exist by design or emerge over time between formal institutions and their actual implementation or enforcement: “these gaps may become key sites of political contestation over the form, functions, and salience of specific institutions whose outcome may

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<sup>2</sup> This is one of the most widespread explanations of change in the social sciences, based on the idea that institutions tend to be path dependent (once a certain institution is set, due to a series of events, it tends to maintain inertia over time and finishes with reinforcing itself with a lock-in effect); only in the case of relevant external shocks (e.g., relevant economic and political crisis) will institutional change take place (Pierson 2001).

be an important engine of institutional change. . . Political institutions are not only periodically contested; they are the object of ongoing skirmishing as actors try to achieve advantage by interpreting or redirecting institutions in pursuit of their goals, or by subverting or circumventing rules that clash with their interests” (Streeck and Thelen 2005, p. 19). Streeck and Thelen propose five types of gradual transformative change: *displacement*, *layering*, *drift*, *conversion*, and *exhaustion*.

With a perspective integrating the previous one, Palier (2010) has explained the defreezing process that has recently characterized the Bismarckian welfare systems on the basis of the accumulation of small, incremental changes: “because of the ‘stickiness’ of welfare state institutions (Pierson 2001), and because of their huge popularity, governments were not able to change the whole system even when they claimed that these systems were failing to deal with economic and social issues. Rather, changes were initially incremental, passing through an intermediary phase based on a relatively ‘silent’ evolutionary institutional transformation (changes in financing, changes in power relations), that . . . facilitated structural reforms based on a new social policy paradigm. . . Even these new social policies have not entirely replaced the former ones, but merely contributed to a conversion of the old system to the new goals” (Pierson 2001, p. 365). The idea here is that the structural addition of institutional transformations over many years has constituted a sort of “critical mass” causing, without an explicit political decision, a radical discontinuity with the old welfare system. Only a long-time perspective on change is able to catch the real impact of a sequence of institutional relatively minor events, not individually significant if not considered within a more general sequence.

This is why we consider the institutional changes in LTC policy that have occurred in a time span of two decades, ranging from the early 1990s to the end of the first decade of the 2000s. This extended time span is essential to allow a consideration of the whole range of changes taking place all over Europe, generally moving a part of the welfare state that was considered, at the beginning of this period, as residual or marginal in most of the European countries, to occupying a more central position, being the object of relevant nation-wide reforms. This process has occurred through an exponential number of major and minor institutional changes, which need to be considered in their time and logical sequence in order to understand what has been their social and institutional impact. We thus rely on theories of institutional change stressing the temporal succession of events in order to contextualize our findings. Finally, we argue that most of the recent literature on institutional change mechanisms has two shortcomings, which become relevant when applied to studying LTC policies:

1. The literature does not usually take into consideration institutional multilevel relations in each country.
2. The focus of research in the last two decades has been mainly on “welfare retrenchment” more than welfare restructuring and expansion.

First, the fact that the international literature is more focused on national mechanisms of policy change, though it might make sense in other fields of policy, becomes a more inadequate choice when applied to welfare policies such as LTC, where a relevant



role is played by local actors. Therefore, following Alber (1995), we argue that, no matter which institutional change theory is adopted, there is a need to introduce as a focus of analysis not only the national level but also the local one and the interplay between these two levels as a key area where institutional change takes place (also due to the fact that LTC is a relatively decentralized policy area): some sort of multilevel institutional change has to be considered.

Second, most of the recent literature on institutional/policy change tends to investigate how governments are able to “impose losses” without losing political power (Clasen and Siegel 2007): the main issue deals with “welfare retrenchment,” whereas, in the case of LTC policies, what seems to be happening in most countries is a situation that can be better described in terms of either “welfare restructuring” or “expansion.” This means that institutional change mechanisms have to be interpreted as a way of not necessarily reducing welfare protection but of rearranging or expanding it.

## 1.7 The Impact of LTC Reforms/Change

Coming to analyze the implementation of LTC reforms, we can focus on four different impacts: the level of expenditures and coverage levels; the level of familization or defamilization of care; the organization of the care delivery system; and the working conditions of workers providing care, either on an individual or collective basis. The first impact is related to the impact of innovations on the entitlements to and the provision of LTC. While universalism has been considered as the basic principle of innovation in some countries, selectivity on the basis of need and means testing has been the main goal elsewhere. As care is still mainly grounded on the families' care capacity throughout Europe, institutional changes also have to be evaluated in respect of their impact on family care arrangements, in order to understand the extent to which they have favored (or reversed) a further defamilization of care. As far as the impact on the regulation of the care system goes, innovation has assumed different configurations, varying from State centralization to local decentralization of public responsibilities, and from assuring more equality in the care provision to diversifying services in order to meet the demand of emergent specific targets. Further impacts have been related to the efficiency and the quality of care provision: a number of new measures have been introduced in order to increase the productivity of care services, to guarantee freedom of choice to users or to empower them, or else to better integrate social and health care (Da Roit and Le Bihan 2010).

Institutional change in LTC policies has not only affected the care delivery system, but it has often been closely linked to specific employment strategies. In many countries, cash for care programs (and public measures supporting, or tolerating, the growth of a transnational care market grounded on the low-cost supply of care work by immigrants), have led to the development of low-skilled, low-paid, care jobs. Home care services have been strongly advocated almost all over Europe as a strategy to keep “ageing in place,” but this care activity remains low-skilled and low-paid in many countries, so contributing to the occupational growth in a marginal,

lowly professionalized sector. At the same time, a new generation of social measures has been introduced in many countries to support the caring responsibilities of informal caregivers (including both family members cohabiting with the dependent persons and other family members and friends). Further programs have been aimed at supporting the work–care conciliation strategies of informal caregivers (also by protecting their work rights and supporting their contributory pension records). Generally speaking, therefore, care policies have not only impacted on the care needs of the dependent, but they have also contributed to the creation of new, low-skilled jobs in the field, and have affected the caregiving activity of working women.

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