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Article

Restructuring the welfare state: reforms in long-term care in Western European countries

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Summary Faced with the problems associated with an ageing society, many European countries have adopted innovative policies to achieve a better balance between the need to expand social care and the imperative to curb public spending. Although embedded within peculiar national traditions, these new policies share some characteristics: (a) a tendency to combine monetary transfers to families with the provision of in-kind services; (b) the establishment of a new social care market based on competition; (c) the empowerment of users through their increased purchasing power; and (d) the introduction of funding measures intended to foster care-giving through family networks. This article presents the most significant reforms recently introduced in six European countries (France, Germany, Italy, the Netherlands, Sweden and the UK) as regards long-term care. It analyses their impact at the macro- (institutional and quantitative), meso- (service delivery structures) and micro-level (families, caregivers and people in need). As a result the authors find a general trend towards convergence in social care among the countries, and the emergence of a new type of government regulation designed to restructure rather than to reduce welfare programmes.

Key words ageing, long-term care, privatization, social care, welfare state restructuring

Current changes in long-term care

The development of long-term care (LTC) services constitutes one of the main testing grounds for the innovative capacities of Western European welfare systems, which in their current state are in fact largely unable to satisfy the needs of an increasing number of care-dependent people (Martin, 2001).

To date, dependence has been a social risk not adequately covered by welfare systems. Traditional forms of public protection provided care-dependent citizens with invalidity pensions and health and rehabilitation services. While government insurance schemes for chronically ill people are generally not sufficient to meet the huge costs of LTC, health services are still designed mainly to deal with the acute phases of disease, not to assist dependent people for long periods of time.

The inadequate growth of LTC programmes has become increasingly apparent as the number of people who are dependent has grown.[1] These programmes still receive very limited funding. At the same time there has been a progressive decrease in the ability of family networks to provide support owing to the increase in the old age dependency ratio and the female activity rate.

Faced with the dilemma of these growing demands for services and the need to contain the costs of care provision, many Western European governments have reformed their LTC services over the last 15 years. The purpose of this article is to describe these changes and to provide a general interpretation of the direction

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taken by this process of reform. The analysis is based on the changes in LTC programmes introduced in six European countries with different types of welfare models (Anttonen and Sipila, 1996): France, Germany, Sweden, the UK, Italy and the Netherlands.

The introduction of these changes has been interpreted in different ways by scholars. The idea that the current changes are strongly connected with institutional factors related to the pressure of costs on residential and health care and to equity and efficiency issues has become quite common in recent years (Jacobzone, 1999; Oesterle, 2001). According to this view, the recently introduced LTC programmes are designed partly to substitute, and complete, health care intervention and disability pension systems.

The critics of this new wave of reforms have stressed their impact on caring, and how it is divided among the state, the market, the family and the community. One line of criticism has interpreted these changes in public policies as a shift to market principles. It emphasizes that the introduction of social care markets and the greater division made between funding and service provision have given rise to a gradual 'commodification of care' (Lewis, 1998; Ungerson, 2003). A second line of criticism focuses on the new public discovery (and use) of informal care giving, which has occurred even in social democratic welfare regimes (Kröger and Silipa, 2005). According to this literature, the negative consequence of these reforms is the emergence of policies that promote the refamilialization of care as a means to reduce the financial burden of public health and welfare programmes by introducing or extending cash programmes. The assumption behind the use of care allowances is that care is a resource easily found in society and promptly granted by women without considering the impact of these cash measures on female labour-market participation (Rostgard and Fridberg, 1998).

The main argument of our analysis is that the reforms undertaken in the past 15 years still move in the direction of a new type of government regulation designed to restructure rather than to reduce LTC programmes (Daly and Lewis, 1998). Even in those countries undergoing a reduction in the coverage of long-term care needs (like Sweden and the UK), the changes introduced in the definition of targets and in the level of service provision are aimed more at fine-tuning the current delivery of services than at simply cutting the costs of service delivery. More generally, while many would expect the privatization of service delivery and the introduction of market criteria to have caused a reduction in government responsibility, the reverse is true in many European countries, where the commodification of care has gone hand in hand with an increase in public coverage and public regulation. A new regulatory approach is therefore emerging across Europe, and the aim of this article is to grasp the fundamental characteristics of this new institutional arrangement.

The recent change of orientation towards the family apparently inherent in the introduction of new cash programmes is also questionable. While it is true that family care is again considered a crucial resource with which to meet the needs of dependent persons, it should also be realized that new public policies tend to recognize and sustain family care giving, making it an explicit and not taken-for-granted activity. To date, care giving has been considered not as an ingredient in the social contract, but as an obligation arising from within private relationships and which can only be replaced by public protection if care cannot be given for 'objective' reasons (the absence of family carers, insufficient economic means, serious dependency).

These innovations reveal a new approach to LTC whereby a more adequate and efficient provision of care could be obtained by creating a social care market and by giving greater state support to families able to care. We will evaluate the impact of this approach on the macro-institutional set-up of LTC policies, on the organization of funding and provision functions (at the meso-level), and on the caring capacities of family (at the micro-level). We will also see how the configuration of these innovations differs according to the policy traditions of the national context in which they have occurred.

Institutional traditions

Before looking at the new reforms, it is important to consider the extension and organization of LTC provision from which the most recent programmes have partially moved away.

Service provision has developed to different extents (see Figure 1). At the beginning of the 1990s, Sweden (21%) and the Netherlands (17%) had a *high degree* of total coverage for the elderly (in terms of percentage of the over-65s receiving services): the former country as a result of the

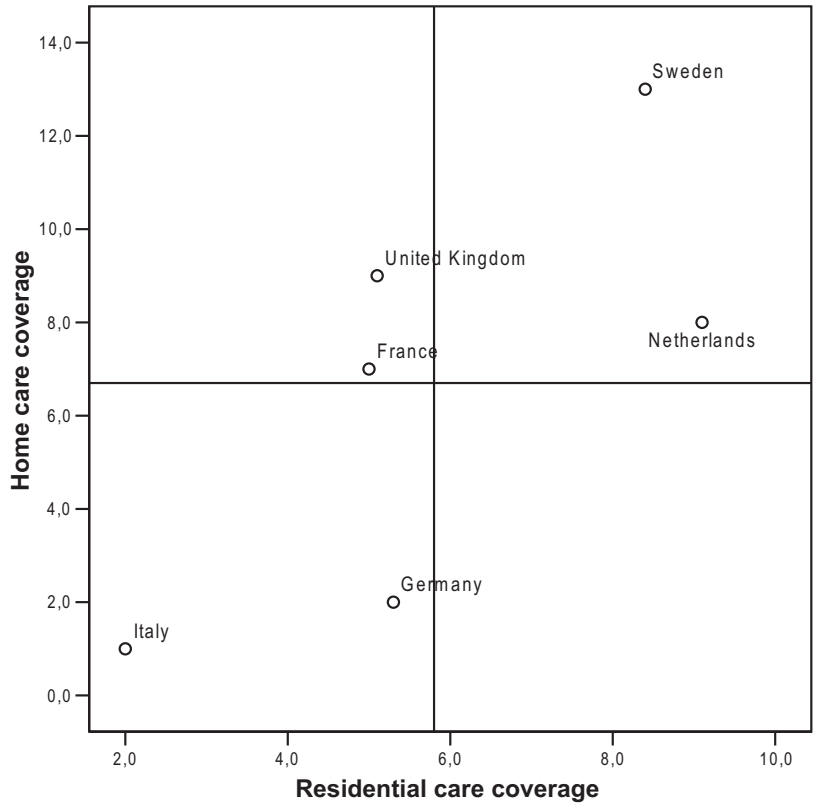

Figure 1 Level of residential and home care coverage (% of over-65s receiving services)
Source: OECD figures (1996).

strong emphasis placed on home care, and the latter because of large investments in residential facilities. The UK had a *medium degree* of coverage (14%) based above all on home care, followed by France (12%) and Germany (7%) with a *medium to low degree* of coverage, while Italy had a *low degree* amounting to only 3 percent of the elderly population.

In addition to the provision of services, European countries developed cash programmes to support families and dependent individuals (Glendinning and McLaughlin, 1993). Sweden made little use of such instruments, relying heavily on service provision instead. The United Kingdom and Germany, mainly starting in the 1980s, however, covered a greater number of people with cash transfers. The UK intervened with a benefit, an *attendance allowance*, widely available to the elderly, and a more limited allowance for family caregivers.

In 1968 the Netherlands had already introduced a specific programme, called AWBZ, for personal care and attendance of dependent people entering nursing homes. At the beginning of the 1990s the AWBZ was extended to dependent people living at home or in other residential facilities.

France and Italy occupied intermediate positions. With the *Allocation Compensatrice pour Tierce Personne* (ACTP) and the *Indennità di Accompagnamento* respectively, they introduced public programmes to meet the care costs of persons in need.

The various mixes of service type (home and residential) and cash benefits can be arranged along a continuum of intervention models, with the *informal care-led model* at one extreme and the occupational *services-led model* at the other.

Public intervention in the *informal care-led* model is based on a limited direct commitment to the provision of services and it involves a certain level of cash transfers. Government responsibility is largely limited to meeting (according to a compensation logic) part of the supplementary costs resulting from dependency. Public intervention is designed to support the income of persons in need of care rather than to provide them with the LTC services that they need. The principle is that citizens must provide these services themselves by relying on informal care networks. Furthermore, there is little public provision of home care services. Within this model we can distinguish between, on the one hand, an institutional tradition grounded on the strong delegation of care responsibility to the family and very limited support from the state; and on the other hand, national traditions grounded on a much stronger responsibility of the state for supporting the most disadvantaged and generally coordinating the system.

Various problems with cash transfer programmes have emerged in recent years. Such programmes are unable to create a system of LTC provision for which there is increasing demand as a consequence of the growing number of the elderly living alone[2], the reduced capacity of families to provide informal care, the excessive discretion given to citizens in their use of the cash benefits, and the risk of women of working age becoming trapped in care giving.

According to the *services-led model*, government support is provided through the creation of facilities for the widespread provision of services designed to take the place of families, at least partially, in care giving activity. Economic support is more limited, while measures are developed (such as leave from work for care giving) to make family care giving compatible, for limited periods, with holding down a job. The underlying objective of this model is to promote a high level of regular employment in the care giving sector and to meet the care needs of those dependent. Also the service-led model exhibits national variations according to specific institutional traditions stressing home care provision or residential care, or striking a balance between these two services.

Shortcomings have also emerged in the services-led model. The main problem is the high cost of running these programmes. As a result of increased demand combined with a shortage of funding, this intervention has grown increasingly concentrated on those most severely in need, with higher proportions of copayments. Another limitation is the strong standardization of these services, which are financed on the basis of rigid standards of service.

The six countries considered are located in different positions along the continuum between the service-led model and the informal-led model.

Sweden is the country which has adopted a services-led model in its most 'pure' state, concentrating above all on home care services (Figure 2). The profile of the Netherlands is similar to that of Sweden, but with greater emphasis on residential services. Italy and Germany have adopted an informal care-led model, with the former having implemented a more residual intervention. The UK and France occupy intermediate positions, the former being oriented towards the Dutch–Swedish model and the latter towards the German model. Intervention in the UK consists of quite widespread service provision, especially in home care, and of a widespread programme of cash transfers such as attendance allowances. France differs from Germany in its greater emphasis placed on home care.[3]

The paths of innovation

Ageing in place

The increased demand for social services and the pressure on costs have been addressed over the past decade by employing a complex strategy based on the idea of 'ageing in place'. From an institutional viewpoint, 'ageing in place' has translated into the

Sweden	The Netherlands	UK	France	Germany	Italy
Services-led model					*Informal care-led model*

Figure 2 Models of elderly care policies

Table 1 Models of elderly care policies at the beginning of the 1990s and today: main reforms

	Original model (80s–90s)	*Revised model (90s–2006)*	*Reforms/programmes introduced*
Sweden	Strong services-led model	Revised services-led model	Adel Reform (1992)
Netherlands	Services-led model	Mixed and integrated model	AWBZ – Home care (1989) Personal budget (1995)
UK	Mixed model more services oriented	Revised mixed model more services oriented	Social care markets (1990) Direct payments (1996)
France	Mixed model more informal care oriented	Mixed and integrated model	APA (2001)
Germany	Informal care-led model	Informal care-led model	Social insurance (1995)
Italy	Informal care-led model	Informal care-led model	No national reform; only regional reforms (mid-90s)

decentralization of government responsibilities at local level, and into the development of programmes to treat the frail elderly in their own homes.

Implementation of this strategy has required the development of new regulatory structures able to reduce the negative impact of both cash benefit programmes and care programmes. The shortage of funding brought two objectives to the fore: (a) to make cash programmes more focused and effective in providing informal assistance, avoiding waste and leakage; (b) to reduce the financial impact of the direct provision of professional care services to the greatest extent possible and rationalize distribution in favour of those most in need.

The development of LTC programmes has therefore focused on two strategies.

First, new measures have developed to increase the *autonomy and caring capacities* of families with dependent members. It is precisely with regard to family care that the approach has changed. Previously, the alternative between cash and care represented two different welfare models: while the former (consisting of cash transfers) was based on delegating care giving responsibility to the family, the latter (based on the provision of services in kind designed to *replace* care giving by families) removed responsibility for caring (at least partially) from the family (Esping-Andersen, 1999). Shared by the two models was the idea that formal and informal services were mutually exclusive alternatives. The new measures have overturned both these philosophies; formal and informal care are no longer considered as alternative solutions but as complementary activities. The purpose of public programmes has become to support and supplement family care giving by means of: increased freedom of choice for citizens; targeted granting of cash benefits to support informal caregivers; the concession of greater flexibility in packaging care services; the diffusion of measures to reconcile care giving with wage earning.

Second, the supply of home care by both public and private providers (organizations and individuals) has been increased. Previously, the home care supply was heavily restricted by two main factors: the high degree of selectivity of the private care market and the de facto monopoly of third sector providers in publicly financed home care programmes (Ascoli and Ranci, 2002). The strategy adopted was to broaden and diversify the range of home care services by introducing competition mechanisms into public sector systems and incentives to develop private services.

Reform experiences over the last 10–15 years

Table 1 shows the main reforms of LTC systems introduced in the six countries since the 1990s.

Germany has considerably strengthened its traditional informal care-led model in terms of government responsibility. A universal programme (*Pflegeversicherung*) was introduced in 1995 for all the citizens requiring care for at least six months. This programme consists of a substantial set of services and/or cash transfers to the beneficiaries and their respective families which they can use either to purchase professional services or to pay informal caregivers. Beneficiaries can choose between receiving services in kind (residential or at home), or cash benefits, or a mix of the two. Following the traditional informal-care model, a large majority of users staying at home have opted in 2005 for receiving cash (69%) or a mix (15%) (BMG, 2006).

There have been no national reforms in Italy over the last 15 years. Local and regional administrations have conducted interesting experiments, mainly based on cash benefit and vouchers programmes. However their diffusion is very heterogeneously distributed, with a concentration in the richest regions of the Centre–North and almost no diffusion in the South, further increasing territorial inequalities in access to public welfare (Pavolini, 2004).

France has innovated considerably in recent years, showing most conviction in the concept of welfare policies as a possible source of permanent employment. The main programme is the *allocation personnalisée à l'autonomie* (APA), implemented in 2002 for citizens aged over 60 dependent on care. Under the plan, recipients receive cash benefits of up to €1,106.77 per month. There is a copayment for expenses incurred by beneficiaries. Teams of medical and social workers also suggest the best form of assistance for each individual case. The beneficiaries must account for how APA benefits are spent. Private individuals may be employed, but not family members living with the beneficiary.

The Netherlands adopted a model similar to that of France. After modifying the AWBZ programme in 1989, extending the coverage to home care, in the second half of the 1990s the country introduced 'the personal budget' (PB) as well. This measure introduced the principle that users should be able to choose between professional services and cash payments, and also in the case of direct cash payments, how to spend the money. The beneficiaries of the PB must state who has given them help and how much they have paid them. The introduction of the PB was also viewed as a strategy to introduce competition into the field of home care.

The UK is the first country in Europe to have explicitly created a model for the provision of social services based on market mechanisms, doing so with the 1990 NHS and Community Care Act, which separated the purchase and provision functions within the National Health Service. The reform created a mechanism based on a number of free market rules, without giving the user any real direct decision making power (Lewis and Glennerster, 1996). It was only with the 1996 Community Care (Direct Payments) Act that mechanisms were introduced which allowed users to establish the terms of the provision of services. Although this new instrument, called *Direct Payment*, by which the local government pays cash benefits to frail persons, seems important in theoretical terms, it is of little importance in practice because less than 1 percent of the population aged over 65 was able to obtain it in 2004.

Finally, Sweden has reshaped its model of intervention heavily based on service provision. The approach adopted has been to target services, and therefore public expenditure, more closely on those most dependent and to require increased copayments from those in less need. The key reform has been the Adel Reform of 1992, which devolved responsibility for LTC services, including the fiscal elements, to the municipalities. Owing to the economic recession in Sweden, municipalities have often been unable to raise new tax expenditure to pay for it. The net result has been a considerable increase in targeting (OECD, 2004).

Innovation in LTC: an evaluation

Highly divergent opinions have been expressed in recent years on the reforms described here (Leichsenring, 2004; Oesterle, 2001). Our analysis evaluates the impact of the implementation of such reforms at three levels:

- *the macro-institutional level*, where the extent of the general coverage provided by LTC programmes and the expenditure allocated to them is considered;
- *the meso-organizational level*, where the consequences of greater recourse to market mechanisms (contracts and competition between providers) in the regulation of LTC are considered;
- *the micro-individual and family levels*, where the actual freedom of choice that citizens have in access to LTC services is considered, together with the impact of the new programmes on family organization, and in particular on the capacity of carers to reconcile caring with working.

The macro-institutional impact

The last 15 years have seen an increase in the financial resources allocated to assistance programmes for the

care of the dependent elderly population (OECD, 2004). The solutions provided by European governments have been very different. While Sweden and the UK have rationed service provision, Germany, France and the Netherlands have considerably increased the numbers receiving care, and Italy has not basically changed its delivery system at all. The Netherlands chose to increase the level of coverage mainly by implementing the second part of the AWBZ reform begun in 1989, with the main focus on home care. While until the beginning of the 1990s the system was closely based on residential care, the shift in the last 15 years has been to home care in its various forms (PB included) (de Boer, 2006). Germany and France significantly increased welfare coverage of the population in need of care by raising the public expenditure allocated to LTC programmes. It must nevertheless be borne in mind that the increase in public spending on welfare programmes has been partially offset by reductions in health spending on the hospitalization and treatment of many of those dependent on care. At the end of 2005 there were over 7m individuals in Germany, almost the entire population, covered by the *Pflegeversicherung* and over 1.5m programme recipients aged over 65. In comparison with the first years of reform in the mid-1990s, the total number of users increased by at least one-fifth (BMG, 2006). According to Rothgang (1998) the introduction of the reform resulted in an increase in public spending of around 150 percent, and the figure has increased further during the 2000s. However, spending by health insurance institutions in the same period has practically fallen to zero, while expenditures of local authorities have fallen by one-third.

ACTP users in France rose from 210,000 in 1995 to 911,000 APA users in 2005 (DREES, 2005a). Public spending on care needs amounted to approximately 21,602m francs in 1988 and 58 percent of that spending came from health insurance schemes and from the pension system, while departmental spending accounted for the remaining 42 percent (Glendinning and McLaughlin, 1993). With the introduction of APA the commitment of the health and pension system gradually diminished. For example, CNAV (the most important *casse maladie*) service users have decreased by around a quarter since the introduction of APA (DREES, 2005a). At the same time the level of departmental spending on elderly care rose from 2,672m in 2001 to 5,746m in 2004 (DREES, 2005b).

The increased public coverage for LTC in these countries reflects greater recognition of such care as a universal right. Nevertheless universalism is subject to financial restrictions and the new programmes only partially cover the financial burden of LTC care. In Germany, although the insurance system is accessible to all citizens without any means testing, it is estimated that the proportion of the benefits paid to those most dependent on care accounts for only half of total LTC costs (Schneekloth and Mueller, 1999). APA is also theoretically available to all French citizens with a defined degree of care dependency. The system is funded out of general taxation, but the beneficiaries must add a quota of copayment (which is very progressive) based on income. Approximately 69 percent of beneficiaries had to contribute part of the cost of APA in 2005 and the average contribution was equal to one-fifth of the total economic amount of APA (DREES, 2005a). In Germany the new principle of 'capacity of expenditures' has been introduced, according to which the amount of benefit paid is based on the financial resources that have been accumulated through the compulsory contributions to the insurance programme.

Coverage of LTC needs in these countries is therefore very extensive. However, there is nevertheless a general principle of limiting spending budgets in relation to available funding that overrides the formal acknowledgement of the right to universal assistance for all citizens.

The growth of coverage in Continental Europe came about at the same time as the tendency in the North European countries to concentrate services on the most serious cases. The aim of reforms in the UK and Sweden was to reduce numbers in nursing homes and simultaneously to increase the average number of hours of home care per service user, rationing though their availability (OECD, 2004). Two strategies have been adopted: a concentration on core service functions with cutbacks in interventions considered 'marginal', and the introduction of stricter eligibility criteria and higher shares of copayments (Bergmark, 1997).

The previous care systems in these countries had reached levels of coverage much higher than in the rest of Europe. The percentage of the elderly receiving public home care in the UK has fallen from 8 to 4 percent over the last 15 years (OECD, 2004). However, the number of hours of care provided has increased immensely: by 90 percent

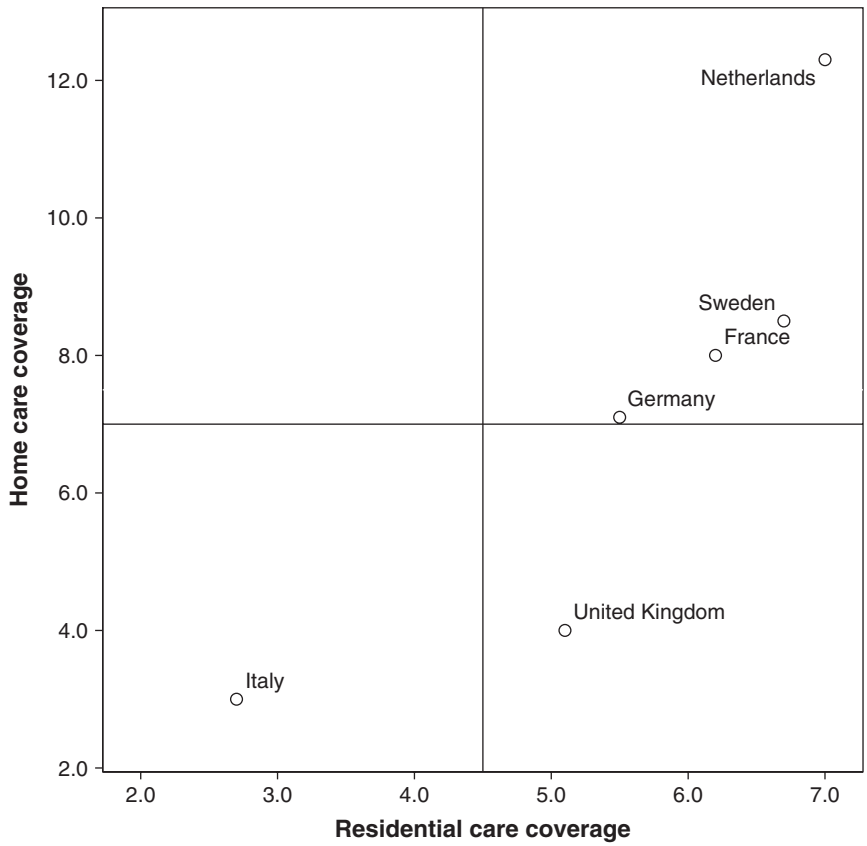

Figure 3 Level of residential and home care coverage in the present decade (% of over-65s receiving services)
Sources: Reprocessing of different sources: BMG (2006); de Boer (2006); DREES (2005a); Lennarth (2005); OECD (2004); Pavolini (2004).

between 1993 and 2003. This is concentrated on the more complex cases which require more intensive care. In Sweden, too, there was a significant reduction in the percentage of the elderly receiving home care: from 13 percent in 1990 to 8.5 percent in 2004. The level of coverage for residential care also decreased from 8.4 percent in 1993 to 6.7 percent in 2004 (Lennarth, 2005). However, the volume of help supplied to this smaller group of home care recipients was higher. For example, in 1988, 16 percent of home help recipients received care at nights and weekends; by 1997 the proportion had increased to 28 percent (OECD, 2004). Both countries are also trying to cut back on LTC spending: legislation introduced in the past decade made it possible for hospitals to charge local authorities when hospital discharges of elderly patients are delayed because suitable LTC has not been arranged in time. As a result of this decision the number of 'bed blockers' has been reduced significantly in Sweden and the UK. The 1990 British reform transferred responsibility for care of the elderly to social service departments so that people with incomes above certain levels must pay, at least in part, the costs of the residential services they receive.

There are two opposing tendencies which have the result that different European systems converge on an average level of LTC coverage, despite different national mixes between residential and home care. While the countries of Continental Europe have increased the numbers of people receiving care, the northern countries have reduced the extent but not the intensity of service provision.

Contrary to these changes, Italy has been characterized by essential inertia in the past decade. The public care system is still quite residual, while those in need are mainly reliant on 'do-it-yourself' care by families and the private market, which is growing in size but depends heavily on informal workers and lacks public regulation. In the absence of a national framework innovations have been concentrated at the local level. This has produced a dual system where many regions in the Centre–North of the country have developed an LTC system of intervention closer in scale to the Continental European countries, whereas the southern regions have achieved an entirely inadequate overall level of coverage (often less than 1–2%) (Pavolini, 2004). Figure 3 shows how different countries have evolved their systems over the last 15 years.

The meso-organizational impact

The introduction of the measures considered here was accompanied by the repeated extolling of the virtues of the market and competition in curbing costs and preventing quality standards from deteriorating. Two main innovations were introduced in this regard: a clearer split between financing and providing functions, and greater recognition of the citizen's freedom of choice.

In Germany the principle of separating funding from the provision of services has led to the inclusion of for-profit agencies in the supply system. In France the APA can be used to obtain services from a wide number of accredited providers. The reform of the quasi-markets in the UK introduced competition with the goal of rewarding the most efficient suppliers. In the Netherlands, too, the introduction of the PB came about with the explicit objective of increasing competition between service providers. Even in Sweden there have been moves to open up the supply of home care services to competition and to private providers. The consequences have been a tendency for service providers to multiply, with the emergence of new private providers who exploit their competitive advantage. This has led to the demise of the traditional neo-corporatist systems, which favoured non-profit providers with close links to public administrations. As a matter of fact, in many European countries, voluntary agencies are undergoing a process of permanent dis- and reorganization due to the more dynamic interrelations taken by public–private partnerships (Bode, 2006).

In Germany the reform has favoured the entry of for-profit providers, which cover increasingly larger shares of the market (more than 40% at the end of the 1990s), while public providers now account for less than 10 percent. In the UK private institutions now comprise 88 percent of the users of residential facilities. The approximate 30 percent reduction of users in public facilities between 2000 and 2004 continued a trend that had already started in the 1990s. The marketization process seems to be even more marked in the home care sector: while 95 percent of care hours were provided by public providers in 1993, the percentage fell to 31 percent in 2004. In France the development of APA has fostered a growth of home care services provided by private organizations, and competition has arisen among providers (DREES, 2006). In 2004, 13 percent of the total provision of institutional care for the elderly in Sweden was contracted out to private for-profit providers and similar percentages were also recorded in the home care sector; only ten years ago private providers were almost non-existent in the country (Lennarth, 2005). In the Netherlands, during the 1990s greater scope was created for commercial home care providers. At the beginning of the present decade, besides the 125 'mainstream' home care organizations, there were around 50 private organizations eligible for funding under the AWBZ. There were also an estimated 150 organizations not funded in this way which provided home care on a commercial basis: a large proportion of the clients were people who had been granted a personal budget and often made use of private agencies if the mainstream home care organizations were unable to meet their demand (de Boer, 2006). In Italy an unplanned privatization of delivery has taken place in the past 20 years even though no specific reform has been undertaken: more than 60 percent of beneficiaries in residential care are hosted in private non-profit facilities paid by the state, and the trend is accelerating (Pavolini, 2004). Even more marked privatization is apparent in home care, where more than 80 percent of the delivery is contracted out to private (non-profit) providers.

A second step in the introduction of market mechanisms has been recognition that citizens have the right to freedom of choice. The power to choose in the German insurance scheme is exercised by being

able not only to select the service provider, but also to choose the best combination of cash (freely usable) and/or care services from a range of possible alternatives. Freedom of choice in the Dutch PB and the French APA is based upon a negotiating procedure through which an individual 'assistance plan' is defined with the active participation of the service user. Rather than introducing an abstract right to change suppliers, this model is designed to make the range of services available more flexible and allows the user's views to be taken into account.

The actual impact of these measures seems to be positive. The beneficiaries of the PB in the Netherlands are more content with the quality of the care received than are those benefiting from services provided by local authorities, and they also appreciate the ability to choose the manner and timing of their care (Van den Wijngaart and Ramakers, 2000). Various surveys in Germany have revealed a high level of satisfaction with what has been done under the reform (Klie, 1998; Schneekloth and Mueller, 1999): it is recognized above all that the quantity of care provided has increased and also the perceived quality of the services has improved. Those receiving cash benefits rather than services are generally more satisfied, also because they perceive more freedom of choice in their care arrangements. In Sweden, too, market mechanisms were introduced during the 1990s. Many municipalities now use quasi-vouchers systems based on the choice among different public and private providers by the beneficiaries, without directly giving them cash resources but only the opportunity to select (and change over time) the provider whom they prefer (Trenneborg, 1999).

Contrary to what most liberals expected, however, the introduction of market mechanisms has required a new regulatory set-up, which effectively guarantees competition and freedom of choice on the one hand, and reduces the risks of market failure on the other hand. The new regulatory policies have developed in different directions in different countries. Germany has laid down the foundations for a rigid price system and for the creation of standard packages of care services. In the UK local agencies have developed purchasing functions (commissioning) and have dedicated significant funds to these new activities. The content of services contracted out in France and in the Netherlands is defined by means of an assistance plan drawn up with participation by the beneficiaries.

One of the main emerging problems is the possibility that the new regulatory approach may foster the growth of informal market care giving. A further question regards the progressive deprofessionalization of care workers brought about by the wide-scale market entry of private agencies and by the tendency of competition rules to encourage lower costs rather than improve quality standards. Measures have been adopted to prevent these risks. Services provided by independent caregivers in Germany are now subject to contracts with payment procedures with close administrative control, and they are accompanied by financial and social security incentives. The Swedish quasi-voucher mechanism, the French APA and the Dutch PB are closely related to a case management system with strong accountability controls.

In conclusion, the reforms have successfully introduced a growing range of service providers, and have empowered the choice capacity of citizens, but a significant portion of purchasing and control power still remains with the public sector. The separation of funding from supply has, however, created room for low quality employment to grow, and this has made it very difficult to control the level of quality of both employment and of care.

The micro- users and family impact

Compared with the predominant policies of previous decades based on the idea of delegating care giving responsibilities to the family, or of providing public services in lieu of family care (with a philosophy of removing responsibility for caring from the family: Esping-Andersen, 1999), the new generation of policies employs a complementary and integrative approach designed to strengthen and support the caring capacities of citizens and their families.

Most of the new programmes considered have innovated the traditional cash measures intended to support the care provided by family members but which is no longer considered as 'naturally' or 'implicitly' available. The new forms of support for informal care activities do not often translate into the simple allocation of money to compensate the caregiver; rather, they make the allocation of cash conditional upon regularization of the employment status of the caregiver, the twofold purpose being to prevent improper use of the funds received and to promote recognition of informal care as a 'quasi-professional

job'. This occurs first by regulating the care giving relationship by means of a contract which transforms the beneficiary into an employer and the caregiver into an employee. Second, it occurs by granting benefits to caregivers: social security contributions for their care work, the provision of training courses, accident and health insurance and the availability of respite services.

The intention behind these measures is to prevent women from being trapped in work that is neither socially nor economically recognized. It must also be borne in mind that the increase of the dependent population is being accompanied by an increase in the average age of caregivers in families (OECD, 2004). While on the one hand this may seem partially to reduce the danger of becoming trapped as a large proportion of caregivers are already retired, on the other hand it poses new problems in regard to the psychological and physical wear to which caregivers are frequently subject when caring is constant and long-term.

The impact on the life and job choices of women with care giving duties is one of the main factors on which the quality and characteristics of programmes introduced in Europe in recent years should be assessed. To date, studies have not offered a final interpretation of the possible 'entrapment effect'. The main comparative study concludes by stating that:

> instituting such allowances does not seem to have the effect, which some feared, of lowering women's labour force participation. However, nor does it mean that they represent a way to promote gender equality, as they do not change the gender distribution of caring work. (Jacobzone and Jenson, 2000: 34)

Conclusion – a new chapter for welfare?

The reforms introduced have sought to strike a new balance between the need to meet growing demand for care and the financial constraints on welfare spending. On the one hand, they have brought about a general expansion of the coverage provided by LTC services (with a special focus on home care services and measures aimed at supporting family care), a better recognition of dependency as a social risk, and a tendency to guarantee a more universalistic right to care to dependent citizens. On the other hand, the provision of LTC services, contrary to the case of health service provision, must still comply with financial constraints decided ex ante: a complete universalistic approach would have a quite considerable impact on expenditure, especially where entitlements to benefits are not as relevant, as for example in the German case (Pickard et al., 2007). An economic contribution is often required of service users, not only in order to reduce moral hazard but also to concentrate the delivery of services on those most in need. Finally, the LTC programmes to support family caregivers cost much less than health services as they implicitly assume that families will take on a substantial part of the financial burden of care.

The reforms implemented in the past ten years do not indicate the retrenchment of the state as the profound restructuring of care systems needed to adapt to the emergence of new social risks in a profoundly changed social context. LTC programmes are emerging in this process as a key sector in the new welfare systems, and their development requires both a redefinition of recognized social rights and the assignment of a new role to families and market mechanisms in protecting citizens and meeting their needs.

The change has, above all, concerned the state, which increasingly acts to enable the self-determination of care giving systems, thus relinquishing its role as a direct provider of services. The two models previously developed, the service-led and the informal care-led models, both revealed their shortcomings when LTC was seen as an increasingly less residual area of public intervention. While the former model was costly and bureaucratic, the latter was residual and inefficient, hence the tendency to develop new models to regulate public intervention.

There have been two principal innovations. First, quasi-markets have been created to support the pluralization of the supply system and to foster competition between public and private suppliers. Traditional care systems already involved the massive use of non-profit suppliers in many countries. The new principles of competition have weakened their de facto monopoly and opened up the market to for-profit companies and private individual care providers, subordinating all of them to strict criteria of accountability. The overall consequence has been a more official status and more contractualization in the financial relationships between private suppliers and public administrations, but

also the greater ability of citizens to choose and to combine services.

In parallel, renewed attention has been paid to cash programmes. While the receipt of cash benefits used to be free of any obligations on the beneficiaries, the tendency today is to increase the volume and to extend these measures by specifying clear requirements for access and imposing 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 benefits are 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.

The introduction of quasi-markets and measures to pay family members for care reflect the emergence of a new model of LTC organization which aims to give more autonomy and responsibility to citizens and greater flexibility to the systems of service provision. Superseding the traditional differences between service-led and informal care-led systems is a necessary condition for striking a new balance between efficiency and effectiveness. By abandoning both the role of pervasive public intervention and a policy of delegating basic responsibility to families for caring, LTC policies are now experimenting with a new approach to welfare, based on closer coordination among a public sector focused on enabling and support functions, care giving by family members, and the functioning of the private care market.

The restructuring process described has occurred in different ways according to the policy traditions and the previous care provision systems. In Sweden and the UK restructuring has translated, as regards home care, into the concentration of services on the most serious cases, with greater recourse to copayment. The UK, moreover, has widely experimented with social care markets, so that market-oriented care provision has expanded.

However, public policies in Italy over the past decade have been characterized by inertia. The absence of public intervention at national level has had two consequences. On the one hand, families have been increasingly forced to resort massively to the private market, encouraged by an abundant supply of low-cost immigrant workers (the prolonged inertia of public polices has therefore given rise to the strong marketization of care giving). The use of female migrant workers has expanded so much that it can be argued that the Italian traditional family model of care is becoming a 'migrant in the family' model of care (Bettio et al., 2006). On the other hand, there has been an increasing territorial North–South polarization in the opportunities to obtain LTC.

The countries of Continental Europe once occupied an intermediate position between a service-led and an informal care-led model. These countries have introduced the most significant innovations, developing new programmes which have established their national LTC systems on new foundations. Although there are significant differences, the reforms introduced in Germany, France and the Netherlands have many features in common: they have recognized that dependency is a social risk against which citizens have a right to public protection; they have considerably extended public coverage in terms of both access and the intensity of the care provided; and a new public regulatory framework has been introduced to promote the autonomy of citizens and care by family members. While Germany has invested mostly in family care, France and the Netherlands have also promoted the greater provision of professional (home) care services as part of a new approach designed to combine employment creation with the greater coverage of social needs.

As a consequence of these different national trends, the reforms introduced in the six countries considered converge on a 'mixed' model of intervention with a growing intermediate level of public coverage of LTC needs, while the organization of care systems endeavours in various ways to combine the service-led model with an informal care-led model. This convergence is the paradoxical result of two opposing trends: while the countries traditionally closer to a service-led model have shifted to new forms of intervention based on greater flexibility (supposedly best guaranteed by the introduction of market mechanisms) and more attention to the family care giving capacity; the countries historically based on an informal care-led model have extended the public coverage of dependency needs and have progressively shifted to more organized forms of intervention where families are supported in their care giving through the introduction of market

mechanisms and new measures aimed at helping the caring families.

This new convergence is a by-product of specific attempts by national policies to adapt their institutional traditions incrementally to the new challenge raised by dependency. At present, innovation seems to be more concentrated in the Continental countries. This finding is not explained by the impact of ageing and of dependency in these countries, because their socio-demographic trends do not significantly differ from those of the other European countries. Rather, the explanation lies in both the timing of the reforms and in the previous political and institutional situation.

While there was a considerable expansion of LTC programmes in the UK and Sweden in the 1970s and 1980s, there was no equivalent broad extension of public provision in Germany and France in those same years. The Netherlands were in an in-between situation, having given priority until the 1990s to institutional care. Faced with exponential growth in demand for services in the 1990s, the existing system in Continental Europe was found to be backward and largely insufficient. Health insurance systems risked rapid financial deficit because they had to deal with the impact of the boom in demand for LTC. Finally, cash benefit programmes were quantitatively small and covered only a few users. Indeed, the pressure applied by the new demand revealed not only the scant development of LTC programmes in quantitative terms, but also the inadequacy of existing assistance systems in coping with the financial impact of the new demand. The introduction of the new measures was necessary for two main reasons: to meet emerging demand and to curb the increasing costs incurred by the health system and by local assistance institutions. The reforms were therefore introduced because the previous institutions were in crisis and because a new protection system was needed to replace them.

This was a demand not present in Sweden and the UK, where the level of protection provided by existing LTC programmes was much higher, and where the financial pressure could be controlled by incremental adjustments which focused and targeted services and improved the efficiency of the system of provision. It was a demand which at the same time went unperceived in Italy, where the absence of previous welfare institutions had legitimated, at least for the time being, the adoption of strategies by families consistent with a widespread culture of 'do-it-yourself' and real marketization.

Notes

1 The growth in the number of dependent people is mainly due to the increase in the elderly population. There is no consensus among experts on whether and to what extent dependency will change as a consequence of longer life expectancy and progress in medicine. Even if a decline in the diffusion of disability is assumed, there will probably be an increase in the absolute number of people in need of long-term care because of demographic trends (see Jacobzone, 1999; Oesterle, 2001).

2 Even if the past ten years have seen a relative decrease in the percentage of elderly people living alone in some Western countries (Tomassini et al., 2004), in absolute terms there has been an increase in the amount of the lone elderly.

3 The six countries also exhibit different mixed structures in the delivery system involving community-based and non-profit organizations in the supply of public services. For a tentative description of these structures see Ascoli and Ranci (2002).

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