Chapter 13
Institutional Change in Long-Term Care: Actors, Mechanisms and Impacts

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13.1 Introduction

As illustrated in the previous chapters of this book, long term care (LTC) has been one of the welfare policy fields in which the most significant institutional changes and policy innovation have taken place over the last two decades, both in Western and Central-Eastern Europe. The national case studies presented in this volume show that very different trends have taken place throughout Europe: from a general growth in public financing, an expansion of beneficiaries, and, more generally, an attempt to define larger social responsibilities and related social rights in some countries, to cuts in public expenditure, targeting of services and a general reduction in social rights in others. This final chapter aims to describe these general trends; identify the factors which explain them; summarize the main differences between European countries; and consider the most important consequences of the various developments. We also look at institutional conditions and the gaps between "problem pressures" and existing solutions which require policy innovation; at the political and institutional processes through which subsequent changes have taken place; and at the general impact of such changes on the structure of the care systems.

The chapter is organized in the following way. Section 13.2 describes the state of affairs in the individual countries at the beginning of the 1990s, just before major reforms were introduced in several different countries. Two fundamental care regimes will be identified which explain the developments which subsequently took place in the countries included in our analysis. Section 13.3 discusses the main drivers which led to reform and also the constraints which hindered it. The subsequent Sect. 13.4 is dedicated to identifying the problems requiring a change: how the gaps between problem pressures and available solutions were perceived in our countries, preparing

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the stage for innovation. Section 13.5 then outlines the main thrust of the reforms introduced in the last two decades in the countries considered.

If Sect. 13.6 is about the politics of LTC reform (who have been the main actors and coalitions who push for change or stability, which are their values, interests and resources), Sect. 13.7 outlines the institutional and political mechanisms through which change has taken place. Section 13.8 then considers the impacts of the reforms on potential beneficiaries and their families, as well as on workers and on the overall organization of the LTC delivery system. Finally, the conclusion (Sect. 13.9) draws a general overview and interpretation of the ongoing reform processes.

13.2 The LTC Policy Field before the Main Reforms

LTC regimes in Europe can be analyzed and classified around different criteria. We have chosen to focus here on two of the most salient: the first concerning the level of coverage to meet demand (measured first by the percentage of the population aged 65+ receiving home or residential care services and second by the relevance of cash programs); the second, the extent to which LTC care services are well-integrated and coordinated with other social and healthcare services. At the beginning of the 1990s, a wide spectrum of coherently different LTC care regimes co-existed, with a "universalistic" model and another "fragmented" model operating at the two extremes (see Table 13.1).

At the beginning of the 1990s, Denmark, Sweden and the Netherlands were already characterized by universalistic approaches, namely, providing very high coverage of LTC needs, completeness of care services and a strong integration among providers (Anttonen and Sipila 1996). In Denmark and Sweden, long-term care policies date back to the late 1950s and were subject to systematic expansion from the 1950s until at least the 1990s; the LTC policy arena was firmly embedded in the structures of central-local relations which are one of the cornerstones of the political system. In the Netherlands, the Algemene Wet Bijzondere Ziektenkosten (AWBZ) dates back to 1968 and it is considered one of the main institutions of the Dutch welfare state. If we look at the level of fragmentation—integration of the LTC as a policy field, these three countries presented a situation in LTC policies of "integration", confirmed by the presence of a mature community, which has been established since the 1960s, and by the fact that LTC was a well-institutionalized policy arena firmly embedded in decades of central-local government relations (in Scandinavia) and public-private providers relations (in the Netherlands). The Netherlands is arguably the best example of a case of maximum integration, given the fact that health and social care are strongly coupled in the case of LTC needs: the main program, the AWBZ, has been historically framed as part of the health-care system. In these countries, therefore, an universalistic, service-led LTC system was already in place at the beginning of the 1990s as a consequence of the extension to the care system of the same approach to welfare that was dominant in the health, pension and education systems.

Table 13.1 LTC policies: the scenario at the beginning of the 1990s. (Source: Huber et al. (2009); for the Netherlands, Anttonen and Sipila (1996) and for the Czech Republic (Barvíková and Oesterle, see Chap. 12); the data for the Czech Republic refers to coverage in terms of beds in residential care in relation to the elderly population)

Country	Coverage at the beginning of the 1990s			(Beginning of the 1990s)	Integration–Fragmentation
	Home care	Residential care	Relevance of cash programs		
Denmark	20	4.1	Low		
Sweden	12	8.4	Low	Universalistic	Integration
The Netherlands	8	10	Low		
Great Britain	14.2	3.9	Medium-Low	Semi-universalistic	Fragmentation
Germany	7.3	3.3	Low		
France	2.5	2.4	Low		
Austria	13.2	2.8	Low	Residual (partially based on residential care)	Fragmentation
Spain	1.1	2.8	Low		
Italy	1.8	2.2	Medium		
Czech Republic	n.g.	2.8	Low		

At the other extreme, continental and Southern Europe both had a residual LTC care regime at the beginning of the 1990s. Within this model, service coverage was relatively limited and was based more on cash programs and residential rather than home care. The LTC policy field appeared also quite fragmented: different institutions, often with different (and overlapping) geographical remits with high levels of discretion, were each responsible for different aspects of LTC and there were problems of coordination among these institutions. For instance, in Italy, cash-for-care programs were run separately from local authorities' social care services for LTC users and, in most of the countries, there were also problems of integration between social care and health care services at the local level. This situation meant that there were different actors operating in different arenas, each working according to partially different definitions of what LTC should be. Great Britain was a peculiar case in this scenario: the level of coverage at the beginning of the 1990s was something in between the prior two regimes, but the level of fragmentation remained high as in Continental and Southern Europe.

Central and Eastern European countries (CEE) found themselves in an even more complicated situation. Before the 1990s, long-term care was largely a family responsibility with rather limited public support. Coverage levels, in terms of residential care or financial support schemes, were lower than in many Continental and Southern European countries. In the early 1990s, with the transition process, cuts in social policies and ideologies referring to traditional patterns of family roles served to reinforce traditional family responsibility in LTC (Barvíková and Österle, cap 2012). The Czech Republic showed a similar, if slightly better picture, than other CEE countries. Also here the LTC system was mainly based on residential facilities and was quite fragmented overall, consisting of a range of health and social care providers, as well as pensions' regulators and other institutions. To sum up, the weak development

of the LTC system in Central and Southern European countries is the result of a combination of familism and residualism in care policies. Moreover, the dominant Bismarckian approach to welfare in these countries, based on a combination of insurance and assistance principles, hampered the progress of universalistic principles in the care policy field.

13.3 The Drivers of Reform: Problem Pressures

All of the countries considered here have experimented with new "problem pressures" since the early 1990s. As we explained in Chap. 1, in our model, a problem pressure is a situation that is characterized by a growing gap between new social and institutional problems emerging in a specific policy field and the capacity of the existing repertoire of political measures to give an adequate answer to these problems (Ferrera 2005). In such cases, a policy crisis becomes increasingly evident and requires policy innovation. This was the case for all the countries analyzed here. Three types of pressures have been most evident: socio-demographic pressures; financial pressures; socio-cultural pressures.

Socio-demographic pressures In the field of LTC, the most relevant pressure came, first of all, from demographic changes taking place all over Europe due to the ageing of the population (see Chap. 2). As a consequence, not only the amount of dependent people in need for care increased, but also the capacity of informal and family ties to provide support was weakened (OECD 2011; Lafortune and Balestat 2007). At the same time, the increasing participation of women to the labor market lowered the supply of family care work, driving more and more dependent people to professional services (Sarasa and Mestres 2007; Saraceno 2008). Disability and dependence mainly concentrated in the elderly, as well as vulnerability related to heavy informal caregiving, emerged as 'new social risks' (Taylor-Gooby 2004): situations in which individuals experience welfare losses and which have arisen as a result of the socio-demographic transformations that have brought postindustrial societies into existence. As Bonoli (2005) states, if during the *trente glorieuses* care for frail elderly or disabled people was mostly provided by non-employed women on an unpaid, informal basis, with the change in women patterns of labour market participation, this task had to be externalised. The inability to do so (because of lack of services) therefore has resulted in a new relevant social risk. All ten countries experienced these trends, even though levels of pressure on the existing systems differed. Also, in the Southern, Germanic Continental and CEE countries, which could count on the very rooted family solidarity that favored the creation of new care arrangements within families, demand for residential and home care services increased exponentially (Lamura et al. 2008). Meanwhile, the individualistic culture that was dominant in the Nordic countries, in England and in France, channeled a new demand for care directly towards professional care services.

Financial pressures The rising demand for care also put pressure on welfare services which were not specifically tailored for long term care, but which were substantially

Table 13.2 Percentage variation in the public per-capita expenditure on healthcare in the 1990s and in the 2000s (constant prices at 2000 level). (Source: Eurostat, Espross database 2011)

LTC Care Regime (early 1990s)	1991–2000	2000–2008
Universalistic		
Sweden (from 1993)	+29.5	−0.2
Denmark	+28.6	+33.5
Netherlands	+11.3	+40.0
Semi-Universalistic		
United Kingdom	+54.9	+5.5
Residual		
Germany	+26.2	+4.6
Austria	+29.2	+13.2
France	+31.1	+20.6
Spain	−4.5	+37.6
Italy	−20	+18.7
Czech Republic	–	+88.5

affected by the growing number of dependent people asking for help and assistance. A second source of pressure was therefore financial, coming from the functioning and difficulties of other welfare institutions and programs. Of these institutions, healthcare systems were and still remain in the front line: in most countries, increasing costs in the healthcare system, as a consequence of the aging population, were reported (see Table 13.2). According to the OECD (2011), between 40 and 50 % of the total costs of healthcare in Europe is currently used to provide services to older people, often with chronic and long-term needs. In the 1990s, the highest growth in healthcare expenditures occurred in the UK, France, Sweden, Austria, Denmark and Germany. Only Mediterranean countries saw strong cuts in healthcare, aimed at matching the Maastricht criteria in order to enter the Eurozone. In the UK, the pressure of costs was so high in the early 1990s that new solutions were sought in order to shift the responsibility for funding residential and nursing care away from the health care system.

The development of new LTC services was seen as a good strategy to shift costs from the health care sector, where services were provided on the basis of universalistic principles, to the social sector where rights and costs were not so highly and precisely defined (Morel 2007). The Ädel-reform (1992) in Sweden was also aimed to shift part of these costs to social care services in order to diminish the pressure on the health care sector. In Denmark, England and Germany, particular attention was paid to the length of stay in hospital of patients with disabilities. The search for new solutions allowing earlier discharges from hospitals had repercussions for the demand on long-term care. In Sweden, the rising costs of nursing homes managed by the health care sector were under scrutiny and paved the way for a shift in their financial management from the health sector to social care services managed by municipalities. In CEE, the health sector has long been the major provider of long-term care services. Throughout the region, home nursing has often been the only community care service available to those with chronic health problems across the entire country. Health care reforms aiming at cost-containment, however, increased pressure to limit health sector provisions to medically-needed acute care provisions and to shift long term care provisions to the social care sector.

These strategies seem to have worked out quite well in many countries as healthcare expenditures slowed down throughout the following decade (with the exceptions of Denmark and partially of France, where expenditures dropped only in the second half of last decade). In other countries, however, expenditure in health care increased only in the last decade, as is the case for the Netherlands and Spain, resulting in increased pressure on LTC reforms more recently.

Other financial strains came from the social security or the social assistance systems. In some countries, such as France, Germany, Spain and England, large parts of care services for older people, including residential and home care, were financed by national or, more frequently, local programs of social assistance (Oesterle 2001). In England, reforms which took place in 1993 capped social assistance expenditure on long term care and shifted both the budget and allocation responsibilities to local authorities. In Germany, the growth of residential care provided at the local level within the framework of the Federal Law of Social Assistance put most of the local authorities under very strong financial pressure. In Spain, the 1985 Local Government Act assigned financial responsibility for providing social care to local authorities. In Italy this responsibility had been assumed by local authorities since 1977, with the national state only playing a residual and complementary role. The same happened in the Nordic countries, which were characterized by a long tradition of a locally based social welfare. In Sweden, the economic crisis of the early 1990s squeezed resources for care for older people in a time of increasing demand for social assistance benefits). These local infrastructures of social services, largely developed in the 1970s and the 1980s to meet the demand for care of particular social groups (older people with limited means or living on their own, people with disabilities and so on), began in the 1990s to be captured by a huge mass of dependent older people seeking care services. Local authorities and the social assistance administrations managing these services were under very tight financial and organizational constraints, and seemed to be unable to keep the social spending under control. In the Czech Republic, as in other CEE countries, the situation was only partially different: a lack of experience in local social care governance and budgetary constraints have for many years constrained modernization, coordination and extension of services at local level. Community care services were unavailable in most rural areas in the 1990s and were only very limited in many urban areas. Funding of residential and community care provisions was usually based on social assistance principles involving substantial user contributions.

Financial pressures also came from the overall economic conditions of the countries, which served both as constraints for LTC reforms and as catalysts of institutional innovation. This contextual factor has been particularly relevant in certain countries and in particular years. Table 13.3 illustrates the financial situation of each country in terms of debt and deficit/surplus in relation to the National GDP. LTC radical reforms were introduced in years that were characterized by relatively low levels of financial debt in all of the countries. Germany introduced the new LTC system in 1995, when the deficit/surplus ratio was under 2.0. Similarly, France introduced the APA reform in 2002, a year in which the financial strain was lower than either previously or afterwards. Spain also introduced a reform in 2007 in the context of a relatively favorable financial situation.

Table 13.3 Fiscal constraints on welfare reforms in Europe: gross debt and deficits in the last two decades. (Source: Eurostat 2011)

LTC Care Regime (early 90s)	General government gross debt (% GDP)	General government deficit/surplus (% GDP)		
	Average 1995–2007	Average 1995–2000	Average 2001–2007	Average 2008–2010
Universalistic				
Sweden	57.7	− 1.2	1.1	0.6
Denmark	51.4	− 0.3	2.8	− 0.7
Netherlands	57.6	− 0.3	− 1.0	− 3.4
Semi-Universal:				
United Kingdom	43.8	− 1.3	− 2.5	− 8.9
Residual:				
Germany	61.9	− 1.7	− 2.7	− 2.5
Austria	65.6	− 3.0	− 1.6	− 3.1
France	60.5	− 3.1	− 2.9	− 6.0
Spain	54.2	− 3.4	0.5	− 8.3
Italy	110.5	− 3.7	− 3.2	− 4.2
Czech Republic	22.3	− 5.5	− 4.1	− 4.3
EU 27	61.8	− 1.2	− 2.1	− 5.3

However, more serious fiscal problems appear to have hindered the possibility of strengthening reforms after their introduction, as in the case of France, Spain, the UK and the Czech Republic. For instance, in Spain, the financial crisis, which started right after the LTC reform in 2007 was adopted, was detrimental to the reform's implementation phase, as shown in Chap. 10. In the UK, after years of discussion and "White Papers", the most recent Labour government in England was not able to finalize a proposal of reform in LTC at the end of its term in office: partially because the deficit had risen from around 2 % to around 9 % between 2008 and 2010. An even bigger problem affected Italy: any expansive and explicit reform proposal in LTC had to first overcome its permanent huge public gross debt.

Socio-cultural pressures Together with socio-demographic and institutional pressures, the 1990s were characterized by a strong change in the political and cultural attitudes towards care provision. These changes concerned the predominant ideas both in the political arena about how to run public services and in the social arena about the role of users in care provision. While the '70s and the '80s were dominated by a demand for professional, highly qualified care services and for a progressive extension of long term care to minorities (such as specific categories of disabled people), a new orientation towards efficiency and flexibility became predominant in the 1990s (Daly and Lewis 1998). On the one hand, the ideology of New Public Management (NPM) largely penetrated the public administration and the political class claiming for a standardization and marketization of service provision. On the other hand, social groups representing the interests of dependent people started to elaborate a new vision of care, based on the principles of self-determination and autonomy.

The influence of NPM has been very significant throughout each of the ten countries' analysis. After three decades in which the expansion of social services was considered a still far-reaching but considerable goal of social policy, high public social expenditures have been seen as a problem since the 1990s. Even in a social-democratic country like Denmark, "concerns for containing expenditure, value for money and responding to individual needs become predominant" (Burau and Dahl, Chap. 4). Therefore new forms of accountability and budget control; novel regulation, splitting the responsibility for financing from provision; new market mechanisms; and new forms of standardization of quality and costs, were introduced into the care systems in all the countries (Ascoli and Ranci 2002). As discussed in following sections, cost-containment has become a dominant principle even in countries where radical reforms and new principles of universalism were introduced. It would be fair to say that, since the early 1990s, the policy field of long-term care in all ten countries has been strongly influenced by concerns about cost-containment and efficiency. The NPM ideas were largely introduced in order to guarantee cost-efficiency, effectiveness and strict budget control on both expenditures and service provision. This "recipe" was also provided in an even more explicit form to CEE countries over the last two decades: international organizations, such as the World Bank and the OECD, promoted reforms based on NPM ideology.

This attention to efficiency has been paradoxically matched by a deep change in the care culture in many countries. Until the 1990s, the most common claim by both groups representing people with disabilities and trade unions was to extend care service provision, to de-institutionalize the care system allowing people to stay at home as long as possible and to guarantee high professional and quality standards. In the 1990s, this idea of the professionalization of care was challenged. Groups representing people with disabilities were strongly influenced by ideas of self-determination and independence, and professionalization of care started to be considered as a synonym of bureaucratization and managerial control on the life strategies of the disabled. Part of this change had to do with the individualization of social life and the consequent refusal of bureaucracy and standardization. But this was also due to the great improvements in the health treatment of chronic diseases and to technological innovations, which did not only lengthen the life expectancy of people with disabilities, but also improved their everyday conditions, thus reducing their dependence on other people and increasing the chances of social and economic integration. Therefore the empowerment of the disabled became not just an appeal as a real opportunity to be taken.

As a consequence of these changes, groups representing people with disabilities started to call for a new public regulation of care giving beneficiaries more autonomy and freedom to organize care according to their wills and needs. User-led care and flexibility became new principles to use against the professional definition of the contents of care. New regulation proposing freedom of choice, welfare pluralism, cash for care measures, was strongly supported by these groups in order to empower users and alter the definition of care provided either by the public administration or by professional providers (Da Roit and Le Bihan 2010). Therefore, calls for free choice and empowerment on the one hand, and the NPM claim for flexibility and

marketization of care on the other, matched together to foster a new cultural definition of care, paving the way for new regulatory principles to be introduced in the care system.

13.4 Diagnosis: How the Policy Crisis has been Defined

Although the pressures for change were almost the same throughout the ten countries analyzed in this volume, these pressures have been perceived and cognitively framed quite differently due to the different LTC care regime traditions.

In the countries that had already adopted before the 90s a universalistic care regime (Sweden, Denmark and the Netherlands), a conflict emerged between universalism and pressures for cost-containment. According to universalistic principles, the provision of care services had to be as complete as possible. Moreover, high quality professional standards had to be guaranteed. However, completeness and high quality of care services significantly increased the costs of service provision. In the Nordic countries, this original, full version of universalism had already proved to be unsustainable in the late 1980s, requiring a number of organizational adaptations in order to cut public expenditure. Shifting public investments from residential services to home care provision was not only a strategy aimed at improving the life conditions of the care recipient, but also implied the involvement of family networks in the provision of care in order to reduce public costs. Since the early 1990s, the strategy of deficit reduction has become dominant, but, in comparison with other countries, the fiscal constrains were less tight (the level of debt and deficit was relatively more limited). As a large part of the financial responsibility for care provision was held by local authorities, new legislation was introduced in Denmark and Sweden to cut the state financing of local governments and to limit taxation and social spending at the local level. A re-centralization strategy was therefore adopted in order to curb social expenditures. As we will see later, innovation was also introduced in the public regulation of the care system in line with the NPM doctrine both by social-democratic and neo-liberal or conservative parties.

In addition, given to the fact that the fiscal constraints were loose, the gap between problems and available solutions was mainly understood in these countries as an organizational and a management problem. Cost-containment was never considered a radical challenge to the mainstream principles of universalism and service completeness. The high public consensus on universalism was untouched and there were no serious attempts to fight against the strong welfare constituencies defending it. Innovation put in place was not explicitly questioning the institutional setting or the normative principles of the care system, but was focused on technical and organizational aspects related to financing and providing services. But even in these technical discussions, entitlements to social care were neither disputed nor formally reduced, even though cutbacks in expenditures and service provision were actually introduced in Sweden and the Netherlands. Only Denmark resisted against cost containment by adopting new regulation which has so far not affected spending and coverage levels.

In Denmark and the Netherlands, the tension between universalism and cost containment was therefore at play. But the policy crisis was not recognized as a problem requiring a radical change in the general orientation and institutional setting of the care system: universalism per se was not considered as part of the problem. Only Sweden experienced a stronger tension between rising costs and an equivalent increase in demand for care. In this country, in contrast with what happened in Denmark and the Netherlands, cost containment was perceived and explicitly discussed as a challenge to the universalistic foundation of the care system. It was not only a matter of targeting and focusing care services. The ideological basis of the welfare system was under strong attack from the NPM approach which deeply influenced the public discourse and was also strongly penetrating the social-democratic culture. A new epistemic community of economists, managers and welfare experts advocated the NPM approach and succeeded in permeating the public arena with these arguments. The strong cultural influence of NPM, as shown by Meagher and Szebehely, can explain the peculiarity of the Swedish case compared with the other Nordic countries, and the fact that, starting from the 1990s, policy makers, including the same traditional constituency groups of the Swedish welfare state, were searching for new solutions outside of the universalistic public care system. Sweden therefore experienced a real policy crisis that paved the way for more radical changes. But even in Sweden, as we will show below, the way out of universalism was achieved through incremental changes which did not explicitly change entitlements and social rights.

In England, the only country defined as a "Semi-Universalistic" LTC care regime at the beginning of the 1990s, local authorities were both the funders and the providers of social care services. The growth of the demand for LTC raised costs in the early 1990s, resulting in an attempt to put the local budgets under the control of the national government, as actually happened with the Community Care and NHS Act enacted in 1993. The new budgetary system failed to prevent cost increases as the responsibility for funding residential care passed from local and health authorities to the national social assistance budget; local and health administrations were also asked to split commissioning from providing, delegating the latter to private care providers. The consequence was a financial disaster as local authorities and hospitals shifted responsibilities for funding residential and nursing care to the social assistance budget and a private market in residential and nursing homes quickly developed in response to this new funding opportunity, as Glendinning showed in Chap. 9.

Over the following years, a labour-led government introduced more financial constraints and did not seem able to reform the LTC system, although older peoples' organizations, regulatory bodies and Parliamentary committees called for increasing resources to be allocated to long term care. As a consequence of this political inertia, proposals for funding reform tended to focus on accessing some of the income and/or wealth held by older people, complemented by very limited additional contributions from general taxation. Over the same period, there was extensive marketization in the provision of care services (both residential and domiciliary). These have been almost entirely transferred from the public sector to third-sector charities and for-profit organizations, with individual service users increasingly expected to exercise consumer choices over the purchase of their own support. The lack of basic changes to

the entitlement structure of the long term care system has therefore been exacerbated by organizational measures aimed at cost-containment and more efficiency in care provision.

In the countries characterized by a residual LTC care regime at the beginning of the 90s, the most important pressure came from the huge rise in demand for care, associated with the increase of the costs of social assistance programs funding the delivery of residential and home care services. In comparison to the universalistic care regimes, the entitlement structure of the care system in these countries was much more challenged as the degree of development of care services was much lower than in the former countries' care regimes. The increase in the demand for care was initially matched by social services managed at the local level. This happened in Germany, where the increasing high costs for residential care provided at local level was the main incentive for introducing a radical reform in 1995. Spain, Italy and Austria experienced the same situation, as the responsibility concerning care services provision and funding had been entirely delegated to local authorities since the 1970s or the 1980s. However, the residual nature of social care programs, mainly provided on the basis of means-tests and highly restricted to specific kinds of patients, contributed to increasing the health costs as hospitals and health territorial services were increasingly seeing dependent people asking for assistance.

In Austria and Germany in the 1990s, and in France, Spain and the Czech Republic in the last decade, local administrations faced financial difficulties, which, coupled with an inability to extend the provision of care services, stimulated the search for new policy solutions that involved a national or regional financial responsibility. The shift from local to regional or national responsibility was perceived as a necessary precondition for any possible change in this policy field. Neither accommodation of the existing programs was seen as possible (as it happened in the Nordic countries), nor alternative cash-based measures were already in place to temper the lack of care provision (as it was the case in Italy). The policy crisis therefore came to a crucial breakpoint, paving the way for a general, radical reform.

In this situation the main problem for all these care regimes was to find a way to finance a new national long-term care program, large enough to respond to the care needs of the dependent, without exploding the public finances or raising taxes. The reluctance to increase taxes played an important role in the delay of any political decision in many countries, such as France, Spain, Italy and the Czech Republic, in spite of the huge public discussions taking place about the need for reform in this policy field. From this point of view, the timing of reforms in different countries is important: Austria, and Germany introduced reforms during a period when fiscal constraints were less strict, both in terms of debt and deficit. France, the Czech Republic and Spain started respectively to discuss or to implement new programs in the second part of the last decade when their financial situation got worse: with deficits between 2008 and 2010 respectively of 6, 4.3 and 8.3 %, reforms and their implementation became a more complicated task, as illustrated in the chapters on these countries.

Specific conditions, moreover, paved the way for reform. In Germany and Austria, the strong family solidarity that is a particular trait of these countries allowed a

reorganization of the care system, under a new nation-wide program, that included the family care provision within a broader public care system, therefore lightening the financial burden for the public budget. In Spain, the strong activism of some regional governments in the previous decades was a good resource in the creation of a new LTC system strongly based on the decentralization of financing and responsibility, with the state assuming only a complementary financial role. Furthermore, in France, the APA reform was based on a mixed funding system, to which both departments (local authorities) and the State contribute.

Italy is the only residual LTC care regime characterized by institutional inertia in terms of reforms. What happened in LTC mirrors a more general landscape of the Italian welfare state as almost "frozen" (Naldini and Saraceno 2008). A pertinent reason for this situation is the fiscal constraint: the huge public debt has forced Italy to be cautious in proposing new expansive LTC policies. Moreover the existence from the 1980s of a cash-based program, the "Indennità di Accompagnamento", providing a limited amount of resources to LTC beneficiaries but universalistic in nature, functioned as a buffer, especially because, thanks to its automatic institutional mechanisms, it was progressively extended to slightly meet the increasing demand for care. In the last decade, more than one million Italian dependent people were in receipt of this cash-based benefit, which substitutes the lack of service provision and is mainly used to support family-based care arrangements.

13.5 The Contents of Reform over the Last 20 Years

Almost all the countries studied went and continue to go through transformations in their LTC systems thanks to either changes in their institutional arrangements or changes in other policy fields, which have an impact on the sector. Table 13.4 tries to synthesize the various reforms. In doing so, it frames the more recent reforms in a longer time span in order to understand what happened, on one hand, taking into consideration what has been written in previous sections on the period before the 1990s, on the other, in more recent years during the implementation of the main reforms where they have taken place. The idea of looking not just on the main reforms but also to frame them within a longer time span is useful in order to better comprehend the transformations in LTC policies. Let us look first at LTC universalistic countries.

As outlined by Meagher and Szebehely, since the beginning of the 1990s, Sweden has gone through significant changes not directly related to the institutions of LTC, but in more general settings: from the Adel reform and the Disability Act at the beginning of the 1990s to tax deductions on household services and personal care in more recent years. Such changes, coupled with the introduction of market practices and rationalization of elderly care provision over the last two decades, have resulted in a retrenchment in overall LTC coverage for older people. Something similar was attempted in the Netherlands through different reforms (from the one concerning health-care to the Social Support Act, and also through different forms of cost-containments in relation to co-payments and limiting access to AWBZ). However,

Table 13.4 LTC reforms in Europe, 1970–2012

Country	Situation in 1970–1980	Main reform since the 1990s	Other reforms following the main one (if present)
Sweden	Universalist regime	None	Disability Act (1994) Rationalizing elderlycare: falling coverage (since 1990s) Adel reform (1992) Municipal Act (1992) Introduction of market practices (1991–2010) Tax deduction on household services and personal care (2007)
Denmark	Universalist regime	None	Re-centralization (1990s) Restructuring (e.g. "Common Language" (1998); "Free choice" in home-care (2002))
The Netherlands	Universalist regime	None	Health-care reform (2005) Restructuring and retrenchment reforms (since 1990) (e.g. cost-containment: de-institutionalization; co-payments; limiting access) Personal budget (1995) Marketization of service delivery (since 1990) Social Support Act (2007)
England	Semi-universalistic regime	None	Community care reforms (1990s) Consumerist initiatives (direct payments and personal budgets; 2000s)
Austria	Residual regime	The Cash-for-Care Reform (1993)	Cost-containment policies (since 2000s) Support for informal care (since 1998) Regularization of migrant care (2007)
Germany	Residual regime	The Care Insurance Reform (1994)	Cost-containment policies (since 2000s) with an increase in benefits in 2008 Complementary Nursing Act (2002)
France	Residual regime	APA (2002) with previous experimentations (PSD—1997)	Ongoing discussion on the role of private LTC insurances vs. a 'fifth' pillar
Italy	Residual regime	None	Piecemeal regularization of migrant care work (since 1990s)
Spain	Residual regime	Dependency law (2006)	Slow and fragmented implementation of the new care system
Czech Republic	Residual regime	Act on Social Services (2006)	Several adjustments (soon after the reform)

the results were closer to restructuring and real retrenchment failed (see Da Roit, Chap. 5). Denmark seems the case where minor reforms were undertaken at the national and at the local level in order to improve and restructure the LTC system, rather than to shrink or to expand it. Experiences such as "Common Language " (1998) and "Free choice ", which were aimed at introducing standardization and rationalization in home care, seem to have had more of an impact on how services are provided than on the level of public coverage and funding (see Burau and Dahl, Chap. 4).

Despite numerous official reports, England has failed to introduce major explicit changes to its long term care funding arrangements. The community care reform of the 1990s (with the introduction of quasi-markets) and the consumerist initiatives of the last decade (the introduction of programs such as Direct Payments and Personal Budgets) seem to have played a bigger role in the intellectual debates about the regulation of LTC than promoting higher needs' coverage: the overall result has been, in any case, a retrenchment in coverage (see Glendinning, Chap. 9).

Among the countries characterized by a residual care regime, five introduced major LTC reforms and programs in the last two decades: these are three continental countries (Austria, Germany and France), Czech Republic and Spain, all of them (old or new) Bismarkian welfare states. All these reforms were aimed at expanding LTC coverage.

As indicated by Oesterle (Chap. 8), 1993 represented a major turning point for the Austrian long-term care system: a Federal Long-term Care Allowance Act and nine Provincial Long-term Care Allowance Acts introduced a cash-for-care system. In addition, the agreement confirmed provincial responsibility for social service developments. Finally, the central level took responsibility for developing a system of social insurance coverage for family carers. The care allowance system aims to enable chronically ill people to stay in their own homes, at promoting autonomy and free choice of care arrangements, at supporting informal care provided in the family and at creating incentives for consumer-driven community care development. On average, in recent years, recipients of the care allowance account for about 19 % of the total population 61+, and for about half of the total population 81+.

With the introduction of the Long term Care Insurance in 1995/1996, Germany established a universally oriented, long term care scheme at a central level to provide support in situations of care dependency valid throughout the whole country. The introduction of the Long-term Care Insurance resulted in a considerable expansion of the available funds—with € 15.94 Billion within the framework of the social Long-term Care Insurance and € 2.10 Billion within the framework of the private Long-term Care Insurance in 1997 (see Theobald and Hampel, Chap. 6). Since the end of the 1990s, the French LTC system has been mainly organized around a specific allowance. Thus, after a period of local experimentations (1995–1996), it consisted of a "cash for care " scheme, initially targeted to the more dependent and economically disadvantaged, and opened to all frail elderly people in 2002. The 2002 reform, which created the 'Allocation personnalisée à l'autonomie' (APA—'personal allowance for autonomy'), represents the main turning point in the policy framing process. The number of recipients rose drastically from 150,000 in 2001 to 1,185 million in 2010 (see Le Bihan and Martin, Chap. 7).

As indicated by Cabrero and Gallego (see Chap. 10), Spain introduced a law for the Promotion of Personal Autonomy and Care for Dependent Persons (otherwise known as the Dependency Act), which came into force in January 2007. It is a system of universal social protection which is financially limited and subject to strict rules of cooperation, as well as some degree of institutional rationalization and coordination. The new system of social protection has had many effects: the extension of public coverage; the creation of social services employment; the broadening of the combined public network of social services; advances and tensions in cooperation between regions; innovative uses of social services; and attempts to develop cooperation between social and health services. The Czech Republic was the first CEE country to establish a new long-term care system in 2006 with the promulgation of an Act on Social Services. Apart from other relevant changes (social services on a contractual basis, establishment of standards for their quality, redefinition of existing services and legal grounding of some new services etc.), a new care allowance was introduced. The level of this care allowance is tailored to the extent of dependence (four levels) and enables people to pay for the required assistance and support, provided by family members or other informal carers or by professional care providers. It is given to individuals over one year of age who are dependent on the assistance of another individual for activities related to their own person and independence (see Barvíková and Oesterle, Chap. 12). The benefit is not means-tested and it is financed from the state budget through taxes.

The fact that there were 'major' reforms in only some countries does not mean either that in the other countries with a residual care regime nothing happened or that, once reforms took place, nothing happened afterwards. In Italy, an extensive cash-based program (Indennità di Accompagnamento) was introduced in 1980, followed in the 1990s by a relatively strong debate about the need of a comprehensive LTC reform in order to expand public service provision and funding. However, Italy proved unable to radically reform the system, notwithstanding many attempts and broad and intense public discussion. Since the end of 1990s, the only intervention has been the regularization of migrant care work. Even if some other minor reforms were introduced (in 2007 for instance a "National Fund for LTC" was created but its financial assets were quite limited and down to 400 million Euros per year), the system seems to be shaped more and more around informal and migrant care work (see Costa, Chap. 11).

If minor changes were to be expected in Italy, it is noticeable that minor changes happened also in the residual countries that had recently introduced major reforms. These minor changes appear to contrast with the previous (expanding) reforms and, even if not of the same magnitude, they represent some sort of retrenchment: in general, different forms of implicit cost containment policies have been implemented.

In Austria there have been some cuts and changes in the definition of benefit levels and the tightening of eligibility criteria for some benefit levels. Moreover benefit levels have not been adjusted to inflation for many years: as a consequence, the "no changes" policy has significantly decreased the purchasing power of the benefit by almost 20 % over a 15 year timespan. In Germany, a similar process happened, at least until 2008, when an increase in the level of benefits was decided:

before 2008 the non-adaptation of the benefits to the increasing service costs led to a loss in purchasing power of 18.8 % and to an increase of beneficiaries resorting on social assistance benefits.

In France and Spain, given the fact that the reforms were quite recent, there has been no room for minor transformations afterwards. The debate taking place in France is complex to detect. Since the Presidential election in spring 2007, a new reform was announced as imminent, but in fact was systematically postponed during the five subsequent years. The last government reports published in June 2011, after a vast consultation of the different main actors, present three main scenarios without supporting any of them officially: to consolidate the current APA system (in order to reduce the private costs for the users); to define a new branch of the social security system (option of universality); or to introduce a new system based on a compulsory private insurance. In Spain the implementation of the 2007 reform has been very slow because of the difficulty of involving regional governments in the financing and in supporting the development of new home care and residential services at the local level; as a consequence, care services are still very poor while cash-based benefits spread over, paving the way for the growth of an extensive provision of care by migrant care workers. The implementation of the LTC law was also territorially "unequal" distributed because only some regional governments have invested with intensity following the spirit of the law, while others have not.

In the Czech Republic, the care allowance program was adjusted several times in the years following the reform of 2006–07. In essence, the amount of the allowance was reduced for individuals in dependency levels I and II aged 18+ and increased for persons under the age of 18. Therefore it went in a direction that lowered the coverage for older people, especially for those who were not particularly frail.

13.6 The Politics of LTC Reform: Actors and Coalitions

13.6.1 Social, Economic and Political Actors

As with other complex policy arenas, the LTC policy arena is characterized by a multiplicity of social, political-institutional and economic actors. Among the social actors, the associations representing frail older people and individuals with disabilities are the key ones. Trade unions, entrepreneurs' associations and care providers associations are the main economic actors. Political parties with different ideological orientations, local and national governments, are central amongst the political-institutional actors.

In comparison with other policy fields, LTC suffers from a deficit in organization and direct representativeness of its main stakeholder: the older population (Taylor Gooby 2004; Bonoli 2005). In most of the countries analyzed in this book, the users' organizations represented the interests of adults with disabilities, while dependent older people were commonly represented, not necessarily with specific attention,

by trade unions or political parties. In some countries, like Italy, trade unions organized specific branches of their organizations devoted to aggregate and represent the retirees. But the political influence of such sub-organizations has been very weak and was subordinated to the mainstream interests of workers, still the "core stakeholders" of trade unions. The only exception is Denmark, where a specific interest organization of older people—DaneAge (Ældresagen)—mobilized to safeguard and expand the user rights of its membership.

If this field is characterized by a political weakness of the main recipients, other actors have played a central role in the innovation process. On the demand side, a major role was played by the organizations of adults with disabilities. These groups have been quite influential, especially in universalistic care regimes, where they had long supported the progressive evolution of welfare services. In the 1990s, they started to mobilize in order to obtain more services and a clearer recognition of social rights for those whom they represented. The capacity of these groups to aggregate the demand of a higher educated population was striking in respect of the latency of trade unions and traditional welfare advocates. In many countries all over Europe, disability rights groups were able to open up public discussions about their needs and rights through demonstrations, strikes, public events, circulation of information about the impact of disability and the aspiration of disabled people to welfare and independence.

In Sweden, the 90s saw the emergence of a strong disability rights movement, which played a critical role in promoting the prioritization of support for people with learning disabilities. Other groups advocated for adults with extensive physical disabilities. The active political role played by these groups helps to explain why the priority in long-term care policies in Sweden shifted from care for older people to services addressing the needs of adults with disabilities. In the Netherlands, the increasing visibility of users' organization represented one of the most important developments in the structure of organized interests in the field of care in the last 20 years. Similar groups also activated in England, in Austria and in France. In the Czech Republic, along with the clear deficit in organization and direct representativeness of the older population, the representatives of people with disabilities were very active during the preparation of the draft bill on social services. As a result, the adopted legislation particularly reflected the interests of this group of users, sometimes to the detriment of patients with internal or psychiatric disorders (including dementia) and sensory disorders.

Other active and influential interest groups in the reform process were social services providers and their representatives. In many countries, social partners were also quite influential actors: trade unions in particular campaigned in order to introduce reforms expanding social rights in the field of LTC policies or tried to resist retrenchment policies. In addition, enterprise representatives in many countries, also did not oppose reforms. On the supply side, innovation was supported by care service providers, which played a relevant role in countries with a residual care regime like Austria, Germany and Spain. In the Nordic countries, the predominance of public-managed services prevented providers from organizing independently, while care and social workers were aggregated in specific unions advocating their interests. In

England, care professionals and the associations of private (for profit and charitable) care providers were relevant players in the 1993 reform, while groups representing people with disabilities lead efforts to introduce the new cash-for care programs. In Austria and in Spain, finally, private and nonprofit providers were involved, together with disability groups and local governments, in national bodies designed to set the stage of the long-term care reforms introduced in these countries.

Generally speaking, the role played by service providers in the reform process was based on a twofold interest: if on the one hand they supported new public programs draining more financial resources to the field, on the other hand they resisted the introduction of competition and free choice, considered as a way to shift responsibility and control from care suppliers to recipients. Only private providers, as new entries in the field, supported the introduction of quasi-markets in order to lessen the monopoly and the privileged positions of traditional care providers (usually public or nonprofit organizations).

In many countries, therefore, care recipients and care providers were on two opposite sides, claiming for regulatory settings that contrasted with the interests of the others. It is, however, unquestionable that the leading role was played by disability groups in the last two decades. As we already explained, their ideological orientation to independence and free choice at the same time mirrored the NPM claims for more efficiency and accountability, favoring the introduction of market mechanisms and welfare pluralism in the care delivery system, promoting flexibility and user-led innovation rather than professionalization and higher quality standards. In spite of their juxtaposed cultural and political orientations, NPM supporters inside political parties and governments and disability groups converged together in demanding a shift of responsibility from care professionals and service providers to individual users. The creation of quasi-markets and the recognition of the users' freedom to choose were the two main regulatory instruments introduced in order to achieve these results. In countries with a strong familistic culture, such as continental Germanic and south European countries, this new vision of care was considered as a good way to recognize the relevance of family solidarity and to support family-based care arrangements. If disability groups were therefore the winners in this process, traditional service providers resisting against welfare pluralism in the name of their high quality standards and care workers arguing for a better recognition of their profession, were the losers, with a few exceptions.

As far as what concerns political actors political parties did not usually play a major role in fostering reforms. As a matter of fact, reforms in many countries were promoted jointly by left-wing and conservative governments or the switch from a government with a specific orientation to another with a different one did not hinder the pace of transformation. This happened both in countries where a LTC expansion took place (e.g. Germany, Austria and the Czech Republic) as well as in countries where restructuring or retrenchment have been at work (e.g. Denmark, Sweden, England). In Germany, for instance, the Reform of 1994–1995 was passed by the Christian-Democratic and Liberal Government, with the Social-Democratic party also in agreement. On the contrary, in Sweden, the NPM-orientation of many Social-Democrats in the 1980s paved the way to retrenchment reforms of centre-right

governments over the last two decades. In England, the marketization approach by the Tories during a good part of the 1990s was not reversed by subsequent Labour governments. In the Czech Republic, there were no clear political and ideological positions with regard to LTC: in 2006 the final version of the Act on Social Services was passed by MPs across the political spectrum.

If political parties did not differentiate among each other in the majority of cases, other aspects of the State functioning played a relevant role. The innovations often occurred within a specific multilevel governance structure of the care systems. We have already described the relevance of local authorities in the provision of care in most of the countries analyzed in this volume. Local authorities and regional or provincial governments have played an important role even in the reform process. As the primary accountable bodies for care provision, these institutions had been experiencing a heavy financial burden for many years until the 1990s. In the early 1990s, a broad re-centralization process started up in many countries, limiting the financial autonomy of local governments, fixing budget ceilings, and stopping the State funding of local programs. The interest in innovation by local authorities retaining responsibility in LTC was therefore clear, and explains why local authorities and provincial/regional governments were very often actively involved in the reform process. Reforming LTC programs was a strategic means to rescale welfare responsibilities and more generally to renegotiate the State-local authorities. Innovative reform was introduced exactly in the interplay between state and local governments and was favored by the multilevel structure of LTC provision (Kazepov 2010).

The main interest of local and regional governments in this process was to retain responsibility in the service delivery and regulatory autonomy, and to shift part of the financial burden to central levels at the same time. National states, for their part, were trying to increase their central control by introducing a more restrictive regulation about care provision and funding. Negotiations between these two different positions were in place in almost all the countries analyzed here. In all the countries, nevertheless, the State had to take greater responsibility in LTC than it had before the 1990s. In the last two decades, all the relevant reforms or incremental innovations here considered were introduced at the national level, fixing specific national thresholds for entitlements and provisions, setting particular regulations, or introducing financial responsibility on the part of the state. Local authorities and regional governments still take an important part in regulating and delivering services in the renovated LTC systems. But national states play today a stronger role than before, taking more financial responsibility and restricting the autonomy of local governments. If the previous LTC systems were characterized by the central states playing a subsidiarity role while the local authorities took the core responsibility for funding and delivering care services, now this vertical subsidiarity system has been overcome by stricter budget controls applied by national governments, new steering regulation by central governments, or direct provision of benefits by central states. In exchange for their greater financial investments in LTC, central states have assumed a stronger control on the care delivery system. Welfare rescaling in this field has meant re-centralization of responsibility at the national level, with local authorities and regional/provincial governments in a complementary position. From a subsidiarity role of the state, we have moved to a new form of state centralism and regulatory power.

13.6.2 Residual and Universalistic Care Regimes: Different Coalitions at Work?

Innovation was the result of interactions between the variety of actors involved, and their main orientation and interests. Reforms or incremental transformations were carried out by specific coalitions and were opposed by other actors (Sabatier 1988). The roles played by the various actors and their relationship in these innovation processes have been quite different according to the care regime. In two of the three universalistic care regimes, Denmark and the Netherlands, the constellation of interests supporting the status quo was very strong. Service providers, social workers and users' organizations were strongly organized as a welfare advocacy coalition. The high level of integration of the LTC policy community resisted against any attempt to frontally attack universalism and social citizenship. Political consensus was also grounded on the diffusion of a solid knowledge of social rights among citizens. In this situation, characterized by impracticality of radical changes, cost-containment concerns were focused on the regulation of the social care system. In these countries, innovation was focused indeed on introducing or strengthening market mechanisms, recognizing freedom of choice, standardizing social care provision, limiting public funding, and focusing social care services on their core functions. The actors leading this process were the new epistemic community organized around the values of NPM and the organizations representing adults with disabilities advocating for flexibility in social care and the empowerment of citizens.

In Denmark, the most relevant action for change came from State attempts to obtain a stronger steering capacity in respect of local authorities. Innovation was focused on regulation and implementation rather than on the redefinition of social entitlements. The NPM ideas were introduced without an open public discussion about the general meaning of free choice and its implication in terms of social rights and redistributive impact, but only on its practical implications (the number of social care providers, the definition of quality standards, the fixing of prices for service delivery, and so on). Managerial and accountability questions predominated in the policy field, in a context still characterized by high consensus about the benefits of universalism and the principles of NPM. Social democrats as well neo-liberal and conservative parties shared this perception of absence of conflicts between these two visions. Trade unions and employers organizations—the traditional constituencies of the Scandinavian welfare state—played a minor role in this policy field. In the Netherlands, the organizations representing people with disabilities became the most important allies of the national government in the attempts to restructure the LTC system and reduce its costs, via de-professionalization, enhancement of informal care and the introduction of customer-driven interventions. Even in this country, however, universalistic principles were not opposed and innovation was more focused on introducing a new public regulation. Cost containment strategies were strongly driven by the national governments together with the establishment of new measures—such as the Personal Budget—granting users some autonomy in the definition of the services to be provided. Local-national relationships were also restructured in this process.

In Denmark, the steering role of the State was strengthened while the financial autonomy of local authorities was placed under stricter central control. New regulatory mechanisms were enforced by the State in order to limit expenditure and restrict service delivery. A stricter standardization of care services was also established in order to focus the supply of care to its core functions and to limit decision-making at the local level.

In comparison with the two former countries, Sweden followed a slightly different path. Three types of actors were particularly relevant in this case: political parties, associations for people with disabilities, and entrepreneurs' associations. Moreover these three actors were able to build a strong and coherent coalition for reform. The role played by Social Democrats was important in facilitating this coalition, especially under the influence of economists inside the ranks of the party; as Meager and Szebehely show in Chap. 3, the process of legislating for market reform began in the mid-1980s under a Social Democratic government, which established initiatives to promote competition in the public sector, with the goals of increasing efficiency and quality. In the same years, the Social Democratic party started viewing the public sector as a part of the problem, not the solution. Once Social Democratic parties positively embraced NPM reforms, it became harder for them to criticize strong marketization reforms by Conservative governments. The different ideological and political approaches to NPM seem to be the main differences between the Danish and the Swedish Social Democrats: the latter were more intent than the Danes on reforming the LTC system through marketization (Green-Pedersen 2002). Furthermore, more so than in Denmark, Swedish Social Democrats and Conservatives agreed on the necessity to restrict the public budget for social care and to limit the supply of care services. Associations advocating on behalf of both children and adults with disabilities also played a major role, especially thanks to their strong ties with Liberal and Conservative parties: they reinforced a "freedom of choice" anti-professional service orientation which helped to raise doubts about the traditional approach to welfare service provision. Also, the main employers' organization, the SAF (Swedish Employers' Confederation), began a strong neo-liberal attack on the welfare state in the 1980s, arguing for market mechanisms and privatization of public services. The SAF's propaganda efforts included sponsoring market-oriented think tanks.

To sum up, in universalistic care regimes, the traditional welfare coalitions were still very strong and did not allow an open discussion of the failures and weaknesses of such care regimes. Under the pressure of cost containment, national governments acted in order to limit social expenditures at the local level by re-centralizing the organization of the care system. This orientation was shared by both right- and left-wing parties with only marginal distinctions. Innovation was focused on regulation and did not explicitly address the issue of social rights and inequalities. Thus, central governments found an unexpected ally in the organizations representing people with disabilities, which became strong and active advocates of a new, flexible and user-driven care system.

In the semi-universalistic LTC care regime of England, the role of organizations representing young and adults with disabilities was almost as relevant as in the universalistic regimes. Over the last thirty years, and particularly since the early 1990s,

these organizations advocated for more freedom of choice, control and flexibility: a good part of the discussion in the LTC arena has been centered on these types of issues. This approach was reflected in successive governments' attempts to tackle long term care pressures mainly through regulatory innovation (Direct Payments, Personal Budget, etc.), while serious prospects for reforms in the levels and distribution of resources for long term care were avoided. Moreover, advocacy organizations' preferences for cash programs already in place prevented them from supporting any serious reform proposal. However, these actors also strongly opposed any attempt to introduce reforms aimed at including the traditional cash programs in a broader, renewed LTC program. The interests of the insiders were therefore used to build a new care system providing adequate care for the older people. The strong fragmentation of the policy field also hampered any attempt to create agreements among the parties. In a care system characterized by a multiplicity of LTC programs, captured by different users with specific interests, coalition building proved to be very unlikely. Moreover, the absent neo-corporatist tradition hindered political effort from moving in this direction, with a bigger role played by social partners.

In residual care regimes, the coalitions leading the innovation process were very different. The role of the associations for people with disabilities was less relevant in these countries, with the exception of Austria, the Czech Republic and Italy, and was to some extent the reverse of that of their equivalents in the Nordic countries. Much of the public discussion about LTC developed at the national level and required a stronger, more direct intervention from the national governments. Local authorities were broadly supporting this centralism in the reform as they wanted to discharge part of the financial burden that had been part of their remit until the 1990s. In Spain, the LTC reform enacted in 2007 assigned a shared responsibility in financing to both the State and the regions, leaving responsibility for delivery at the regional and local levels. In Germany as well as in France, the previous locally-based care delivery systems were largely substituted by new national measures for financing and regulation at the national level.

The active role played by national governments in residual care regimes is the product of a strong aggregation of multiple interests around a specific reform project. This happened in Germany, in Austria, in France, in Spain and in the Czech Republic, though not in Italy. In the former countries, with the exception of the Czech Republic, the reforms were strongly favored by a tradition of neo-corporatist agreements, involving not only the main political parties, but also traditional social forces as trade unions and employers' organizations. The final reforms gained a strong and broad consensus from opposite sides as they were the results of a protracted intermediation between the principal actors. The capacity to coordinate such intermediation was one of the main drivers of the institutional change taking place in LTC in these countries.

In Germany, the national LTC insurance scheme was established in 1995 by a coalition government held by the Christian Democratic Party and the Liberal Party (lead by Helmut Kohl), with the final agreement of the Social Democratic Party and of trade unions. The social insurance solution was adopted by both the main parties against other options carried out by minor actors. But the most disputed issue was related to the funding mechanism, namely, on which different options, ranging

from State taxation to a new contributory plan, were on the table. Trade unions and employers' organizations were deeply involved in the decision making process. After long negotiations, the abolishment of a bank holiday was accepted as a compromise between the unions and the Social Democratic Party on one hand, and the federal government and employers' organizations on the other.

In Austria, the policy formulation of the reform to be introduced in 1993 was delegated to several working groups involving disability organizations, trade unions, the main parties and local/provincial authorities. The strong corporatist structure of the representativeness system favored such an approach, which in turn made it possible to find a general agreement around a new national cash for care measure. This approach was supported not only by the Conservative Party and some provinces, but also by disability groups strongly advocating for the cash option. As Oesterle states in Chap. 8, political actors across the political spectrum have been in favor of a cash-for-care schemes even if for very different reasons, including support for family care, support for autonomy, for user-driven market developments or cost-containment. Lately, in 2007, most of the parties, with the exception of the right wing party, again supported the legalization of 24 h care workers. In Spain, finally, the reform was the result of a very complex negotiation involving institutional actors (regions, national government), political parties, nonprofit organizations, trade unions and employers' organizations, professional organizations. There is no evidence that users' associations played a relevant role in this reform process. While nonprofit providers and the trade unions proposed a finance system based on social security (following the German pattern), employers' organizations and autonomous regions advocated financing through taxes. The final compromise saw a dual system, by which the state finances part of the system and regional governments fund the rest (at least two-thirds) of the resources.

This capacity to build a general political agreement around a specific reform project seems to be crucial to distinguish between the situation of residual care regimes in which a reform took place in the last two decades from the only country where no change has been achieved: Italy. In Italy, the strong fragmentation of the policy field, as in England, hampered any attempt to create agreement between the various stakeholders. Moreover the landscape of the local governments was more complicated than in other countries: the contrast between the poorest regions of the South, requiring more financial intervention by the State, and the richer regions in the Northern part of the country, claiming for more regulatory autonomy, was one of the obstacles to the reform process. Also, the weaker neo-corporatist tradition hindered any political effort into this direction. The preference for cash programs already in place dissuaded many stakeholders, including trade unions and the disabled organizations, from supporting any serious reform proposal.

Overall, the composition of the reform coalitions playing a relevant role in residual care regimes was very different from the similar coalitions in the universalistic care regimes. In the former, the most important actors were nationally-organized neo-corporatist actors, supporting general interests including those of the traditional stakeholders of the welfare state. Trade unions and employers' organizations played a key role not only in the general support to reforms, but also in the discussions about

financing and delivering. The horizontal co-ordination of national neo-corporatist actors was also complemented by the vertical co-ordination of local, regional and national institutions. The multilevel structure of LTC favored a mutual adjustment process by which the re-centralization process was easily supported by both local and national actors. A distinction in the responsibility between funding, commissioning and providing was also introduced in such systems and eased the general agreements of all parties.

Finally, in the universalistic care regimes, and even in the residual ones, LTC reforms were not considered a partisan issue. Reforms were introduced by conservative as well as social democratic parties. Political turnovers did not endanger the previous reforms. Extension of entitlements and service provision on the one hand, and cost containment on the other, were goals shared among the different stakeholders. When conflicts emerged about the financing model to be introduced, the assumption of more State financial responsibility offered a good basis for compromise. That is why, with the relevant exception of Germany, all the LTC reforms were financed through taxation instead of social security. The coalition at work in the Czech Republic was partially different to the other ones seen in the traditionally residual LTC systems: experts from the Ministry of Labour and Social Affairs and other levels of the state administration as well as social service providers and users' organizations perceived the need to implement new legislation. Trade unions, employer organizations as well as regional and municipal administrative bodies only played a minor role in designing the reform.

13.7 Mechanisms and Forms of Institutional Change

Innovation taking place in the LTC policy field assumed different shapes in the countries here analyzed. In order to understand the mechanisms and forms taken by institutional change, we adopt the typology discussed in the first chapter proposed by Streeck and Thelen (2005) in their approach to evolutionary transformation based on incremental but cumulatively transformative changes. In particular we found three models of institutional change:

a. Gradual transformation;
b. Reproduction by adaptation;
c. Breakdown and replacement.

In order to understand the complexity of such process, in the first chapter we proposed a basic distinction between institutional changes affecting welfare entitlements, and institutional changes that are related to the provision of benefits and the organization of care services (Dahrendorf 1988)—Social entitlements are directly related to encompassing policy goals (such as equity, social citizenship) or paradigmatic tensions (such as universalism vs. residualism, centrality of the market vs. centrality of the State, etc.): changes in the definition of entitlements can be understood, following the well-known typology of policy changes proposed by Hall (1993), as "third order

policy changes" affecting overarching policy goals. Provisions must comply with entitlements, but they also depend on specific regulations and the organization of the care delivery system; changes affecting provisions can be understood as "first" or "second order policy changes" according to Hall (1993), namely, changes related to specific policy instruments and their setting. First order changes are related, for example, to measures increasing/decreasing contributions, or lowering/increasing benefit levels. Second order changes can be considered as new rules for calculation of benefits or to control the access to specific welfare benefits, and policy instruments aimed at introducing new forms of care delivery.

Thus, it can be seen that LTC policy changes in the countries analyzed here can basically affect two aspects of LTC systems: first, they may change the existing balance/stability between policy goals (entitlements) and policy means (provisions) through either the introduction of new entitlements (third order policy change) or recalibration of provision indirectly affecting entitlements (second order policy change); second, it has introduced innovation in the policy instruments, through replacement of old instruments with new ones (second order change) or a re-shaping and recalibration of the previous ones (first order change).

In order to understand the relevance of these changes, we look at two aspects of policy innovation: first, we consider the forms of institutional transformation and the process that has been in place; second, we assess the impact of these processes in terms of continuity/discontinuity in respect of the previous situation. This section is devoted to the analysis of the institutional process, while the next section will discuss the main impacts.

Institutional changes took different shapes and produced different outcomes according to the care regime existing in the early 1990s. This differentiation in care regimes has proved to be very useful in understanding the direction and the shape of policy change. Universalist or semi-universalist care regimes have been characterized by either adaptive (Denmark and Netherlands) or incremental (Sweden and England) transformations, which were focused on policy instruments and regulation affecting the level and organization of provisions (first and second order changes), without altering basically the explicit goals of the care system. Only in Sweden and England has incremental change been able to implicitly reverse the (semi-)universalist orientation of the care system.

In universalistic care regimes, the pressure for cost containment was matched by adopting new administrative procedures and new regulation aimed at restraining the use of care services without explicitly challenging universalism of social entitlements. Denmark and the Netherlands have been characterized by "reproduction by adaptation" institutional change, where relevant transformations have not turned into third order policy change. This outcome is the result of different dynamics in each of the two countries. Denmark shows signs of first and second order policy changes from "below" (non-legislative change) and from "above" (legislative change). NPM regulation instituting the partial marketization of care provision was attached to existing institutions and free choice principles were softly introduced by establishing a new "users-centered-stage approach" giving individual users the right to express their preferences about care services. Even if market mechanisms and

Table 13.5 LTC regimes and types of institutional change in the last two decades

LTC Care Regime (early 90s)	Type of institutional change	First or Second order policy change (provision)	Third order policy change (entitlements)
Universalist			
Denmark	Reproduction by adaptation	Quasi-markets and Consumerism	–
Sweden	Gradual transformation	Quasi-markets and Consumerism	(Hidden) attack to Universalism
The Netherlands	Reproduction by adaptation	Quasi-markets and Consumerism	–
Semi-universalist			
England	Gradual transformation	Quasi-markets and Consumerism	(Hidden) attack to (Semi)-universalism
Residual			
Germany	Breakdown and Replacement	Tightening regulation on provision	LTC as a "universal" right
France	Breakdown and Replacement	Tightening regulation on provision	LTC as a "universal" right
Austria	Breakdown and Replacement	Tightening regulation on provision and migrant care worker regulation	LTC as a "universal" right
Spain	Breakdown and Replacement	–	LTC as a "universal" right
Italy	Gradual transformation	Migrant Workers regulation	–
Czech Republic	Breakdown and Replacement	Partially tightening regulation on provision	LTC as a (partial) "universal" right

consumerist approaches were introduced, rationing did not come into the picture: regulation was concerned with both 'securing' and 'extending' the welfare rights of citizens and, as a consequence, encompassed both measures of control and measures of choice/flexibility.

The Dutch LTC system has been undergoing a continuous process of reform in the past 20 years, which reflects an incremental approach to policy changes. Cost containment policies have been central and they have been pushed forward through a mix of first and second order policy changes: a series of tools have been introduced restricting the eligibility criteria in order to access public LTC, rising co-payments, switching from more to less costly forms of care, providing incentives to access informal and privately paid care as well as less costly alternatives to formal care. Cost containment was also pursued by adding new market-oriented measures (like the Personal Budget) in an attempt to replace more expensive in-kind service provision with cash for care. These attempts mainly failed thanks to appeals to the judiciary system: for instance an important court decision in 1999 clarified that Dutch residents had a "right to care," based on the social insurance legislation and the government was held responsible for upholding this right, also against budgetary considerations. Some "seeds" of possible third order policy change in the future have been planted anyway. Da Roit (Chap. 5) suggests that potentially disruptive transformations can be produced by shifting non-core activities (home care) presently covered by the AWBZ to other fields of social protections (e.g. social assistance). Moreover, specific care needs of particular disabled categories (such as the patients with dementia) were also moved out from AWBZ to specialized health care services. This trend represents a qualitatively different development with respect to all previous reforms in the field, as it involves the redefinition of the boundaries of LTC.

England and Sweden share common features of a gradual transformation process through first and second order policy changes: in both countries, new rules on access to care services and new policy instruments were introduced in order to restrict public expenditures. These policies have turned out to have significantly changed, even though by an implicit process, the previous universalistic structure of entitlements and opened the way to a hidden marketization of the care system. It is valuable to notice that these policies were adopted not only for reducing the traditional public sector provision system, but also to shift the attention and the focus of the discussion in the public arena from (cuts in) public financial resources for LTC (through rationing) to the tools used to provide care (quasi-markets, choice, etc.). In both countries, left-wing parties participated in this transformation of their LTC systems, being either unable to reverse previous Conservative parties choices (as in England) or partly the promoters of market reforms (as in Sweden).

In England, a series of marketization policies has been pursued very consistently over two decades by different governments (Glendinning, see Chap. 9). In 1993, quasi-markets were introduced and a funding system boosting the number of private agencies providing residential and domiciliary care was established. In subsequent years, numerous attempts were made to control costs. However, all these efforts broke against the lack of interest of dependent people for cash-for care measures, and the strong opposition of specific constituencies to any reform aimed at replacing

old measures into a broader LTC program. The institutional fragmentation of the care system was a result of opposing specific interests and cultural orientations to a general change. Veto points and indifference therefore resulted in the care system remaining substantially untouched after more than two decades of discussions and experimentations. Meanwhile rationing became, since the mid-1990s, one of the main leitmotiv in LTC policies (e.g. the increase in the levels of needs required to qualify for local authority-funded social care; the lack of investment in services for people with lower level needs for help).

In Sweden, incremental change has been able so far to significantly alter the existing LTC system through first and second order policy changes aimed at rationing LTC expenditures and at introducing marketization of care. In this country the "gradual transformation" can be explained in terms of "layering" and "displacement" mechanisms and effects (Meagher and Szebehely, Chap. 3). Layering took place in the last 20 years, firstly, through a policy of rationalizing care for older people, actuated by a series of first and second level policy changes (e.g. a related shift from a more person-centered organizational model, under which each care worker was responsible for a small number of clients, towards a Taylorized 'assembly-line' model; the tax-freeze of the early 1990s for local governments; the deregulation of the fees municipalities charged older people for services; and the Ädel-reform which shifted responsibility for nursing homes from the health care sector to the social care sector). Secondly, thanks to the Disability Act of 1993, which separated provision for specific groups of younger disabled people only, creating a new 'layer' (and distinct constituency) in the social care system: because services under the Act are aimed explicitly at people under 65, this approach enabled the government to contain demand for costly services among another group with arguably similar needs (people with significant disabilities acquired after the age of 65). Displacement of the public sector came in through the marketization of the LTC provision system. Displacement and layering seem to have merged together in more recent years: the pace of marketization increased with the change of government in 2006, when new behavioral logics and new system dynamics were introduced through a sort of 'Freedom-of-choice revolution', encouraging municipalities to introduce customer choice models, with quasi-voucher system. Although the new private provision-based system has not replaced the old public provision-based one, a primary goal of the act is to promote the type of 'differential growth' that Streeck and Thelen (2005) argue is central to the system-changing dynamics established by institutional layering.

In brief, universalistic and semi-universalistic care regimes adopted mechanisms of institutional change that were based on incrementalism and mutual adjustment. The strategy of cost containment was pursued by altering the existing regulation and adding new measures to the old ones, without any explicit restructuring of universalistic entitlements to care (third order change). This approach was possible thanks to the fact that no potential conflicts were perceived, either by social democrats or by conservatives, between the need for cost containment and universalistic principles. Tensions and trade-offs were managed by introducing new regulatory instruments into the existing system and, especially in Sweden and England, through the incremental addition of new care measures, driving people to a more focused and targeted use of public care services.

Most of the countries adopting a residual care regime were characterized by a "breakdown and replacement" institutional change. Reforms were introduced at different times in each country, and explicitly affected the entitlement structure of the LTC system, therefore constituting a third order change in Hall's terms. However, this radical transformation was immediately followed by incremental or adaptive changes (first and second order) aimed at recalibrating the new care system to emerging fiscal and cost-containment constraints. All these reforms were facilitated by a large debate at the national level, involving all the relevant political actors and social partners, in line with an interpretation based on an incremental social learning process, as described by Hall (1993).

In Austria, initiatives and debates about LTC started in the 1980s and finally led to a major reform in 1993. Three phases led to this reform. The period prior to 1985 can be defined as a period of problem definition. The second phase was the agenda setting period lasting from the mid 1980s till 1990. The third phase started after the federal election in October 1990. The new government defined the objective to develop a comprehensive nationwide system of social protection towards the risk of long-term care. Policy formulation was delegated to several working groups and was repeatedly pushed by manifestations of disability organizations, including a hunger strike. In 1991 and 1992, draft acts were sent out for opinions from experts, local governments and social partners.

In Germany the path to reform followed a similar process: the path that led to the 1994–1995 reform was a result of a long lasting discussion among a series of public and social actors. The LTC insurance scheme was an extraordinary innovation not only for Germany but also for all European countries, stimulating public discussions in many other countries. Nevertheless, it should not be forgotten that, in Germany as well as in Austria, the new design of the care system, with its focus on cash for care, was in perfect continuity with the traditional, familistic care culture that was dominant in these countries.

France followed a slower and more hesitant process. Since the mid-1990s, a series of steps can be identified in the creation of a specific public LTC scheme and the gradual broadening of the number of recipients. Initially, in 1994-1995, a group of local authorities were invited by the government to test a pilot program. In 1997, the government and the Senate decided to scale down the initial ambition of the experimentation and to adopt and implement a temporary national assistance scheme throughout the French territory—the 'Specific dependency allowance'. Due to the many criticisms related to the PSD scheme, after a prolonged phase of "non-decision" in 2001, a new reform was introduced, promoting (a sort of) universalism. The new allowance, called 'Personal allowance for autonomy' (APA), is allocated to older people with high and middle dependency levels. This phase anticipated the big reform, established in 2001, through which the previous experimentation was extended and partially redefined. Even in France, the new measure introduced in 2001 recognized the social right of the dependent to be provided with care services. The same reform fixed specific national criteria for the needs assessment and the amount of benefits given in accordance to the level of disability.

Spain's 2006 LTC reform was the accumulation and convergence of political and socio-demographic changes as well as consciousness-raising among the professional

classes, experts, and social actors. In 2001, the Policy for the Dependent fully entered the Social Dialogue Agenda between government, trade unions and employer organizations, paving the way for the introduction of a national program. The final reform in 2006 entailed a radical change through the breakdown of the old assistance-based system and its replacement with a universalistic system recognizing care as subjective rights for all citizens with dependency. Fundamentally the reform was the consequence of the accumulation of national and regional programmers, many being experimental and sporadic.

In the Czech Republic, the process towards the reform of 2006–2007 took more than ten years with only incremental changes to the system and with various attempts to implement more comprehensive social service legislation. The path that led to the reform was similar to the Spanish one. The reform debate and the direction of the changes were determined by demographic and economic factors and were inspired by concepts brought in by other EU countries LTC experiences: in particular, the care allowance scheme implemented with the reform was influenced by Austrian and German programs.

All of these countries therefore experienced a profound transformation in the care system, through which new responsibilities for funding and providing care, new regulatory settings, new forms of financing, and especially new entitlements were introduced. All these reforms appeared to create a discontinuity with the previous order, and therefore they were long discussed and prepared through a number of studies and local or national experimentations. A large political and social consensus was searched and found in order to establish these reforms, and to implement them. They were the result of national agreements among the most important national parties and LTC constituencies.

However, the implementation of these reforms after their official approval, or their maintenance in the following years, were not so clearly disruptive as the reforms first appeared to be. In Germany, right after the insurance fund was introduced in 1995, a large discussion started up about its financial sustainability. The financing of the reform through social contributions and an abolished one-day holiday put the new LTC system under cost pressure very soon, driving an open discussion about its reproducibility in the medium and long run. The amount of the social contribution had to be raised in order to keep the system in balance. But, over the last few years, cost concerns have brought the government to delay the adjustment of the benefits to inflation, so lowering the real value of care benefits. In Austria as well, cost-containment considerations have driven decisions not to adjust benefit levels by the inflation rate as Oesterle shows in Chap. 8. Opposition by disability groups and social service providers was not widely considered. In these two countries, nevertheless, entitlements have not been changed after the reform and only first order changes were introduced in order to guarantee the financial sustainability of the care system.

In France, Spain and the Czech Republic, difficulties and delays characterizing the reform process also followed the implementation phase. In France, the APA reform of 2001 has been placed under discussion and new public schemes supporting private LTC insurances could be introduced in the next years. In Spain, implementation of the 2006 reform proved to be very difficult as regional governments had different

propensities to develop a new care system. A similar situation took place in the Czech Republic. Consequently cash-based measures have been actually introduced rather than in-kind services in both these two countries, opposing the original goals of the reform and strongly depressing its potentially disruptive impact. The recent financial crisis seems to have left the implementation of the new LTC scheme out of the political agenda, seriously endangering its actual accomplishment.

Overall, in these countries, innovation occurred by means of a disruptive change, completely restructuring the previous care system on the basis of a new public scheme. New rights, more public money and new forms of service provision were indubitably introduced. The social and political consent was very high at the time when these reforms were accepted. However, the maintenance and implementation of such reforms have been much more difficult and less disruptive than expected. Cost containment concerns have driven governments either to moderate the amount of benefits (as happened in Austria and Germany) or to alter the reform implementation (as happened in Spain and the Czech Republic), or to change the system again (as seems to be happening in France). In the long run, reforms brought about sharp discontinuities in the institutional path of LTC systems, which have been followed by incremental decisions restricting part of the benefits, or delaying further planned developments. However, these further steps cannot be considered as the restoration of the previous situation, as an incremental process of adaptation has recalibrated the original reforms, resulting in changing financial and institutional situations.

Italy is a different case in respect of all the other residual care regimes as no reform in the care system has been introduced since the 1980s. There have been significant discussions and proposals concerning LTC, but no serious attempts to reform the previous system. Two facts have mitigated against any chance for change: first, the Indennità d'accompagnamento (IdA), a cash-based measure designed for the disabled according to universalistic principles, was extended to large part of dependent older people, therefore guaranteeing them a limited, but effective benefit. Second, the organizations representing disabled which were constituencies of such measure opposed any attempt to reform it. Notwithstanding the absence of an abrupt reform, a process of institutional change has taken place in Italy anyway, that can be explained as a "drift mechanism", by which, according to Streeck and Thelen (2005), the neglect of institutional maintenance in spite of external change results in actual slippage in institutional practice: the missing recalibration of IdA has actually made this program the broadest LTC service used by an increasing number of severely dependent older people. It is interesting to notice that, in this case, contrary to how the concept has been used so far in the policy literature, the gradual transformation brought about through a policy drift went in the direction not of retrenchment but of an expansion of coverage. In the absence of national reform, attempts to reform LTC were taken at the local and regional level, through the introduction of quasi markets and complementary cash measures addressed to the most deprived dependent people. But the lack of funding and the high geographical heterogeneity of such policies have not significantly changed the situation. Lately, the development of a huge private and grey (migrant) care market has allowed Italian families to respond to their care needs, without any substantial public specific regulatory or financial intervention.

The legalization of such migrant care workers, established many times by the Italian government in the last years, confirms the profound political inaction in this policy field once again (as shown by Costa in Chap. 11).

Thus, it can be seen that Italy is the only residual country unable to introduce reforms in the LTC system. This substantive institutional inertia was complemented by high emphasis given to aspects of care regulation that were not effective in the absence of additional financial resources to be allocated in this policy field. The lack of public money and the reluctance of national governments to invest in this policy field, together with the absence of constituencies advocating for the needs of older dependent people, explain why in Italy the same problems which led to profound reforms in other similar countries, have not had any political solution so far.

13.8 The Impacts of the Reforms

One important aspect in considering LTC reforms in the last 20 years in Europe is their impact. However, the concept of impact or effect is quite complicated and needs to be clearly specified. According to Clasen and Siegel (2007) change in welfare state needs to be evaluated through a multiplicity of dependent variables: not only social expenditures but also measures that are related to social rights (Kangas and Palme 2007) and to the levels of generosity or conditionality of welfare programs. As LTC policies are characterized by a large gap between entitlements and provisions in all countries, both measures of expenditures and coverage on the one hand, and measures about the organization of the care delivery system (considering the impact both on professional services and on individual care workers) will be considered. Furthermore, as the needs of the dependent are still mainly met through informal caregivers, also the impact on the family care capacity has been reviewed. Therefore, our framework of analysis, together with the findings from the individual country case studies, allows us to differentiate between four different types of impacts:

a. the impact in terms of *public expenditure and needs' coverage* (relative number of recipients, etc.),
b. the impact on the structure and characteristics of the *LTC labor market*,
c. the impact on the *regulation* and the *forms taken by provision in the field*,
d. *the impact on the family care activity*.

13.8.1 Impact on Needs Coverage

Figure 13.1 summarizes the results of the cross-country analysis. As it can be seen from the graph, the results of the transformations and reforms are not unidirectional. As already outlined in Sect. 13.5, Germany, Austria, Spain, the Czech Republic and France experienced an expansion of coverage and public funding. Since the 1990s (or in more recent years in France and Spain), the total amount of beneficiaries has

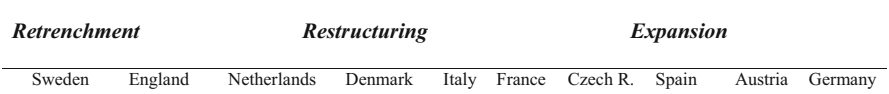

Fig. 13.1 The impact of LTC reforms on coverage and public expenditure: retrenchment, restructuring and expansion

increased strongly and nowadays many more frail people do receive public help. In the Czech Republic, the increase in the total amount of beneficiaries has been mostly related to care allowances and not to formal service provision (residential and home care). The number of care allowance recipients significantly exceeded the legislators' estimates: 2005 estimates expected about 175,000 recipients, whereas in 2010 the average monthly number of beneficiaries was 310,006. However, to a much lesser extent than expected, recipients use their care allowances to purchase social services: older people often seem to consider the care allowance as a simple supplement to their pension compensating for worsening health conditions (see Barvíková and Österle, Chap. 12).

However, after a first wave of expansion, Germany and Austria introduced mechanisms slowing down the pace of growth in their LTC programs. As already underlined, cost-containment issues in relation to sustainability of the reforms continuously worked as a limiting factor: a set of tools were introduced in order to limit costs. In Spain, the policy making in the implementation phase has been not only adaptive but has introduced a gradual transformation of the original goals, substantially reducing the universalist orientation of the reformed system. In France, a public discussion has opened up in order to introduce a second LTC pillar based on private contributions, so challenging the original universalist orientation. In the Czech Republic, provision levels have been partially reduced for less in need beneficiaries.

Italy can be seen as a case of "expansion as a perverse effect of institutional inertia". Even if no reforms were introduced and the changes to the institutional arrangements of the system were very limited (apart from the regularization of migrant care work), there has been a strong increase in coverage, mainly thanks to the growth in the amount of beneficiaries of the principal cash-for-care program (the "Indennità di accompagnamento"): in just a few years the percentage of older people receiving the IdA increased significantly, from around 6 % in 2000 to around 11 % in 2011. This expansion was partial and related only to a cash program and not to services and also because the amount of benefits is very poor and was not related to dependency levels (see Costa, Chap. 11).

Denmark is arguably a case of welfare restructuring aimed at rationalizing the system. Since the 1990s, LTC policies have included elements of both control/standardization and flexibility/choice. This has led to substantial changes in terms of the organization of long-term care, through the introduction of market mechanisms and the tailoring of services to meet individual needs (through consumerism), in order to respond to the complex needs of a more individualized society (see Burau and Dahl, Chap. 8). However, levels of coverage and public expenditures were left untouched.

The Netherlands present a mixed picture. Several incremental reforms have been introduced: a set of different measures explicitly aimed at containing or reducing

the costs of the LTC system, increasing the power of the users and redistributing the responsibility for LTC between the public and private sector and also across the public sector more broadly. As previously shown, despite all the attempts of limiting the access to the AWBZ benefits, formal care provided through the national insurance system remains the pillar of Dutch LTC system. There is no evidence of a reduced accessibility to the system and of the substantial substitution of formal care with informal and market care. Possibly the most disruptive transformation introduced in the system is the shift of part of the risks covered by the AWBZ to other fields of social protection. Since the early 2000s the idea has become dominant that, in order to be sustainable, the AWBZ should go back to its "core business" and leave the coverage of complementary interventions to other policy domains. This trend represents a qualitatively different development with respect to all previous reforms in the field, as it involves the redefinition of the boundaries of LTC, outside of which the logics themselves of social protection differ significantly (see Da Roit, Chap. 5).

England and Sweden, to a larger extent, represent two cases of LTC policy retrenchment. In England, the coverage of publicly-funded adult social care, including for older people, has contracted significantly in the last 20 years (see Glendinning, Chap. 9). Intensive home care services are provided only to those with the highest levels of need: many people are excluded altogether from publicly funded residential or domiciliary care because of modest levels of assets and/or income. With the introduction of quasi-markets, care services have become more fragmented and personal budgets shift responsibilities for managing resources and risks onto individual older people and their families. At the heart of this failure is the challenge of finding a politically acceptable way of driving more money into the social care system. Over the past 20 years, the publicly-funded long term care system with a semi-universalistic orientation has shifted closer to a residual, safety-net only for the poorest older people with the very highest levels of need (and without families to provide essential daily care). The Swedish LTC system has also changed significantly during recent decades. There has been some *retrenchment* in eldercare, evident in reduced public spending, falling coverage and stronger targeting on people with higher levels of need. This development has led to the *informalization* of care for some groups of older people, as services, that for a previous generation would have been available as public services, must now be provided by family members, as well as to the decommodification of care as a private care market is emerging to fill the gaps of public and family-based care provision (see Meagher and Szebehely, Chap. 3).

13.8.2 Impact on LTC Labor Market

Usually analysis of social policies focus on how reforms and changes affect citizens, (potential) beneficiaries and their families, and public financing. However, LTC, as with other social care and social policy fields (health care, education, child care, etc.), also plays an important role in terms of occupation. As care is basically a personal service delivered by individual workers, it is useful to understand to what extent

reforms have affected the care industry. As illustrated by the OECD (2011), there are millions of LTC workers in Europe: their incidence on the overall employment shift from around 2 % in countries like Germany, the Netherlands and Spain to almost 5 % in some Scandinavian states (Sweden for example). Moreover the just quoted OECD publication underlines that the number of LTC workers has grown by 3.2 % per year in the last decade, when, instead, the general occupational growth has been quite more limited (+0.4 %). In countries such as Germany, the yearly growth rate was even stronger (+4 % vs. + 0.6 % in the general labour market).

The results of our analysis (see Table 13.6) show a double-faced impact: on one hand, there has been a strong growth in overall employment levels in this field over the last 20 years, on the other, there has been also a deterioration of working conditions. The ageing of the population with its consequent growth in terms of social demand and, where they took place, the increasing amount of financial resources available to beneficiaries thanks to the reforms, played a major role in fostering labor developments in the field. The conditions in which these workers are employed have often deteriorated in comparison with the past. Two different phenomena seem to explain this change. On one side, a "Taylorist-like" approach to LTC service delivery has been introduced. On the other, there has been a push toward a more consumerist approach.

A Taylorist-like approach means that in many countries there is a tighter definition of the tasks that have to be performed by care professionals when delivering services. For instance, under the influence of ideas from New Public Management, there was in Sweden a related shift from a more person-centered organizational model, under which each care worker was responsible for a small number of clients, towards a Taylorized 'assembly-line' model, under which a number of care workers jointly provided specific tasks to a larger number of clients. The Danish experience of "Common Language" shows a process of standardization of services provided, which reduces the autonomy of the homecare worker and therefore also changes her status. More specifically, her flexibility is limited as she is not able to respond to emergent and unassessed needs. Further, the time available for hands-on care is being limited as more time is being used for assessing needs and documenting the care delivered. This is an unintended effect which changes the ideal of care from providing care responsive to the immediate needs of the user to providing care based on standardized packages, and from a focus on delivering care to a focus on documenting care. In Germany, similar processes of standardization of care tasks (and the timing related to provide them) can also be found.

13.8.3 Impact on the Care Delivery Regulation

Institutional changes have affected not only the level of benefits and the amount of care work in the field, but also the public regulation of care services. Two main changes are evident: the recognition of more autonomy and freedom of choice to recipients and their families, and the increase of competition in care delivery. Both

Table 13.6 LTC reforms: the effects on public financing, beneficiaries, the labor market and regulation

LTC Care Regime (early 1990s)	Effects on funding and coverage	Effects on care workers	Other effects on the LTC regulation and provision
Universalist			
Sweden	Retrenchment (and partial re-familization) the risk is the loss of the middle class as a constituency for, and user of, public services	Increase in occupation in the field but Taylorization of care tasks Strengthening of a cash-based (voucher-based) option	Rise of large, corporate for-profit providers; privatization of provision (and financing)
Denmark	Restructuring	Ambivalence between: Mix of control/standardization and choice/flexibility	Rise of private provision (with public funding)
The Netherlands	No retrenchment (even if attempts were made) but possibly most disruptive transformation introduced in the system is the shift of part of the risks covered by the AWBZ to other fields of social protections (redefinition of boundaries)	Taylorization of care work; De-professionalization of care work; substitution of formal with informal care	
Semi-universalist			
England	Retrenchment Risks/Responsibilities shifting from LAs to individual older people and their families	Increase in occupation in the field but risk of de-qualification of work (partially migrant care work)	Higher fragmentation in the management of LTC public provision Privatization of provision
Residual			
Austria	Expansion in the 90s with some retrenchment in the 2000s (cost-containment considerations have continuously worked as a limiting factor)	Increase in occupation in the field but risk of de-qualification of work (migrant care work)	

Table 13.6 (continued)

LTC Care Regime (early 1990s)	Effects on funding and coverage	Effects on care workers	Other effects on the LTC regulation and provision
Germany	Expansion (in the 90s) with some retrenchment in the 2000s (cost-containment considerations have continuously worked as a limiting factor)	Increase in occupation but also Taylorization, deterioration of employment conditions, substitution of formal with informal care (and rise of a semi-formal, grey care market)	Weakening of non-profit providers and rise of for-profit providers
France	Expansion and now attempts/discussion to support the development also of private insurance	Strong increase in occupation; APA scheme has significantly increased the number of qualified workers, even though they remain insufficient with precarious working conditions	
Italy	Unplanned (partial) expansion	Expansion of the care labor market but dequalification of work (migrant work)	
Spain	Expansion	Expansion of the care labor market but dequalification of work (migrant work)	
Czech Rep.	Expansion	Limited expansion of the care labor market but risks of dequalification of work (possible migrant work in the near future)	Limited increase in private provision (also nonprofit)

Fig. 13.2 The drivers of beneficiaries increasing autonomy

of these regulatory changes have been driven by the idea that both marketization and more flexibility of care provision reduce costs, increase efficiency and effectiveness, without basically altering the existing entitlement setting. In most of the countries analyzed here, an increasing amount of public resources dedicated to LTC are provided in a way that, in comparison with the past, offer more autonomy to beneficiaries. This process has taken mainly different inter-related forms: the rise of cash-for-care programs (alternative to service provision) and more freedom of choice given to users in deciding care arrangements even when services are provided (see Fig. 13.2).

Countries like Italy and Austria, and to a lesser extent Spain and Germany, have introduced or strengthened cash-for-care programs that transfer allowances to beneficiaries with high discretion in the way they can be used. The Italian IdA is a classical example, whereas the German LTC insurance offers beneficiaries the choice between services or cash, with the result that the vast majority of users opts for the latter.

Conversely, Scandinavian countries have chosen not to allow too much discretion to users within cash programs but they have strengthened the freedom and autonomy of beneficiaries in organizing the services they receive. For instance, the Danish "freedom of choice" program allows users to some extent the possibility to choose precisely which services they would like to receive. However, choice is conditional: the choice of individual users has to be approved by a care worker, and practical help cannot be exchanged for personal care tasks, if these are not included in the initial needs assessment.

France, England and the Netherlands have tried to mix cash programs and choice with some forms of professional supervision. The Personal Budget in the Netherlands, the direct payments in England and the way the APA works in France all share a common approach: the resources given directly to beneficiaries have to be spent appropriately and approved by social workers. A second relevant change deals with the regulation of the care delivery system. A main trend is common to most of the countries: a rise in private provision through for-profit enterprises. This outcome is clearly not only in countries traditionally characterized by public provision (as the Scandinavian ones), but also in those countries where there was a tradition of subsidiarity through non-profit provision (such as Germany).

In Sweden, private service providers nowadays play a significant role inside the publicly funded LTC system. In 1993, only 2 % of publicly funded homecare hours for older people were privately provided, whereas by 2010, this proportion had increased to 19 %. In 2010, a similar proportion of older people in residential care lived in privately run facilities. The entire increase in private provision has been among *for-profit* providers. Large corporate providers are dominant among for-profit private providers. The two largest players, Carema and Attendo, both owned by international private equity companies, held half the eldercare market in 2008. In Denmark, the

market for long-term care services has become more attractive for private providers and in 2010 every third recipient of home help chooses a private provider, although this applies exclusively to practical help such as cleaning, whereas only 4 % of older people receiving personal care choose private providers. In England, the reforms on social care which took place in the early 1990s have been the driver for a sky-rocketing increase in private provision in home-care: in 1992, the year before the reforms, the private sector was supplying only two per cent of all home care contact hours; by 2001 this had already increased to 60 %. By 2001, 85 % of all residential care places for adults were also in the private sector.

In Germany, the funding from the LTC insurance has opened up a market for for-profit providers, in a country traditionally characterized by non-profit provision. Since the introduction of the LTC insurance scheme, the proportion of private for-profit home-based and residential care providers has steadily increased. In 2009, 61.5 % of home-based service providers were private for-profit organization, whereas within residential care 39.9 % of the care providers were private for-profit organizations.

13.8.4 Impact on the Family Care Activity

Institutional changes in LTC policies have had influence also over the level of familisation–defamilisation of care (Esping-Andersen 1999). In a previous study we already showed that in the early 1990s, a distinct dualism between a (formal) service-led model and an informal care-led model characterized LTC systems over Europe (Pavolini and Ranci 2008). At that time an extension in social rights in LTC was assumed as necessary as a development in state-funded services and a corresponding decrease in family care responsibility. In the course of the following two decades, however, tensions between formal and informal care (Pfau-Effinger and Rostgaard 2011) have been rising as reforms did not bring about a clear advance towards defamilisation of care as it was assumed. The boundaries between formal and informal care have been shifting and blurring, paving the way for intermediate, semi-formal care arrangements (Pfau-Effinger et al. 2009).

In general, most of LTC reforms considered in this study (in Germany, Austria, France, the Netherlands) have carried out some forms of inclusion of family care within the public care system. A relevant part of public responsibility for care has been recognized, either implicitly or explicitly, as a proper task also of informal caregivers.

The most widespread approach in most of the European countries has been to increase home care in order to reduce the amount of people who have to be institutionalized or hospitalized (or to shorten the time of their institutionalization). But home care is an activity requiring the presence of a social network supporting the dependent for many hours. Responsibility for everyday life activities has to be necessarily shared among many persons, including care workers, private suppliers of care, nurses, family relatives or friends, private family assistants, and so on. The uncertain status of care—an activity mixing professional and relational tasks—has

made it easy for governments to cover only a part of the needed care. Therefore a relevant part, implicitly, has been left to the responsibility of the informal networks, including relatives, friends, neighborhoods.

In parallel, renewed attention has been paid to cash and cash for care programs. While the receipt of cash benefits had used to be free of any obligations on the beneficiaries, the new tendency has been to increase the volume and to extend these measures by specifying clearer requirements for access and imposing better accountability for the use of these resources. It is in this context that measures have been introduced to regularize informal care workers and to pay benefits to family caregivers. The new forms of cash or cash-for-care benefits are not only a low-cost way to pay for care services provided by family members but they also constitute strong institutional recognition of the care work performed by women, previously considered as an implicit and 'natural' duty. Informal care, as a consequence, has been recognized as in integrated part of the public provision system. Informal caregivers have been financially sustained, providing them also with social rights, contributory schemes, respite services, income support. Part of the responsibility for the actual provision of care has been therefore delegated to private citizens, opening the door to the inclusion of family provision of care within the "public" care system. The expansion of LTC policies throughout Europe, therefore, has gone together with the introduction of new forms of regulation aimed at sharing the burden of costs and the responsibility for care provision between the public sector and individual citizens. The restructuring process that has been taking place in the last two decades has involved not only the creation of new responsibilities for the welfare state, but also the recasting of the relationship between State and the family.

13.9 Conclusions

The general debate on welfare policies in the last 20 years has turned around concepts such as (hidden and explicit) retrenchment, status quo and restructuring (Pierson 2001). According to Pierson, perspective restructuring has been merely considered as a "mitigated" form of retrenchment due to the "stickiness" of welfare institutions and to the high public opinion support towards the welfare state. In many policy fields we have witnessed cuts in social provision (pensions and healthcare reforms, etc.) directly implemented by governments, or indirectly promoted through different "policy drifts" mechanisms, as indicated by Hacker (2004) and Streeck and Thelen (2005).

Policy change occurring in LTC does not fit this classical model of policy change. LTC is indeed one of a few welfare policy fields where not only retrenchment but also expansion of coverage and expenditures has taken place. Restructuring in this policy field, therefore, is located in a broader area running from retrenchment to expansion. The pressures for change in LTC policy are related not only to cost-containment and financial constraints (like in Pierson 2001), but also to the need to address a new social risk (Armingeon and Bonoli 2006; Taylor Gooby 2004) emerging in contemporary

society that is related to demographic (ageing of population), social (higher women activity rate) and cultural (new vision of care) transformations. Change occurs in different ways in each of the various EU countries analyzed here in their attempts to deal with emerging trade-offs between cost-containment pressures and rising demand for care. Policy change in LTC is caused by new social risks which result in new demands for welfare in a time of permanent austerity.

From our analysis, policy change in LTC is not only the result of particular actions or reforms, but it is the product of a long-lasting process of institutional restructuring. It is a protracted institutional dynamic in which change and continuity are inextricably linked (Mahoney and Thelen 2009). In this long-standing transformative process, different forms of institutional transformation may occur simultaneously. The overall institutional transformation is the result of variable combinations of reproduction by adaptation, gradual transformation, and breakdown and replacement changes (Streeck and Thelen 2005). This interpretation is coherent with Palier's (2010) description of the "Long good-bye to Bismarck," characterizing continental welfare regimes, where the overall change in these regimes is the result of "evolutionary transformation based on incremental but cumulatively transformative incremental changes". Complementing Palier's interpretation, moreover, our analysis found a broader range of connections between institutional changes: not only an accumulation of reforms that created the conditions for radical transformation to occur, but also sudden innovations followed by adaptive/gradual transformation mechanisms reducing their original social and financial impact, combinations of layering and displacement giving way to gradual transformations, and expansion as a perverse effect of a policy drift mechanism. What is relevant is that in a situation of permanent trade-off between rising demand for care and financial constraints, institutional change becomes a continuous institutional activity, permanently restructuring and recalibrating policy instruments and their settings, and also indirectly affecting social entitlements and the extension of benefits.

In the early 1990s, institutional changes took different shapes and produced different outcomes according to the care regime in operation. This differentiation in care regimes has proved to be very useful in providing an insight into the direction and the shape of policy change. Universalistic care regimes were characterized by a large extension of care provision and a full recognition of the social right of dependent citizens to be provided with care services and/or cash benefits. The UK was somewhat closer to these systems. Residual care systems differentiated so that they had not developed social entitlements and, accordingly, adequate provision for the dependent people. In all care regimes, therefore, there was a substantial coherence between entitlements and provisions, to use the famous conceptual definition of Dahrendorf (1988). The policy crisis in the early 1990s was caused precisely because of new gaps emerging between entitlements and provisions. Innovation basically represented a way to restructure entitlements and/or provisions in order to recalibrate the care systems and fill this emerging gap.

In universalistic care regimes, social entitlements were not challenged. Social rights of people with disabilities were already established and were not really questioned in the process. Innovation was focused on the provision system, as first or

second order policy changes affecting the public regulation, the relationship between providers and funders, and the position of users in respect of care professionals. Cost containment and users' autonomy were the two most relevant drivers of such trend. Restructuring, rather than retrenchment, was the main effect of such changes. In the absence of a comprehensive reform of the whole care system, innovation focused on provisions was incremental and adaptive, adding new regulation and provisions to the existing ones, without any relevant attempt to reconfigure the whole system. Only in Sweden and partially in England, as has been shown, the regulatory change implicitly affected the care structure, bringing about a progressive decommodification of the LTC system.

In residual care regimes, reforms introduced new entitlements and established new social rights, understood as third order policy change. In these countries, dependent people finally obtained a right to care. The provision system was hugely expanded accordingly, on the basis of additional financial resources that were mobilized for the reform. However, cost containment pressures were soon at work, and conditioned the regulatory setting of the reform as well as its further implementation and maintenance. Cash for care measures were introduced not only in order to meet the demand for free choice, but also to contain public costs by supporting informal care provided by families. In some countries, such as Austria and Spain, the pre-existing locally based service systems were incorporated in the reform, which was limited to specific national measures or functions. Moreover, further limitation in provision was established in the implementation process, largely due to a lack of adjustment of benefits to inflation; the legalization of individual social workers offering care at very low costs; and a general deterioration in the quality and professionalism of the care work. After the reform had redefined the entitlements to LTC and the care provision system, an incremental innovation of first or second order occurred in the attempt to recalibrate the new provision system to fiscal and cost-containment constraints.

How can we explain these different processes? The most important factors are the following:

a. *problem pressures:* financial pressures were weaker in universalistic regimes in the 1990s and required only light adjustments of the existing LTC policy (already well established), while they were stronger in residual regimes calling for a major shift of costs from local assistance and health care programs to new LTC programs; where fiscal constraints were too high (such as in Italy), there was simply no way for further change. On the demand side, the previous family-based care arrangements typical of many continental countries were put under strong pressure because of the increase in women's participation in the labor market; in universalistic regimes, a strong individualism in care obligations and higher provision of public care services and re-conciliation services did not impede these trends.
b. *diagnoses:* in universalistic regimes, cost-containment was perceived as a functional problem unable to challenge the universalistic paradigm; changes were introduced in order to adapt the system to new constraints; in residual regimes, a State direct intervention was perceived as the only possible solution to the failure

of social assistance to provide an adequate answer, paving the way for a radical reform.

c. *politics:* in universalistic regimes, the high consensus for already established welfare programs prevented a paradigmatic debate about the existing system; moreover, the actual alliance between NPM advocates and very strong disability movements allowed changes in the regulation of the system (marketization, freedom of choice, accountability, standardization, etc.); in residual regimes, stable neo-corporatist coalitions joined with state officials, care providers, local authorities and trade unions to claim for a general reform of LTC.
d. *path-dependency:* in universalistic regimes, social care programs had been already installed since the 1970s or 1980s, creating a broad popular support and strong constituencies; in residual regimes, the existing locally-based care system collapsed because of rising costs and too weak development of their service infrastructures; the same constituencies of LTC favored a direct responsibility of the state; where nation-wide care programs were already setup, as in Italy, they functioned as relevant buffers that delayed or avoided a general reform of LTC.
e. *rescaling:* in universalistic regimes, the bulk of care provision was local, and cost-containment pressures have brought to a re-centralization of spending responsibility and introduction of accountability under the auspices of NPM concepts; but responsibility for care provision was kept at the local level without basically altering the institutional architecture of the care system; in residual regimes, responsibilities for provision were also locally based, but the level of development of local assistance was much poorer; a new system was based on new responsibilities held by the State and regional governments. Both regimes faced a rescaling, centralizing process, but in residual regimes the poor development of local programs required a massive and substituting intervention of the state.

To sum up, LTC systems have been under a period of strong revision and adaptation in the last two decades. The trade-off between extending entitlements and constraining provisions has made innovation a very narrow path. Reforms in entitlements have been followed by incremental innovation focused on provisions that partially modified the impact of the former. When disruptive reforms proved impossible, innovation in care provision was achieved through incremental transformation in public regulation. As a result, it seems that radical reforms can take place inside a long run process of incremental innovation aimed at restructuring the provision system within the framework given by the entitlement system.

The main impacts of such changes are twofold. First, the original care regimes have developed in different directions, contributing to increased complexity today. The universalistic care regime seems to leave room for increased internal differentiation. Denmark adapted its care system without relevant changes in the coverage and funding, basically preserving the original model. Sweden introduced innovations in the system through a layering process, by which a partial privatization of care is now taking place. The Netherlands have followed a middle ground, alternating continuity with its universalistic path with some discontinuities. Great dynamism has moreover characterized the innovation taking place in residual care regimes, where expansion

and further adaptation of the care system have characterized Germany, France, Austria, Spain and the Czech Republic. The organization of such care systems differs from country to country, ranging from the cash-based delivery system dominant in Germany and Austria to the more decentralized and service-based system developing in France and Spain. Finally, two countries are outliers in respect of the others: Italy and England basically retained the old care systems, characterized by high level of fragmentation and separation between national cash measures and locally-based service systems, and by a general inadequacy of the public care system, in Italy supplemented by a strong family solidarity and lately by the diffusion of a large private market of migrant in-house care workers.

The overall result of these trends is, however, a partial convergence in LTC systems over Europe. While the universalist regimes have reduced the extension and generosity of their care systems, most of the residual care regimes have expanded entitlements and public expenditures. Moreover, the regulation of care provision is today more complex, but at the same combines in different national configurations, flexibility and autonomy of beneficiaries with market mechanisms and cost-containment measures.

The second outcome is related to the progressive dualization of the care systems all over Europe. In the last 20 years, there has been a first phase of progressive convergence of European care systems towards a care model characterized by a limited universalism: while universalistic care regimes retrenched they provision systems, most of the residual care regimes expanded the existing provision by introducing new national LTC schemes. This process has lasted until 2006, when Spain and the Czech Republic established their national LTC program. In the last decade, however, with only these two partial exceptions, all the countries converged towards retrenchment and cost containment. No radical reforms have been introduced in this direction so far, but incremental innovation has been always driving the care systems towards further restrictions in the public supply of care and in the quality of professional services. Shortage in the care supply and low quality of care services could well push more and more dependent people out of the public care system. The trend towards a partial re-familisation of LTC is also shifting responsibility from state to individuals and their kinship networks. If this trend towards retrenchment is confirmed in the future, then the risk of polarization between insiders and outsiders will be dramatically heightened.

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