



closing gaps in European social citizenship

Gaps in the provision of long-term care across Europe

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Abstract

Since the early 1990s, European welfare states have increasingly started to take responsibility for the provision of long-term-care (LTC) for older persons with care needs by introducing or extending different forms of welfare state support. However, LTC is still associated with gaps in social security and the risk of unmet care need in many welfare states. This report identifies main gaps in the structures of LTC provision and examines how differences in policy design are connected with care gaps based on a new typology of LTC policies that considers the relationship between the generosity of policies supporting extra-familial and paid familial care. It also analyses the link between cultural and structural factors and cross-national differences in the extent and type of care gaps. Furthermore, the report discusses in how far care gaps affect the risk of poverty and unmet needs for persons with LTC needs based on age, income and gender.

The comparative study draws on a new multi-dimensional approach to the measurement of LTC policy generosity. It includes seven European welfare states of different welfare state traditions: Norway, Germany, Spain, Italy, the United Kingdom, Estonia and Hungary. The empirical analysis is based on legal documents of care policies, data from comparative European policy databases, quantitative data from EU-SILC, EVS and Special Eurobarometer 283 as well as national statistics.

The findings show that cross-national differences in the extent and type of care gaps are mainly based on differences in institutional constellations of LTC policies. Generosity of access and extent of support need to be analyzed separately and the evaluation of LTC policy needs to be based on support measures for familial and extra-familial LTC in order to identify care gaps sufficiently. The findings also show that cross-national differences in cultural ideas regarding the “adequate” form of LTC as well as structural factors, such as the degree of policy implementation or the availability and quality of extra-familial LTC, can play an important role in the explanation of international differences. Moreover, the results of the investigation show that women and older people (85+), as well as people with a low income are exposed to particularly high social risks in countries with less generous care policies. In this regard, attributes that are associated with higher care needs can accumulate in the sense of intersectionality for specific social groups.

1. Introduction

This report analyses current gaps in the provision of public support for long-term care (LTC) in order to examine their consequences for social risks for different groups of persons with LTC needs.

In industrial societies, LTC for persons with disabilities and older people was typically organized as unpaid work provided by women in the private family household. However, 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 (León 2014; Ranci & Pavolini 2013), after demographic ageing and increasing female labour market participation put the traditional organization of LTC under pressure. As a consequence, the share of older and disabled persons' who receive extra-familial care increased significantly. However, family care remains a relevant factor in care provision in many European countries, despite the extension of extra-familial care services (Spasova et al. 2018). Meanwhile, most welfare states support family members of older people in need of care, on the basis of pay and social security rights for the family caregivers (Ungerson & Yeandle 2007; Frericks et al 2014; Eggers et al. 2020). Nevertheless, LTC in many welfare states is still associated with gaps in social security and the risk of unmet care need (Ranci & Pavolini 2015; Kröger 2022). Older persons are particularly affected by insufficient public support for LTC and resulting care gaps, since the risk of care needs increases with age (Koller et al. 2014) and the prevalence of care needs is 2,7 times higher for persons 65 years and older in comparison to persons below the age of 65 in Europe (Eurostat 2018). Against this background, we mainly address care gaps for older people (65+) in this report¹. The report aims to answer the following research questions:

- How does the extent and the type of gaps in the provision of long-term care ("care gap") for older people differ between European welfare states?
- How far are cross-national differences in gaps in the provision of long-term care for older people connected with different types of LTC policies as well as cultural and structural factors?
- Which social groups of older persons are particularly affected by social risks that result from gaps in the provision of LTC, and how is this related to the respective LTC policy?

The report identifies main gaps in the structures of LTC provision and introduces a new typology of welfare state policies towards LTC for persons with care needs based on the relationship between the generosity of policies supporting extra-familial care and policies supporting paid familial care in order to examine how differences in policy design are connected with care gaps (Eggers et al. 2020; Grages et al. 2021). The report also analyses the link between cultural and structural factors and cross-national differences in extent and type of care gaps. We define "culture" as a system of collective ideas related to the idea of a good society and morally good behavior. Cultural ideas comprise cultural values and models and belief systems. Cultural ideas can be coherent or contradictory, contested between social groups and actors, and they are changeable (Pfau-Effinger 2005).

Furthermore, the report discusses how far care gaps affect the risk of poverty and unmet needs for persons with LTC needs. Finally, it will explore the extent to which care gaps differ between social groups based on age, income and gender.

In its broadest sense, "care" can be defined as support for people to manage their everyday life who have some restrictions in this regard (Anttonen & Sipilä 1996). With regard to the concept of LTC, we refer to the WHO definition, which defines LTC as: *"The system of activities undertaken by informal*

¹ The focus on older persons with care needs is also results from data availability and differences in specific policy measures regarding care provision for different age groups.

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 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). In accordance with the OECD *"System of Health Accounts"* an encompassing LTC provision consists of different dimensions of LTC such as medical, personal and assistance care (OECD 2017). Based on this definition we define a "care gap" as a full or partial lack of provision of different forms of LTC for people with care needs. Against this background, we follow a multilevel approach that differentiates between care gaps at different societal levels.

Our main assumption in this report is that cross-national differences in the extent and type of care gaps are mainly due to differences in institutional constellations of LTC policies. We argue that cross-national differences in cultural ideas regarding the "adequate" form of LTC as well as structural factors, such as the degree of policy implementation or the availability and quality of extra-familial LTC, can also play an important role in the explanation of international differences. The report furthermore argues that different types of gaps are associated with different social risks and that they affect different social groups to different degrees.

With regard to its methodological basis, the report draws on a new multi-dimensional approach to measure the generosity of LTC policy that we developed in an earlier stage of the EU-project EUROSHIP (Grages et al. 2021). Grages et al. (2021) also offers a new approach to the measurement of cultural ideas and structural factors and their role in the explanation of differences, using data from international surveys and secondary literature.

The comparative study includes Norway, Germany, Spain, Italy, the United Kingdom, Estonia and Hungary. These seven European welfare states represent different regions of Europe and different types of welfare state traditions (Esping-Andersen 1999; Ranci & Pavolini 2013). The empirical analysis of institutional constellation of LTC policies is based on the analysis of legal documents of care policies, standardized EUROSHIP country reports on national social protection systems and data from comparative European policy databases, such as MISSOC and EUROCARERS. Furthermore, quantitative data from European Union Statistics on Income and Living Conditions (EU-SILC), European Value Study (EVS) and the Special Eurobarometer 283 on Health and Long-term Care in the EU as well as national statistics are considered.

In the second section, we discuss the state of the art of the literature on gaps in LTC provision. Section three introduces the analytical approach for the study. It is followed by a fourth section on the methodological framework. On this basis, in section five, we present the findings of the comparative study of gaps in care provision and factors that help to explain cross-national differences. Moreover, consequences regarding social risk for different social groups are discussed. The article ends with a conclusion.

2. State of the art

Development of LTC provision in European welfare states

In industrial societies, LTC for older persons with care needs was mainly seen as a responsibility of the family. It was provided mainly by women in the realms of the private household on an unpaid, informal basis (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 an

associated increase in the share of older people experiencing care needs (WHO 2015), together with the increase in female labour market participation in many countries that decreased the number of potential caregivers, led to growing gaps in care provision and facilitated the risks of unmet needs (Colombo et al. 2011; EU 2021; Pavolini & Theobald 2015; Pfau-Effinger 2012; Taylor-Gooby 2004). Against this background, social policy researchers concluded that the need for LTC is one of the main “new” social risks that mature welfare states have to protect their citizens against based on their social security system (Bonoli 2005).

Therefore, since the 1990s many European welfare states have restructured their LTC policies for older people by strengthening social rights to receive publicly provided and funded care and extending the care infrastructure (Anttonen & Sipilä 2005; Bureau et al. 2007; Gori et al. 2016; Ranci & Pavolini 2013). In this process, care work was increasingly outsourced from the family to professional service providers (Anttonen & Sipilä 2005; Carrera et al. 2013; Lyon & Glucksmann 2008). The extension of home care services and the “deinstitutionalization” of the care provision from the more cost-intensive nursing homes to “aging in place” and community living in old age was a central element of this process (Bureau et al. 2007; Mansell et al. 2007; Deusdad et al. 2016a; Halvorsen et al. 2017). With this development, the number of older persons receiving publicly provided or supported LTC increased in European welfare states.

Despite the extension of extra-familial care services, family care in many European countries remains a relevant factor in care provision (Spasova et al. 2018). Several factors are discussed that may explain this trend, which include a gap in public extra-familial LTC provision and the persistence of the cultural idea according to which family care is the “best” type of care (Eichler & Pfau-Effinger 2009). Also, the financial crisis of 2008 led many European countries, particularly the Mediterranean welfare states, to retrenchment policies, which hindered the extension of older persons’ social rights to extra-familial LTC so that family care in these countries is for some groups the only affordable solution (Deusdad et al. 2016a; Ranci & Pavolini 2015). In order to offer some financial compensation to family caregivers, most welfare states have meanwhile introduced pay and social security rights for care-giving family members (Ungerson & Yeandle 2007; Da Roit & Le Bihan 2010; Grootegeed et al. 2010; Pfau-Effinger et al. 2011; Frericks et al. 2014; Eggers et al. 2020).

Cross-national differences in LTC provision in European welfare states

There are significant cross-national differences in the generosity of social rights towards support for familial and extra-familial LTC that concern the access to and/or extent of support. Accordingly, the share of older people with care needs who are excluded completely or partly from public support differs substantially between welfare states. Comparative research shows that the generosity of social rights toward public support for LTC is lowest in post-socialist welfare states, and also shows considerable shortcomings in liberal and Mediterranean welfare states, whereas conservative and especially social-democratic welfare states provide higher levels of support (Eggers et al. 2020, Gori et al. 2016; Grages et al. 2021; Greve 2017; Léon 2014; Ranci & Pavolini 2015).

Conceptual issues with regard to analyzing gaps in LTC provision

Different approaches to measure gaps in LTC provision evolved in the research literature that all refer to the imbalance between needs and adequate LTC coverage in one or the other way. Based on differences in definitions and the type of measurement, cross-national studies are rare and show large variations in their results (for an overview see Kalánková et al. 2021 and Kröger 2022).

The first problem that arises when measuring gaps in LTC provision refers to the distinction of the group of persons with care need and the measurement of care needs (García-Gómez et al. 2015; LaFerrere & Van Den Bosch 2015). At the theoretical level, it is important to distinguish between objectively existent care need and the subjective perception of a person regarding his/her care need. In order to measure the objective care need, it would be adequate to use a uniform and standardized socio-medical indicator, like for instance the ADL and IADL scales (Lagergren et al. 2014; Vlachantoni et al. 2011). Instead, most studies focus on self-reported care needs (Albuquerque 2020; Privalko et al. 2016). This is problematic, since data based on self-reporting can in general be biased on the basis of the subjectivity of perceptions which might be influenced by structural or cultural factors (Rogerio-García & Ahmed-Mohamed 2014). However, research that evaluated how far older persons tend to be biased in the case of self-reported care needs shows that they do not tend to overestimate their care needs (Brimblecombe et al. 2017).

A second issue concerns the differentiation between the gerontological concept of unmet care needs e.g. the absence of any kind of support by a third party on the one hand (Williams et al. 1997; Allin et al. 2010) and the concept of policy generosity or coverage on the other hand (Eggers et al. 2020; Ranci et al. 2021). While the problem of low degrees of public support for older persons with care needs is at the heart of social policy research, this issue might not be problematic from a gerontological perspective, since low policy support does not necessarily correlate with unmet needs. For instance, it may be possible for people with care needs to rely on traditional structures of informal familial LTC provision or to finance LTC provision out-of-pocket. Only in the case that such private resources are not available, insufficiency of policy support tends to translate into unmet needs. Specific disadvantaged and vulnerable social groups are on this basis disproportionately exposed to the risk of unmet needs in LTC systems that do not offer generous public support (Privalko et al. 2016).

A third conceptual issue refers to the degree of support persons with care needs receive regardless of the question whether this is public or private support. Kröger (2022) distinguishes in his concept of “care poverty” between absolute care poverty, referring to a complete absence of support (Vlachantoni 2019) and relative care poverty, referring to insufficient levels of support (García-Gómez et al. 2015). A measurement that only considers absolute care poverty can lead to a significant underestimation of the extent of unmet needs because receiving just any kind of support does not guarantee that older persons with care needs receive sufficient care provision (Kröger 2022).

Explaining cross-national differences in gaps in LTC provision

Studies on unmet care needs mostly focus on individual factors at the micro level, whereas macro factors are only included in the form of socio-economic background variables, if any. Kröger (2022) points out that the societal context of LTC policy is rarely considered when the relationship between policy designs and the insufficient coverage of care needs is analyzed. Studies based on case studies that include the design of LTC policy mainly focus on support for extra-familial LTC (Privalko et al. 2016). Little research considers the role of LTC policy towards family care - including the role of new forms of paid family care – when analyzing unmet needs or gaps in LTC provision. We argue that to include this would be important, since parts of the population prefer (and choose) familial care, which may have cultural reasons or it can be a reaction to an insufficient support, availability or lack of good quality extra-familial care (Eichler & Pfau-Effinger 2009). It also follows from this, that besides policy generosity, its implementation as well as cultural values regarding ideal forms of care provision and the perception of care quality need to be taken into account when investigating cross-national differences in care gaps.

3. Theoretical framework

3.1. Care gaps – Multilevel approach

Concept of care gap

We introduce a new multi-level approach to theorizing and analysis of care gaps. We define a “care gap” as a full or partial lack of publicly supported provision of different forms of LTC for people with care needs. By this we combine the gerontological and the social policy perspective on gaps in care provision. We distinguish a care gap in institutional basis of LTC policies, a care gap in the structures of LTC, and a care gap at the individual level. For each level, we are not only interested in the question *if* care needs are met, but also *how* and *to which degree* they are met.

a) Gaps in the institutional basis of policy support for LTC

We refer here mainly to care gaps that exist at the level of the institutional constellations on which LTC policies are based (Grages et al. 2021). The focus is mainly on institutional restrictions with regard to access and to the extent of support for various forms of care (e.g. familial and extra-familial care). Care gaps in access to support at the institutional level result in a situation in which public financial support for long-term care is only provided for a certain group of people in need of care and a significant part of the population in need of care is denied access. Care gaps in the extent of support with LTC at the institutional level result in a situation in which 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 or provided without pay by family members in order to prevent unmet needs (see also Grages et al. 2021).

b) Gaps in the structures of LTC

Gaps in the structures of LTC exist if there is an imbalance between the demand for care and the actual coverage of the demand by the welfare state, e.g. between the amount of people who articulate a need for care and those who receive publicly (co-) funded care. Two things should be noted here: 1) The gap can be based on non-take-up, which means that persons with care needs who are eligible for public support do not make use of it for several reasons. This could be due to missing knowledge about eligibility for support in the first place or due to insufficient or lacking support for specific forms of LTC (like familial care), which are nevertheless preferred by the population, based on cultural ideas (Eichler & Pfau-Effinger 2009). 2) It should be noted that even in the case of coverage the extent of support can differ. Despite full coverage (everyone who articulates needs also receives some kind of support), a gap may remain which stays uncovered or which has to be bridged either based on private payments or on the basis of unpaid familial care work, which may create social risks like poverty. Drawing on Kröger (2022), we distinguish between *absolute* care gaps referring to a complete absence of public support and *relative* care gaps referring to insufficient levels of public support.

c) Care gaps at the individual level

A care gap at the individual level is based on the lack of coverage of the individual’s articulated need for care. In this case, people in need of care may receive support from the state (possibly also comprehensive support), but the kind of support is not matching the individual priorities regarding care provision, for instance with regard to the form of care (e.g. familial or extra-familial care provision) or the type of care (e.g. medical care, personal care or domestic help and social support). Such gaps are closely connected to people’s options to exercise active citizenship and ensure self-determination (see also Eggers et al. 2019).²

² This kind of care gaps will be analyzed in more detail in Deliverable 7.3. of the EU-Project EUROSHIP.

3.2. Theorizing and typology of institutional constellations of LTC policies

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 (Eggers et al. 2020; Grages et al. 2021). The relationship of extra-familial and familial LTC policies has been broadly discussed in comparative literature on LTC policy and it has often been argued that welfare states tend to treat both types of care policy as opposites, e.g. they prefer to generously support either extra-familial care or care delivered by family members instead of extra-familial care.

The report 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 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. We analyze the generosity of institutional constellations of LTC policies regarding access and extent of support for two main policies separately. These include: a) policies towards extra-familial care, and the extent to which they support people in need of care with publicly funded extra-familial care in their own home or in nursing homes and b) policies towards care work by family members with regard to the extent to which they offer benefits and allowances or compensated leave schemes. The theoretical typology allows for cross-national comparative analyses regarding the ways in which institutional constellations of LTC policies at the level of the central state combine both types of policies on the basis of their generosity. The ideal-typical typology therefore provides an adequate and innovative scientific basis to identify and evaluate care gaps and to analyze how they vary in a comparative cross-national perspective.

Table 1: Typology of institutional constellations of LTC policies (ideal types)

Generosity of familial LTC policy	Generosity of extra-familial LTC policy	
	High	Low
High	Overall Generous Support Type	Family Support Type
Low	Extra-Familial Support Type	Minimum Support Type

Source: Grages et al. 2021

3.3. The relationship between institutional constellations of LTC policies and care gaps

We assume that there is a close connection between these LTC policy combinations and structural care gaps. There is a high chance that the “Overall Generous Type” leaves only small structural care gaps, since encompassing access and extent to public support potentially ensures a high degree of coverage, and since it also offers persons in need of care the option to choose between different forms of care based on high levels of generosity. In contrast, it can be assumed, that structural care gaps are

relatively high in the “Minimum Support Type”, since the majority of persons in need of care are not eligible to public support and its extent is also rather low. The “Extra-Familial Support Type” promotes the outsourcing of the care and reduces structural care gaps by offering generous support for extra-familial care. However, we may assume that in all European countries it is common that people in need of care – of course to different degrees - prefer and receive care by family members. Against this background, the “Extra-Familial Support Type” may be associated with structural care gaps in such cases, because of insufficient public support for familial care provision. The “Family Support Type” on the contrary reduces structural care gaps for persons that prefer familial care provision but creates high risks of structural care gaps in case larger shares of the population prefer extra-familial care provision or that no family members are available.

Table 2: Different types of LTC policy and associated risks of care gaps

Type of LTC policy	Risks of care gap	
Overall Generous Support Type	Low risks	
Extra-Familial Support Type	Relatively low risks for people in need of care who receive extra-familial care	Relatively high risks for older people who receive family care
Family Support Type	Relatively high risks for people who prefer extra-familial care	Lower social risks for older people who receive family care However, high risks in case that no family members are available
Minimum Support Type	High risks	

Source: Grages et al. 2021

However, we should consider that the causal relation between LTC policies and outcomes can be modified by factors like the extent to which LTC policies are actually implemented, (Riedel & Kraus 2011), by cultural ideas (Eichler & Pfau-Effinger 2009), and by structural factors like the quality of care. 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 depending on the nationally specific composition of the moderating factors (Pfau-Effinger 2005).

3.4. Main assumptions about factors that may contribute to the explanation of cross-national differences in care gaps

The relationship between LTC policies and care gaps

Differences in the types of institutional constellations of LTC policies may contribute to the explanation of cross-national differences in the extent and type of structural care gaps, since institutional restrictions of generosity may result in limited access and extent of support for various forms of care (e.g. familial and extra-familial care).

The relationship between policy implementation and care gaps

Differences in the implementation of LTC policy may contribute to the explanation of cross-national differences in the extent and type of structural care gaps, since social rights do not automatically translate into corresponding structures of LTC provision. Implementation can be inadequate if access to care services is dependent on budgetary resources and/or availability varies between regions.

The relationship between culture and care gaps

Cross-national differences in the main cultural orientations towards the “best” form of LTC provision may contribute to the explanation of cross-national differences in the extent and type of structural care gaps. The reason is that it is possible that LTC policies offer support in a particular field of LTC provision, regarding either extra-familial care or family care, whereas relevant parts of the population prioritize the other field of LTC provision, on the basis of common cultural ideas about the “best” form of LTC. Therefore, we assume that cultural ideas relating to how older persons should “ideally” be cared for (e.g. care provided by the extended family or extra-familial care) that are dominant in the population may influence the distribution of the use different forms of support for LTC. In case of a high cultural support for familial care provision, the use of support for familial LTC may be increased even if institutional incentives promote the use of support measures for extra-familial LTC.

The relationship between care quality and care gaps

Cross-national differences in self-perceived extra-familial LTC quality may contribute to the explanation of cross-national differences in the extent and type of structural care gaps. The reason is that the share of people who do not make use of publicly provided extra-familial care and choose publicly supported or unsupported family care instead may differ, since the supply of LTC does not match with their expectations regarding the quality of public LTC provision. Therefore, we assume that the assumed quality of extra-familial care provision may have an effect on the distribution of the use of different forms of support for LTC. In case the majority of the population assumes a low quality of familial care provision, use of support for familial LTC may be increased even if institutional incentives promote the use of support for extra-familial LTC. It is also possible, that a share of older persons with care needs foregoes support for extra-familial LTC even in case of complete absence of public support for familial LTC which impacts the extent of absolute structural care gaps.

3.5. Main assumptions about the relationship between care gaps at the institutional level of LTC policies and social risks

In this part, we introduce our main assumptions regarding the relationship between care gaps and the type and extent of social risks. Care gaps are potentially connected with particularly high social risks for people in need of care and in some cases also risks for their relatives (Eggers et al. *forthcoming*). These are the main theoretical assumptions:

1. Social risks are particularly low in the context of the “Overall Generous Type”.
2. Poverty risks for care recipients due to high levels of private (co-)financing of extra-familial LTC are most common in the “Minimum Support Type” and in the “Family Support Type”
3. Risk of interrupted career patterns for caring relatives that lead to a lack of income and social security rights, and therefore increase financial dependence on the partner’s income are particularly relevant in the “Minimum Support Type” and in the “Extra-Familial Support Type”
4. Completely unmet care needs are most common in the “Minimum Support Type”

3.6. Main assumptions about social groups among older people in need of care particularly affected by structural care gaps

We assume that particularly vulnerable groups of people are mainly affected by structural care gaps and that the risk of being in need of care can be unevenly distributed between different social groups. On this basis, it can be assumed that some social groups are exposed to particularly higher social risks associated with care needs due to their increased vulnerability and/or they suffer to a greater extent from inadequate care provision in the event of an insufficiently generous care policy. Based on previous research we assume that persons with lower income, older people and women are disproportionately affected by social risks that are connected to structural care gaps.

4. Methodological approach

The analysis is based on quantitative data from EU-SILC, EVS, Eurobarometer and national statistics as well as data regarding LTC policies from national care policy documents, standardized EUROSHIP country reports and international policy databases like MISSOC and EUROCARERS.

Approach for measuring structural care gaps

The measurement of absolute structural care gaps is based on the difference between the share of persons 65+ that receive publicly (co-)financed LTC, calculated based on latest available data for different forms of publicly supported LTC from national statistics, and the share of persons 65+ that report self-perceived long-standing limitations in usual activities due to health problems based on comparative data from EU-SILC for 2018 (item hlth_silc). Additional information on relative care gaps is based on institutional analysis of generosity of extent of LTC policy support (see below).

Approach for measuring generosity of LTC policy

On the basis of the theoretical framework of “institutional constellations” and the theoretical typology that derives from Grages et al. (2021) and that was introduced above, the comparative study analyses the institutional regulation of LTC policies towards the support of extra-familial and familial care separately with regard to the generosity level of each of them. For each type of LTC policy, we systematically measure the degree of generosity in a) access to and b) the extent of support as sub-indicators. Measurement of the degree of generosity regarding access to support considers the strictness of relevant modes of restrictions towards access: a) needs-testing and b) means-testing. In the case of familial LTC, we also consider restriction of eligibility regarding specifications of the familial caregiver: a) place of residence b) type of kinship relationship c) income or d) working situation of familial caregiver. The measurement of the degree of generosity regarding the extent of support is based on the average amount of co-payment for comprehensive care provision; defined as a combination of a) medical or nursing care b) personal care services (ADL) and c) assistance services (IADL) in the case of extra-familial LTC. In the case of familial LTC, we consider the difference between public financial support and country specific average net pay for full-time professional care and pension contribution (cash benefits/care allowances) or the amount of wage replacement and pension contributions (for compensated care leave). We differentiate between three levels of regulation (high, medium and low) on an ordinal scale for each sub-indicator and then calculate the mean values from both indicators (for further information on measurement see Grages et al. 2021).

Approach for measuring degree of LTC policy implementation

Social rights do not automatically translate into actual LTC provision. 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 risk of insufficient implementation of social rights 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 like allocation of budgets that limit policy implementation (Riedel & Kraus 2011). Such barriers might lead to a lack of publicly supported care provision and/or unmet needs despite the de facto existence of social rights. We differentiate between three levels of regulation (high, medium and low) on an ordinal scale, depending on the degree of existing barriers for implementation.

Approach for measuring degree of cultural support for familial care provision

The measurement of the degree of cultural support for familial care provision is based on item QA 27C “It is a child's duty to provide long-term care for parents” from 2018 European Value Study. We differentiate between three levels of support (high, medium and low) based on the share of the population that agree with the statement.

Approach for measuring degree of (assumed) LTC quality

The measurement of the degree of (assumed) LTC quality is based on item QA 29.3 “Institutions such as nursing homes offer insufficient standards of care” from 2007 Special Eurobarometer 283: Health and long term care in the European Union. We differentiate between three levels of assumed quality (high, medium and low) based on the share of the population that agree with the statement.

5. Findings

The following section will introduce and discuss findings of the comparative study of gaps in care provision and factors that help to understand cross-national differences. Moreover, consequences regarding social risk for different social groups are discussed at the end of the section.

5.1. Cross-national differences in the absolute structural care gaps

The share of persons 65+ reporting care needs vary considerably among the study countries: While only 23,2% of the population 65+ report care needs in Norway, followed by 36,8 % in Germany and 45,6% in the UK and Spain, more than half of the population 65+ report care needs in Italy (54,5%), Hungary (55,4%) and in Estonia (68,3%). These large differences are noteworthy. Potential factors that might contribute to the explanation of these cross-national differences might be differences in the general provision of health care, differences in life expectancy but also due to cultural differences with regard to the country-specific perception of care need (Kröger 2022). It is beyond the scope of this report to explain these differences in more detail.

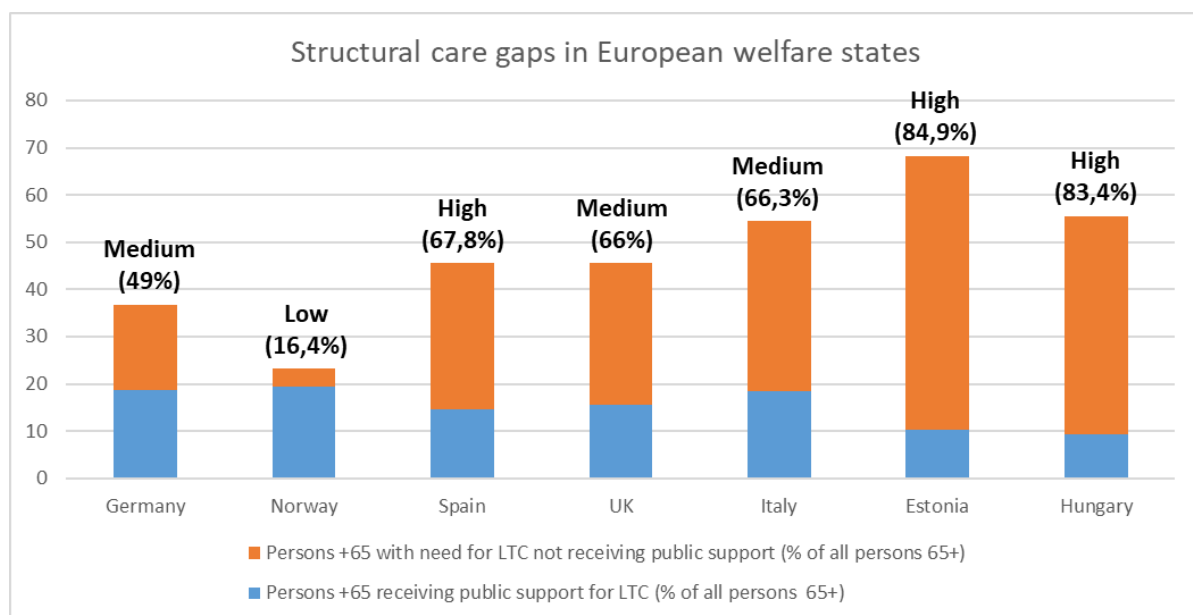
The question that is more important for this report is the imbalance between the demand for care and the actual coverage of the demand by the welfare state. In order to evaluate if an imbalance occurs, we first need to take a look at the share of persons 65+ that receive publicly (co-) funded care: It is

with 19,4% highest in Norway, followed by 18,7% in Germany, 18,4% in Italy, 15,5% in the UK, 14,7% in Spain and only 10,3% in Estonia and 9,2% in Hungary.

If we compare the group of people who articulate a need for care and those who receive publicly (co-) funded care, we can calculate the absolute structural care gap for each of the study countries. However, before interpreting the results we have to remind ourselves that the *absolute* structural care gap does not consider that the extent of support can differ and might therefore lead to a significant underestimation of unmet needs; receiving just any kind of support does not guarantee that the older persons receive sufficient care. Only a look at the *relative* structural care gaps, which also considers the extent of public support, allows for a precise interpretation.

The only EUROSHIP country showing a low level of absolute structural care gap is Norway, where only 16,4% of the population 65+ with self-reported care needs do not receive any kind of public support. In Germany about half (49%) the population 65+ with self-reported care needs does not receive any kind of public support. In the UK, Italy and Spain the absolute structural care gap accounts for roughly two third of the population 65+ with self-reported care needs. Estonia and Hungary perform poorest with a coverage of self-reported care needs that does not exceed much more than 15% in both countries.

Graph 1: Cross-national differences in the share of people with self-reported care needs and publicly (co-)financed care provision (+65)



High = more than 67% of population think that it is a child's duty to provide long-term care for parents; Medium = between 66% and 34% of population think that it is a child's duty to provide long-term care for parents; Low = 33 % or less of population think that it is a child's duty to provide long-term care for parents

Source: EU-SILC 2018 and National data (own calculations)

5.2. The role of institutional constellations of LTC policies for the explanation of cross-national differences in care gaps

Taking a closer look at the empirical reality in our study countries, reveals that the empirical puzzle is rather diverse against the background of a parallel but sometimes differently pronounced extension of social rights towards extra-familial LTC *and* a trend towards semi-formalization of familial LTC, based on the introduction of pay and social rights which both took place in European welfare states since the 1990s. We see a higher degree of support for both types of care in Norway and also in Germany and

Spain. All three countries can be assigned to the “Overall Generous Type” of LTC policy. 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, barely offering opportunities besides informal and unpaid family care work or private LTC funding.

Table 3: 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 care gap= LOW							IT care gap= MEDIUM		
	Medium		DE care gap= MEDIUM		ES care gap= HIGH						
								HU care gap= HIGH			
			Extra-Familial Support Type						Minimum Support Type		
						UK care gap= MEDIUM					
	Low								EE care gap= HIGH		

(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: Grages et al. 2021; EU-SILC 2018; National data (own calculations)

We assume that institutional restrictions of generosity may result in limited access and extent of support for care provision. A first look reveals a quite strong correlation between absolute structural care gaps and the policy generosity. The results show that the countries with the highest absolute structural care gaps (Estonia with 84,9% and Hungary with 83,4%) both also show a low level of policy generosity and can be classified as members of the “Minimum Support Type”. Absolute structural care

gaps show medium level in the UK (66%) which can be considered part of the “Extra-Familial Support Type” and Italy (66,3) which can be considered part of the “Family Support Type”. Both countries show a generosity that is medium level or higher in at least one of the main forms of LTC policy support. Against this background, we can assume a close relation between policy generosity and the prevalence of absolute structural care gaps. The results for Norway and Germany also suggest a close relationship between policy generosity and care gap since they show that the countries with the lowest absolute structural care gaps (16,4% in Norway and 49% in Germany) both have a highly generous LTC policy that can be assigned to the “Overall Generous Type”. However, the absolute structural care gap in Spain shows with 67,8% a higher level even though the Spanish LTC policy shows higher levels of support in extra-familial and familial LTC and is also considered to be part of the “Overall Generous Type”. In this case, a highly generous LTC policy does not translate into a comparably low absolute structural care gaps.

5.3. The role of policy implementation for the explanation of cross-national differences regarding care gaps

One factor that might help to understand the outlier status of Spain might be the role of policy implementation. Social rights do not automatically translate into corresponding support for LTC because coverage is sometimes inadequate since access to care services is dependent on budgetary resources or availability of support or services varies between regions. Against this background, the evaluation of the risks of insufficient implementation of social rights can be 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).

Table 5: The role of policy implementation in different types of LTC policy types

	Overall Generous Type			Extra-Familial Support Type	Familial Support Type	Minimum Support Type	
	Germany	Norway	Spain	UK	Italy	Estonia	Hungary
Extent of implementation of social rights	High	High	Medium (insufficient allocation of budgetary resources)	High	Medium (regional differences in the availability of care infrastructure)	Low (insufficient resources & regional availability of care infrastructure)	Low (insufficient resources & regional availability of care infrastructure)

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

Source: Grages et al. 2021

In the case of Spain, the implementation of social rights is significantly hindered since organizational barriers in coordination undermined the ambitious goals regarding universalizing individual social rights of the 2006 LTC reform because of strict budget constraints after the economic crisis in 2008 (Deusdad et al. 2016b; Ibáñez et al. 2021). This might partly explain the comparably high absolute structural care gap despite the high policy generosity – on paper. In contrast, we see no significant

barriers for policy implementation in Germany and Norway that would affect the extent of absolute structural care gap.

However, one can observe such limitations in policy implementation in other study countries. There is for instance a risk of insufficient policy implementation in Italy, since the types of support and services vary substantially between Northern and Southern regions, generating inefficiencies in service provision and availability of support (Arciprete et al. 2021; Ranci & Pavolini 2015). Against this background, one can assume that the absolute structural care gaps would shrink in the case of a consistent implementation of the already existing policies.

One interesting peculiarity with regard to policy implementation is the fact that the needs assessment system for support for family care (based on cash-for-care benefits) in the UK and Italy allow for high degrees of subjective discretion because of poor transparency and low standardization of the procedure besides a restrictive formulation of needs assessment criteria in the legislation. The consequences are that access to support for familial LTC can in practice be much less restricted than the institutional regulation implies. However, Ranci et al. (2021) argue that uncertainty and opacity in this context can have ambivalent outcomes since *“in times of increasing need pressure and limited capacity of policy reform of the overall LTC systems, the British and Italian CfC³ programmes could be easily expanded, whereas in times of austerity, discretion has been used to limit access and decrease the coverage rate. In these countries, need assessment has been a weak policy instrument easily dependent on more general policy goals”* (Ranci et al. 2021: 558).

Besides that, risks of insufficient policy implementation are comparably low in the UK since there are no significant barriers in coordination regarding regional availability of infrastructure. However, due to recent cuts of nearly £8 billion on the budget for social care since 2010 and more stringent eligibility for benefits, this can be assumed to have increased the absolute structural care gaps despite encompassing reforms in policy (Cromarty 2019).

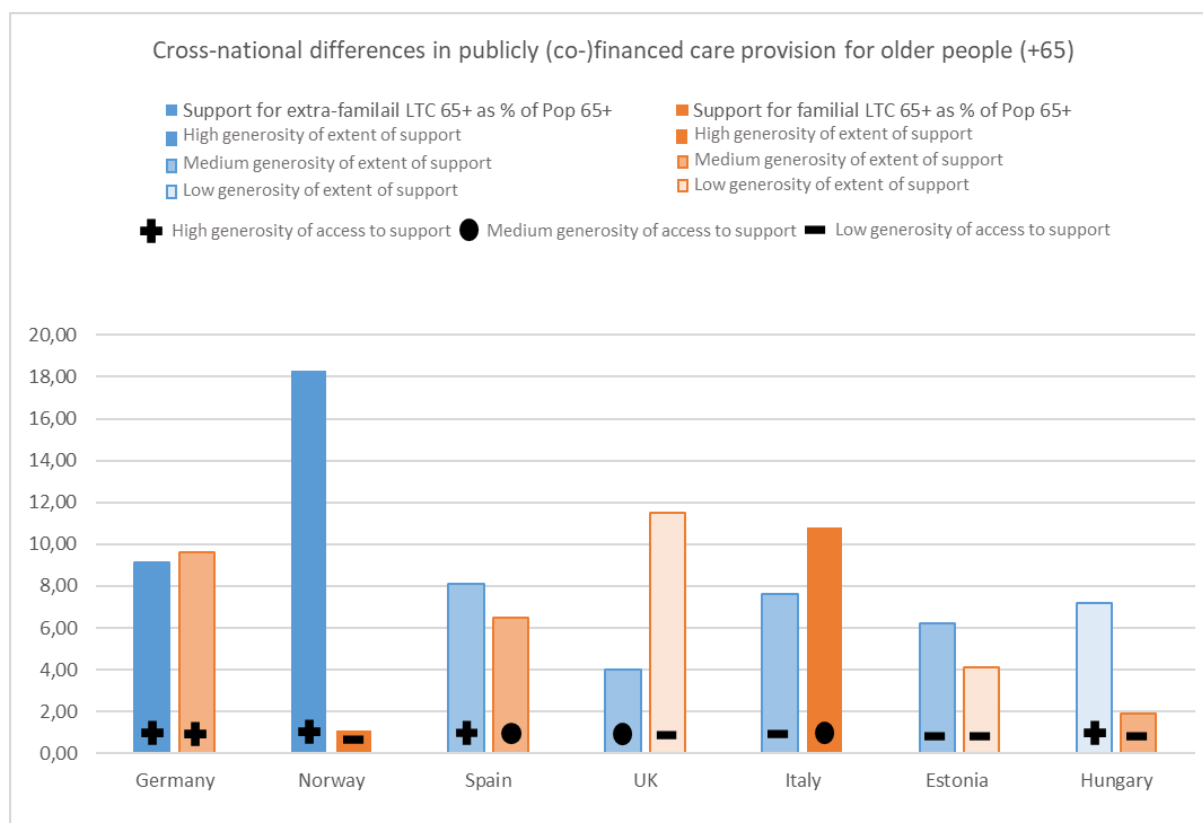
The highest degree of risks of insufficient policy implementation can be observed in Estonia and Hungary which is particularly problematic given the already low generosity of the policy with regard to access and extent of support. In both countries, support for LTC is often inadequate since access to care services and benefits varies between regions (almost half of Estonian municipalities do not offer any kind of support for familial LTC) and availability of services is often dependent on local government's budgetary resources (Albert et al. 2021; Taru et al. 2021). Against this background, it can be assumed that difficulties in consistent implementation of the existing low generosity LTC policy increases the extent of the absolute structural care gaps even more.

5.4. Relative structural care gaps and use of different forms of support for LTC

The differentiation between absolute and relative structural care gaps implies that *access* to support is only one part of the story if one wants to evaluate the extent of a structural care gaps. The *extent of support* is a second dimension that needs to be considered in order to evaluate whether older persons receive sufficient or insufficient care. Therefore, a closer look at the extent of support for different forms of LTC can help to better understand the relationship between policy generosity and cross-national differences in absolute und relative structural care gaps.

³ Cash-for-Care

Graph 2: Cross-national differences in use of different forms of publicly (co-)financed care provision



Source: Grages et al. 2021; National data (own calculations)

A look at the empirical findings demonstrates that only Norway shows a high degree of generosity with regard to the extent of public support in both extra-familial and for familial LTC provision. This implies that besides the low degree of absolute structural care gap, the relative structural care gap is also low. The majority of older persons with care needs receive an encompassing and sufficient support for care provision regardless of the form of LTC they use. The sharp differences in the use of the two forms of support for LTC that attract attention might be closely connected to the fact that access to support for extra-familial LTC is on a high level, while it is only on a low to medium level in the case of support for familial LTC.

The situation in Germany differs since the extent of support varies with the different forms of care. While the extent of support for extra-familial LTC shows a medium to high level, the support for familial LTC is only on a low to medium level. Against the background of a medium level of absolute care gap and a more or less equal distribution regarding the use of extra-familial and familial LTC, we can conclude that only half of the people with care needs receive public support. However, those who prefer familial care provision experience a higher relative structural care gap than those who prefer extra-familial LTC. In general, a sufficient support for LTC provision is granted neither for familial LTC nor for extra-familial LTC but the risk of unmet needs for support are disproportionally higher for persons who chose family care over extra-familial support. The slightly higher use of support for familial LTC even more calls for an explanation that goes beyond institutional generosity, since the level of access for support for extra-familial LTC (high) exceeds the level of access for support for extra-familial LTC (medium-high).

In Spain, the extent of support is on a medium level for both forms of LTC. This suggests that besides the high degree of absolute structural care gap, the relative structural care gap is on a medium level.

The one third of older persons with care needs that receive public support does not receive sufficient levels of support - neither in the case that they choose extra-familial nor in the case that they choose familial LTC provision. However, we assume that on average roughly half of the need for support is covered by the welfare state for recipients of public support. Differences in the use of the two forms of support for LTC might be linked to the fact that access to support for extra-familial LTC is on a medium to high level, while it is only on a medium level in case of support for familial LTC.

The situation in the UK somehow mirrors the picture in Germany, since the extent of support in this case also varies with the different forms of care. However, the absolute structural care cap exceeds the German level and the use of the forms of LTC are less equally distributed with a significantly higher prevalence of familial than extra-familial LTC. Surprisingly, the level of the extent of support points in the opposite direction with a medium level extent of support for extra-familial LTC and only a low to medium level extent of support for familial LTC. This indicates that the one third of older persons with care needs that receives public support disproportionally decides for the option of LTC support that offers less sufficient levels of support. The situation becomes even more puzzling if one is taking the generosity of access to support for the different forms of LTC into account since it implies that the level of access to extra-familial LTC (medium) exceeds the level of access to familial LTC (low). One potential explanation for the high level of use of support for familial LTC might be the fact that benefits for familial care provision are not means-tested (in comparison to support for extra-familial LTC). The needs assessment for extra-familial LTC allows for higher degrees of subjective discretion and is based on a restrictive statutory formulation of the needs assessment criteria. The consequence is that access to support for familial LTC is in practice much less restricted than the institutional framework of LTC policies implies (Ranci et al. 2019).

In Italy, the level of extent of support (medium to high) as well as the level of access to support (medium) for familial LTC exceed the level of access to support (low) and extent of support for extra-familial LTC (medium). This difference is mirrored in the distribution of the use of the two forms of LTC with a significantly higher prevalence of support for familial LTC provision. Moreover, the level of access to support for familial LTC is further increased by high degrees of subjective discretion in the needs assessment procedure. This significantly weakens its restrictiveness in practice like in the case of the UK. Against the background of an absolute structural care gap that roughly excludes two third of those potentially in need of care from access to public support, the majority of the remaining third opts for support for familial LTC provision which on average covers more than half of the need for support. Research shows that in the case of Italy, the support is also often used for employing low-cost migrant care workers instead of familial care provision (Cordini & Ranci 2017). However, a significant number of persons with care needs still decides for extra-familial LTC, even if it is associated with a slightly higher degree of unmet need for support.

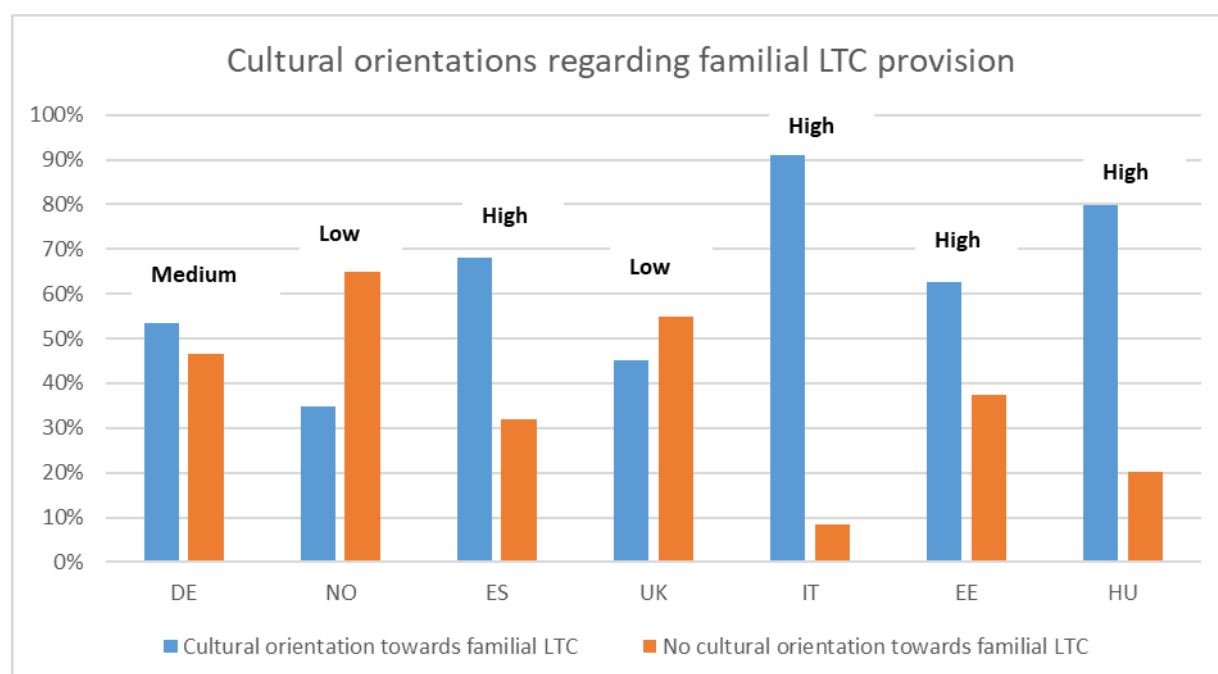
In Estonia, we see the opposite picture where the level of extent of support for extra-familial LTC (medium) exceeds the level of extent of support for familial LTC. Again, in this case the level of the extent of support correlates with the actual use of forms of support for LTC and the prevalence of support for extra-familial LTC is higher than the prevalence of support for familial LTC. Differences in the use of the two forms of support for LTC are not further facilitated since the generosity of access to support is on a low level for extra-familial as well as for familial LTC. The majority of the older persons that receive public support – which is rather low due to the high absolute structural care gap – decide for support for extra-familial LTC and are on this basis exposed to a medium level relative care gap since the extent of support on average roughly covers half of a sufficient LTC provision. In the case that older persons decide to claim support for familial LTC, the coverage of care needs is considerably lower.

The situation in Hungary is again characterized by an imbalance between the level of access to support for extra-familial and familial LTC on the one hand and level of extent of support for extra-familial and familial LTC on the other hand, which both point in opposing directions. While the level of access to support for extra-familial LTC (medium to high) exceeds the level of access to support for familial LTC (low to medium), the level of extent of support is on a level for familial LTC (medium) and exceeds the level for extent of support for extra-familial LTC (low to medium). The distribution of the use clearly falls in favor of support for extra-familial LTC. Due to the high absolute structural care gap, only around 15% of the persons with care needs receive public support. Of those, only a small share is able to access support to familial LTC, which is associated with a medium level relative structural care gap and therefore accounts on average for roughly half of the needed support for a sufficient care provision. The majority of older persons that receive support for LTC has no other option than to accept support for extra-familial LTC, which is due to the low generosity of the extent of support associated with a considerably higher relative structural care gap and covers less than half of the need for public support for LTC.

5.5. The role of cultural factors and assumed quality of extra-familial LTC provision for understanding differences in the distribution of the use different forms of support for LTC

In this part, we present our findings regarding the role of cultural ideas and the assumed quality of extra-familial LTC for the explanation of cross-national differences with regard to the care gap. However, it needs to be pointed out that policies and cultural factors and assumed quality of extra-familial LTC provision could also be in line and support each other reciprocally.

Graph 3: Cross-national differences in culturally based ideas towards familial LTC provision

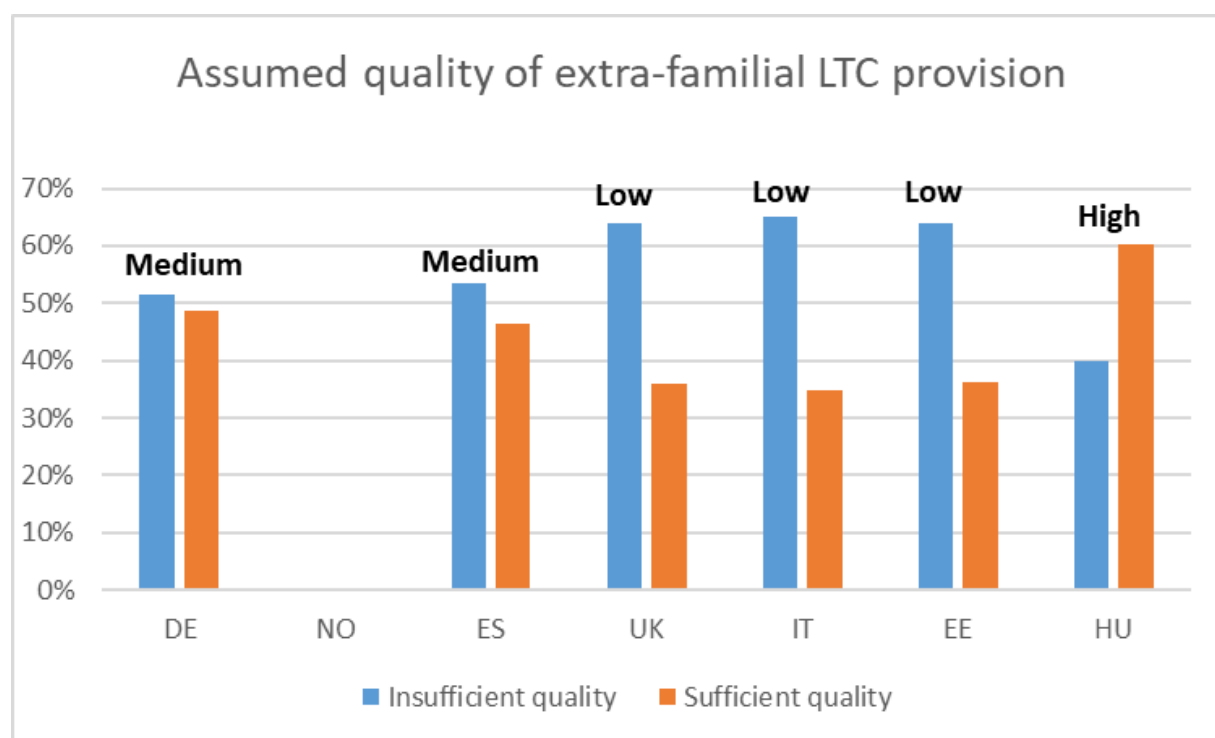


High: the majority of people who claim that it is a child's duty to provide long-term care for parents (percentage points > 55);
Medium: Share of people who state that it is a child's duty to provide long-term care for parents is equal to the share of people not thinking that it is a child's duty to provide long-term care for parents (less than 10 percentage points difference);
Low: Majority of people who respond that it is not a child's duty to provide long-term care for parents (percentage points > 55)

Source: European Value Study (EVS 2018, QA 27C)

A look at data regarding dominant cultural ideas regarding care provision for older people in the study countries reveals that most countries – with the exception of Norway and the UK - show a medium or high level of cultural orientations for family care. Italy shows the highest level of cultural orientations for family care, while Norway shows the lowest level, indicating that the Norwegian population has a strong cultural orientation towards extra-familial care provision. In both countries, cultural orientations and institutional incentives support each other reciprocally and data on the use of different forms of LTC reveals that the use of different form of LTC is in line with a coherent combination of culture and institution. The more pronounced use of support for familial LTC might be further facilitated by the assumption of low quality in extra-familial LTC provision in Italy. With regard to the use of public support for extra-familial LTC it has to pointed out, that the use of support for extra-familial LTC is generally much higher in Northern Italy, based on more generous local criteria for access to residential and home care (Arciprete et al. 2021). Data regarding assumed quality for extra-familial LTC provision is missing for Norway. However, studies indicate that Norway has above average levels of care quality if one considers “objective” measures of extra-familial LTC provision like the ratio between care recipients and staff (Kirkeveld & Engedal 2006; Kjøs & Havig 2015). Against this background, the strong cultural orientation towards extra-familial LTC in Norway appears as a logical outcome.

Graph 4: Cross-national differences in (assumed) LTC quality of extra-familial LTC provision



High: Majority of people think nursing homes offer sufficient standards of care (percentage points > 55); Medium: share of people thinking nursing homes offer insufficient standards of care equals share of people thinking nursing homes offer sufficient standards of care (less than 10 percentage points difference); Low: majority of people think nursing homes do not offer sufficient standards of care (percentage points > 55);

Source: Special Eurobarometer 283 on Health and Long-term Care in the EU (EB 2007, QA 29.3); data for Norway is missing.

The relationship between institutional regulations and main cultural ideas regarding the ‘best’ form of LTC is less coherent in other countries. In Germany institutional incentives are higher for extra-familial LTC but the share of persons who are culturally oriented towards familial care provision exceeds the share of persons who are culturally oriented towards extra-familial care (only slightly however). In this

case, the majority of older persons with care needs uses the form of support for LTC that matches their cultural orientation even though the decision for support for familial LTC comes at the expense of the level of extent of support. In addition, the fact that quality of extra-familial LTC is only assumed to be on a medium level might contribute to the explanation of the distribution of use of different forms of support for LTC.

The case of UK also provides a more complex case with regard to interrelations of the influencing factors. While institutional regulations and cultural orientations are in favour of support for extra-familial LTC, most older persons with care needs use support for familial LTC. As already argued above, the less restrictive implementation of the needs assessment - which allows for an easier access to benefits in practice - is a crucial factor for explaining this puzzle. Moreover, the assumption of low quality extra-familial LTC might also contribute to understanding the high use of support for familial LTC. Furthermore, libertarian cultural ideas of self-determination that are of high importance in liberal welfare regimes (Eggers et al. 2019) might be relevant for understanding the distribution of the use of different forms of support for LTC in this case. It seems plausible that the specific design of support for familial LTC in the form of an unregulated cash-for-care benefit that could be spent rather freely allows for high degrees of autonomy and is therefore favoured by the majority of older persons with care needs in the UK.

While institutional incentives are slightly stronger with regard to support for extra-familial LTC in Spain, there is a clear cultural orientation for familial LTC. However, the majority of older persons with care needs uses support for extra-familial LTC even though extra-familial care provision is assumed to be of low quality. A closer look at specific restrictions regarding access towards support for familial LTC can help in understanding this empirical puzzle. In order to receive cash benefits for familial care, the care must be provided by a relative 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). However, huge problems in the implementation of the new LTC policy after the reform in 2006 make it difficult to evaluate the Spanish case in the light of policy design and generosity.

Estonia is characterized by an incoherent mix of institutional incentives for the support of extra-familial LTC and a high cultural orientation for familial LTC provision. Yet the use of support for extra-familial LTC exceeds the use of support for familial LTC, despite the fact that the quality of extra-familial LTC is assumed to be low. In order to shed light on the situation in Estonia, one needs to keep in mind that unpaid familial care provision is a statutory obligation in Estonia. On this basis, in the majority of municipalities family members cannot receive any kind of public support (Taru et al. 2021). Against the background that most LTC is delivered informally since access to public support is not available in most cases, it becomes clear why the very small share of publicly supported LTC provision is centered around extra-familial LTC provision. Welfare state inactivity with regard to expansion and implementation of social rights combined with cultural ideas suggesting that the 'best' care is provided by relatives, manifests itself in widespread informal care provision. Such informal care takes place beyond the framework of publicly funded forms of care and can be associated with a considerable social risk for the caring family members. They are requested to reduce their working time or stay at home in order to provide the care. On this basis, they are not able to earn employment income and to contribute to social insurance during this time. Caring family members therefore have a higher social risk of low income.

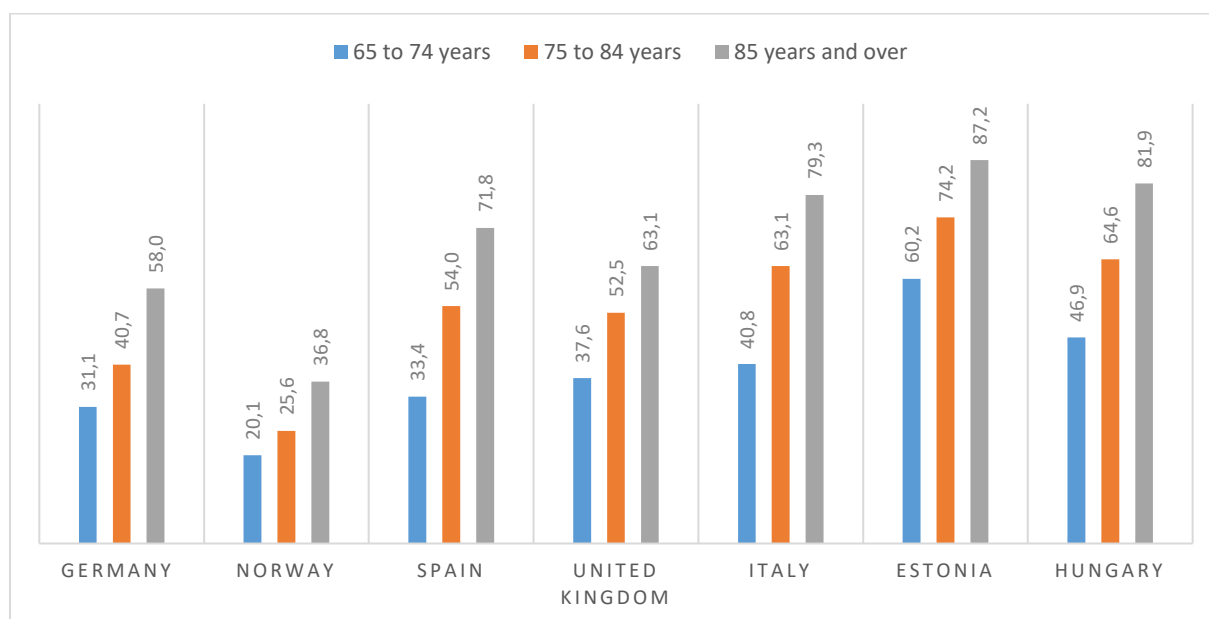
The situation in Hungary is somehow comparable to the situation in Estonia. Again, we see stronger institutional incentives in the direction of support for extra-familial LTC mixed with a high cultural orientation towards familial care, which results in a significantly higher use of support for extra-familial

LTC – within the very narrow scope of limited public support. However, in contrast to the Estonian case quality of extra-familial LTC is assumed to be high in Hungary, which might explain part of the puzzle. In addition, the limited possibilities to access support for familial LTC are also an important factor in the Hungarian case, which leave barely any option besides extra-familial LTC for older persons with care needs that want to receive public support. Furthermore, responsibilities of relatives are also enshrined in law in Hungary: In case of care need of a family member, relatives are expected to provide the necessary care (in most cases informally) or to contribute to the co-payments for extra-familial LTC (Gal 2018). These obligations combined with insufficient policy implementation and a high cultural orientation towards familial care provision put the mayor share of the care burden on the shoulders of the (mostly female) relatives of care dependent older persons, who provide care without any chance to receive support from the welfare state.

5.6. Social groups particularly affected by care gaps and the role of LTC policy

The risk of being in need of care is unevenly distributed between different social groups. The data supports our assumption that the extent of the need for care is influenced by factors like age, gender and income. The risk of needing care increases with age, as well as with decreasing level of income, and data also shows that women have a higher risk of needing care than men. The direction of the effects is almost the same in all study countries (only exception is income in Spain), but the extent of the effects differs between groups and countries. On this basis, it can be assumed that women and older people, as well as people with a low level of income, are exposed to particularly high risks associated with care needs due to their increased vulnerability and/or they suffer to a greater extent from inadequate care provision in the event of an insufficient generous care policy. However, if care policy protects those in need of care based on a highly generous policy with regard to access and extent of public support, it can potentially keep the risks low for the groups mentioned. It should also be considered that there may be an increase in the risk of care needs and thus potentially an increase in disadvantage if a person combines several of the attributes mentioned in the sense of intersectionality. According to this, in countries with less generous care policies there is a particularly high risk for women over 65 years of age with a low level of income.

Graph 5: Cross-national differences in LTC needs for different age groups



Source: EU-SILC 2018

The risk of being in need of LTC increases with age in all study countries. The effect of age with regard to the risk of being in need of care is highest in Spain. Persons over 85 years report care needs 2,15 times more than persons between 65 and 74 years. Against this background, the insufficient implementation of the potentially generous LTC policy in Spain leads to disproportionate risks for persons of older age (85+) and the high care gap in Spain is particularly problematic for this group.

The second highest difference concerning care needs between age groups can be found in Italy, where persons aged 85+ are 1,94 times more likely to be in need of care than persons between 64 and 74 of age. Significant gaps in support for extra-familial care in the Italian LTC policy are particularly disadvantageous for very old persons with care needs since they often have higher levels of needs that cannot be covered solely by family care.

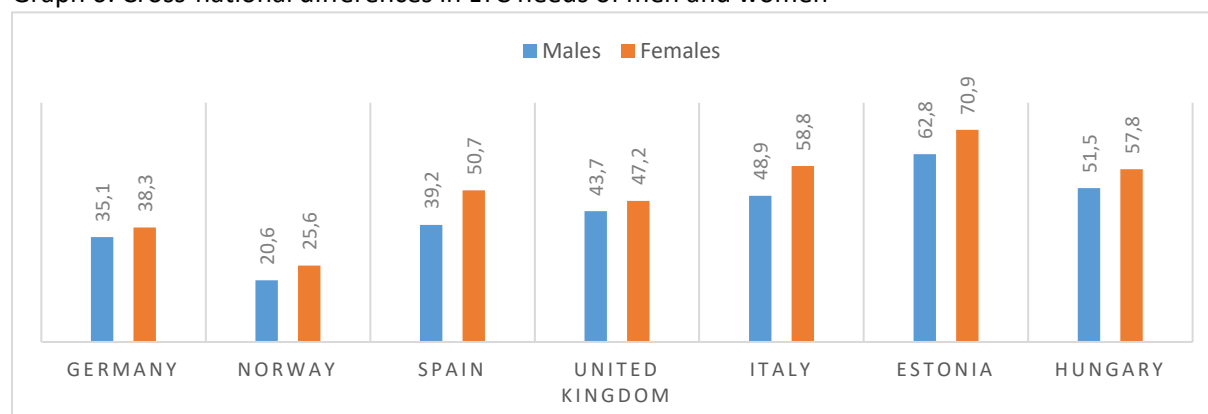
The probability of developing care needs also significantly increases with age in Germany, where it is 1,86 times higher for persons 85+ and in Norway where it is 1,83 times higher for this age group. However, against the background of overall generous measures of public support for familial and extra-familial LTC, the disproportionate risks of insufficient or lacking support for very old persons with care needs is significantly attenuated in both countries. However, it needs to be emphasized that higher levels of mandatory co-payment in German care homes - that concern cost of care but also cost for housing, investments and food - particularly affect the group of very old persons. This is based on the fact that they have to rely on extensive extra-familial care more often than younger age groups because of overall higher care needs. This results in significant disadvantages for persons 85+ in the form of disproportionate poverty risks.

In Hungary, persons over 85 years report care needs 1,75 times more often than persons between 65 and 74 years. Against the background of an overall less generous LTC policy, this results in a clear disadvantage for the oldest group of people in need of care, since they are disproportionately affected by high absolute and relative care gaps.

Care needs also vary between age groups in the UK and persons over 85 years are 1,75 times more likely to report care needs than persons between 65 and 74 years. However, the higher degree of policy generosity regarding public support for extra-familial LTC is able to reduce the risk of lacking or insufficient care provision more effectively. However, extensive means-testing and co-payment creates poverty risks from which older people in particular have to suffer from disproportionately.

In Estonia, differences between age groups are the lowest. However, the insufficient generosity of LTC policy results in high absolute and relative care gaps that pose particularly high risks of unmet needs and/or poverty for the oldest group of people in need of care, even though the differences between age groups are comparatively low.

Graph 6: Cross-national differences in LTC needs of men and women



Source: EU-SILC 2018

The risk of being in need of LTC is higher for women than for men in all study countries. The gender differences are highest in Spain, where women 65+ are 1,29 times more likely to be in need of LTC. In Norway the probability is 1,24 times higher and in Italy it is 1,2 times higher. Based on the low absolute and relative structural care gaps in Norway, these gender differences are of less importance since the welfare state ensures a needs adequate LTC provision for all persons with care needs based on generous public support. Against this background, the actual disadvantage for women with care needs can be classified as low.

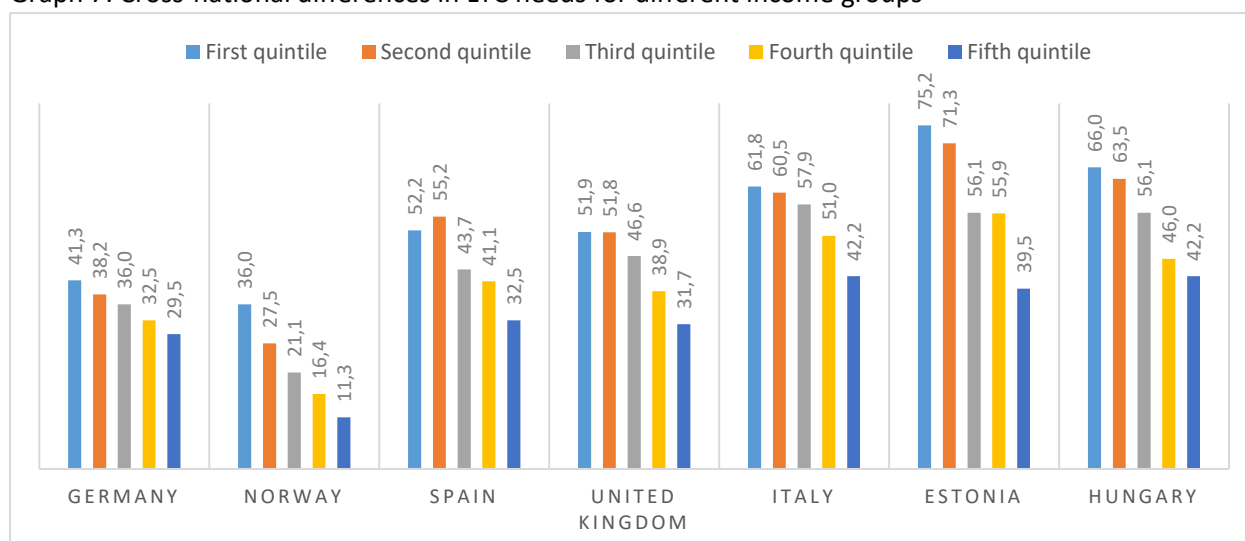
In contrast, in Spain and Italy higher gender differences in care needs are more problematic. In Spain, the insufficient implementation of social rights which actually should guarantee generous public support for extra-familial and familial LTC leads to a situation where inadequate access and extent of LTC support hits women significantly harder than men. In Italy, women also suffer disproportionately from disadvantages of the LTC policy, which has an unbalanced focus on support for familial LTC. Accordingly, the medium level absolute structural care gap affects women in general more strongly and gaps in the extent of support which are especially pronounced in support for extra-familial LTC, are particularly problematic for women of high age that do not have relatives who can take over or organize LTC provision for them.

In Estonia women 85+ are only 1,13 times more likely to be in need of LTC. In Hungary, the probability is 1,12 times higher, in Germany it is 1,09 times higher and in the United Kingdom it is 1,08 times higher. The gender difference in the probability of developing a need for care is the least problematic in Germany, since the comparatively generous care policy can cushion the risks of inadequate support for both sexes equally. However, it must be emphasized that the lower generosity of care policy in comparison with the Norwegian policy, which is reflected above all in the higher absolute care gaps, creates a gender disadvantage that should not be neglected even though it is comparably small.

In the UK, gaps in the public support of LTC provision also translate into disproportionate risks for women, although gender differences are comparably small in this case, too. Gaps in the extent of support for familial LTC are particularly problematic for women that prefer LTC provision by family members because of insufficient public support.

Gender differences in the probability of care needs in the cases of Estonia and Hungary are also not strongly pronounced. Nevertheless, the high care gaps affect women disproportionately and they suffer from the disadvantages of the low generosity of LTC policy more than men do.

Graph 7: Cross-national differences in LTC needs for different income groups



Source: EU-SILC 2018

The risk of being in need of LTC is by far the highest in Norway, with persons from the lowest income quintile being 3,19 times more likely to have care needs than persons from the highest income quintile. However, the universal citizenship-based approach of the Norwegian LTC policy, which guarantees highly generous social rights towards public support for LTC that result in low absolute and very low relative care gaps, ensures that income differences merely create disadvantages for persons with low income. Even though co-payment for nursing homes is based on income, property and capital assets are left untouched and beneficiaries with financially dependent family members and a tight financial situation qualify for reduced co-payment.

In Estonia, persons from the lowest income quintile are 1,9 times more likely to have care needs than persons from the highest income quintile. In contrast to the Norwegian case, this imbalance creates severe disadvantages for persons with lower incomes because of the low-level generosity of LTC policy and high care gaps that disproportionally affect this group in Estonia. Especially if people with low incomes cannot rely on family members that provide unpaid care or cover the costs of extra-familial LTC, there is a high risk of unmet needs since support measures from the welfare state are fragmented and insufficient.

LTC policy is generally targeted at persons with lower income in the United Kingdom. Against this background, the 1,64 times higher probability of developing care needs for persons from the lowest income quintile is less problematic compared to the Estonian case, since persons with income and assets below a threshold of £14.250 (= €16.387) are able to receive comprehensive support for extra-familial LTC without co-payment. However, the unilateral focus on public support for extra-familial LTC creates a particular problem for low-income persons that prefer care provision by family members, since public measures to support family caregivers are inadequate.

With regard to differences in LTC needs for different income groups, Spain presents the only case in which the probability to have care needs is higher among persons of the second lowest income quintile (55,2) than for the lowest income quintile (52,2). Persons from the second lowest income quintile are 1,69 times more likely to have care needs in comparison with persons from the highest income quintile. Persons with low income disproportionally suffer from high structural care gaps that are primarily based on insufficient policy implementation in Spain. However, publicly funded extra-familial LTC is free for all who only have a monthly income (without assets) of the minimum standard IPREM (Indicador Público de Renta de Efectos Múltiples = €565 in 2021).

In Hungary, persons from the lowest income quintile are 1,56 times more likely to have care needs in comparison to persons from the highest income quintile. While this difference is comparably low, its consequence with regard to particular problems for the low-income group are nevertheless significant against the background of the high absolute and relative care gaps. While co-payment can, in theory, be topped up in order to cover the full costs of extra-familial LTC in case a person with care needs has no significant financial assets (including residential property), adult children of the care recipient can be legally obligated to co-pay LTC. Furthermore, nursing homes often demand very high additional admission fees of up to 8 million forint (about €23.000) which excludes persons with low income from care provision.

Differences in LTC needs between the highest and the lowest income quintile are lowest in Italy with a factor of 1,46 and in Germany, with a factor of 1,4. In both countries, the slightly increased risk of low-income persons developing care needs is cushioned - at least to a certain extent - by specifically designed political measures. Against the background of a generous LTC policy in Germany, the risk of lacking support is in general comparably low regardless of income. In addition, social assistance steps in if people are unable to cover the costs of extra-familial LTC (which is especially relevant in care homes), but only after all assets including housing property have been sold. In Italy, the level of co-

funding for extra-familial LTC varies with the economic situation of the care-dependent person, and persons with low income are partially or fully exempt from co-payment.

6. Conclusion

This report introduces analyses of current gaps in the provision of public support for Long-Term Care (LTC) and their consequences for social risks for different groups of persons with LTC needs, with a main focus on care gaps for older people (65+). The report aims to answer the following research questions:

1. How does the extent and the type of gaps in the provision of long-term care (“care gap”) for older people differ between European welfare states?
2. How far are cross-national differences in gaps in the provision of long-term care for older people connected with different types of LTC policies as well as cultural and structural factors?
3. Which social groups of older persons are particularly affected by social risks that result from gaps in the provision of LTC, and how is this related to the respective LTC policy?

With regard to the first question, the report draws on a new multi-dimensional approach to measure the generosity of LTC policy that we developed in an earlier stage of the EU-project EUROSHIP (Grages et al. 2021) that is based on the relationship between the generosity of policies supporting extra-familial care and policies supporting paid familial care (Eggers et al. 2020; Grages et al. 2021). The comparative study found in part huge gaps in the structures of LTC provision for older people, with substantial variations in the extent and types of care gaps between the countries of the study.

With regard to the second question, the findings support our theoretical assumption that cross-national variation in the structural care caps are closely related to the extent of LTC policy generosity in the different types of institutional constellations of LTC policies. In some countries, insufficient implementation of existing social rights further widens the structural care gap – however, fuzziness in formulation and high degrees of subjective discretion can also reduce gaps. We also found that the influence of LTC policies on care gaps is mediated by cultural ideas regarding the “adequate” form of LTC. In several countries cultural preferences for familial care and/or assumptions about low quality of extra-familial LTC increase the use of political support for familial LTC even if this is connected with higher relative care gaps. Further, structural factors contribute to the explanation of cross-national differences, such as the degree of policy implementation or the availability and quality of extra-familial LTC.

In relation to the third question, the report analyses and discusses how far care gaps affect the risk of poverty and unmet needs for persons with LTC needs on the basis of age, income, and gender. According to the findings, among older people with care needs, women, older people (85+) as well as people with a low income are exposed to particularly high social risks in countries with less generous care policies. In this regard, attributes that are associated with higher care needs can accumulate for specific social groups as indicated by the intersectionality approach, which creates particularly high risks.

The paper offers the following theoretical and analytical innovations:

- It stresses the need to differentiate between different forms of care gaps at different societal levels
- It argues that policy generosity is crucial in the understanding of cross-national differences in care gaps

- Evaluation of LTC policy needs to be based on institutional constellation of support measures for familial and extra-familial LTC in order to identify care gaps sufficiently
- Generosity of access and extent of support need to be analyzed separately in order to differentiate between absolute and relative care gaps
- Institutional constellations of LTC policies play an important role in the explanation of cross-national differences in structural care gaps, but their influence is mediated by specific cultural and structural factors
- Care gaps are closely connected with social risk and shows that specific disadvantaged social groups suffer disproportionately

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