EUROSHIP

closing gaps in European social citizenship

Long-term care regimes in Europe

EUROSHIP Working Paper No. 6

October 2021

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This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 870698. The opinions published in this deliverable only reflect the authors` view. The Agency and the Commission are not responsible for any use that may be made of the information it contains.

EUROSHIP Working Papers are outputs from EUROSHIP project (euroship-research.eu). The series is edited by the project coordinator Professor Rune Halvorsen. The working papers in the series are intended to meet the European Commission's expected impact from the project:

i) to advance the knowledge base that underpins the formulation and implementation of relevant policies in Europe with the aim of exercising the EU social rights as an integral part of EU citizenship and promoting upward convergence, and
ii) to engage with relevant communities, stakeholders and practitioners in the research with a view to supporting social protection policies in Europe. Contributions to a dialogue about these results can be made through the project website euroship-research.eu, or by following us on Twitter: @EUROSHIP_EU.

To cite this report:

Grages, C, Eggers, T, Pfau-Effinger, B (2021) Long-term care regimes in Europe. EUROSHIP Working Paper No. 6. Oslo: Oslo Metropolitan University. DOI: 10.6084/m9.figshare.16782868. Available at: https://euroship-research.eu/publications.

The original version of this working paper was submitted to the European Commission's Research Executive Agency (REA) as EUROSHIP Deliverable 7.1 in June 2021.

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Abstract

Against the background of demographic ageing and increasing female labour market participation, many European welfare states restructured their long-term care (LTC) policies for persons of age and persons with disabilities by strengthening social rights to receive publicly funded care and extending care infrastructure since the 1990s. Despite this trend, care by family members remains a relevant factor in care provision. However, most European welfare states introduced forms of pay and social security rights for care-giving family members in the meantime and thereby transformed the previously informal character of family care provision. The aim of this report is to examine European LTC policies in a historical and international comparative perspective. It identifies existing institutional constellations in LTC to highlight salient policy differences and assess the policies in terms of current demographic and epidemiological trends. The study is based on the analysis of care policies legislation and political documents, standardized EUROSHIP country reports, data from comparative European policy databases as well as secondary literature. It compares welfare states of Norway, Germany, Spain, Italy, the United Kingdom, Estonia, and Hungary, representing different European regions and welfare state traditions. The report introduces an innovative multi-dimensional approach to the measurement of policy generosity and develops a new typology of LTC policies based on the relationship between the generosity of different policy instruments supporting extra-familial and paid familial care. It also examines how far LTC policies potentially affect poverty risks, gender inequality and unmet needs as well as options for choice. Furthermore, historical trends in LTC policy development are discussed in order to analyze historical changes and path dependencies in the investments in publicly financed LTC and social regulation of providers of LTC services. Finally, it is explored in how far European welfare states differ with regard to their social resilience in the context of current demographic and epidemiological trends in Europe, especially population ageing and the increase in prevalence of multi-morbidity and higher levels of disability.

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1. Introduction

This report introduces the research in the context of Task 7.1 in the WP 7 on long-term care (LTC) in the EU Horizon 2020 Project "EUROSHIP – Closing gaps in social citizenship". The aim is to examine LTC policies for persons of age and persons with disabilities in a historical and cross-country comparative perspective: i.e. historical changes and path dependencies in the investments in publicly financed health and social services for people in need of LTC and social regulation of providers of LTC services.[1] The analysis will identify existing institutional constellations in LTC to highlight salient policy differences and assess the policies in terms of current demographic and epidemiological trends in Europe.

In industrial societies, LTC for persons with disabilities and older people with care needs was mainly organized as unpaid work provided by women in the private family household. Since the early 1990s, more European welfare states have started to take responsibility for the LTC provision by introducing social rights and extending infrastructure for publicly funded care provision outside of the family. This began after demographic ageing and increasing female labour market participation put the traditional organization of LTC under pressure. However, the development and design of European LTC policies show considerable cross-national differences regarding the generosity of support for LTC inside and outside the familial household. Against this background, we address the following research questions:

- How do European welfare states differ in their institutional constellations of LTC policy?
- How far was the historical development of European LTC policies path dependent?

The report discusses historical trends in LTC policy development and introduces a new typology of welfare state policies towards LTC for persons with disabilities and older people with care needs based on the relationship between the generosity of policies supporting extra-familial care and policies supporting paid familial care (Eggers et al. 2020). The report also discusses how far LTC policies affect the risk of poverty and gender inequality and people's options to exercise active citizenship[2] as well as risks of unmet needs. Finally, we will also discuss how far European welfare states differ with regard to the extent to which they are resilient in the context of current demographic and epidemiological trends in Europe, especially population ageing and the increase in prevalence of multi-morbidity and higher levels of disability.

With regard to the concept of LTC, we refer to the broad WHO definition, which defines LTC as: "*The system of activities undertaken by informal caregivers (family, friends, and/or neighbors) and/or professionals (health, social and others) to ensure that a person who is not fully capable of self-care*

[1] In this context it is crucial to point out, that not every person with disabilities needs LTC. However, in a more universal sense, every ageing individual experiences disability to a certain degree (Bickenbach et al. 2017). Bickenbach (2021) also points out that it is important to distinguish between those ageing with disabilities and those aging into disability. It should be considered that the trajectories are very different. Also, the 'voice' dynamics are very different for people with intellectual impairments, whose ageing trajectory is different again.

[2] The concept of "active citizenship" (Jensen & Pfau-Effinger 2005) refers to newer forms of citizenship that have been connected with welfare state reforms and partly weakened the state responsibility for social security by placing more emphasis on citizens' self-responsibility. On the one hand, welfare states encourage citizens' self-responsibility by increasing their options for (consumer) choice instead of, or in addition to, merely offering "passive" benefits and services. However, it was on the other hand agued, that "*claiming responsibility for one's own life and well-being is, in the context of these policies, not merely an option; to an increasing degree, it also represents an obligation"* and might thereby be associated with new social risks (Eggers et al. 2019: 45f).

can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity" (WHO 2000: 6). For the operationalization of different dimensions of LTC (medical, personal and assistance care) we refer to the System of Health Accounts by the OECD (2017).

The main focus of the policy analyses is on the institutional level of legislative regulation. We understand an institution according to neo-institutionalist thinking (Hall/Taylor 1996; Streeck & Thelen 2005) as a set of rules that enable and restrict human behavior. In this regard, the regulations on which policies are based can be defined as institutions. In comparative welfare state research, LTC is often treated as a single institution which varies with regard to the extent to which policies support extra-familial care or familial care. We provide an innovative approach in that we treat LTC policies of a country systematically as an "institutional constellation", in which policies towards extra-familial care and policies towards familial care present two different types of policies that may interact relatively autonomously (see also Eggers et al. 2020).

On this basis, the report introduces a new typology of institutional constellations of LTC policies that is based on the interaction between the degree generosity of public policies towards extra-familial care on the one hand and the degree generosity of public policies towards care provided by family members on the other. According to the main assumption of the report, different combinations of both types of LTC policies can be expected to have different effects on risk of poverty, people's opportunities to exercise active citizenship and potential for gender equality. With regard to the methodological approach, the report introduces a new multi-dimensional approach to measure the generosity of LTC policy for persons with disabilities and older people with care needs that analyses the institutional level of the regulations.

We compare seven European welfare states which represent different regions of Europe and different types of welfare state tradition (Esping-Andersen 1999; Ranci & Pavolini 2013): Norway, Germany, Spain, Italy, the United Kingdom, Estonia, and Hungary. The empirical analysis is based on the examination of legal documents of care policies, standardized EUROSHIP country reports on national social protection systems including data on the institutional logics and reforms in LTC provision that were provided by the EUROSHIP country teams; data from comparative European databases, such as MISSOC and EUROCARERS, as well as secondary literature. The analysis is mainly restricted to the legal regulations set out by welfare state institutions in the field of LTC and considers actual structures of care provision in the different study countries only in passing.

In the second section, the report discusses the state of the art of the scholarly literature regarding international differences and historical trends in LTC for persons with disabilities and older persons in need of care. Section three introduces the analytical approach for the study and the new typology of institutional constellations of LTC policy. Section four presents the methodological framework. In section five, we present and discuss the findings of the cross-national comparative study of LTC policies. We focus on their effects on risk of poverty, opportunities to exercise active citizenship, potential for gender equality and barriers in coordination leading to unmet needs. In the sixth section we discuss the general and country specific historical policy developments and evaluate the potentials for social resilience of different types of LTC policy in the face of future demographic and epidemiological trends. In the seventh section, we conclude.

2. State of the art

General development of LTC policies

In industrial societies, LTC for persons with disabilities and older persons with care needs was mainly seen as a responsibility of the family. The LTC was provided mainly by women in the realms of the private household on an unpaid, informal basis where it was not recognized as work, contrary to the gainful employment of men within the public sphere of the formal labour market (Daly & Lewis 2000; England 2005; Fraser 1990; Lewis 1992; Waerness 1987).

However, since the late-20th century, the post-industrialisation of societies and demographic change put pressure on mature welfare states (Pierson 2001; Taylor-Gooby 2004). Demographic ageing in general and the increasing share of older people experiencing disability due to multi-morbidities, i. e. multiple LTC conditions (Koller et al. 2014; Johnston et al. 2018; Rechel et al. 2013; WHO 2015), together with the increase in female labour market participation in many countries led to growing care gaps and rising financial costs (Colombo et al. 2011; EU 2021a; Pavolini & Theobald 2015; Pfau-Effinger 2012; Taylor-Gooby 2004).

As a consequence, many European welfare states restructured their LTC policies for older people by strengthening their social rights to receive publicly funded care and extending the care infrastructure in the last decades (Anttonen & Sipilä 2005; Burau et al. 2007; Gori et al. 2016; Greve 2017; Léon 2014; Ranci & Pavolini 2013). In this process, care work was increasingly outsourced from the family and transformed into gainful formal employment within the labour market where it was performed by professional care workers (Anttonen & Sipilä 2005; Carrera et al. 2013; Lyon & Glucksmann 2008). Especially the extension of home care services and the "deinstitutionalization" of the care provision from the more cost-intense nursing homes to "aging in place" and community living in old age was a central element of this process (Burau et al. 2007; Mansell et al. 2007; Deusdad et al. 2016a; Halvorsen et al. 2017; Pavolini & Ranci 2008).

Despite the extension of extra-familial care services, family care in many European countries remains a relevant factor in care provision, since most of the care tasks are still provided by (mainly female) family members (Spasova et al. 2018). However, most welfare states introduced pay and social security rights for care-giving family members since the mid-1990s (Ungerson & Yeandle 2007; Da Roit & Le Bihan 2010; Grootegoed et al. 2010; Pfau-Effinger et al. 2011; Frericks et al 2014; Eggers et al. 2020). This process led to a "semi-formalisation" of family care work (Geissler & Pfau-Effinger 2005), which was also considered as a "commodification" of care work (Knijn & Ostner 2002; Ungerson 1997; 2004). Moreover, the financial crisis of 2008 led in many European countries, particularly the Mediterranean welfare states, to retrenchment policies which hindered the extension of older persons' social rights (Deusdad et al. 2016a; Ranci & Pavolini 2015) so that family care is for some groups the only affordable solution.

Furthermore, the extension of LTC policies was often closely interlinked with the "marketization of care" (Bode 2008; Brennan et al. 2012; Harrington et al. 2017). The marketization refers to a stronger provider competition as welfare states also promoted private, for-profit care providers (Brennan et al. 2012; Meagher & Szebehely 2013; Gilbert 2015). Additionally, welfare states started to conceptualize care recipients as "care consumers" (Clarke 2006; Rummery 2009; Pfau-Effinger et al. 2011), offering them a choice regarding their care provision, which was discussed as a way to enhance their autonomy and active citizenship (Johansson & Hvinden 2007; Köppe et al. 2016; Clotworthy 2020). However, European welfare states differ considerable in regulating options for choice. In some countries care recipients can choose between different forms of LTC provision and kinds of services, like in most Nordic countries, or they receive relatively unregulated cash-for-care payments allowing for completely free provider choice such as in Austria or Italy (Bettio et al. 2006; Da Roit et al. 2016). But, in how far persons with LTC needs can actually make a choice between different types of care provision also depends strongly on the generosity of the social rights to publicly funded care, since a low

generosity hardly leaves persons from poorer social backgrounds any other option than to rely on family care or on the informal care sector (Eggers et al. 2020; Fotaki 2011; Glendinning 2008).

The focus on promoting the choice and self-determination of older persons in need of care is in many countries rooted in the claims of the disability movements that gained influence on policies from the 1980s onwards, particularly in the UK and Austrian case (Da Roit & Le Bihan 2019; Glasby & Littlechild 2009; Rummery 2011; Theobald & Kern 2011). For instance, the direct payment scheme in England was first introduced for persons with disabilities (late 1990s) and only in 2014 completely extended to older persons in need of care (Glasby & Littlechild 2009). Moreover, it should be noted that European welfare states aimed not only at strengthening older persons' self-determination by the means of market choice, but also by user participation based on more democratic ideas of giving them a "voice" in the decision-making about their own care provision, as in Norway (Christensen & Pilling 2019; Da Roit et al. 2016). In this context it is also important to consider the role of international organisations such as the UN and the EU who have influenced these policies. These policies include the European Union Disability Strategy 2010-2020, the European Disability Rights Strategy 2021-2030, and the Convention on the Rights of Persons with Disabilities of the United Nations that stress the role of autonomy and choice (EU 2010; EU 2021b, UN 2007).

In the last decade, some welfare states - mainly Scandinavian and Anglo-Saxon countries - started to offer home-based "reablement" services for older persons, which mainly relates to rehabilitation services that aim at improving their capacity to remain to some extent active and independent in their daily lives (Aspinal et al. 2016; Glendinning 2017; Rostgaard 2014). Even though welfare states differ in their policies on reablement, most provide services that are short-term goal-oriented interventions in older persons' own homes or in residential care facilities, targeting specifically older persons with newly developed needs of support due to longer hospital stays and illnesses. The focus on providing reablement to older persons in need of care is relatively recent, since traditionally rehabilitation measures were in most countries mainly targeted at working age people to maintain their employability, at persons who suffered severe illnesses or longer hospital stays or persons with disabilities (Bickenbach 2020; Sainsbury et al. 2017).

The relationship between LTC policies towards extra-familial care and policies towards family care

The relationship of extra-familial and familial LTC policies has been broadly discussed in comparative literature on LTC policy. It is on the one hand argued that generous support for extra-familial LTC compensates traditional familial care provision thus creating a "crowding-out effect". On the other hand, it is argued that the absence of generous extra-familial LTC policies could strengthen familial care provision, leading to a "crowding-in effect" (Lowenstein et al. 2008). Empirical findings on this approach are mixed (van Oorschot & Arts 2008; Verbakel 2018). A third approach in the literature on LTC argues that extra-familial LTC policies do not automatically replace familial care but that rather a "specialization effect" occurs, i.e. medical and personal care tasks tend to be covered by extra-familial care services, while assistance services like housekeeping tend to be provided by familial care-givers (Suanet et al. 2012).

While the latter assumption is not implausible in general, all of the aforementioned approaches conceptualize extra-familial and familial LTC policies as mutually exclusive or as two opposite poles on a continuum, which neglect the fact that the role of familial care in LTC policy may also be facilitated by active welfare state support in the form of pay and social security contributions for family members. (see also Leitner 2003). Geissler & Pfau-Effinger (2005) have argued that welfare state policies have introduced a "semi-formalization" of care by family members, in that they offered elements of pay and social security contributions. Against this background, Eggers et al. (2020) challenge the common

assumption about the relationship between familial and extra-familial LTC policies and argue that LTC policies on extra-familial and on paid familial care represent two different types of policies which can vary relatively autonomously of one another in theory and do not necessarily relate to each other in opposing ways (see also Table 1 below).

Comparative research on international differences in LTC: Strands of research on LTC regimes, typologies and classifications

When it comes to typologies on LTC policies, various dimensions have been considered in welfare research so far. From a citizenship perspective, the quality and extent of social rights and the extent to which policies aim at strengthening capacity and active agency of persons with disabilities and in need of care, particularly in terms of "choice" have recently been the centre of interest in studies on disability policies (Christensen et al. 2014; Halvorsen et al. 2017), but also with regard to LTC policies for older persons (e.g. Eggers et al. 2019).

So far, studies that analysed cross-national differences in the generosity of social rights in LTC policies often focused on the type of care a welfare state promotes: whether it supports formal care by extra-familial care providers or relies on informal care by family members (Anttonen & Sipilä 1996, 2005; Sainsbury 1996; Ranci & Pavolini 2013). However, such a dichotomous distinction between informal, unpaid care in the private household and formal, paid care work by professional providers in the public sphere does not reflect that many welfare states have introduced public funding for family care since the 1980s (Daly 1997; Frericks et al. 2014; Geissler & Pfau-Effinger 2005; Ungerson 2004). Therefore, Knijn and Kremer (1997) include in their classification of care policies not only the rights to receive care, but also the right to time to care arguing that both are important dimensions to achieve inclusionary citizenship. In this regard, Leitner (2003) proposed a typology that differentiated between de-familialising care policies that promote extra-familial services, familialising policies in which the welfare states either actively supports family care or does so implicitly due to a lack of any support in this policy field, and a third optional type in which familial and extra-familial care are both publicly supported (Saraceno & Keck 2010; Zagel & Lohmann 2020). However, such approaches often lack an adequate methodological framework to measure cross-national differences in the generosity of LTC policies on the institutional level of the policy regulation (see Eggers et al. 2020). In this regard, particularly the generosity of policies towards extra-familial care is often measured with outcome data about older persons who receive home care services or care in nursing homes.

Furthermore, there is a vast amount of literature that focuses on LTC policies that strengthen the choice of persons in need of support, regarding their potential to promote the care recipients' participation and active agency in the context of typologies on the so-called cash-for-care systems (Bettio & Plantenga 2004; Da Roit & Le Bihan 2010; Da Roit & Gori 2019; Rummery 2009; Ungerson & Yeandle 2007) and the marketization of care (Anttonen & Meagher 2013; Bode 2008; Bode et al. 2013; Brennan et al. 2012; Pfau-Effinger & Rostgaard 2011; Pfau-Effinger et al. 2011). While these studies show how far choice is regulated in different welfare states, they often lack a comprehensive perspective on the institutional design of the totality of LTC policies in a country. Often these studies consider structures and outcomes instead of the institutional regulations.

Overall, the following research gaps can be identified in the literature: So far, a typology of LTC policies is missing that a) encompasses the entirety of publicly funded types of LTC; b) that considers and classifies them against the background of social security gaps and c) that systematically analyses cross-national differences on the institutional level of LTC policy regulations.

3. Theoretical framework

This section introduces a new typology about institutional constellations of LTC policies for cross-national comparative and historical analyses of that offers the possibility to identify social security gaps. The report draws on an innovative theoretical and methodological approach first introduced by Eggers, Grages, Pfau-Effinger and Och (2020) for the systematic analysis and measurement of the generosity of LTC policies at the level of national institutional regulation. It conceptualizes the institutional basis of LTC policies theoretically as an institutional constellation in which institutional regulations that are framing different dimensions of LTC policies interact in a coherent or incoherent way. The institutional constellation of LTC policies that is the basis of this typology is formed by the interplay between the institutional regulation for LTC policy for extra-familial care on one hand and LTC policy for familial care on the other, on the basis of the generosity level of each of them, which can vary in relation to each other relatively autonomously. The theoretical approach is a further development of Eggers, Grages, Pfau-Effinger & Och (2020).

With regard to both types of LTC, we analyze the generosity of two main policy instruments separately:

- Policies that support people in need of care with publicly funded extra-familial care in their own home or in nursing homes
- Policies towards care work by family members.

On this basis we develop a theoretical typology which allows for cross-national comparative analyses of LTC policies on the basis of their generosity. The typology provides the basis to identify social security gaps in LTC policies and analyse how they vary in a comparative cross-national perspective. It can also be used to analyse the hypothetical consequence of LTC policies for poverty risks, people's option to exercise active citizenship and gender inequality.

Table 1 introduces the typology of institutional constellations or LTC policies. We define a policy that combines a relatively high generosity in both types of policies as the "Overall Generous Type", a policy that combines a high level of generosity towards familial care with a low level of support for extra-familial care as "Family Support Type". If the generosity level is reversed, so that the policy is only generous to extra-familial care but not to familial care, we call this the "Extra-Familial Support" type. If both policies are non-generous, we talk about the "Minimum Support Type".

Table 1: Typology of institutional constellations of LTC policies

		Generosity of extra-familial LTC policy (1)	
		High	**Low**
Generosity of familial LTC policy (2)	**High**	**Overall Generous Support Type**	**Family Support Type**
	Low	**Extra-Familial Support Type**	**Minimum Support Type**

Source: EU Project EUROSHIP based on Eggers et al. 2020.

We assume that there is a close connection between these types and gaps in social security. There is a high chance that the "Overall Generous Type" leaves only small gaps, whereas they can be supposed to be relatively high in the "Minimum Support Type". The "Extra-Familial Support Type" promotes the outsourcing of the care and offers support for extra-familial care to a relatively high extent. However, we may assume that in all European countries it is common that people in need of care receive care by family members. This can have cultural reasons (Eichler & Pfau-Effinger 2009), or it may be caused by difficulties in the availability of LTC services. On the one hand, a low generosity of policies towards familial care can hinder family members to take over the caring task in such cases, and otherwise may be connected with poverty risks. On the other hand, a policy that one-sidedly supports familial care as in the "Family Support Type" is connected with substantial risks of poverty for the care recipients, who may be forced to buy the care on the market, if they do not have caring family members. In other cases, a low generosity of policies towards familial care may be connected with the risk that family members lose labour market income and career chances if they take over the care only because there is no other to outsource it to LTC services.

However, we should consider that the causal relation between LTC policies and outcomes can be modified by cultural and structural factors like ideals and preferences in relation to LTC provision (Eichler & Pfau-Effinger 2009) or the degree of locally available care infrastructure or policy implementation based on geographical and organizational coordination that may cause unmet needs if inadequately designed (Riedel & Kraus 2011; Ranci & Pavolini 2015). Therefore, social rights do not translate into corresponding structures straightforwardly. The same combination of LTC policies can potentially lead to different outcomes in different countries (Pfau-Effinger 2005). Against this background, it is especially important not to blur "*the dividing line between policies and outcomes*" (Saxonberg 2013: 31) when analysing the influence of policies on society in order to provide suitable policy recommendations. Hence, we speak of hypothetical consequences when evaluating the potential effects of different policy combinations instead of using the term outcome.

4. Methodological framework

The report is based on a cross-national comparative case study of LTC policies in seven European welfare states which include Norway, Germany, Spain, Italy, the United Kingdom, Estonia, and Hungary representing different regions of Europe and different types of welfare state tradition (Esping-Andersen 1999; Ranci & Pavolini 2013). It is part of the EU Project "EUROSHIP – Closing gaps in social citizenship. New tools to foster social resilience in Europe". The report uses document analysis of care policy laws, standardized EUROSHIP country reports on national social protection systems including data on the institutional logics and reforms in provision of care which were provided by the country teams in Norway, Germany, Spain, Italy, the United Kingdom, Estonia, and Hungary; data from the comparative European database MISSOC and EUROCARERS, as well as secondary literature. The empirical analysis is mainly restricted to the analysis of social rights and legal regulations of the relevant national welfare state policy understood as institutional constellations.

Approach for measuring generosity of LTC policy

On the basis of the theoretical framework of "institutional constellations" and the theoretical typology that we introduced above, the comparative study analyses the institutional regulation of LTC policies towards extra-familial care and for familial care separately with regard to the generosity level of each of them.

With regard to extra-familial LTC policy we examine:

- Public support for care by professional home care services
- Public support for care in nursing homes

With regard to familial LTC policy we examine:

- Public support for care by relatives on the basis of a care allowance or cash benefit
- Public support for care-giving family members based on a compensated care leave

For each of the LTC policy instruments, we systematically measure the degree of generosity in access to and the extent of support.[3] We differentiate between three levels of regulation (high, medium and low) on an ordinal scale for each indicator and the endpoints of the scales are clearly defined Weberian ideal-types (Frericks et al 2018; Frericks 2021).
Deviations from the ideal types indicate potential social security gaps:

- Gaps in access to support: Public financial support for LTC is only provided for a certain group of people in need of care; a significant part of the population in need of care is denied access.
- Gaps in the extent of support: Public financial support for LTC is not comprehensive enough or does not exist at all; a significant part has to be financed out of pocket in order to prevent unmet needs.

As a general rule, the level of generosity for a respective indicator is classified as low if the regulation varies locally and there are no nationally defined minimum standards regarding social rights that imply something else. For more information regarding the details of the analysis see Appendix 1.

Historical development of LTC policies

In a second step, we also examine LTC policies for older persons and persons with disabilities in a historical perspective: i.e. the historical changes and path dependencies in the investments in publicly

[3] For a comprehensive discussion regarding the suitability of different indicators for measuring generosity of LTC policy see Muir 2017; Ranci et al. 2019; Eggers et al. 2020 and Simmons et al. 2020.

financed LTC services for people in need of care and social regulation of providers of LTC services. We mainly focus on four developments between 2000 and 2020 regarding general and country-specific trends in LTC expenditure; marketization and "consumer choice"; de-institutionalisation as well as reablement.

Social resilience of different types of LTC policies

In a last step, we highlight salient policy differences and assess the policies in terms of its social resilience in the context of current and future demographic and epidemiological trends in Europe. We will therefore evaluate the country specific policy design with regard to its potential to cushion evolving trends in terms of regarding population ageing, increasing levels of disability and multi-morbidity.

5. Empirical examination

5.1. Classification of LTC policies based on generosity of social rights

5.1.1. Generosity of extra-familial LTC policy

Norway

Access to public support for home care and nursing homes is highly generous in Norway. There is no means-testing and no minimum level of care dependency that the claimaint has to reach to receive extra-familial LTC services. However, besides a generally non-strict interpretation regarding needs assessment based on citizens' rights to "necessary" health and care services (Grødem 2018), the scope for professional discretion leaves room for variance in local practice (Halvorsen et al. 2021).

Moreover, the extent of support is also rather high with comparably low levels of co-payment (on average between 0-33 percent) for both types of extra-familial LTC. With regard to home care, medical and personal care services are completely free of charge. User controlled personal assistance (*brukerstyrt personlig assistanse*), which is only selectable for disabled people under 67 years, also involves free assistance services like house cleaning, shopping, and out-door and leisure activities (MISSOC 2020). Co-payments for additional assistance services for older people with care needs vary among the municipalities but are limited and beneficiaries cannot be asked to use their savings. Co-payment for nursing homes is based on income and persons in need of care must pay 75 percent of after-tax income above a deductible of NOK 9000 (ca. €900) and up to the basic amount (*grunnbeløpet*) of NOK 101.315 (ca. €10.000), and 85 percent of any exceeding income. Property and capital assets are left untouched and co-payment is limited in such a way that everyone withholds at least 25 percent of the basic amount for their own use in addition to the deductible income. Furthermore, beneficiaries with financially dependent family members and a tight financial situation qualify for reduced co-payment (Grødem 2018; Halvorsen et al. 2021). For most people, the co-payment is far below unit costs and it amounts to only 13 percent of municipalities' current gross costs per nursing home resident on average (Theisen 2020).

Germany

In Germany, the generosity of access to public support for home care services and nursing homes is also high. Care-dependent persons have an individual right to public support for extra-familial care without means-testing. Access to support is only based on a low-threshold needs assessment which distinguishes five levels of dependency. However, persons with very minor impairments of independence or abilities only receive a cash benefit of €125 (Gerlinger 2018).

The extent of support is high for home care and based on low levels of co-payment (on average between 0-33 percent). The public co-financing of the care costs varies with the levels of dependency (between €689 and €1995) and is meant to fully cover the costs of the necessary medical and personal care and to some extent also assistance services. Only additional care needs beyond basic provision have to be funded privately (Eggers et al. 2020). The extent of support for care in nursing homes is only on a medium level and covers on average between 33-66 percent of the cost for LTC. It is based on lump-sum payments for care-related expenses which also vary with the levels of dependency (between €770 and €2005) and are paid directly to the care provider. People living in nursing homes are obliged to pay a monthly care-related co-payment (*Einrichtungseinheitlicher Eigenanteil*) which amounts to €786 per month on average. In addition, they must cover their own living costs (accommodation, food, investment costs/maintenance) which amounts to €1229 on average (Rothgang et al. 2020). However, if people are unable to cover these costs, social assistance (*Hilfe zur Pflege*) steps in, but only after all assets including housing property have been sold.

Spain

The generosity of access to public support for home care services and nursing homes ranges between medium and high in Spain. All persons with care needs, who were for more than 5 years stable residents in Spain, can be entitled to receive extra-familial LTC if they pass a non-strict needs-assessment which differentiates between three levels of dependency. The economic resources of the claimant are considered in the calculation of co-payments but policies do not exclude claimants from access to publicly financed LTC based on means-testing (Ibáñez et al. 2021). While home care is accessible for all three levels of dependency, care in nursing homes is only possible for people with severe care needs (Rodríguez-Cabrero et al. 2018).

The extent of support for extra-familial LTC is overall medium and covers on average between 33-66 percent of the cost for home care or care in nursing homes. The support varies with the three levels of dependency and includes mainly personal care services. Beneficiary's share of co-payment for publicly funded care depends on income and assets. Housing property is only included when care provision takes place in a nursing home (Ibáñez et al. 2021). Publicly funded extra-familial LTC is free for all who only have a monthly income (without assets) of the minimum standard IPREM (= €565 in 2021). The co-payment is progressive towards 90 percent of the reference costs of the services (Marbán 2019). Care recipients can also receive cash benefits (€300–€715) which may also be subject to income-based deductions in order to buy care services by private licensed providers (*prestacion economica vinculada al servicio*) if the public sector is not able to provide the necessary LTC, or to buy care from professional personal assistants (*prestacion economica de assistencia personal*) (Rodríguez-Cabrero et al. 2018). Furthermore, it has to be mentioned that the institutional implementation of the aforementioned individual social rights introduced by a reform in 2006 have suffered from strict budget constrains due to the economic crisis after 2008 (Léon et al. 2019; Marbán 2019).

Italy

Access to public support for home care services and nursing homes is not based on a uniform nation-wide regulation in Italy and is therefore considered not generous. The provision of home care services and care in nursing homes is in general compulsory for all municipalities and every citizen has in principle the right to a minimum set of social services (so called "LIVEAS"). However, minimum standards are not legally defined and there is a mismatch between formal entitlement and actual implementation of social rights (Arciprete et al. 2021). Accordingly, the criteria for access to extra-familial LTC differ within the country, depending on the region and the municipality of residence which have different criteria for co-payment (Hohnerlein 2018).

However, since the national legislation sets some standards regarding the co-payment of extra-familial LTC services, their generosity is ranked medium. Home care is fully funded by the national *Servizio Sanitario Nazionale* (SSN) for 30 days after a de-hospitalization and costs are afterwards equally split between SSN and municipalities which may demand co-payment by recipients. The level of co-funding varies with the economic situation of the care-dependent person, and persons with low income are partially or fully exempt from co-payment. Constant attendance allowance (*assegno di accompagnamento*) may in some cases be used for co-funding (see section on familial LTC in Italy for further information). Half of the costs for nursing homes are also covered by the SSN, but the remaining costs need to be covered by residents based on their individual economic situation. Thus, people with low income can benefit from partial or total exemption depending on local regulation (Arciprete et al. 2021). Constant attendance allowance is being suspended if a person stays in a nursing home partly or entirely funded from public budgets (Simmons et al. 2020).

United Kingdom

In the United Kingdom, the generosity of access to public support for home care services and nursing homes is in general on a medium level. The needs assessment is not strict since it stipulates that the care-need level must be "substantial", which does however not mean that full-time care is needed (Statutory Guidance 2014). However, only persons who pass a means-test are partly or fully entitled to publicly funded care. Persons with income and assets above a certain threshold are denied access to public support for extra-familial LTC. These thresholds vary across the UK: £23.250 for England & North Ireland; £27.250 for Scotland and £24.000 (home care) or £50.000 (care in a nursing home) in Wales (Verdin & O'Reilly 2021). This leads to a situation where 45 percent of care recipients have to fund cost for care completely privately (Cromarty 2019). The means-test is considered strict since the relevant threshold on average falls below the median household income in the UK, which was £29.900 in 2020, based on estimates from the Office for National Statistics Household Finances Survey (ONS 2020).

The extent of support for extra-familial LTC is medium in general and covers on average between 33-66 percent of the costs for home care services or care in nursing homes. Co-payment is related to income and assets. Property in which the care-dependent person lives is only included in case of care in a nursing home. Persons with financial resources between the aforementioned upper thresholds and a lower threshold which accounts to £14.250 (= €16.387) in England have to contribute progressively to the cost for extra-familial LTC with increasing income and assets, except for Scotland and North Ireland, where personal care is generally free for older people.[4] In all other parts of the UK, medical, personal and partly assistance services are only fully publicly funded for those below the lower threshold (Glendinning 2018). On average the state funds nursing home places with £636 (=

[4] Wales only has one threshold, under which support is provided (Verdin and O'Reilly 2021).

€731) for older persons and £1320 (= €1518) for working age adults on a weekly basis (see kingsfund.org.uk), but recipients have also to pay towards the costs with only a personal expense of weekly £24,90 (= €29) they can keep. Those above the income/asset threshold have to self-fund the whole nursing home place, and their fees are on average 41 percent higher than those paid by the local authorities. For those with mainly medical continuous and severe care needs the NHS fully pays the costs of a nursing home place without means-testing, but with very strict needs-testing (Glendinning 2018). Furthermore, disabled people may qualify for non-means-tested *Personal Independence Payment* (below pension age) or *Attendance Allowance* (above pension age), which are cash benefits that should cover disability-related extra costs. The amount is based on the level of dependency and can under certain circumstances be used for co-funding extra-familial LTC (Verdin & O'Reilly 2021).

Estonia

The generosity of access to public support for home care services and nursing homes is on a low level in Estonia. Although national legislation generally obliges municipalities to provide basic LTC services, they have broad autonomy to define their policies, and their capacities to fund and provide services are highly unequal and not based on binding national standards. Therefore, coverage of extra-familial LTC is often inadequate since regulation on access to care services based on needs-testing[5] and means-testing[6] varies between regions and availability of services depends on local government's budgetary resources (Taru et al. 2021; World Bank 2017). Therefore, municipalities are only in principle obliged to provide extra-familial LTC services and a care-giver allowance (*hooldajatoetus*). Cash benefits and benefits in-kind are both means-tested and may be combined: if persons in need of care only partly claim the benefits in-kind, they are entitled to receive a proportionate care allowance. However, access to extra-familial LTC services or benefits is often prevented by large infrastructural shortages, especially regarding the provision of home care services or tight budgets. Furthermore, older persons are usually not eligible for home care services if their children live in the same municipality (Mozhaeva 2019). It is generally a legal obligation of family members related in the first and second degree to cover the costs of LTC or to provide care themselves.[7]

In case support is granted, the extent is on a medium level in general and covers on average between 33-66 percent of the costs for home care services or care in nursing homes. There are local differences regarding the content and extent of co-payment of home care provision. Furthermore, due to different responsibilities regarding specific types of LTC provision, different components of LTC (medical, personal services, assistance services) are not integrated into single services by one and the same service provider. While medical care financed by the national health insurance is free of charge in most cases and provided by nursing home care services, social home care services (including personal care and assistance services) are provided by local governments and require complete or partial co-payment. Means-tested care-giver allowance can be used to co-finance personal home care services. The level of care-giver allowance also varies considerably by municipalities: from €16 to €260 per month (Taru et al. 2021Estimated public costs per beneficiary receiving home care service was € 62 in 2012 (Paat-Ahi & Masso 2018). There are also local differences regarding the content and extent of co-payment of care provision in nursing homes. There are two different types of nursing homes in

[5] The national government has recently developed an instrument to assess the need for care (MISSOC 2020).

[6] Access to in-kind service and care allowance varies by municipality. As a rule, in-kind services and care allowance are only available if the person in need of care or their family members are unable to fully cover the LTC costs.

[7] The Constitution of the Republic of Estonia (Art. 27) stipulates that the family is responsible for taking care of its members in need of assistance. The family members who are required to provide such care include spouses and adult first and second-degree ascendants and descendants (Family Law Act, 2009).

Estonia: first, institutions funded by the Estonian Health Insurance Fund which are specialized for medical care and mostly free of co-payment and second, institutions specialized for social care based on the National Social Welfare Act with no right to provide health care services. Many social care home residents also need medical LTC, but the amount of LTC provided in social care homes is constrained by limited local budget resources (see eurocarers.org/country-profiles/Estonia/). The persons in need of care or their family are generally expected to pay the full costs for care in a social care home. The estimated public cost per beneficiary was on average € 519 per month in 2012. In 2013, out of pocket expenditure made up 68,3 percent of the total service budget for nursing homes (Paat-Ahi & Masso 2018).

Hungary

The generosity of access to public support for home care and nursing homes ranges between medium and high in Hungary. Persons with care needs are in principle entitled to receive extra-familial LTC services without means-testing if they pass a non-strict needs-assessment which differentiates between four levels (0-3) of dependency.[8] Persons at level 0 are only eligible for home care if they meet further conditions regarding age and housing situation. Care in nursing homes is only available in category 3 of the needs-test. The responsibility for the provision of extra-familial LTC is generally split between municipal governments and the central government. This division of responsibilities causes serious problems for the implementation of LTC policy. It does not affect the right to access in general, but the availability of services at the local level. Both health care and social care services are based on social rights defined at the national level, but these rights do not automatically create entitlement to LTC services. Therefore, people with care needs often are, left without services if these are not available or accessible (Albert et al. 2021). Despite major developments in home care services over the past decade, coverage remains inadequate and either places the burden on families or leaves the needs of older people unmet (Gal 2018). In some regions up to 80 percent of older people with care needs are guaranteed care services, while it is only a few percent in others. Furthermore, no new places in state-funded nursing care accommodation have been created since 2011 despite increasing numbers of people with care needs. Waiting lists for a place in nursing homes already number more than half of those already receiving services (Gyarmati 2019).

The extent of support for extra-familial LTC is on a medium level for home care and covers on average between 33-66 percent of the cost for LTC. It is on a low level for care in nursing homes covering only between 0-33 percent of costs. Co-payment for home care services increases proportionally with recipient's income up to 30 percent and it is provided free-of-charge to beneficiaries who have no income. Co-payments for nursing home care are also progress with the recipient's income up to 60 percent for temporary-stay care and 80 percent for permanent care in nursing homes (Gal 2018). The co-payment can be topped up in order to cover the full costs if the care recipient has significant financial assets (including residential property). If the care recipient has no financial resources to cover co-payments their adult children can be legally obligated to co-pay. Furthermore, residential services – nursing homes and group homes – often demand very high admission fees of up to 8 million forint (about €23.000 which is more than four times higher than the average annual pension). However, the number of places in residential services that can be based on an admission fees is regulated and as a general rule it cannot exceed 50 percent of the total number of places in non-profit services, and is even lower in publicly provides services. In case beneficiaries have no income, no wealth and no adult children LTC services in nursing homes are provided free-of-charge (Albert et al. 2021).

[8] In 2015, the needs assessment has been exacerbated and lowered the accessibility for potential applicants (see eurocarers.org/country-profiles/hungary/).

Table 2: Generosity of extra-familial LTC policy regarding home care services

Country	Access to public support (1)	Average extent of public support (2)	Overall degree of generosity on home care services (3)
Norway	**High**	**High** 67%-100%	**High**
Germany	**High**	**High** 67%-100%	**High**
Spain	**High**	**Medium** 34-66%	**Medium to High**
Italy	**Low** No national standards	**Medium** 34-66%	**Low to Medium**
UK	**Medium** Strict means-test	**Medium** 34-66%	**Medium**
Estonia	**Low** No national standards	**Medium** 34-66%	**Low to Medium**
Hungary	**High**	**Medium** 34-66%	**Medium to High**

For further information on the measurement see Appendix 1
Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

Table 3: Generosity of extra-familial LTC policy regarding care in nursing homes

Country	Access to public support	Average extent of public support	Overall degree of generosity on care in nursing homes
Norway	**High**	**High** 67%-100%	**High**
Germany	**High**	**Medium** 34-66%	**Medium to High**
Spain	**Medium** Strict needs-test	**Medium** 34-66%	**Medium**
Italy	**Low** No national standards	**Medium** 34-66%	**Low to Medium**
UK	**Medium** Strict means-test	**Medium** 34-66%	**Medium**
Estonia	**Low** No national standards	**Medium** 34-66%	**Low**
Hungary	**Medium** Strict needs-test	**Low**	**Low to Medium**

For further information on the measurement see Appendix 1
Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

Table 4: Generosity of extra-familial LTC policy

Country	Generosity of LTC policy on home care services (1)	Generosity of LTC policy on care in nursing homes (2)	Overall degree of generosity of extra-familial LTC policy (3)
Norway	**High**	**High**	**High**
Germany	**High**	**Medium to High**	**Medium to High – High**
Spain	**Medium to High**	**Medium**	**Medium – Medium to High**
Italy	**Low to Medium**	**Low to Medium**	**Low to Medium**
UK	**Medium**	**Medium**	**Medium**
Estonia	**Low to Medium**	**Low to Medium**	**Low to Medium**
Hungary	**High to Medium**	**Low to Medium**	**Medium**

(1) Average of values of generosity of LTC policy regarding access to and support of home care
(2) Average of values of generosity of LTC policy regarding access to and support of care in nursing homes
(3) Mean value of indicators 1 and 2.

Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

5.1.2. Generosity of familial LTC policy

Norway

Access to public support familial LTC is in general only medium in Norway since it is based on stricter conditions of needs-testing than extra-familial LTC but also not on means-testing. The most important precondition for care-giving family members to receive a care allowance (*omsorgsstønad*) is that care work has to represent an extraordinary burden based on a high care need of the respective relative. It is furthermore only granted by a municipality if family care is considered the best solution for a person (Halvorsen et al. 2021). The compensated care leave for relatives (*pleiepenger*) is mainly targeted at parents providing care for a severely ill or disabled child under 18 who needs constant supervision and care. In case the child is mentally disabled or suffers from a serious or potentially fatal disease or injury, there is no age limit. It can be also granted to relatives who perform care for terminally ill family members. In the latter case, the allowance is limited to 60 days (Grødem 2017).

The extent of support for familial LTC is generally high. The care allowance is equivalent to the wage of the lowest-paid municipal employees in professional care services, it is taxed as income, typically granted for one years or less and includes comprehensive pension contributions. The compensated care leave is based on a wage replacement of 100 percent of the previous salary (based on average income reported last 3 months) with a maximum of an annual income basis of 6 times the basic amount (Grunnbeløpet) i.e. NOK 599.148 (€54.961) and includes comprehensive pension contributions. It can be combined with part-time work and is then proportionally reduced down to a minimum of at least 20 percent (Grødem 2018; MISSOC 2020).[9]

[9] There is also an attendance benefit (*hjelpestønad*) which is a cash benefit (standard rate is NOK 14,748 / ca. €1,400) paid directly to the person in need of care. Care needs to be provided by an informal care-giver and the

Germany

Access to public support familial LTC ranges between medium and high. Access to support is generally based on the same regulations regarding needs- and means-testing as is the access to extra-familial care. However, while the cash benefit (*Pflegegeld*) which is paid to the person in need of care is not further regulated (relatives just have to be officially registered in order to receive pension contributions), in case of the care leave (*Pflegezeit*), only employees working in companies, which employ at least 15 employees, have a legal right to partial or full-time leave for up to 6 months (Grages et al. 2021).

The extent of support for familial LTC also varies with the two types of support. The amount of the tax-free cash benefit, which should allow for adequate personal care support, and other care support measures such as household assistance by relatives or somebody from their social network vary with the five dependency levels (€125 to €901). The benefit for care level 5 (which comprises at least full-time care need) equals roughly 60 percent of the average net pay for full-time professional care with basic qualification. Familial care-givers who are regularly unable to work more than 30 hours per week and care for at least 10 hours per week receive comprehensive pension contributions (Eggers et al. 2020). It is therefore on a medium level. Care leave is only based on low extent of support since employees who decide to provide care for relatives only continue to receive comprehensive pension contributions, but no wage replacement. However, they are entitled to receive an interest-free loan in order to mitigate the loss of salary (MISSOC 2020).

Spain

In general, access to public support for familial LTC is based on a medium level of generosity. Regulations on needs- and means-testing are the same as for extra-familial care. However, there are strict restriction of eligibility with regard to specifications of familial care-giver. In order to receive cash benefits for familial care, the care must be provided by a family member (up to the third degree of kinship) who has already provided care for the care-dependent person for one year and who lives in the same household. The entitlement is furthermore only granted if no suitable formal care is available (Rodríguez-Cabrero et al. 2018). The option of a care leave (*excedencia por cuidado de un familiar*) is also only possible for specific family members (second degree of kinship) who provide care for severely disabled or ill relatives.

The extent of support for familial LTC significantly varies with the two types of support. The extent of the cash benefit can be considered high even though it depends on the level of dependency and the economic situation of the older person. It is €153 per month for level I, between €201 and €268 for level II, and between €290 and €387 for level III. The maximum benefit for level III (which comprises at least full-time care) equals roughly 70 percent of the average net pay for full-time professional care with basic qualifications. Familial care-givers receive pension credits while providing care. The extent of support for the care leave is only on a low level, since there is no wage replacement and only social security credits (including pension credits) are covered for two years. Job security is however limited to one year (Ibáñez et al. 2021).[10]

cash benefit is not to be used to cover services provided by public service providers under other laws (e.g. home care), even in case of co-payments, but to establish or maintain private arrangements and cover special costs or expenses (Grødem 2018; see also https://www.nav.no/en/home/benefits-and-services/relatert-informasjon/attendance-benefit).

[10] Public sector employees can extend the unpaid leave to care for a relative for up to three years, with the whole period credited with social security contributions and related social protection benefits. In cases of chronic dependency, they can furthermore receive a payment for family care work if both live in the same household (Meil et al. 2020).

Italy

Access to public support for familial LTC is ranging between a low and medium level of generosity in Italy since it is based on strict needs-testing and in case of the care leave also on specifications regarding eligible of familial care-givers but generally not on any kind of means-testing. Care by relatives or often also by migrant care workers (Cordini & Ranci 2017) is primarily based on constant attendance allowance that is only granted in case of 100 percent level of dependency (Arciprete et al. 2021). The option of a care leave is also only accessible for people who provide care for a seriously disabled child or relative, and additionally under the precondition that both live in the same household (Jessoula et al. 2018).[11]

The extent of support based on constant attendance allowance (*assegno di accompagnamento*) is on a medium level. The unregulated cash benefit is forwarded to the person in need of care to encourage family members to provide the necessary care. It accounts to €520 per month (in 2020) which equals about 75 percent of the country specific average net pay for full-time professional care with basic qualification. However, familial care-givers are only entitled to minor pension credits that compensate for 25 days per year, even when the familial care is full-time (Lamura et al. 2004). The extent of support for the care leave is highly generous, since it offers a wage replacement of 100 percent up to an annual ceiling adapted over time according to inflation (it amounted to €47.446 in 2016) including comprehensive pension coverage up to two years (Jessoula et al. 2018).

United Kingdom

In general, access to public support for familial LTC is based on a medium to low level of generosity in the UK. There are different allowances that could be used for the payment of familial care provision in the UK: *Attendance Allowance* (for those above pension age) and *Personal Independence Payment* (for those below pension age) which are paid to the person in need of care and *Carer's Allowance* which is paid to the care-giver. Access is in all cases based on a high-threshold needs-test that requires at least frequent help or constant supervision per day or night. In order to receive *Carer's Allowance*, the care-giver is furthermore not allowed to have weekly earnings above £128 (€592 per month), to be in fulltime education or to receive a state pension that is higher than £67.25 per week (€311 per month). Care must be provided for at least 35 hours a week. A compensated care leave scheme does not exist in the UK.[12]

The extent of support for familial LTC is generally on a medium level. There are two possible rates of *Attendance Allowance* and *Personal Independence Payment* depending on care need at £59.70 per week (€276 per month) or £89.15 (€412 per month). In addition, *Carer's Allowance* which amounts £67.25 per week (€311 per month) can be combined with the *Attendance Allowance* or *Personal Independence Payment*. However, even the highest rates combined only equal about half of the country specific average net pay for full-time professional care with basic qualification. Care-givers who care for someone at least 20 hours a week receive National Insurance Credits towards pensions based on Carer's Allowance (see eurocarers.org/country-profiles/uk/).[13]

[11] This regulation was initially designed for working parents with seriously disabled children. Only recently relatives who provide care for older people became eligible (see https://eurocarers.org/country-profiles/italy/).
[12] There are only emergency leaves (time off for dependents) if a close family member needs support (no limit about frequency or time) and a statutory right to request flexible working time (if they have a minimum of 26 weeks of continuous work with the employer). Both schemes have to be negotiated with employer and are usually unpaid (Glendinning 2018).
[13] Scotland used its devolved powers to increase the level of Carers Allowance in 2018, at an annual cost of approximately €34.000.000 (Glendinning 2018).

Estonia

Access to public support for familial LTC is in general only low in Estonia since it is not based on any nation-wide regulation on needs-testing or means-testing. According to the Family Law Act (*Perekonnaseadus*) adult relatives related in the first and second degree are required to provide LTC without any public support. Based on that clause, some local governments do not pay cash benefits to familial care-givers. In 44 out of 79 municipalities family members cannot receive a compensated care allowance (Taru et al. 2021). Moreover, compensated care leave is only available for a short-term in Estonia (Võrk et al. 2016).

The extent of support for familial LTC is generally also on a low level. The level of care-giver allowance varies considerably by municipalities: The average payment for a child was €71 and for adults €45 per month in 2019 (Taru et al. 2021). As a rule, the tax-free benefit corresponds to approximately one tenth of the average monthly net pay for care work with basic qualification. In case it is possible to use care allowance for familial care, the municipality is obliged to pay the minimum contribution for the state pension insurance and/or the social security contributions (which is much higher than the cash benefit for care-giving), care-giver which guarantees the health insurance (Võrk et al. 2016).

Hungary

In Hungary, access to public support for familial LTC varies with the two types of support. While a compensated care leave does not exist in Hungary, access to the Nursing Allowance (*ápolási díj),* which is paid to the familial care-givers. is on a medium level since it is not means-tested but based on stricter needs-testing that requires severe care needs. The cash benefit is based on three categories depending on the needs of the care recipient (Albert et al. 2021).

The extent of support for familial LTC is generally on a medium level but only refers to the extent of the Nursing Allowance. The extent of support amounts to €111 per month for the Standard Nursing Allowance, €166 per month for the Increased Nursing Allowance (*emelt összegű ápolási díj*, 150 percent of the standard allowance) and €199 for the Extra Nursing Allowance (*kiemelt ápolási díj*, 180 percent of the standard allowance). The benefit for the Extra Nursing Allowance (which comprises at least full-time care need) equals roughly 80 percent (70 percent if pension contributions are deducted) of the average net pay for full-time professional care with basic qualification. The Nursing Allowance is exempt from income tax but subject to pension contributions (10 percent) unless the care provider is a pensioner. It can be combined with for 4 hours of work per day (Gal 2018). Employed family members who provide personal care for a permanently ill relative are allowed to go on full-time unpaid leave for a maximum of 2 years. However, needs have to be confirmed by the healthcare system and the leave is unpaid and does not generate eligibilities for pensions (Albert et al. 2021).

Table 5: Generosity of familial LTC policy regarding cash benefit/care allowance

Country	Access to public support (1)	Extent of public support (2)	Overall degree of generosity on cash benefit/care allowance (3)
Norway	**Medium** Strict needs-test	**High** 100% + pension	**Medium to High**
Germany	**High**	**Medium** 64% + pension	**Medium to High**
Spain	**Medium** Restriction of eligible familial care-givers	**High** 69% + pension	**Medium to High**
Italy	**Medium** Strict needs-test	**Medium** 74% + no pension	**Medium**
UK	**Low** Strict means-test and needs-test	**Medium** 48% + pension	**Low to Medium**
Estonia	**Low** Strict means-test and not available in all municipalities	**Low** 13% + pension	**Low**
Hungary	**Medium**	**High** 71% + pension	**Medium to High**

For further information on the measurement see Appendix 2

Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

Table 6: Generosity of familial LTC policy regarding compensated care leave

Country	Access to public support (1)	Extent of public support (2)	Overall degree of generosity on care leave (3)
Norway	**Low** Strict needs-test + restriction for eligible familial care-givers	**High** 100% replacement + pension	**Medium**
Germany	**Medium** Restriction for eligible familial care-givers	**Low** No replacement + pension	**Low to Medium**
Spain	**Medium** Restriction for eligible familial care-givers	**Low** No replacement + pension	**Low to Medium**
Italy	**Medium** Restriction for eligible familial care-givers	**High** 100% replacement + pension	**Medium to High**
UK	-	-	**Low**
Estonia	-	-	**Low**
Hungary	-	-	**Low**

For further information on the measurement see Appendix 2

Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

Table 7: Generosity of familial LTC policy

Country	Generosity of LTC policy on cash benefit/care allowance (1)	Generosity of LTC policy on compensated care leave (2)	Overall degree of generosity of familial LTC policy (3)
Norway	**Medium to High**	**Medium**	**Medium – Medium to High**
Germany	**High**	**Low to Medium**	**Medium – Medium to High**
Spain	**Medium to High**	**Low to Medium**	**Medium**
Italy	**Medium**	**Medium to High**	**Medium – Medium to High**
UK	**Low to Medium**	**Low**	**Low – Low to Medium**
Estonia	**Low**	**Low**	**Low**
Hungary	**Medium to High**	**Low**	**Low to Medium - Medium**

(1) Average of values of generosity of LTC policy regarding access to and support of cash benefit/care allowance

(2) Average of values of generosity of LTC policy regarding access to and support of compensated care leave

(3) Mean value of indicators 1 and 2.

Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

5.1.3. Relation between familial and extra-familial LTC policy in terms of generosity levels

The relationship of extra-familial and familial LTC policies has been broadly discussed in comparative literature on LTC policy. Our findings (Table 8) show that welfare states in general do not prefer to generously support either extra-familial care or care delivered by family members instead of extra-familial care. There is neither a clear pattern of a "crowding-out effect" of generous support for extra-familial LTC that compensates traditional familial care provision, nor of a "crowding-in effect" that strengthens familial care provision based on the absence of generous extra-familial LTC policies.

The empirical puzzle is more diverse, and most welfare states tend to combine both types of care policy in other ways than by treating them as opposites. Our analysis shows that in parallel to an extension of extra-familial LTC policy a semi-formalisation of familial LTC policy took place in European welfare states since the 1990s in many European welfare states. Against this background, a more complex situation evolves with regard to the relationship between support for familial and extra-familial care provision in LTC policies. We see a higher degree of support for both types of care in Norway and also Germany and Spain. All three countries can be assigned to the "Overall Generous Type" of LTC policy. While this is in some cases based on a more or less equal treatment of both types of care which creates opportunities for exercising active citizenship regarding the selection of individually preferred forms of LTC provision, it might also be based on a specialization effect, which is in some cases explicitly facilitated by an option to combine paid familial and extra-familial LTC provision, like in Germany (Grages et al. 2021).

However, other welfare states tend to support one type of care policy to a somewhat stronger degree even though this tendency is not based on an either-or-decision. The UK puts a stronger emphasis on extra-familial LTC policy combining a medium level of support for extra-familial LTC policy with a low support for familial LTC policy and therefore shows characteristics of the "Extra-Familial Support Type" of LTC policy. Italy shows an opposing profile with a focus on supporting familial LTC provision combining a low to medium degree of support for extra-familial LTC policy with an above medium support for familial LTC policy and can therefore be assigned to the "Family Support Type". Hungary and Estonia can be classified as "Minimum Support Type". They show a lower degree of support for both types of LTC policy, enforcing a traditional and outdated situation regarding LTC provision that has been described as "*familialism by default*" (Saraceno & Keck 2010) since LTC policy barely offers opportunities besides informal and unpaid family care work.

Table 8: Institutional constellations of LTC policies on familial and extra-familial LTC on the basis of their generosity

		Generosity of extra-familial LTC policy (1)								
		High				Medium				Low
Generosity of familial LTC policy (2)	High									
			Overall Generous Type					*Family Support Type*		
		NO						IT		
	Medium		DE		ES					
							HU			
			Extra-Familial Support Type					*Minimum Support Type*		
						UK				
	Low							EE		

(1) Average of values of generosity of LTC policy on home care and residential care (see table 4).
(2) Average of values of generosity of LTC policy on cash benefit/care allowance and compensated care leave (see table 7).
Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

5.1.4. Hypothetical consequences related to different types of institutional constellations of LTC policy

Overall Generous Type

Poverty risks associated with social security gaps in LTC policy are low in Norway and only slightly more pronounced in Germany and Spain, since extra-familial LTC policy allows for comprehensive access to LTC services with only lower degrees co-payment on average. However, we have to point out that in all of the three countries additional cost related to care provision in nursing homes (hotel and investment cost) are associated with significant financial burdens which might put pressure on the economic situation of people in need of care. Risks of unmet needs are rather low in Norway and Germany since there are no significant geographical and organizational barriers in coordination regarding regional availability of infrastructure and policy implementation. However, in Norway a certain risk of unmet needs is based on a more strict interpretation of eligibility criteria especially for families with sick or disabled children in some municipalities. In the case of Spain the risk of unmet needs is only on a medium level since organizational barriers in coordination have limited the implementation of the ambitious goals regarding universalizing individual social rights of the 2006 LTC

reform because of strict budget constrains after the economic crisis in 2008 (Deusdas et al. 2016b; Léon et al. 2021). The opportunities for exercising active citizenship are high, since in all three cases persons in need of care can both decide whether they prefer familial or extra-familial care provision and whether they prefer home and residential care. With regard to the gendered implications of LTC policies Norway has puts focus on gender equity since working and caring women can be financially autonomous. LTC policy in Germany and Spain is characterized by a more productivist focus on gender equality since only working women can achieve financial autonomy since social rights to access and extent of pay for family care are not designed generous enough in both countries.

Extra-Familial Support Type

On the one hand, LTC policy in the United Kingdom only offers a very limited security against poverty risks since public support for LTC is generally targeted at persons with lower income. A noteworthy exception to this is the fact that personal care is free for older people in Wales and Scotland (Glendinning 2018). On the other, risks of unmet needs are comparably low since there are no significant barriers in coordination regarding regional availability of infrastructure and policy implementation. However, due to recent cuts of nearly £8 billions on the budget for social care since 2010 and more stringent eligibility for benefits experience of unmet need increases and the quality of LTC services for older persons and persons with disabilities severely suffers (Cromarty 2019; Ryan 2019). The degree of opportunities for exercising active citizenship is on a medium level since people with care needs are only able to choose between extra-familial home and residential care since policy on familial LTC is not generous enough to qualify as a suitable alternative. Based on this, there is no opportunity for the mostly female family care givers to achieve financial autonomy on the basis of their care work. Only women who decide not to care for their relatives are able to be financially autonomous on the basis of gainful employment since LTC policy– at least partially - frees them from their care obligations. Accordingly, LTC policy is based on a productivist perspective on gender equality: the idea that social policies should foster participation in the labour market

Family Support Type

LTC policy in Italy ranks medium regarding its ability to secure against poverty risks. Generosity of public support for extra-familial LTC is only low level, but Italian LTC policy compensates this to a certain degree by offering a stronger support for caring family members with its focus on unregulated cash payments and generous care leave. The risk of unmet needs is also only medium, since the types of support and services varies substantially between Northern and Southern regions generating inefficiencies in service provision (Jessoula et al. 2021; Ranci & Pavolini 2015). The degree of opportunities for exercising active citizenship is low since familial care or care by migrant care workers is in most cases the only affordable option. Against this background, women with relatives in need of care are imposed a care burden and have difficulties if they want to participate in gainful employment. Even though they might achieve – a very basic level of - financial autonomy on the basis of their care work, they stay trapped in the domestic sphere and/or need to interrupt their career in order to provide LTC.

Minimum Support Type

LTC policy in Hungary provides a limited security against poverty risk based on a slightly below medium support for extra-familial and familial care while the Estonia welfare state barley takes any specific responsibility for LTC besides minimal support for persons in need of care that do not have any relatives or financial assets. Both countries have high risks of unmet needs because coverage of extra-familial LTC is often inadequate since access to care services varies between regions and availability of services

is dependent on local government's budgetary resources. Against the background of insufficient generosity, both welfare states do not offer real opportunities for exercising active citizenship. Instead, it is even expected that family members provide unpaid care in the case of Estonia (Taru et al. 2021). LTC policy focus is on traditional gendered division of work and a strong or complete financial dependence on male breadwinner for caring women.

Table 9: Comparative discussion of the results with regard to poverty risks, risks of unmet needs, options for active citizenship and gender equality

	Poverty risks (1)	Risk of unmet needs (2)	Active citizenship (3)	Gender equality (4)
Norway	**Low**	**Low**	**High**	**High**
Germany	**Medium** (extra-familial LTC = higher than medium	**Low**	**High**	**Medium**
Spain	**Medium** (extra-familial LTC = higher than medium)	**Medium** (organizational barriers)	**High**	**Medium**
Italy	**Medium** (familial LTC = higher than medium)	**Medium** (geographical barriers)	**Medium**	**Low**
UK	**High**	**Low**	**Medium**	**Low**
Estonia	**High**	**High**	**Low**	**Low**
Hungary	**High**	**High**	**Medium**	**Low**

For further information on the measurement see Appendix 3
Sources: National legislation, EUROSHIP Country Reports, ESPN Country Reports, MISSOC Database, EUROCARER Database.

5.2. Development of LTC policies 2000-2020 - path dependence?

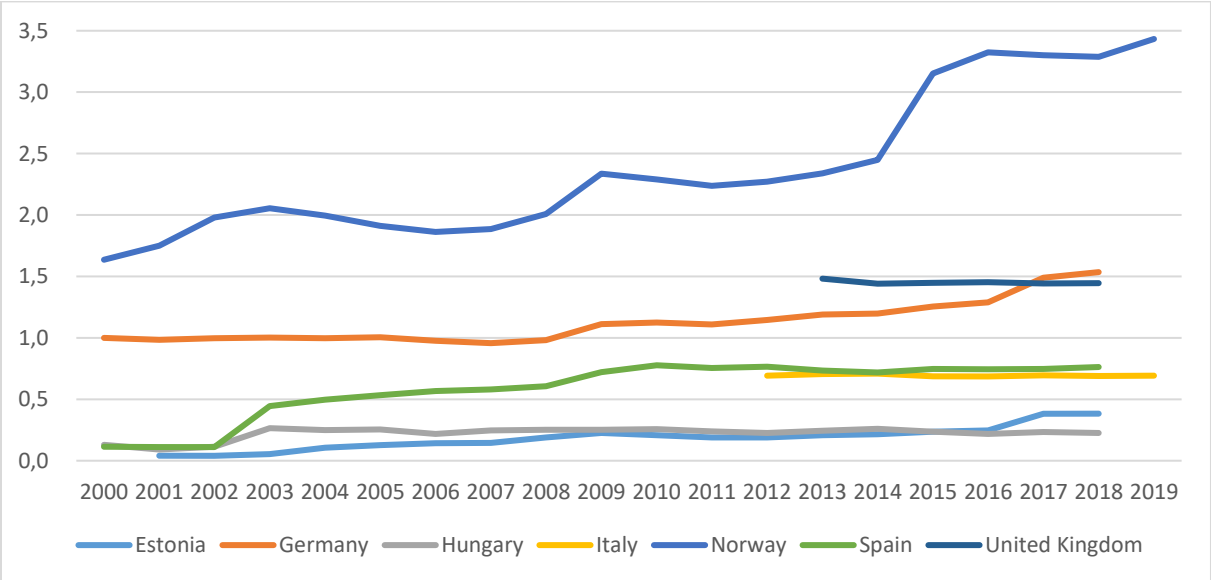
5.2.1. General and country specific trends in LTC expenditure

Increasing demand for LTC due to population ageing, increased rates of noncommunicable diseases and a reduced availability of familial care support based on increasing female labour force participation has led to rising public expenditure rates in many European countries in the last two decades. However, the persistence of traditional care culture (Pfau-Effinger 2017) and fiscal austerity experienced in several European countries since economic crisis in 2007-2009 (Ranci & Pavolini 2015; Deusdad et al. 2016a) has limited the ability or willingness to initiate or implement reforms in order to expand public expenditure for LTC (Costa-Font & Zigante 2017). If we take a look at the seven EUROSHIP countries in 2018, we can identify four patterns of spending levels that more or less correlate with the welfare regime affiliation of the countries (Esping-Andersen 1999; Halvorsen et al. 2017): Norway with its social-democratic welfare approach shows with almost 3,5 percent of its GDP a very high level of expenditure on LTC. The conservative welfare state of Germany and the liberal welfare state of the UK both show with about 1,5 percent of their GDPs medium levels of spending. They are followed by Italy and Spain which represent the Mediterranean welfare regime and only show medium to low levels of spending which range around 0,75 percent of their GDPs. Post-socialist countries are performing worst and show expenditure levels which are below 0,5 percent of their respective GDP.

If we look at the development of public expenditure on LTC, we see a more or less steady growth between 2000 and 2018 in Norway and Estonia. Norway has always been a high spender and their

expenditure level more than doubled between 2000 and 2018, which shows that the policies already in place have not been substantially modified by changes in the economic climate (Halvorsen et al. 2021). Estonia showed even higher rates of growth, even though expenditure only increased on a very small scale from below 0.1 to about 0.4 percent in the same period. Even though LTC expenditure was not negatively affected by the economic crisis in 2008, the level of public funding for LTC is still too low to ensure adequate coverage and provides little financial protection (Paat-Ahi & Masso 2018). Spain shows a strong increase from 0,1 to 0,8 percent in its public LTC expenditure until the beginning of the financial crisis. Expenditure stagnated or even decreased to a small degree afterwards. The period between 2011 and 2015 has been the toughest years of the Great Recession, and the financial sustainability of the comprehensive LTC reform introduced in 2006 have been questioned by the government resulting in budget cuts that even led to severe drops of beneficiaries (Costa-Font 2016; Ibáñez et al. 2021; Spasova et al. 2018;). The dynamic of the growth in public spending for LTC in Germany shows a diametrically opposite development: While expenditure more or less stagnated around 1,0 percent of GDP between 2000 and 2008, it shows considerable growth rates after 2008 and especially after 2016/17 due to LTC policy reforms which comprised an expansion of the scope of beneficiaries by the introduction of a new concept of "need of care" now including people with mental and psychological disabilities (Grages et al. 2021). Data is incomplete for Italy (only 2012-2019) and the UK (only 2013-2018). However, both countries show more or less a stagnation or in case of the UK even a slight decrease in public LTC expenditure. There was a twofold development in Italy: while budget devoted to LTC services decreased after the economic crisis in 2008, expenditure for cash benefits increased even in times of austerity (Jessoula et al. 2018). Decreasing expenditure in the UK can be explained by the fact local authority budgets have been cut successively since 2010, despite rising demographic demand and increasing LTC costs (Glendinning 2018). Public expenditure in Hungary also more or less stagnated on a very low level between 0,2 and 0,3 percent of the GDP even though there has been some dynamics in expenditure for different types of LTC: While expenditure on residential LTC remained constantly low, there was a stronger investment in home care after 2008. However, rising costs have been compensated by cutting back the per capita quota in 2013 and tightening eligibility criteria for LTC in 2015 which resulted in a severe drop in the number of recipients (Gal 2018; Albert et al. 2021).

Graph 1: Public Expenditure on LTC (total) as Share of GDP in %



Source: OECD Health Statistics 2020

5.2.2. General and country specific trends with regard to marketization

Since the 1990s, many welfare states in Europe have introduced or expanded marketization of LTC policies in order to improve efficiency of care provision and/or to contain public LTC expenditure (Gingrich 2011; Klenk & Pavolini 2015; Deusdad et al. 2016a; Harrington et al. 2017). Comparative welfare state research mainly deals with two key forms of marketization: a) privatization and increasing competition among care providers and b) the strengthening of the consumer role of care recipients. Social services have been privatized and public LTC systems have been opened to for-profit providers in many European welfare states since the 1990s (Anttonen & Meagher 2013; Brennan et al. 2012; Gingrich 2011). This process of out-sourcing is closely related to the strengthening of provider competition (Meagher & Szebeheli 2013; Nullmeier 2004) and it has been shown that for-profit provision of publicly funded care can pose the particular risk of low care quality (Rostgaard 2011). However, LTC markets are often conceptualised as quasi-markets which are framed to varying degrees by government regulations which should limit free market forces (Le Grand & Bartlett 1993).

In the late 1990s, ideas of marketization have started to influence the development of LTC policy in Norway and promoted privatization, "consumer choice" and new public management (Harrington et al. 2017; Vabo et al. 2013). In principle, private providers (non- and for-profit) are allowed to supply services based on contracts with municipalities according to the same quality criteria and prices as public LTC providers. However, only about 10 percent of all beds in nursing homes are provided by private providers of which only half are for-profit (Førland & Hatland 2020). Moreover, 97 percent of public support for home care go towards services run by municipalities (Sivesind 2016). Outsourcing of LTC to private enterprises is politically contested in Norway and the numbers of for-profit providers are recently decreasing (-14,2 percent between 2015-2019) due to pressure from left-wing local governments. Furthermore, there are labour conflicts regarding the working conditions of private sector employees (Halvorsen et al. 2021). However, Vabø et al. (2013) found no evidence that private providers offer working conditions that are systematically poorer than those in public services

Private providers (for-profit and non-profit) have been allowed to supply services based on public funding and contracts since the mid-90s in Germany. Provider competition is however limited by strict regulation on pricing and minimum requirements for care quality (Hagen & Rothgang 2014; Eggers et al. 2020). The share of for-profit providers has substantially increased during the last two decades and reached 66 percent for home care providers and 43 percent for nursing homes in 2017 (Pflegestatistik 2018). Furthermore, a shortage of care professionals and poor working conditions have created problems with regard to care quality in for-profit services (Bogai 2014). Working conditions and job satisfaction tend to suffer due to marketization particularly at for-profit providers (Theobald 2014) and wages in for-profit nursing homes are lower than in non-profit and public nursing homes (Auth 2014).

Growing demands for different forms of extra-familial LTC have led to changes in the balances between public and private provision (for-profit and non-profit) in recent years in Spain. While the public sector is on the one hand expanding LTC infrastructure, the government has also started to subsidize private services (Ibáñez et. al 2021). A large part of publicly-owned nursing homes (26 percent) has already been replaced by private nursing homes (74 percent). While public and partially subsidized private places account for 60 percent of all places in nursing homes, completely private place account for 40 percent (IMSERSO 2020). This development can be explained by the absence of public investment and minimal regulation (León et al, forthcoming). However, the proportions of public, partially subsidized and private provision vary largely across the Autonomous Communities which accredit private providers based on nation-wide criteria regarding staff qualifications, minimum care-worker-to-recipient ratios and material resources (Rodríguez-Cabrero et al. 2018). Issues regarding quality of

care, working conditions of the care-givers, and adequacy of profits for private providers are currently critically discussed in Spain (Ibáñez et al. 2021).[14]

Marketization of LTC has also significantly increased during the last decades in Italy (Da Roit & Sabatinelli 2013). The welfare states only provides a minor share of LTC services publicly and partly delegates care provision to private providers (profit and non-profit) via accreditation and agreement procedures setting tariffs thresholds. Against this background, LTC provision by private providers on the basis of public funds plays a significant role in the Italian LTC system (Jessoula et al. 2021). In 2016, only about 7 percent of LTC provision was publicly provided, 64 percent referring to non-profit providers and about 29 percent to for-profit providers, with the latter having the largest incidence in Southern Italy (Osservatorio SPI CGIL 2017). Against the background of a generally insufficient support for extra-familial LTC and a strong focus on unregulated cash-for-care payments, there is another type of highly competitive, barely regulated and constantly growing private market for LTC in Italy: migrant care work (Pasquinelli & Rusmini 2013; Pavolini et al. 2017).

The LTC system in the UK and especially in England has been successively restructured based on the introduction and strengthening of marketization since the early 1990s and it is now dominated by private providers (mostly for-profit but also non-profit) which are in part funded by local authorities which negotiate contracts with private providers. Private providers account for approximately 90 percent of LTC provided by home care services and nursing homes in the England (CHPI 2016). There are major threats to the quality of services based on the high degree of marketization and routine monitoring by public authorities regularly reveals significant quality shortcomings of private care providers; especially in nursing homes (Glendinning 2018). Conditions of professional care work have generally suffered from privatization. Among other reasons, this is based on the fact that ordinary care workers do not need qualifications, and training costs are mostly not covered by publicly paid fees (House of Commons 2017). Against this background, private providers are increasingly closing down or opting out of public contracts in order to concentrate on private purchasers who can be charged higher fees (Verdin & O'Reilly 2021).

In Estonia, all private providers (non- and for-profit) are allowed to supply LTC services based on a license given by the Estonian Social Insurance Board that encompasses a care plan and defines qualifications for personnel (MISSOC 2020). In 2019, about 55 percent of the nursing homes were in public hands and the rest was privately owned (Sotsiaalkindlustusamet 2020). Quality requirements are the same for public and private LTC providers and they are monitored by the Social Insurance Board. The pricing for extra-familial LTC is not regulated and based on free market forces, but there are often fixed prices for certain periods that are agreed between private care homes and municipalities in case a municipality lacks public nursing home places and outsources part of the service provision to private providers (Taru et al. 2021). The involvement of NGOs and private sector LTC provision has been supported in recent years financed by European Social Fund, in order to provide a wider range of service and create new opportunities for home care services provision (Paas-Ahi & Masso 2018).

The degree of marketization is low in Hungary since there is no public funding of LTC provision by for-profit providers. Extra-familial LTC services are only provided by the state or local governments (53 percent of nursing home provision and 55 percent home care provision) or are outsourced to private non-profit providers (47 percent of nursing homes provision and 45 percent of home care provision) like churches and other NGOs, which mostly employ professional care-givers (CSO 2019). Private non-

[14] Furthermore, emerging needs in combination with a lack of public resources have resulted in "informal marketization" based on unregulated collaborations between social workers and third sector organizations (Deusdad et al. 2016b: 259).

profit providers have no restrictions unless subject to local agreements with municipalities. Especially church provision has increased during the last years. However, there is a grey economy of unregistered and unregulated private nursing homes for older people and domestic services and home care, with a small but significant number of live-in care-givers from neighboring countries but concrete numbers are unknown (Albert et al. 2021).

5.2.3. General and country specific trends with regard to "consumer choice"

Rights and responsibilities for those in need of care have also changed in many European welfare states. By promoting the direct buyer-seller relationship, care recipients are increasingly being conceptualized as consumers with freedom of choice between different providers (Clarke et al. 2007; Eichler & Pfau-Effinger 2009). People in need of care receive funds (often on the basis of "cash-for-care" systems), with which they can "buy" care services that meet their individual needs (Da Roit et al. 2016; Da Roit & Gori 2019; Rummery 2009). However, it is sometimes overlooked that some welfare states (especially those of the social-democratic welfare regime) offer a wide range of different services and benefits in order to promote the self-determination of persons with care needs without putting a strong emphasis on marketization (Da Roit & Le Bihan 2010; Eggers et al. 2019). In this regard such policies can strengthen people's options to exercise "active citizenship". Moreover, it has been pointed out that marketization and choice can be associated with risks for people in need of care. Many authors have criticized the concept of "consumer choice" in the context of care dependent people, since autonomous decision-making presupposes "competent consumers" (Evers 2006; Glendinning 2008; Grootegoed et al. 2010; Yeandle et al. 2012). People in need of care have limited capacities for decision-making due to physical and/or cognitive limitations due to their "vulnerability" (Costa & Ranci 2010). They often do not have the necessary information and/or skills required in order to be able to compare different types of offers, services and providers and to make informed and rational choices (Naegele 2014).

Choice is traditionally deeply rooted in the Norwegian LTC system but not necessarily related to strong degrees of newly introduced marketization (Grødem 2018). People with care needs can freely choose service provider themselves. Even though the system is mainly based on extra-familial LTC provision including home help services, there are manifold opportunities that support familial care provision (Grødem 2016). However, the possibility to choose user controlled personal assistance is only available for persons under-67 with extensive care needs (Halvorsen et al. 2021).

In Germany, options for "consumer choice" are in general high for people being able to decide upon different care types and providers. The scope of selectable services is mainly limited to medical and personal care even though it increased with the LTC reform in 2017 (Grages et al. 2021). However, transparency with regard to quality and performance is low which makes it difficult to exercise active citizenship effectively (Ehrentraut et al. 2015).

In Spain, free choice of professional providers is only ensured on the basis of cash benefits linked to the purchase of services by private licensed providers if the public sector is not able to provide services (Rodríguez-Cabrero et al. 2018). Moreover, care-dependent persons and their families are reluctant to choose nursing homes care due to long waiting list and/or significant personal co-payments, while home and tele-assistance are still both only reaching around 15 percent of all LTC services (Ibáñez et al. 2021). Consequently, there is a stronger emphasis on cash benefits than on in-kind extra-familial services, which is in opposition to the original goals of the 2006 LTC reform (Cabrero & Gallego, 2013).

Possibilities for "consumer choice" are ambivalent in Italy: while there is in general no free choice between providers with regard to in kind services (MISSOC 2020), but the use of the cash allowance is

not monitored and therefore creates options for provider choice (within the scope of the legally stipulated low level of benefits) which is indeed limited. Accordingly, it is mostly used for employing low-cost migrant care workers and not for professional extra-familial LTC services (Jessoula et al. 2021).

English LTC policy puts a strong emphasis on "consumer choice" based on Personal Budgets which mostly take the form of direct cash payments controlled by individual service users. However, older people in need of care tend not to make use of their choice, since it is often not clear what types of benefits and support are available. Instead, they prefer to rely on public authorities to manage their personal budgets on their behalf (Rabiee et al. 2016).

Against the background of the very residual LTC system in Estonia, opportunities for choice are extremely limited. The provision of publicly financed LTC is mainly based on nursing homes which still absorbs most public budget devoted to LTC (Aaben et al. 2017). In case, costs for LTC provision are covered by the municipality, there is no provider choice because municipalities allocate care recipients directly to public or publicly subsidized nursing homes (Taru et al. 2021).

Even though the care market is strongly regulated in Hungary, individuals have in principle considerable choice with regard to the selection of different LTC services, especially with regard to residential facilities. However, options are in fact limited by high financial burdens due to admission fees and a general shortage of availability of service (Gal 2018).

5.2.4. General and country specific trends with regard to de-institutionalisation

Another trend is based on de-institutionalisation which refers to the replacement of institutional with community-based settings of LTC provision. It has originally evolved as a way to strengthen self-determination and dignity of life of people in need of care, triggered by the disability and independent living movement. More recently it has also been used as retrenchment strategy in European welfare states (Deusdad et al. 2016a; Illinca et al. 2015). The extension of home care services instead of more cost-intense nursing homes to supporting "aging in place" was a central element of LTC reforms during the last decades (Burau et al. 2007; Deusdad et al. 2016a; Halvorsen et al. 2018; Mansell et al. 2007; Pavolini & Ranci 2008; Spasova et al. 2018). Furthermore, high accommodation costs that have to be paid by care recipients in many European welfare states often make care in nursing homes a "last resort"-option (Heger & Korfhage, 2018).

In Norway, there is a strong emphasis on opportunities for community living and de-institutionalisation. "Home as long as possible" has been the dominating ideology in LTC care in Norway after the second world war but it took until the 1970s before community and home-based services became a real alternative to institutional care (Daatland & Otnes 2015). The numbers of care recipients in nursing homes have still been the highest among Scandinavian countries in the 1980s. However, since the 1990s, community-based residential care homes (*omsorgsboliger*) have been given more priority. Moreover, there is a trend towards shorter duration of stay in residential care: While short-term stays increased by 5,2 percent, long-term stays decreased by 4,8 percent in the same period (Statistics Norway 2020). Even though home care services are now the dominant form of LTC in all age groups, institutional care in nursing homes is still offered to a significant proportion of older persons with care needs, especially if they suffer from dementia or other cognitive impairments (Grødem 2018).

The general prioritization of home care is explicitly regulated in German LTC policy and persons in need of care should be enabled to stay in their homes or to "age-in-place" as long as possible. Shared housing arrangements are also supported (Doetter & Schmid 2018). There is a clear trend towards de-

institutionalisation since the number of people with care needs in nursing homes decreased from 34,9 percent in 2005 to 26,3 percent in 2017 (Pflegereport 2018). This trend might be further facilitated by the fact that the level of benefits related to home care increased significantly in the course of the 2017 LTC reform (Loman 2019).

In Spain, since the introduction of the reform, community-based care is in general gaining importance over nursing homes and there has been a constant growth in home care services. However, the existing extent of public support is quantitative and qualitatively still far lower than expected which undermines opportunities for choice and creates unmet needs (AEDGSS 2020, Rodríguez-Cabrero et al. 2018). On this basis, Deusdad et al. (2016b: 258) state a "false deinstitutionalisation" that was not based on choice but rather brought on by the economic crisis and was mainly carried out on the back of care-giving family members. Nevertheless, new policy approaches focusing on opportunities for community living, de-institutionalisation and individual choice have been initiated at the municipal level (Ibáñez et al. 2021).

De-institutionalisation has a long history in Italy and dates back to the end of the 1970s.[15] It was legally consolidated in the late-1990s, based on the concept of "Independent Living" for people with severe disabilities to promote their self-determination. In 2016, de-institutionalisation was further strengthened in LTC policy based on national funds to support individual de-institutionalisation, develop innovative nursing home solutions such as co-housing, and increase people's levels of autonomy. However, there are considerable regional disparities regarding the implementation of de-institutionalisation since national funds are supplemented with (often insufficient) regional funding and coordination between different governance levels and relevant stakeholder is often problematic (Jessoula et al. 2021).

In general, there is strong focus on de-institutionalisation in the UK, which was also embedded in legislation via the Care Act 2014. Policy directive has increasingly been to help people stay in their homes for longer, even those with severe needs. This development is also manifested in a significant growth of home care services by 23 percent during the last 5 years (CQC 2019).

Home care is not publicly supported but implicitly enforced due to strong familial care obligation. Only very recently, a new focus on de-institutionalisation emerged and the welfare state started efforts to promote LTC provision based on home care services, which have relatively low unit costs in Estonia (Paas-Ahi & Masso, 2018).

Hungary started to put more emphasis on de-institutionalisation in the last two decade, even though the LTC system is still generally targeted at care provision at nursing homes for person with severe care needs. Since 2008, the number of home care recipients more than doubled, while nursing home capacities basically did not change (Central Statistical Office 2017). However, availability of home care services is still limited and there are large regional disparities. Furthermore, there was an initiative to replacement large nursing homes with smaller residential services that has been co-financed by the Albert et al. 2021). However, despite huge investments it has not yet resulted in high take-up (Gal 2018).

[15] Franco Basaglia was an Italian psychiatrist who proposed the dismantling of psychiatric hospitals after exposing catastrophic prevailing conditions.

5.2.5. General and country specific trends with regard to reablement

In recent years, European welfare states have strengthened the right to rehabilitation services. Such policies can strengthen the physical and personal autonomy of people in need of care and support them in their options to exercise active citizenship (Rostgaard 2014). They often mainly target people in working age to help them maintain or regain their employability due to disabilities and severe illnesses or longer hospital stays (Bickenbach 2020; Mehrhoff 2017). However, many countries also started to introduce rehabilitation services for older persons in need of care (Aspinal et al. 2016). Besides the institutionalized provision of rehabilitation, home-based reablement services that also address psychological and societal dimensions have especially in Norway and the UK been extended. These services are often short-term goal-oriented interventions that aim at helping persons in need of support to improve their capacity to remain to some extent active and independent in their daily lives (Aspinal et al. 2016; Glendinning 2017; Rostgaard 2014). They tend to serve the double-aim of reducing the older persons' need for long-term support and thereby reducing health-care costs (Aspinal et al. 2016).

Overall, the studied welfare states differ significantly with regard to the extent to which they promote rehabilitation and reablement services for older persons with care needs, but all have established to some extent rehabilitation and (re-)integration measures for working-age persons with disabilities.

In Norway, rehabilitation services have for several decades played an important role in LTC policies for older persons and persons with disabilities, with the aim to support people to cope to some extent independently with activities of daily living (Halvorsen et al. 2021). In addition, in the last decade, home-based goal-oriented and individualized reablement services were extended in most, particularly the larger municipalities (Hjelle et al. 2017; Tingvoll & McClusky 2015). Similarly, there is also a strong focus on rehabilitation of working-age persons to diminish health-related and social problems that could obstruct their working life, or to promote the re-entry after illnesses (vocational and medical) and long-term disabilities, which also should help to prevent persons to become dependent on disability benefits (Halvorsen et al. 2021).

The entitlement of especially older persons in need of care to receive an assessment and recommendation for institutional, ambulant or home-based rehabilitation (around 20 days) (SGB XI) has also been strengthened in the last decade in Germany (Eggers et al. 2019). However, different from the Norwegian policies, these measures mainly address medical rehabilitation and prevention (German Ministry of Health 2021). In contrast, rehabilitation for persons with disabilities (Social Code IX) has a stronger focus on the self-determination and social inclusion, for example in working life which is a priority over receiving LTC allowances (Gerlinger 2018).

A similar trend can be detected in the UK, where rehabilitation and reablement measures have been extended in the last decade (Glendinning 2017). While traditionally being provided by the NHS for persons after longer hospital stays, reablement services are home-based and target persons with newly established care needs, primarily after longer hospital stays, which are for up to 6 weeks free of charge (Glendinning 2017). In the UK, the instruments aim at (re-)integrating working-age persons with disabilities into employment, including training, workplace adaptions, equipment or mental health assistance (Verdin & O'Reilly 2021).

While the Spanish LTC policy has a commitment to promote rehabilitation and prevention, it still lacks comprehensive implementation and differs considerably between municipalities (Ibáñez et al. 2021). With regard to working-age persons with disabilities, Spain has recently established different instruments to promote inclusion and re-entry into the labour market, such as quotas, workplace adaption, wage subsidies or sheltered employment (ibid.; Tursa et al. 2018).

Similar instruments for the labour market integration and re-entry of working-age persons with disabilities have been strengthened in Italy, while there is not a strong focus on rehabilitation of older persons with need of care within the scope of the Italian LTC policies and considerable regional disparities exist (Jessoula et al. 2021).

In Hungary and Estonia, rehabilitation for older persons in need of care is not part of the LTC policies, there is however to some extent vocational rehabilitation for working-age persons with disabilities in order to promote re-integration in the labour market (Albert et al. 2021; Taru et al. 2021).

5.3. Assessing the differences with regard to their social resilience

Population ageing, increased prevalence of non-communicable diseases, and multi-morbidity; commonly understood to be the coexistence of multiple health conditions of ageing individuals (Fortin et al. 2012; Johnston et al. 2018), have represented serious challenges for LTC systems in European welfare states and will continue to put pressure on LTC systems in the future. The share of the population 65+ has nearly doubled from 9 percent in 1960 to more than 17 percent in 2017 on average across OECD countries (OECD 2019). Demographic projections by Eurostat over the long term reveal that Europe is turning even greyer in the coming decades with an increase of the share of people 65+ from 19,3 percent in 2016 to 28,8 percent in 2070. An even stronger increase will manifest in the group of people 80+: Their share will increase more than double from 5,4 to 12,4 on average in the EU28 in the same period (EU 2018).

This development is particularly challenging, since multimorbidity is especially common among people aged 65+ with prevalence rates estimated as high as 65 percent (van der Heide et al. 2015) and the risk of multimorbidity increases with age (Salive 2013). The relationship between multimorbidity, age and need for care has not yet been fully clarified. However, research showed that the likelihood of LTC needs is increased in the case of multimorbidity (Koller et al. 2014; Marengoni & Angleman 2011). Against this background, it can be assumed that especially a rising share of very old people (80+) will be accompanied by an increase in LTC care needs in the population due to higher prevalence of multimorbidity. Furthermore, high degrees of persons with multimorbidity demand for highly coordinated LTC systems in order to prevent fragmented, incomplete, inefficient and ineffective care provision (van der Heide et al. 2015). With the COVID-19 pandemic just recently another social risk took the stage that particular posed a threat to persons with care needs due to their high degree of vulnerability. Comparative research showed that a lack of coordination in LTC systems also lowers the ability to implement effective policy responses that helped to control the pandemic (Daly et al. forthcoming).

Against this background of the outlined developments, the pressure on LTC systems is growing and their social resilience, i.e. the ability to cushion social risks and to sustain and advance well-being in face of challenges (Hall & Lamont 2013), will increasingly be tested in the next decades. Even systems that are currently resilient will have to invest a lot in order to remain resilient in the future. Systems that are already badly set up will come under further pressure.

Table 10: Trends on demographic and economic development

	Old age dependency ratio[16] in 2016 (1)	Old age dependency ratio in 2070 (2)	Increase of Old age dependency ratio (3)	Share of people 80+ in 2016 (4)	Share of people 80+ in 2070 (5)	Increase of Share of people 80+ (3)	GDP growth rate in 2016 (2070)
Norway	**lower** 22,1	**lower** 47,2	**medium** +25,2 (114%)	**lower** 4,2	**medium** 10,7	**higher** +6,6 (155%)	**decreasing** 2,1 (1,6)
Germany	**higher** 32,2	**medium** 55,9	**lower** +23,7 (73%)	**medium** 5,9	**higher** 13,3	**medium** +7,4 (125%)	decreasing 1,8 (1,3)
Spain	**medium** 28,6	**lower** 46,6	**lower** +18 (62%)	**higher** 6,1	higher 12,8	**medium** +6,7 (110%)	**increasing** 0,4 (1,9)
Italy	**higher** 34,5	**higher** 60,3	**medium** +25,8 (75%)	**higher** 6,7	**higher** 14,6	**medium** +7,9 (118%)	**increasing** -0,3 (1,1)
UK	**medium** 27,0	**lower** 46	**lower** +18 (70%)	**lower** 4,8	**medium** 10,7	medium +5,8 (123%)	**stable** 1,5 (1,6)
Estonia	**medium** 28,7	**medium** 52,7	**medium** + 23 (84%)	**medium** 5,2	**higher** 13,9	**higher** +8,7 (167%)	**decreasing** 2,3 (1,3)
Hungary	**medium** 27,5	**medium** 52	**medium** +24,5 (89%)	**lower** 4,3	**higher** 12,3	**higher** +8 (186%)	**decreasing** 1,9 (1,3)

(1) Lower dependency ratio = 25% or below; medium dependency ratio = 25-30%; higher dependency ratio = 30% or more
(2) Lower dependency ratio = 50% or below; medium dependency ratio = 50-60%; higher dependency ratio = 60% or more
(3) Lower level of increase = below 75%, medium level of increase 75-125% , higher level of increase = above 125%
(4) Lower share of people 80+ = 5% or below; medium share of people 80+ = 5-6%; higher share of people 80+ = 6% or more
(5) Lower share of people 80+ = 10% or below; medium share of people 80+ = 10-12%; higher share of people 80+ = 12% or more

Source: EU Ageing Report 2018

Assessing country specific potential to establish or maintain social resilience in the future

Norway shows a lower old age dependency ratio (below 25 percent) in 2016 and will still have lower level ratio (between 50-60 percent) in comparison to the other countries in 2070 based on a medium level increase (114 percent). The development of the 80+ ratio also started with a lower rate (below 5 percent) but will then show a high-level increase (155 percent) up to a medium level ratio (between 10-12 percent) in 2070. There is no general need to reform the Norwegian LTC systems since it is already based on a high level of generosity, a very high expenditure level and a medium to high degree of coordination which make it resilient. Norway will need to moderately increase its public expenditure in LTC in times of future economic downtrend in order to cushion the additional cost associated with the medium to high increase in population ageing even though it started with comparably low-level old age ratios. But since the Norwegian welfare state has kept the relatively high level of generosity over a longer period and has adapted well to changes, it can be expected that the welfare state will also react adequately to this challenge.

[16] Old-age dependency ratio = Population aged 65 and over as a % of the population aged 15-64

The old age dependency ratio started with a higher level (above 30 percent) in Germany which will increase with lower intensity (73 percent) up to a medium ratio (between 50-60 percent) until 2070. The 80+ ratio initially showed a medium rate (between 5-6 percent) and keeps growing also on a medium level (125 percent) but still reaches a high-level ratio (above 12 percent) in 2070. Against the background of a high to medium level of generosity and expenditure and a highly coordinated LTC system, there is no need for any large-scale reforms since the system already shows a good degree of resilience. However, it is well known that LTC policies in Germany are somewhat under-financed and therefore problem with regard to the quality of care occur (Grages et al. 2021). Germany will need to significantly increase its public expenditure in LTC in order to absorb additional cost even though the increase in population ageing only shows low to medium level intensity since old age ratios were already on a medium to high level at the starting point. A decreasing economic growth rate will make increasing investments in LTC even more difficult.

In Spain, the old age dependency ratio showed a medium level (between 25-30 percent) at first and will then only grow on a lower level (62 percent) ending with lower-level ratio (below 50 percent). However, the 80+ ratio already started with a higher rate (above 6 percent) and will still shows a higher level (above 12 percent) in 2070, based on a medium level growth rate (110 percent). The Spanish LTC system has a high to medium to high level of generosity but only a medium to low expenditure level since organizational barriers in coordination weaken the implementation of social rights. This set up is only partially resilient and calls for further adjustment. Against this background, there is a need for significant increase in future public LTC expenditure in order to improve policy implementation and to absorb the additional cost associated with the medium to high increase in population ageing since it already started with comparably high-level old age ratios. However, increasing GDP growth rates might help to support this development.

Italy showed the highest old age dependency ratio (above 30 percent) in comparison to the other countries in 2016 and it will be still on a higher level (above 60 percent) in 2070 even though the ratio will only grow with a medium intensity (75percent). The development of the 80+ ratio also started with a higher ratio (above 6 percent) and will – based on a medium level of increase (118percent) – still be higher (above 12 percent) by the end of the projection. The resilience of the Italian LTC systems is already now undermined by a lack of generous LTC policy (especially regarding extra-familial LTC) and an expenditure level that is only medium to low. Moreover, geographical barriers in coordination make the availability of services dependent on local budgets and call for substantial reform. The Italian welfare states will need to strongly increase its public expenditure to expand LTC policy generosity, eliminate inefficiencies in service provision between northern and southern regions and contemporaneously compensate for additional costs associated with population ageing since the Italian population will also in 2070 be one of the oldest in Europe. However, the need to increase investment is promoted by continuous economic growth which is predicted for the next decades.

The United Kingdom shows a medium-level old age dependency ratio (between 25-30 percent) at the start, but a lower level of increase (70 percent) will lead to a lower level ratio (below 50 percent) in 2070. The development of the 80+ ratio started with a lower rate (below 5 percent) but then increases with medium intensity (123percent) up to a medium-level ration (between 10-12 percent). Against a medium level of generosity towards extra-familial LTC and a high to medium expenditure level in combination with a medium to high degree of coordination, there is limited need for reform to make the LTC system resilient. The UK will need to significantly increase its public expenditure in LTC in times of stable future economic growth in order to increase LTC policy generosity and cushion the additional cost associated with population ageing even though it started with comparably low-level old age ratios which only show lower to medium levels of increase.

The development of Estonia's old age dependency ratio started with a medium level (between 25-30percent), increases with a medium intensity (84 percent) and will be still on a medium level (between 50-60 percent) in 2070. The 80+ ratio also started on a medium level (between 5-6percent) but will show a very high level of increase (167 percent) leading to a higher ratio (above 12percent) by the end of the projection. The resilience of the Estonian LTC systems is already now very low since LTC policy generosity and expenditure level are both low. Moreover, geographical and organizational barriers in coordination call for substantial reform since they hinder the implementation of existing social rights and result in a lack of local availability of service infrastructure. Estonia will need to strongly increase its public expenditure in LTC to expand LTC policy generosity, improve the coordination of its LTC system and compensate for additional cost associated with population ageing based on medium to high levels of increase of old age ratios which were already on a medium level at the starting point. However, the need to strongly increase investment will be very difficult, given the prediction of a decreasing economic growth rate during the next decades.

The situation in Hungary is quite similar to the Estonian picture: The old age dependency ratio also showed a medium level (between 25-30 percent) at the beginning and will increase with a medium intensity (89 percent) leading to a ratio that will be still on a medium level (between 50-60 percent) in 2070. The development of the 80+ ratio started on a lower level (below 5 percent) but will then show the high level of increase (186 percent) of all study countries successively leading to a higher ratio (above 12percent). The resilience of the Hungarian LTC systems is also currently low since LTC policy generosity is only low to medium and expenditure level is persistently very low. Moreover, there is an urgent need for encompassing reforms of the LTC system since existing social rights are not implemented properly and service infrastructure is insufficient because of geographical and organizational barriers in coordination. Even though GDP growth rates will decrease in future, Hungary will need to strongly increase its public investment in LTC in order to make its LTC system more resilient based on higher levels of generosity and coordination and compensate for additional cost associated with population ageing that started on a medium to low level but will increase massively until 2070.

6. Discussion and conclusion

The aim of this report was to examine LTC policies for persons of age and persons with disabilities in a historical and cross-country comparative perspective. The main focus was on the institutional regulation of LTC. We addressed the following research questions:

- How do European welfare states differ in their institutional constellations of LTC policy?
- How far was the historical development of European LTC policies path dependent?

The analysis has identified existing institutional constellations in LTC and explored how the institutional framework of LTC has developed during the last decades.

A new typology and analysis of institutional constellations of LTC policies

For the comparative analysis, the report introduced a new typology of welfare state policies towards LTC for persons with disabilities and older people with care needs. The analysis is a further development of Eggers, Grages, Pfau-Effinger and Och (2020) and conceptualizes the institutional basis of LTC policies as an institutional constellation in which institutional regulations that are framing different dimensions of LTC policies interact on the basis of relative autonomy and in a coherent or incoherent way. For the comparative study a theoretical typology was constructed that is based on the interplay between LTC policy for extra-familial care and for familial care with regard to the generosity level of each of them. We distinguish four different types of institutional constellations of LTC policies

on the basis to their generosity level, which we classify as "higher" or "lower": (1) the "Overall Generous Type", (2) the "Extra-Familial Support Type", (3) the "Family Support Type" and (4) the "Minimum Support Type". We argue that the position of welfare states in this typology reflects how far LTC policies may be associated with poverty risks, opportunities to exercise active citizenship and potential for gender equality.

Welfare states of the "Overall Generous Type" (Norway, Germany, and under reserve Spain) are characterized by a comprehensive security against poverty risk for all types of LTC. Opportunities for exercising active citizenship on the basis of choice are available which allows for the consideration of cultural diversity regarding LTC preferences and puts emphasis on gender equity since working and caring women can be – at least to a certain degree – financially autonomous. Welfare states of the "Extra-Familial Support Type" (United Kingdom) generally offer security against poverty risk to a lesser degree and do not compensate family care adequately. The opportunities for exercising active citizenship are also more limited. The policy aim is to turn away from traditional familial care provision and such a constellation is based on a focus on productivist gender equality since only working women can be financially autonomous. Welfare states of the "Family Support Type" (Italy) only provide limited security against poverty risk since support is only provided if familial care provision is possible. Such a policy constellation does not provide much opportunities for exercising active citizenship and aims to maintain traditional familial care provision. Against this background, there is a focus on gender specific recognition caring roles since caring women can achieve a certain degree of financial autonomy but stay trapped in the domestic sphere. Finally, welfare states of the "Minimum Support Type" (Estonia and Hungary) show no or very limited security against poverty risk since welfare states take no specific responsibility for LTC and only provide minimal support. Such a constellation provides no opportunities for exercising active citizenship. It is expected that mainly family members provide unpaid care and traditional gendered division of work and financial dependence on male breadwinner for women are still dominant.

However, the analysis also revealed that geographical and organizational barriers in coordination can lead to insufficient policy implementation and a lack of LTC infrastructure which may lead to unmet care needs. Such barriers in coordination are especially present in East European welfare states, but also to a smaller degree in Mediterranean welfare states. Actual structures and gaps regarding LTC provision will be evaluated on the basis of the comparative analysis in the next report of WP 7 (D 7.2).

Main trends in the development of LTC policies in Europe

The report also discussed some main trends in the development of LTC policies in Europe. Since the early 1990s, European welfare states have increasingly started to take responsibility for the LTC provision by introducing social rights and extending infrastructure for publicly funded care provision outside of the family, after demographic ageing and increasing female labour market participation put the traditional organization of LTC under pressure. We analysed four main policy trends which were connected with this development and have also affected the provision with LTC. These include the trend to marketization, the strengthening of "consumer choice", which can under certain conditions strengthen people's options to exercise active citizenship; de-institutionalization and reablement.

There was a general trend to marketization with regard to privatize care homes and care services in all countries of the study. The extent of marketization differs largely between the countries. In the social democratic welfare state of Norway, political support for this trend was relatively low, as well as the role of for-profit providers, which was also contested and reversed. In Hungary, only non-profit but no for-profit providers are allowed to enter the publicly financed care market, but there is a relevant grey care market with informally employed care workers. In Germany, Italy, Spain and Estonia, policies have

substantially promoted the marketization of LTC, and a relevant part of the care services are organized on a for-profit basis. In England nearly the whole care provision is based on for-profit providers. The comparative analysis show that the trend to marketization, mainly as a trend to the for-profit provision of care, is connected with high problems of the care quality and of the quality of jobs in the LTC sector.

Moreover, welfare states may offer a wide range of different services and benefits in order to promote the self-determination of persons with care needs without necessarily putting a strong emphasis on marketization. We found this trend in the social democratic Norwegian and to some extent in the German welfare state. However, such policies can otherwise also be connected with the construction of persons in need of care as "consumers" who choose their care services on care markets on the basis of public funding, which is connected with particular social risks. We found this concept to some extent in Germany and Spain as well, and to larger degree in the UK. Since the demand of LTC policies with regard to transparency, quality and performance of care providers is often low, it is difficult for care recipients to exercise their choice effectively. In Italy, the choice between providers on the basis of an unregulated cash benefit is often used to hire migrants as cheap care workers instead of professional staff of care services and thus leads to a problematic sector of low wage work. In Hungary and Estonia, admission to LTC is in principle difficult because of lacking and fragmented LTC infrastructure.

De-institutionalisation is another trend in LTC policy development. The term refers to institutionally guaranteed social rights to community-based settings of LTC provision. We found this trend in all welfare states of the study. With this kind of policy, welfare states originally reacted to the demand to strengthen self-determination and dignity of life of persons with disabilities of the independent living movement. The de-institutionalisation strategy can be a policy strategy to strengthen the autonomy of people in need of care. This was a central element of the policies in Norway, Germany and England. It can also be used as a retrenchment strategy of welfare states. We found this strategy in Spain, Italy, Estonia and Hungary. In general, measures to ensure de-institutionalisation - as the core of the change brought about by the CRPD - did not yet sufficiently enable persons with disabilities and care needs to live autonomously and independently throughout Europe (EU 2017).

Finally, reablement policies can strengthen the physical and personal autonomy of people in need of care and support them in their options to exercise active citizenship. They often mainly target people in working age to help them maintain or regain their employability due to disabilities and severe illnesses or longer hospital stays. However, many countries also started to introduce rehabilitation services for older persons in need of care. All studied welfare states have established to some extent rehabilitation and (re-)integration measures for working-age persons with disabilities, with substantial variations in the extent and instruments they applied; it was mainly relevant in Norway and the UK (see also Bickenbach 2020).

The question of institutional path dependency

The comparative analysis revealed the following connection between the different types and the institutional constellations of LTC in the countries included in the study, which represent different types of welfare regimes according to Esping-Andersen (1990) and the further development of the classification (see Eggers et al. 2019). We found that LTC policies in the Norwegian welfare state, a social democratic type of welfare regime, has a high level of path dependency in its development, on the basis of an "Overall Generous Type" of LTC policy and a strong role of the welfare state for the provision of care. LTC policies are also connected with a high level of citizen's autonomy and active citizenship. For Germany, we found a path departure from a conservative type of LTC policy that traditionally strongly relied on the family and women as unpaid and informal providers of LTC towards a relatively generous LTC policy regarding extra-familial care as well as paid family care, with a medium

level of marketization causing moderate problems of care quality. In Spain we found a similar type of path departure, which is particularly noteworthy, since Spain is often still ranked as a residual, Mediterranean type of welfare regime. However, the position of Spain should be treated as an open question, since it seems that these policies are not well implemented, so that the actual care structures may fare less well in the extent to which they cover older and disabled people's care need. This was also a consequence of the financial crisis at the end of the 2000s.

On the contrary, Italy which is also considered a Mediterranean type of welfare regime, shows a relatively high path dependence on the basis of a high support for familial LTC policy ("Family Support Type"). On the basis of an unregulated cash-for-care system with relatively low pay for the care, policies indirectly support and maintain a broad sector of low-paid migrant care workers that increasingly substitutes family care.

LTC policies have also a relatively high path dependence in the liberal type of welfare regime in the UK. Mainly people with low-income are eligible for public finances for LTC, which they then have to buy on a care market that is to a large extent based on extra-familial for-profit providers. Budget cuts and low care quality are typical and remaining problems in this welfare state that is based on the "Extra-familial Support Type". Also the development of LTC policies in Estonia and Hungary is path dependent, on the basis of a very residual post-socialist welfare regime which strongly mirrors the characteristics of the "Minimum Support Type". In both countries, LTC is not a social policy system of its own. The Estonian welfare state does not give the state much responsibility for the provision of LTC as a public task. Instead, this remains a familial obligation. Also, the Hungarian welfare state mainly relies on family care, but it offers some financial support for family care and extra-familial care, which is however not well implemented and suffers from infrastructural shortcomings.

The social resilience of LTC policies

In a last step, we assessed the policies in terms of their social resilience in the context of current and future demographic and epidemiological trends in Europe. With regard to the sustainability of LTC policies, the European Commission has formulated this at an ambitious target at EU level. The member states should financially support the development of accessible, affordable and high quality community-based LTC services across Europe. We would add that this should include financial support for caring family members that offers them the opportunity of financially autonomy and care leaves programs that offer them the continuous integration into gainful employment.

We evaluated the country specific policy design with regard to its potential to cushion evolving trends in terms of regarding population ageing, increasing levels of disability and multi-morbidity and to support familial and extra-familial LTC generously. We came to the conclusion that mainly LTC policies in Norway, which we have classified as "Overall Generous Type" on the basis of a relatively high level of generosity of LTC to extra-familial care as well as to familial care, can be characterized as resilient in relation to future trends. The other two welfare states which are also classified on the basis of this type still have some shortcomings, which is mainly the lack of expenditure and limitations in the care quality in Germany, and the lack of an adequate overall implementation of the LTC in Spain. All other countries have even more deficits in their LTC policies and do not meet with the demand for a sustainable LTC policy.

However, it will be a challenging task for all of the European societies to adapt to increasing care needs and associated financial pressure in order to improve or maintain LTC policy that offers generous support for extra-familial and familial LTC and thus create LTC systems that will be sustainable and resilient in future.

Acknowledgement

We would like to thank the Jerome Bickenbach and Déborah Knecht who supported our work on this report as participants of WP 7 with very helpful comments and materials. We would also like to thank the national teams led by Matteo Jessoula, Jacqueline O'Reilly, Toth Istvan Gyorgy, Marge Unt, Margarita León, and Rune Halvorsen for their tremendous work on the country reports on national social protection systems which provided a main source for this report. We would furthermore like to thank Rune Halvorsen and his team at OsloMet for scientific coordination of the EUROSHIP Project.

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Appendix

Appendix 1

Measurement of generosity regarding extra-familial LTC policy

The measurement of the degree of generosity regarding access to support for extra-familial LTC considers the strictness of two relevant modes of restrictions towards access (needs-testing and means-testing) as sub-indicators and is based on an ordinal scale that differentiates three levels of generosity:

- High = Access towards support for extra-familial LTC is neither based on a strict means-test nor on a strict needs-test
- Medium = Access towards support for extra-familial LTC is either based on a strict means-test or on a strict needs-test;
- Low = Access towards support for extra-familial LTC is based on a strict means-test and a strict needs-test.

A means-test is considered strict if access to publicly financed extra-familial LTC is only possible if persons have low income (below national median household income) and assets. It is considered not strict if there is no means-test or access to publicly financed extra-familial LTC is possible if persons have higher income (more than national median household income) and assets are not taken into account or only to a limited degree, e.g. houses are not considered.
A needs-test is considered strict if access to publicly financed extra-familial LTC is only possible on the basis of full-time or severe care need and/or there is no gradation of different levels of care need. It is considered not strict if there is no needs-test or access to publicly financed extra-familial LTC is possible without full-time or severe care need and or there is gradation of different levels of care need.
The measurement of the degree of generosity regarding the extent of support for extra-familial LTC is based on an ordinal scale that differentiates three levels of generosity and considers the average amount of co-payment for comprehensive care. In order to create a universal yardstick for a measurement that allows for systematic comparison we conceptualize "comprehensive care" based on OECD System of Health Accounts (2017) indicators HC.3 and HC.R.1 that define three main components of care provision: a) medical or nursing care, b) personal care services, which provide help with activities of daily living (ADL), and c) assistance services related to help with instrumental activities of daily living (IADL). Cost for accommodation in nursing homes are not considered as part of care provision in the narrow sense.[17] We weight each of the three types of care equally.[18] If, in addition to benefits in-kind, cash benefits for extra-familial care services are also available, these are included when calculating the generosity of co-payments. It differentiates

- High = 67 to 100 percent of the share of the costs for extra-familial LTC are covered by the welfare state on average
- Medium = 34 to 66 percent of the share of the costs for extra-familial LTC are covered by the welfare state on average
- Low = 0 to 33 percent of the share of the costs for extra-familial LTC are covered by the welfare state on average

[17] In this context, we refer to the original version of SHA which states that cost for accommodation in *"institutions providing social services, where health care is an important but not predominant component should not be included in the health function. Examples might include institutions such as homes for disabled persons, nursing homes, and residential care for substance abuse patients"* (OECD 2000: 113).

[18] This means for instance, that if medical care is completely free of charge and co-payment only refers to the other two components of comprehensive care then the generosity of the extent of support for extra-familial LTC is considered at least medium.

Appendix 2

Measurement of generosity regarding familial LTC policy

The measurement of the degree of generosity regarding access to support for familial LTC considers the strictness of three relevant modes of restrictions towards access (needs-testing, means-testing and restriction of eligibility regarding specifications of the familial care-giver) as sub-indicators and is based on an ordinal scale that differentiates three levels of generosity:

- High = Access towards support for familial LTC is neither based on a strict means-test, a strict needs-test nor a strict restriction of eligibility regarding specifications of familial care-giver;
- Medium: Access towards support for familial LTC is either based on a strict means-test, a strict needs-test or a strict restriction of eligibility regarding specifications of familial care-giver
- Low = Access towards support for familial LTC is based on at least two of the aforementioned limitations of access classified as strict.

The classification of strictness for means-test and needs-test is the same as for access towards extra-familial LTC (see above). Restriction of eligibility regarding specifications of familial care-giver is considered strict if access to publicly financed familial LTC is restricted by one or more specifications for familial care-giver. It is defined as not strict if access to publicly financed familial LTC is not restricted by any specifications for the familial care-giver. Potential specifications for familial care-givers refer to dependency of access to paid familial care on 1) place of residence of familial care-giver, 2) type of kinship relationship and 3) income of familial care-giver or (4) working situation of familial care-giver.

The measurement of the degree of generosity regarding the extent of support for familial LTC is based on an ordinal scale that differentiates three levels of generosity. Different measures are considered for the measurement of cash benefits or care allowances on one hand and compensated care leaves on the other.

With regard to support in the form of cash benefits or care allowances the estimated difference between public financial support and the country specific average net pay for full-time professional care with basic qualification and pension contribution are considered. Data for average pay for full-time professional care with basic qualification (net wage for 160h/month) based on Bettio and Verashchagina (2012). Calculations for net pay based on data on country specific share of taxes and social security contributions in total labor costs for average earners (OECD 2019).

- High = Public financial support equals between 67 and 100 percent of the country specific average net pay for full-time professional care with basic qualification and comprehensive pension contribution
- Medium = Public financial support equals either between 67 and 100 percent of the country specific average net pay for full-time professional care with basic qualification without comprehensive pension contribution or between 34 and 66 percent of the country specific average net pay for full-time professional care with basic qualification plus comprehensive pension contribution
- Low = Public financial support either equals between 34 and 66 percent of the country specific average net pay for full-time professional care with basic qualification without comprehensive pension contribution or between 0 and 33 percent of the country specific average net pay for full-time professional care with basic qualification plus comprehensive pension contribution.

With regard to support in the form compensated care leave the amount of wage replacement and pension contributions are considered. Leave schemes that do neither include pay nor comprehensive pension contribution and leave scheme that are shorter than one month are excluded. The threshold for high generosity is based on the definition for "well-paid" leave of the "International Network on Leave Policies & Research" (Koslowski et al. 2020).

- High = Wage replacement between 67 and 100 percent of former wage and comprehensive pension contribution
- Medium = Wage replacement between 34 and 66 percent of former wage and comprehensive pension contribution included;
- Mow = Wage replacement between 0 and 33 percent of the former wage and comprehensive pension.

Appendix 3

Evaluation of the relation between LTC policies and hypothetical consequences

Finally, we analyse how familial and extra-familial LTC policies relate to each other in terms of their generosity levels, and we ordinally rank the LTC policies regarding their average generosity level based on the mean values of generosity for each of the two policy instruments regarding extra-familial and familial LTC. Hence, the overall level of generosity of extra-familial LTC policy is based on the mean value of the average generosity on home care and residential care. The overall level of generosity of the familial LTC policy is based on the mean value of the average generosity on cash benefit/care allowance and compensated care leaves.

Against the background of the country specific combinations of LTC policies, we then discuss the hypothetical consequences of different types of LTC policy regarding poverty risks, unmet needs, choice and gender equality.

The evaluation of the hypothetical risk of poverty is mainly based on the level of generosity of extra-familial LTC policy since it cannot be assumed that all persons in need of care have relatives that are able or willing to provide care. Against this background, the prevention of poverty risks is mainly based on generous public support for extra-familial LTC that ensures comprehensive access to the majority of persons in need of care without high co-payments or the need to sell their assets. However, the level of public support for familial LTC is also considered since a high level of support might at least help to cushion risks of poverty to a certain degree in the absence of generous extra-familial LTC policy. Against this background, the measurement of the degree of poverty risks is based on an ordinal scale that differentiates three levels:

- High = If the LTC policy is based on public support for extra-familial LTC that is ranked below medium and there is no compensating high-level public support for familial LTC
- Medium = If the LTC policy is either based on higher than medium public support for extra-familial LTC or if a below medium-level public support of extra-familial LTC is compensated by a support for familial LTC that is ranked higher than medium
- Low: If LTC policy is based on high-level public support for extra-familial LTC

Social rights do not automatically translate into corresponding LTC provision because coverage is sometimes inadequate since access to care services is dependent on budgetary resources or availability of services varies between regions. Against this background, the evaluation of the hypothetical risks of unmet needs is based on the one hand on geographical barriers in coordination

like local differences in the availability of care infrastructure and on the other hand on organizational barriers in coordination that limit policy implementation (Riedel & Kraus 2011). Such barriers might lead to unmet needs despite the factual presence of social rights. Based on this assumption, we differentiate the following three degrees of risks of unmet need:

- High = If both geographical and organizational barriers occur.
- Medium = If either geographical or organizational barriers occur.
- Low: If neither geographical nor organizational barriers occur.

The degree of opportunities for exercising active citizenship for persons with disabilities and older people with care needs with regard to their preferred LTC provision is based on the availability of the generous support for different LTC options. There are two main options that can be differentiated and that depend on the policy's generosity: The option to decide between extra-familial care provision at home or in a nursing home, and the option to decide between familial and extra-familial care provision. In order to create an actually feasible option, public support for the respective type of LTC must be at least ranked higher than medium to prevent that selecting such an option would be automatically linked to a risk of poverty. With that in mind, the following three levels of opportunities for exercising active citizenship can be distinguished:

- High = If there is an option to decide between familial and extra-familial care and between home and residential care.
- Medium = If there is either an option to decide between familial and extra-familial care or between home and residential care
- Low = If there is neither an option to decide between familial and extra-familial care nor between home and residential care.

The measurement of the potential of LTC policies to promote gender equality is mainly based on the assumption that different combinations of LTC policies are associated with different possibilities for the traditionally mostly female family care-givers to achieve financial autonomy: While generous extra-familial LTC policies do so by minimizing care obligations and thereby allowing women to participate in gainful employment, generous familial LTC policies offer financial support for familial care work. A combination of both would be most fruitful since both working and care-giving women could be financially autonomous. However, a policy must be at least ranked higher than medium in order to actually ensure the possibility of achieving – a certain degree of - financial autonomy. Against this background, we differentiate three degrees of gender equality:

- High = If there is a possibility of achieving financial autonomy on the basis of familial care and on the basis of gainful employment due to a liberation from care obligation
- Medium = If there is a possibility of achieving financial autonomy either on the basis of familial care or on the basis of gainful employment due to a liberation from care obligation
- Low = If there is neither a possibility of achieving financial autonomy on the basis of familial care nor on the basis of gainful employment due to a liberation from care obligation