European Network of Economic Policy Research Institutes

ANCIEN

Assessing Needs of Care in European Nations

THE ORGANISATION OF FORMAL LONG-TERM CARE FOR THE ELDERLY

RESULTS FROM THE 21 EUROPEAN COUNTRY STUDIES IN THE ANCIEN PROJECT

MONIKA RIEDEL
MARKUS KRAUS

ENEPRI RESEARCH REPORT NO. 95

NOVEMBER 2011

Abstract

This report investigates the organisation and provision of long-term care for the elderly population in 21 member states of the European Union, thus including both old as well as new member states. We highlight several aspects regulating long-term care systems, e.g. which level of government is responsible for regulation or for capacity-planning and how access to services is organised. We further elaborate on public and private provision of services, and on the possibility of persons in need of care to choose between different care providers or different settings of care.

Keywords: formal care, long-term care, provision, European overview

ENEPRI Research Reports present the findings and conclusions of research undertaken in the context of research projects carried out by a consortium of ENEPRI member institutes. This report is a contribution to Work Package 3 of the ANCIEN project, which focuses on the future of long-term care for the elderly in Europe, funded by the European Commission under the 7th Framework Programme (FP 7 Health-2007-3.2.2, Grant no. 223483). See back page for more information. The views expressed are attributable only to the authors in a personal capacity and not to any institution with which they are associated.

ISBN 978-94-6138-143-9
Available for free downloading from the CEPS website (www.ceps.eu)
and the ANCIEN website (http://www.ancien-longtermcare.eu/)

Contents

List of Figures

List of Tables

The Organisation of Formal Long-Term Care for the Elderly

Results from the 21 European Country Studies in the ANCIEN Project

ENEPRI Research Report No. 95/November 2011

Monika Riedel and Markus Kraus*

1. Introduction

There is no single history of the evaluation of formal care services across Europe. The development of these services is connected to the emergence of complex systems of welfare, social security and health care, which have followed different patterns of provision, organisation and funding within each country. The result is a rich mix of approaches and strategies for organising and funding formal care services (WHO, 2008).

All European countries know about the importance of providing a range of care services for those in need. The precise meaning and the policy challenges vary within each country. For example, in many southern European countries, home care is still not fully developed, whereas in some northern European countries informal care is comparatively underdeveloped. These differences can be explained by differing histories, inherited levels of provision, and the traditional roles of state and civil society (WHO, 2008).

We portray the organisation of formal care systems across 21 European countries. We focus on three issues: organisation of the overall system, including the most important level of decision-making and capacity-planning as well as questions concerning quality assurance (chapter 2), organisation of access (chapter 3), and selected characteristics for the organisation of supply (chapter 4).

For the description of the organisation of formal long-term care, we use information gathered in Work Package 1 of the ANCIEN project. The objective of the Work Package was to portray the long-term care (LTC) systems in EU member states in light of provision and financing of care and derive a typology of LTC systems. For this purpose a questionnaire was developed and distributed to project partners in order to collect a comparable set of comprehensive information on national LTC systems. The questionnaire was organised in several blocks of questions focusing on macrostructure, funding and financing, informal care, formal institutional care, formal home-based care and policy issues. Special emphasis was put on the comparability of data. Therefore, a set of relevant definitions was discussed and agreed upon between project partners. Contributed data were checked with regard to comparability and plausibility; in several cases the data provided could not be included in further analyses due to severe deviations from definitions. For further information on the ANCIEN project and cooperating partner institutions, see www.ancien-longtermcare.eu, and for further details on the data collection process, see Kraus et al. (2010).

* Monika Riedel (riedel@ihs.ac.at) and Markus Kraus (kraus@ihs.ac.at) are Researchers at the Institute for Advanced Studies, Vienna. The authors thank Andreas Goltz for excellent research assistance. See the penultimate page for a description of the Institute.

2. Organisation of the overall system

Long-term care policies differ considerably between countries. They may be influenced by a nation's structure, history, culture and last but not least by its economic performance. The following tables intend to give some ideas about the most important level of decision-making and capacity-planning and ask how binding is the quality assurance for LTC systems in 21 member states of the European Union. Finally, we provide a cross-European overview on the influence of different stakeholders on the design of the provision of long-term care.

2.1 Most important level of decision-making

Efficient regulation is among the basic requirements of any long-term care system. Social systems in general, but specifically long-term care systems are usually not regulated by just one level of governing body: often several hierarchies of government share responsibilities, even in small countries like the Baltic states. In about half of all countries covered by the ANCIEN project, the main responsibility for regulating LTC resides at the national level, while in the other half this responsibility usually is shared between central authorities and those at a lower level (see Table 1). This proportion holds for institutional and home-based care alike, as in all but one country of our sample, responsibilities for both settings of care (institutional care, home-based care) are allocated in a parallel way, e.g. shared responsibility in both settings, or responsibility placed mainly at the central level in both settings of care.

Finland and France are the only countries that have a high degree of decentralisation in both settings. In Finland, for instance, municipalities play the most important role in organising LTC services. Thus, decisions on resource allocation, planning and organisation of LTC are also made on a local or regional level: by municipal health and/or social services boards, municipal councils and municipal executive boards (Johansson, 2010).

It is remarkable that in a country with such a distinctively centralised organisation as in France, responsibilities for LTC are predominantly on a de-centralised level. On the national level, the responsibilities of parliament and central government are limited to designing the overall framework for care services. Parliament and care insurance reserve a budget for care purposes which then is distributed to the general councils (*conseil général)* by the national care insurance. Since the second wave of decentralisation in France in 2004, these general councils fulfil a key role in organising long-term care. Situated in the 101 départements, they devise 5-year-plans for the current and future supply of care services in the département, based on an analysis of the current and future need for care. Together with representatives of nursing homes and the départemental authorities for health and social affairs, they are involved in capacity-planning, price-setting and quality-monitoring of nursing homes. They are also concerned with capacity planning and quality assessment of home care services. Responsibilities of municipalities and regions, on the other hand, are quite limited. On the regional level, a tri-annual evaluation of needs aims at diminishing differences in levels of care between regions. The main influence of municipalities relates to the supply of home help services (Joël et al., 2010).

Belgium is a good example of a country in which responsibilities for long-term care are shared between national, regional and local authorities. The federal Ministries of Health and Social Affairs are, together with the national institute for health and disability insurance, responsible for the overall LTC budget (essentially residential care and home nursing care, which are part of the public health insurance system), overall capacity-planning, fees and levels of public intervention. Responsibility for certification, monitoring and quality control of residential care services is divided between the federal and regional level. A part of the budget corresponding to the maximum number of beds set at the federal level is allocated to the regions, which can decide on the allocation over services in different semi-residential and residential settings, or to

support home care. Home-care services are regulated at the regional level and organised locally (Willemé, 2010).

The division of responsibilities between the federal and the regional governments creates its own coordination problems, which are being addressed by special inter-ministerial working groups. One of the results of their work is the formulation of common objectives by the communities and regions in collaboration with the federal government. One outcome of this process is an agreement of the parties which provides a budget to the Communities. The local authorities have some autonomy to use the budget. It can be used to convert beds from homes for the elderly into nursing-home beds, to increase trans-mural supply or to establish alternative types of care as well as new care functions in order to support home (nursing) care (Willemé, 2010).

Table 1. Most important level of decision-making

Country	Institutional care			Home-based care		
	Mostly central	Both, central and decentral	Mostly decentral	Mostly central	Both, central and decentral	Mostly decentral
Austria		X			X	
Belgium		X			X	
Bulgaria		X			X	
Czech Republic	X			X		
Denmark		X			X	
England		X			X	
Estonia		X			X	
Finland			X			X
France			X			X
Germany		X			X	
Hungary	X			X		
Italy	X			X		
Latvia		X			X	
Lithuania	X			X		
Netherlands	X			X		
Poland	X			X		
Romania	X			X		
Slovakia		X			X	
Slovenia	X					X
Spain		X			X	
Sweden	X			X		

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

One might expect from history that the East European countries are in general more centralised than West European countries. This expectation applies to six of the 10 analysed East European countries, namely Czech Republic, Hungary, Lithuania, Poland, Romania and Slovenia. In contrast, Bulgaria, Estonia, Latvia and Slovakia are organised in a less centralised way. In the latter countries, central and de-central levels are responsible for decision-making.

In Slovenia, we find a unique distribution of responsibilities over regulatory authorities. While the responsibility for residential care lies with the health system and thus with the (central) ministry, which also monitors volume and quality of provided care through special social inspectors, home care is in the area of social care, for which the municipalities are responsible (Prevolnik Rupel & Ogorevc, 2009).

2.2 Most important level of capacity-planning

Capacity-planning is a crucial point of long-term care governance. It takes place at national, regional or local levels, reflecting the various steps of government within the long-term care system. The majority of the countries handle capacity-planning on both the centralised and de-centralised levels. Only a few countries strictly delegate capacity-planning to the centralised level. Hungary is the only country that administers capacity-planning of both settings of care centrally. In general, de-centralised levels tend to be more important in capacity-planning than in decision-making for regulations (see Table 2).

Table 2. Most important level of capacity-planning

Country	Institutional care			Home-based care		
	Mostly central	Both, central and decentral	Mostly decentral	Mostly central	Both, central and decentral	Mostly decentral
Austria		X			X	
Belgium		X			X	
Bulgaria			X		X	
Czech Republic		X			X	
Denmark			X			X
England			X			X
Estonia		X			X	
Finland		X			X	
France		X			X	
Germany		X			X	
Hungary	X			X		
Italy			X			X
Latvia		X			X	
Lithuania		X			X	
Netherlands	until 2009	X			X	
Poland			X			X
Romania			X			X
Slovakia		X				X
Slovenia	X				X	
Spain		X			X	
Sweden			X			X

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

Before 2009, capacities for institutional care in the Netherlands had been planned at the centralised level to facilitate expenditure control. Central planning, however, turned out to hinder the efficient development of innovations in institutional care. In 2005, the shortage of residential and nursing-home places was estimated at 13,000 places, resulting sometimes in very long waiting periods. In January 2009, capacity-planning for institutional care was abandoned by the government. Since then, it has been left up to the individual long-term care facilities to decide how many places they want to offer. With this approach the government aims at increasing freedom and responsibility for planning and investments, and long-term care facilities gained possibilities to adjust their capacities to current demand. We cannot say yet which impact this changed policy had/has on available capacities for residential long-term care (Ettelt et al., 2008; Mot, 2010).

In German long-term care, it is the *Länder* that are responsible to provide an efficient, economical and, in quantity and quality, sufficient infrastructure. Details of planning and supporting care facilities are to be specified by legislation of federal *Länder* (§ 9 Sozialgesetzbuch XI). Long-term care insurance follows the principles of fair competition and market deregulation; there are no instruments implemented to steer supply. Any facility that is able to provide services of the required quality will be allowed to do so. Additionally, LTC insurance is required if one prefers private over public providers in order to ensure a plurality of suppliers. This open market policy is only marginally limited by the requirement to follow the mandatory standards; it limits the political impact and public planning possibilities on the care sector, not only in general but specifically concerning capacity-planning. In order to stimulate competition between the individual residential and home-care facilities, LTC insurance allows for over-capacities (Klie, 2005). In 2009, for instance, the degree of capacity utilisation in residential and nursing homes in Germany was 87% (Statistisches Bundesamt, 2011).

2.3 Is quality assurance binding?

Quality regulations are a key indicator for the technical depth of a LTC system. Quality in LTC provision has attracted a lot of interest in recent years and is one of the most challenging issues for policy-makers. In many LTC systems, quality deficits are an issue of public concern. The OECD and WHO report on inadequate care in institutions, such as poor housing, inappropriate treatment of depression and use of restraints. Quality problems in home-based care have also been described, e.g. instances in which care recipients have received highly insufficient care or care that puts them at a risk (OECD, 2005; WHO, 2002).

Thus, many recent reforms of LTC systems also include aspects of quality assurance and improvement, such as setting minimum requirements on providers as preconditions of licensing and contractual decisions. These standards often regulate structural aspects of the quality of care, like staffing ratios in institutions or minimum space per resident. Such standards of care establish a basic accountability but do not automatically translate into higher quality of outcome or prevent poor outcomes. The responsibility for setting standards is either unified at the centralised level or delegated to regional or local levels. For example, Germany and UK introduced nation-wide standards of care, whereas in the Scandinavian countries standards of care are monitored by regional or local governments (OECD, 2005).

Regulations and quality assessment in home-based care are relatively new compared to those in institutional care. Policies for quality assessment and improvement have been introduced in a number of countries, e.g. Germany and the UK. These policies focus on setting structural and procedural-related standards for provider organisations (OECD, 2005).

Table 3 describes the organisation of quality assurance within our country sample. Quality assurance is mandatory in all old EU member states in our sample, except in Austria and Finland.

Table 3. Quality assurance

Country	Institutional care			Home-based care		
	Voluntary	Not mandatory but usual	Mandatory	Voluntary	Not mandatory but usual	Mandatory
Austria		X			X	
Belgium			X			X
Bulgaria			X			X
Czech Republic		X				X
Denmark			X			X
England			X			X
Estonia			X			X
Finland	X			X		
France			X			X
Germany			X			X
Hungary[a]	X			X		X
Italy			X			X
Latvia[b]			X		X	X
Lithuania	X			X		
Netherlands			X			X
Poland		X			X	
Romania			X			X
Slovakia			X			X
Slovenia		X		X		
Spain			X			X
Sweden			X			X

[a] In Hungary quality assurance is mandatory in home nursing care, but not mandatory for home care services.

[b] In Latvia quality assurance is mandatory for home care services, but is only 'usual' for home nursing care.

Source: IHS HealthEcon compilation 2010 based on experts' data collections.

In England, for example, all providers are assessed annually for quality assurance purposes and are given a star rating (excellent, good, adequate or poor). The method of assessment varies depending on the current star rating of the provider. However, all registered providers are required to complete annually an AQAA (annual quality assurance assessment) form which is a self-assessment of performance. It asks providers to comment on how well they think they are meeting the needs of their service users and requires them to provide data about the service. For providers that have had an inspection in the past year (due to adequate or poor quality before, or due to the regular assessment interval), the rating will be formed subsequent to the inspection, and the AQAA will inform the inspection process. For providers that have not had an inspection in the past year (i.e. those judged to be excellent or good who are inspected every three or two years respectively), the rating will be formed subsequent to the completion of the AQAA in what is known as an 'annual service review'. The annual service review combines information from the AQAA, with responses to a survey of service users conducted following the completion of the AQAA form, and other information about the provider (e.g. from complaints).

Assessments are guided by the Key Lines of Regulatory Assessment (KLORA) which set out what an excellent, good, adequate and poor provider looks like (Comas-Herrera et al., 2010).

In Germany the Medical Review Board of the Social Health Insurance and other bodies assume the technical monitoring of inpatient and outpatient facilities on behalf of the Regional Associations of the LTCI (long-term care insurance) funds. From 2011 onwards, facilities will be inspected annually, without prior notice. The inspection report must be published in a language that is easy to understand and a summary of the current report needs to be visibly posted in each facility (Schulz, 2010b).

In the Netherlands organisations that deliver care have to have a deliberate policy to ensure the right care (effective, efficient, patient-centred and attuned to the realistic needs of the patient) according to the law on quality in care organisations (Kwaliteitswet zorginstellingen; KWZ). They also have to have a quality system to preserve the quality of care and make an annual quality report that has to be sent to the Health Care Inspectorate (Inspectie voor de Gezondheidszorg; IGZ). A special law determines that most of the quality requirements of the KWZ are also relevant for individual care professionals, even though those do not have to make an annual quality report (Mot, 2010).

Six out of ten Eastern European countries lack mandatory quality assurance in one or both settings of care. One reason for this might be that in those countries not even the basic LTC services are available in sufficient quantity neither in institutional care nor home-based care. Only in a later step of the development of the system might those countries think about the implementation of a mandatory quality assurance system.

2.4 Stakeholders' influence

The ANCIEN questionnaire includes questions aimed at identifying the key stakeholders for national long-term care systems. It comes as no surprise that the impact on design and layout of the national systems is concentrated on legislative bodies and governments (see Figure 1). Respondents of the questionnaire cite ministries for both, health and social affairs, as important stakeholders with roughly the same frequency, and without discernible differences between old and new EU member states. We take this as another indicator for the overarching tasks of long-term care.

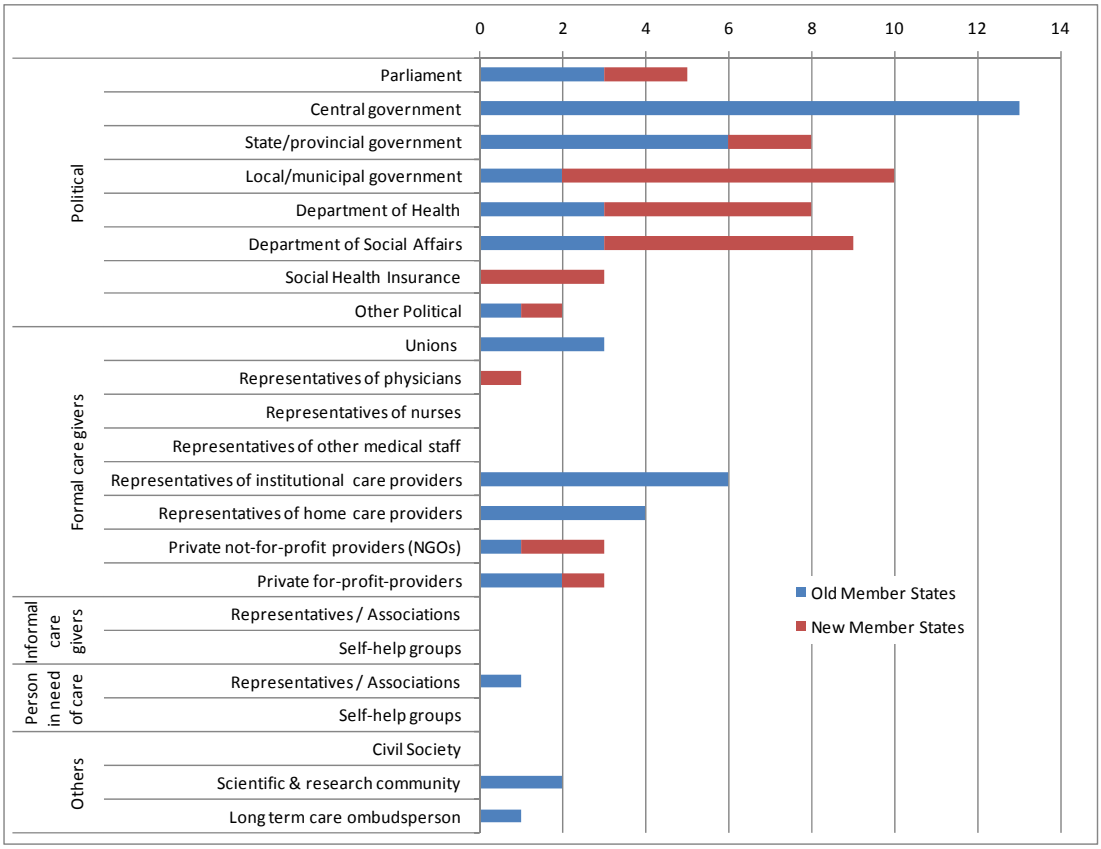
Furthermore, this figure corroborates that across Europe, social insurance is attributed only a small role regarding the design of long-term care systems. True enough, in Europe only Germany and the Netherlands have a 'comprehensive' social insurance for long-term care, with a two-fold comprehensiveness: covering a large portion of the overall population (e.g. in Germany, the 2007 reforms introduced compulsory enrolment in health and long-term care insurance for everyone), and responsibility for a large portion of the tasks that together form the long-term care system. On the other hand, in several countries social health insurance holds full (including financial) responsibility for nursing care, and thus certainly exerts a certain degree of influence over the LTC system. This includes new EU member states like Poland, and some old member states (e.g. Belgium), but not all traditional social (health) insurance countries (e.g. Austria). Other tasks of long-term care like home help are usually integrated into the social or welfare system rather than into the health care system.

And finally, Figure 1 corroborates that care receivers and givers alike lack the support of influential lobbies, which seems to be an internationally widespread phenomenon. Hardly any respondents to the ANCIEN questionnaire cite representatives of care receivers or givers among influential stakeholders. Only for formal care providers did we find any degree of influence, and this seems to take place more on the level of institutions than on the level of care professions: representatives of nurses, like those of informal carers, are cited *nowhere* as influential.

As mentioned above, caregivers hardly have any influence on the design and layout of the national LTC systems. This is especially true for informal caregivers, although they are carrying the major burden of caregiving in many European countries. Calculations for Austria show that the provision of informal care would cost about €2-3 billion per year if it were to be paid at market prices, which is about the same amount that is actually being paid by public authorities for long-term care (Schneider et al., 2006).

Pickard et al. (2007) simulate which effect the implementation of entitlements for home-based care would have on the number of receivers of these services and on expenditures for LTC in Germany, Italy, Spain and the UK. Their calculations for the UK show that in 2050 around 80% more persons will receive home-based care than in the base case for 2000. For Italy, Germany and Spain the respective numbers are nearly 100%, over 200% and nearly 500%. Effects on long-term care expenditures would be substantial as well. Expenditures expressed as a percentage of GDP would be 14% higher in Germany, nearly 20% higher in the UK, around 30% higher in Italy and over 40% higher in Spain. These projections highlight the major contribution of informal caregivers to the LTC systems of the different countries. The role of informal care is therefore important in its own right but hardly recognised by policy-makers. Thus, informal caregivers should be recognised as one central part of an LTC system and gain more influence in questions of design and layout of LTC systems.

Figure 1. Influence of the stakeholder



Note: X-axis – number of countries where a stakeholder has a strong / very strong influence (sample size: n=19).

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

3. Organisation of access

The WHO (2003) identifies two key characteristics regarding the design of LTC systems. First, it asks whether the system is targeted at the poor population only, or at the total population. And second, it asks whether or not access to services is based on an entitlement? We follow this logic and focus our attention regarding access to services on these questions.

The **first question is whether an LTC system only targets the poor**. An LTC system that targets the poor only needs some kind of means-testing. In LTC systems that include both the poor and the non-poor, there still can be some degree of means-testing e.g. to exclude the very high-income population or to vary the level of benefits (WHO, 2003). Additionally, the question if and how much co-payments are levied can pose financial barriers to access.

Two of the three LTC systems provide access to publicly financed LTC services without a means test. The use of means-testing clusters neither geographically (e.g. Western or Eastern countries, Scandinavian or Mediterranean countries) nor along the lines of traditional welfare models (e.g. formal vs. informal care-oriented LTC system) (see Table 4).

Table 4. Means-tested access to LTC

Country	Means-tested access to LTC	
	Yes	No
Austria		X
Belgium		X
Bulgaria		X
Czech Republic		X
Denmark		X
England	X	
Estonia		X
Finland		X
France		X
Germany		X
Hungary		X
Italy	X	
Latvia	X	
Lithuania	X	
Netherlands		X
Poland	X	
Romania	X	
Slovakia		X
Slovenia		X
Spain	X	
Sweden		X

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

In England, for example, the current charging regime for residential and nursing home care takes into account income and assets (in most cases including any housing wealth) of residents.

Those with assets over an upper limit, currently set at approximately €27,000 (£23,250) in England, are not eligible for local authority support. The NHS makes a non-means-tested contribution towards nursing costs in care homes (Comas-Herrera et al., 2010).

In Spain, access to publicly funded long-term care has been traditionally restricted through the use of means tests, which progressively take into account individuals' wealth (primarily housing assets). Means testing applies in the case of nursing homes, day care centres and home care services, which lie in the responsibility of the local authorities. The design of the means test is quite heterogeneous across provinces (Costa-Font et al., 2006).

In Italy health care services provided by the Italian National Health Service (Servizio Sanitario Nazionale; SSN) are free of charge, whereas social care services are means-tested (Tediosi & Gabriele, 2010).

Apart from a means test, access to LTC services can also be restricted due to geographical or organisational barriers. Geographical barriers are most often caused by regional disparities (rural vs. urban areas) in the supply of care. Belgium, Bulgaria, the Czech Republic, Finland, France, Hungary, Italy, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia, Spain and the UK report such access barriers. The Czech Republic reports an unequal distribution of pensioners' homes and long-term care homes between regions, Slovenia a shortage of supply in some regions and an excess of supply in other regions, Spain large regional variations in terms of resourcing, coverage rates of social services, and the UK a wide variation between different local authorities. In contrast, for example, in the Netherlands 80% of the population have a nursing home or home for the elderly within 5.2 kilometres.

Organisational barriers such as waiting times for nursing home admission due to low capacity are frequently reported. Such a barrier to LTC services exists in Austria, Belgium, Bulgaria, the Czech Republic (3 to 4 weeks), Denmark, Estonia, Hungary, Italy, Latvia, Lithuania, the Netherlands, Poland, Slovakia, Slovenia, Spain and Sweden. Thus, 16 countries out of a sample of 21 EU member states suffer at least to some degree from inadequate capacity to care properly for their older population.

In Denmark, for example, the reduction of long waiting times poses a big challenge and stands high on the political agenda. As a consequence, a so-called 'maximum waiting time guarantee' was introduced, effective 1 January 2009. It guarantees persons in need of care a place in a nursing home or special dwelling within at least two months after being accepted on the waiting list (Schulz, 2010a).

In the Netherlands, 35,000 persons were waiting for residential care or nursing-home care at the beginning of 2005. For about 5,000 persons who were waiting for institutional care, the waiting was characterised as problematic. This is especially true for persons with dementia. Sometimes the 'waiting' is caused by persons waiting for a place in their institution of first preference. For example, they may want to wait for a place in a project for small-scale living for persons with dementia (living in a normal household and not in a large institution) (CPB, 2009).

In Spain long waiting times are the result of severe restrictions on access to publicly financed institutional-based care. The priority for the provision of institutional care services depends on family income. The lower the family income is, the higher is the likelihood of being admitted to a public institutional care home. This severely restricts access for people with upper-middle income and results in very long waiting times for them (FEDEA, 2009).

Another organisational barrier is the lack of care workers or employees who are willing to work in the LTC sector. Lithuania and Romania report such a shortage of staff. As a consequence, sufficient supply of care services cannot be ensured (CASE, 2009a, 2009b).

In Germany access to long-term care services is reserved for persons who are covered either by a social or private LTC insurance scheme. This applies to around 99% of the German population (Schulz, 2010b).

The Bulgarian partners describe a completely different type of barrier to LTC services in their country: Bulgarian people do not accept any formal care services; they only trust informal care by family members. Roughly speaking, there is a 'psychological barrier' to formal LTC services.

The **second question is whether or not an LTC system provides services on an entitlement basis**. Entitlement implies that everyone who fulfils the eligibility criteria must be granted services, which are almost always established through specific legislation. Thus, the implementation of entitlement makes LTC services less accessible for policy in times of fiscal strains. The ability to control costs is limited and can only be carried out through changes in eligibility criteria, which would require changes in legislation, not just in administration. Such changes in the eligibility criteria would be subject to the public debate and difficult for governments to bring about if there is a recalcitrant legislature or significant opposition (WHO, 2003).

Table 5. Entitlement to LTC services

Country	Institutional care		Home care		Home nursing care	
	Yes	No	Yes	No	Yes	No
Austria		X		X		X
Belgium	X		X		X	
Bulgaria	X		X		X	
Czech Republic	X		X		X	
Denmark	X		X		X	
England		X		X	X	
Estonia	X		X		X	
Finland	X		X		X	
France	X		X			X
Germany	X		X		X	
Hungary	X		X		X	
Italy	X		X		X	
Latvia	X		X		X	
Lithuania	X		X		X	
Netherlands	X		X		X	
Poland	X		X		X	
Romania		X		X		X
Slovakia	X		X		X	
Slovenia	X		X		X	
Spain	X		X		X	
Sweden	X		X		X	

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

In contrast, non-entitlement offers the possibility to control expenditures as services do not have to be provided when the budget runs out, even for those who meet the eligibility criteria. Thus, the budget allocation can be more flexibly adjusted to fit the budget situation (WHO, 2003).

Almost all European countries provide entitlement to LTC services. Notable exemptions are Austria, England and Romania (see Table 5 above).

In Austria the entitlement depends on the kind of benefit. In general, the Austrian LTC system is a combination of benefits in cash and in kind. Its core part is a long-term care allowance programme at the federal and provincial levels. Thus, unlike other European countries, cash benefits are the most important ones. Persons in need of care have a legal entitlement to receive these benefits in cash. In contrast, they do not have any legal entitlement to obtain benefits in kind (Riedel & Kraus, 2010).

In England entitlement to LTC services is restricted to home nursing care. Access to publicly funded long-term care health services (mostly home nursing) is based on a referral from a general practitioner (GP) or as a result of a care package arranged following a hospital discharge. As there is universal entitlement to health care, there are no means tests for these services. In contrast, persons in need of care have no entitlement to institutional care and home care (Comas-Herrera et al., 2010).

Summing up, our analysis of organisational characteristics governing access to publicly funded LTC services reveals only a low level of organisational barriers to access for most countries. The highest possible level of accessibility (no means-tested access plus entitlement to LTC services) can be found in 13 of the 21 countries (Belgium, Bulgaria, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, the Netherlands, Slovakia, Slovenia and Sweden). In England and Romania access to LTC seems to be most difficult (Kraus et al., 2010).

4. Selected characteristics for the organisation of supply

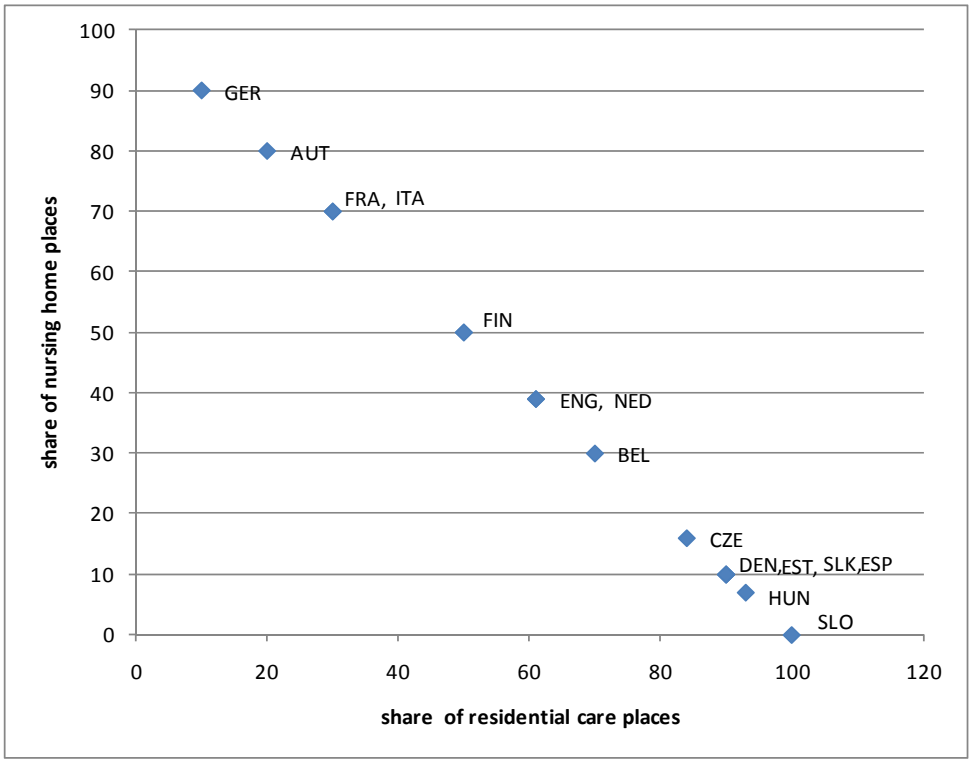
The importance of the cultural and historical context for the understanding of national LTC systems has already been stressed before. Needless to say, this diversity is reflected in diverse patterns of service provision. A recent World Bank study for instance concludes that there is no one model of provision and that countries have adopted various models based on country conditions and social acceptability (World Bank, 2010). One aspect of this diversity is highlighted in Figure 2. All countries provide some degree of institutional care,[1] with comparable numbers of the amount of care provided being hard to collect. There is, however, a broad variation between European countries regarding the inclusion or exclusion of nursing services in these facilities. Traditional social insurance countries like Austria and Germany provide institutional care mostly in nursing homes rather than residential homes, and to a lesser degree this holds also for France. New EU member states, but also Spain and Denmark have the opposite strategy and the majority of special housing for the older population concentrates on the provision of ‘hotel services’ and personal services.

Across Europe, we find almost the full spectrum of theoretically possible distributions over both kinds of facilities. In Slovenia, for instance, provision of institutional care for the older population has a long tradition. Facilities concentrate on providing housing, meals and personal services, even though the main reason for 57% of the inhabitants in 2006 to live in a home for the elderly rather than in the private household was age in combination with a bad health status,

[1] Following the definitions used in the ANCIEN questionnaire, we refer to institutional care for care settings including housing. Thus, institutional care might include the provision of nursing care (nursing homes) or it might not (as in residential homes).

and for another 12% the main reason was a physical illness (Prevolnik Rupel & Ogorevc, 2010). In Austria, as the other extreme, national policy has defined a target to severely limit (public) facilities providing only housing for the elderly, and some provinces even plan to transform all remaining facilities into nursing homes. In general, there is the goal of preferring the provision of home-based care over the provision of residential or nursing home care (Riedel & Kraus, 2010). The Danish policy shares the latter view, but combines this with a very different strategy (see Schulz, 2010a). The target there is to phase out nursing homes and switch completely to home-based care and intermediate forms of supported living arrangements. There are homes for the elderly, but nursing care and home help – if needed – are increasingly being provided by mobile nurses and carers. Thus the proportions between different settings of care are currently shifting, with nursing dwellings already offering 5.66 places per inhabitant in 2007, and traditional nursing homes 2.13 places per 100,000 inhabitants (DIW 2009 referring to Statistics Denmark).

Figure 2. Estimated shares of nursing vs. residential homes in total bed capacity, 2006



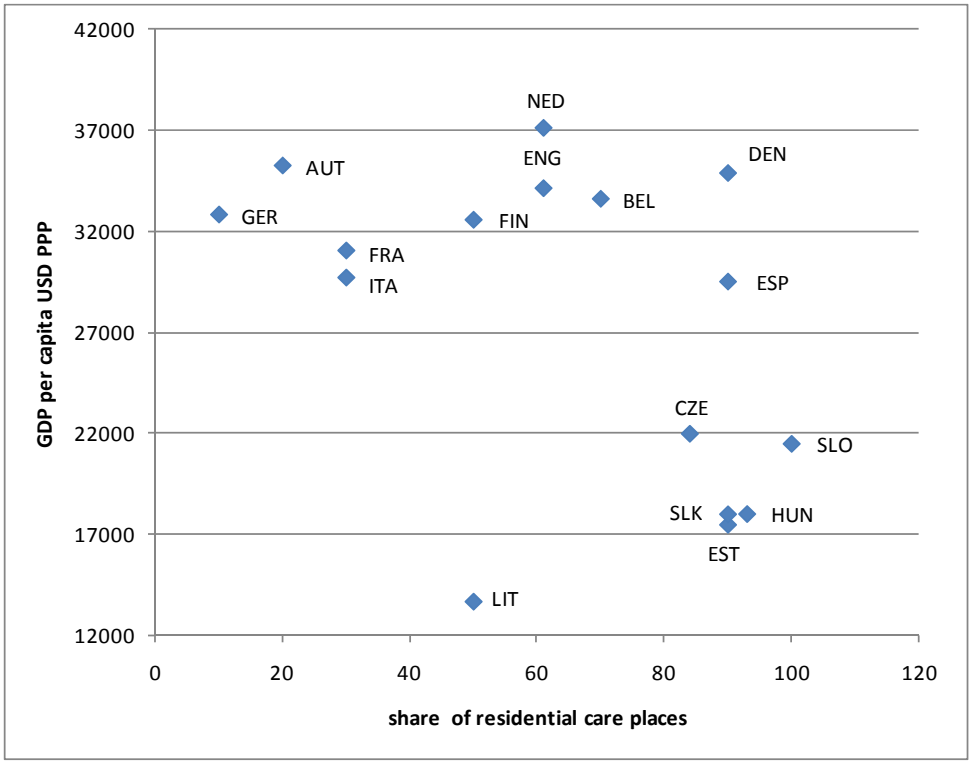
Note: If no concrete data were available, country experts were asked to give an approximate estimate (0-20%, 21-40%, 41-60%, 61-80%, 81-100%). For the figure, the mean of the respective interval was used (10% instead of 0-20%, etc.)

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

Thus, it seems that a high share of residential as opposed to dedicated nursing home places is compatible with at least two completely different backgrounds: First, the background of a relatively affluent society like Denmark, which stresses values like self-determination and support of private autonomy, thus avoiding the (not much desired) life in a nursing home and replacing it as long as possible with life in a chosen environment, with support on a mobile basis providing the needed amount and kind of help. Second, a higher share of residential homes was found in less affluent societies, where perhaps more often older persons do not have the necessary financial means to remain in their own household, and residential care fills a gap that

used to be seen as a family responsibility but is less often than before compatible with current life styles (higher mobility of the younger generation, fewer multi-generation households, …) and economic necessities (like that for two earners in a couple or family). A chart of the share of residential places against GDP per capita corroborates this assumption (see Figure 3).

Figure 3. Share of residential places in all care places for the elderly (% of GDP per capita)



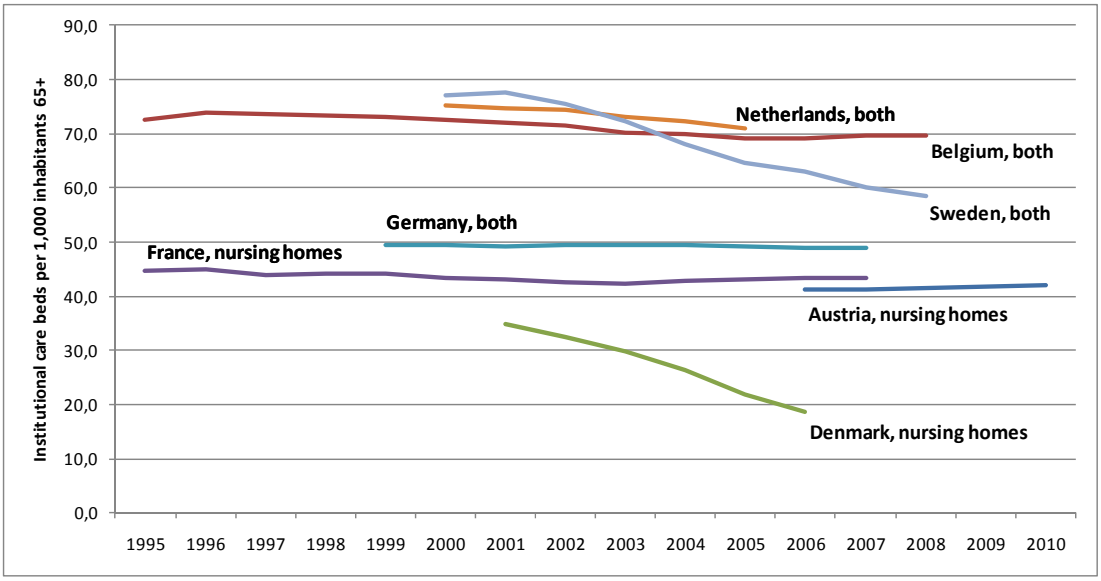
Note: GDP for UK instead of England. If no concrete data were available for residential care, country experts were asked to give an approximate estimate (0-20%, 21-40%, 41-60%, 61-80%, 81-100%). For the figure, we used the mean of the respective interval (10% for 0-20%, etc.).

Source: IHS HealthEcon compilation 2010 based on country experts' data collections; GDP: OECD health data 2009 except EST, LIT, SLO: Index Mundi.

In general, the collection of quantitative data turned out to be very difficult. This was also true for data on supply of LTC services. For example, time series on the number of beds in institutional care, the number of provided care hours and the number of recipients of home-based care could only be obtained for a few countries. A further problem in the data collection process was the limited comparability of data, as not all data referred to the same reference year and the same setting of care. Thus, Figure 4 and Figure 5 are limited to countries with reliable data. A comprehensive description of the data collection can be found in Kraus et al. (2010). Figure 4 and Figure 5 present some trends in the provision of institutional and home-based care. Figure 4displays a trend to scale down institutional care in Northern European countries. The policy objective behind it is to enable care recipients to stay in their own home as long as possible. The observed trend is particularly strong in Denmark and Sweden. In Denmark this trend can be attributed to the Act on Housing for Older People from 1987 which completely abolished the erection of new conventional nursing homes. Since then no new ones have been built (Karlsson et al., 2010). In traditional social insurance countries no clear trend is visible yet; see Austria, France and Germany in the figure. It is also noteworthy that Austrian and German social policies state the objective to favour home-based care over institutional care. When

interpreting both figures remember that data refer to care provision per 1,000 inhabitants 65+. For example, the seemingly constant number of German recipients of home-based care translates into an increase of about 20% in home-based care (1999: 415,289 recipients, 2007: 504,232 recipients) and 24% (1999: 645.456 places, 2007: 799.049 places) in institutional care. In contrast, countries like Denmark and Sweden succeeded in actually reducing their bed capacities. Thus, the current demographic development necessitates more capacity for the provision of constant level of care per older inhabitant.

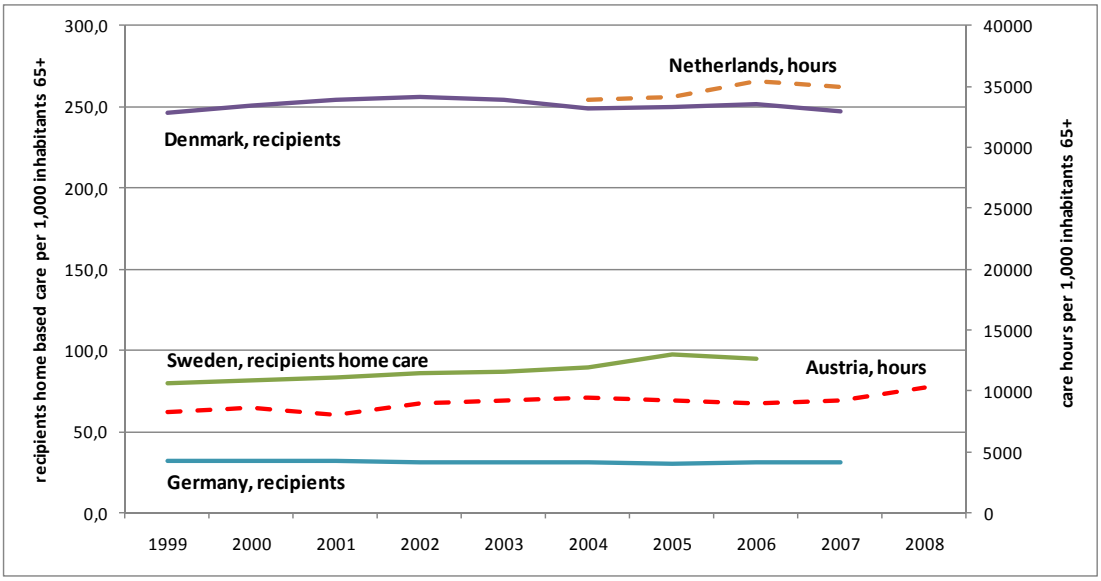
Figure 4. Provision of institutional care in selected countries



Note: "Both" includes beds in residential as well as nursing homes.

Source: IHS HealthEcon compilation 2011 based on country experts' data collections.

Figure 5. Provision of home-based care in selected countries

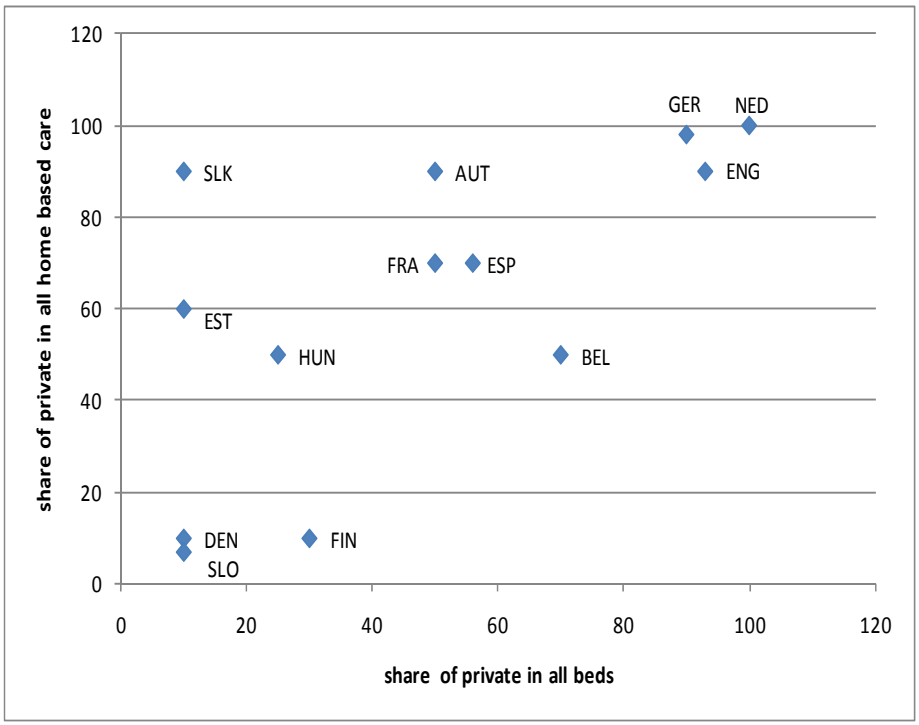


Source: IHS HealthEcon compilation 2011 based on country experts' data collections.

4.1 Public vs. private provision of services

According to the World Bank (2010), the main public policy question concerning the provision of LTC services is whether to 'make or buy', that is, how much formal long-term care services should be provided by the public sector and how much should be contracted out to private facilities? Economic theory connects both possibilities with different incentives and diverging impacts on the quality of care.[2] European countries answer the question for the optimal (or at least, for the feasible) public-private mix in the provision of long-term care services quite differently, as Figure 6 shows. The Netherlands hold the most extreme position with virtually all long-term care services being provided by private enterprises: Institutional care is being provided by private not for-profit facilities, while home-based care is being provided by both kinds of private firms (for-profit or not for-profit). Also the German market for long-term care services is dominated by private enterprises in both settings of care, institutional and home-based. The majority of clients in both settings receive care from not for-profit rather than from private for-profit facilities. Note, however, that the provision of care in both settings is increasingly becoming a 'normal' rather than a charitable business in Germany: from 1999-2007, the share of persons receiving home-based care from not for-profit providers declined from 62% to 52%, while public providers remained below 2% of the market share during this period. In institutional care during the same time span, the market share of not for-profit providers declined from 63% to 59%, and that of public providers from 11% to 7% (Schulz, 2010b, calculated from Tables 21 and 25).

Figure 6. Estimated share of public vs. private provision of formal LTC services and institutional care vs. home-based care



Note: If no concrete data were available, country experts were asked to give an approximate estimate (0-20%, 21-40%, 41-60%, 61-80%, 81-100%). For the figure, the mean of the respective interval was used (10% instead of 0-20%, etc.).

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

[2] See Konetzka (2006) for a discussion of some of those incentives against a US background.

The position of Denmark and Finland in Figure 6 exemplifies the strong tradition of public provision of services in Scandinavian welfare systems. The only non-Scandinavian country with a similarly strong position of the public sector in LTC provision is Slovenia. For all other countries in this figure, we can assume that about 30% or more of the market, at least for formal home-based care, are held by private providers.

In general, private provision plays a larger role in the provision of home-based care than in institutional care. This especially seems to be true for new EU member states, most notably for Slovakia. In Hungary, there seems to be a special dividing line of public/private ownership for the provision of home-based care: while most legal entities providing home nursing care are private, most providers of home care are public (TARKI, 2009).

When interpreting Figure 6 we have to keep in mind, however, that shares refer to relative provision of care only. For example, England, Germany and the Netherlands are very close with regard to the high shares of private provision only, but not necessarily with regard to overall capacity.

4.2 Choice

The freedom of choice in general and in long-term care in particular can be discussed from different perspectives. In the following we focus on the choice between public and private providers as well as on the choice between benefits in cash and in kind.

4.2.1 Choice between public and private providers

Introducing market competition is seen as one major approach towards insuring quality in LTC. It enables the care recipients to choose among alternative providers and increase their self-determination. Having choice among alternative providers can empower care recipients as consumers and may help to strengthen their role in the care process. Choice can also help address quality aspects that are difficult to quantify but easy to experience for users, such as the personal interaction between care recipients and caregivers (Lundsgaard, 2005; OECD, 2005; WHO, 2003). The majority of European LTC systems offer free provider choice in both institutional care and home-based care. In Denmark, Italy and Spain free provider choice is limited to home-based care. Only in Finland are care recipients not free to choose their provider (see Table 6).

Denmark opened the market for providers in home-based care in the beginning of 2003. Since then, Danish municipalities have an obligation to contract with private providers that are willing to offer home-based care at a price equal to the cost level of the public agencies, provided that they fulfil the quality requirements. In this context, in 2002, all municipalities were obliged to calculate the average cost per hour of home-based care for their own provider(s) and to publicly announce the calculated hourly price together with the quality requirements for the private providers. The cost/price calculations as well as the service conditions are updated every year (OECD, 2008).

During 2003, the number of approved providers grew rapidly. Most of them were small companies such as existing cleaning firms. By March 2006, 74% of the municipalities had at least one private provider of practical help, but only 37% of the municipalities had at least one private provider of personal care. Although persons in need of care have the opportunity to choose a private provider, they rarely make use of this possibility. 21% of the receivers of publicly funded practical help on a permanent basis had chosen a private provider in March 2006, and only 4% of the receivers of publicly funded personal care made use of private providers. The main reason given by the persons in need of care for having the municipality provider is that it has always been like this. One reason for the larger use of private providers in

practical help than in personal care might be that choice already existed in this area in a limited number of municipalities before 2001, but not yet regarding personal care (OECD, 2008).

Persons in need of care using private providers appear to be quite happy about having a choice among alternative providers on the one hand and more influence over the care they receive on the other hand. Some 73% of the clients with a private provider indicated that they are "very satisfied" compared with 54% of the clients using a municipality provider (OECD, 2008).

The interesting question from the perspective of the policy-makers is whether the choice mechanism has led to effective contestability and driven productivity improvements in the sector as a whole. A first evaluation showed two results (OECD, 2008):

- A slightly negative correlation between municipal hourly costs and the share of older persons choosing a private provider can be identified. This could be a sign that contestability works with firm entry driving down municipal costs. Of course firms should be expected to seek out municipalities with high costs offering a high hourly price, but in equilibrium, this may be offset by a cost-saving reaction of municipal agencies when exposed to competition.
- A clearly positive correlation between the entry of private providers and average income in the municipality can be observed. This is particularly true for private providers of practical help. Here older persons with higher income might often be interested in purchasing supplementary services on top of what is publicly funded, such as cleaning of the whole house or gardening.

In Sweden private providers have been allowed to enter the market of long-term care since the beginning of the 1990s. In the first few years the number of private providers grew rapidly. This trend continued at a lower level throughout the 1990s and the last decade. This growth is also reflected in the number of persons in need of care using private providers, both in institutional care and home-based care. In 1993 only about 5% of the clients used private institutional care services and about 3% private home-based care services. By 2006, the usage of private providers increased to nearly 14% in the institutional care setting and to around 11% in the home-based care setting (Karlsson et al., 2010).

In Sweden vast regional differences in the availability of private providers exist, because the emergence of the private providers is restricted to some 40 local authorities in metropolitan areas and some larger towns; these make up less than 15% of all local authorities. The presence of the private providers has emerged when choice possibilities between public and private providers were introduced. In other cases, the private element is simply the result of procurement at the local authority level (Karlsson et al., 2010).

Table 6 is limited to explaining in which countries and care settings the regulations of the respective LTC systems allow prospective care recipients to choose their providers, at least in theory. We do not have information on how many providers prospective care recipients on average can choose in practice. Obviously, the possibility to choose is only valuable as long as there is sufficient service capacity available, with 'availability' being multi-faceted: more than one provider should be near enough, affordable and offering the 'right' kind of care. Considering that respondents from most countries covered in this study reported their national LTC systems to offer free provider choice, we should keep in mind that most respondents mentioned at least some kind of waiting time or lack of supply as well.

Table 6. Choice of providers

Countries	Choice of providers		
	Free provider choice in IC and HBC	**Free provider choice only in HBC**	**No free provider choice**
Austria	X		
Belgium	X		
Bulgaria	X		
Czech Republic	X		
Denmark		X	
England	X		
Estonia	X		
Finland			X
France	X		
Germany	X		
Hungary	X		
Italy		X	
Latvia	X		
Lithuania	X		
Netherlands	X		
Poland	X		
Romania	X		
Slovakia	X		
Slovenia	X		
Spain	X		
Sweden	X		

Note: The definition of the variable refers to the regulatory definition whether or not choice is possible. Systems where choice is allowed in theory are coded in the same way whether or not there is sufficient supply of services to actually offer possibilities to choose for care recipients.

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

4.2.2 Choice between benefits in cash and in kind

All European countries provide benefits related to long-term care. These benefits can be provided in kind or in cash. In general, the existence of cash benefits supports the possibility for individual choice as they improve the opportunity to choose between different settings of care (e.g. to buy either formal care services or to support informal caregivers). This empowers the care recipients and strengthens their role in the care process.

In nine out of 21 countries both benefits in cash and in kind are available in institutional care (e.g. Austria, Belgium, England, Finland, France and Spain). In the other countries institutional care is provided in kind only. Table 7 summarises this aspect of care provision also for home care and home nursing care.

The Austrian cash benefits are available for all persons in need of care (60 or more hours of care per month for more than six months), independently of age, income and assets. The assessment of need for long-term care is based on individual requirements for personal services and

assistance. The need for both personal services and assistance is required in order to qualify for the cash benefits. In 2011, cash benefits range from €154.20 for care between 60 and 85 hours per month (level 1) to a maximum of €1,655.80 (level 7) for more than 180 hours of care per month in combination with complete immobility. These cash benefits can be used to buy formal care services from public or private providers or to reimburse informal caregiving and are funded by national taxes (Riedel & Kraus, 2010; BMASK, 2011).

The Finnish LTC system also offers some kind of cash benefits, although it is mostly based on benefits in kind. The cash benefits scheme (Care Allowance for Pensioners) is intended to make it possible for pension recipients with an illness or disability to live at home, as well as to promote home care and to reimburse pension recipients for extra costs caused by illness or disability. The mean monthly allowance is around €100 and it is paid out by the Social Insurance Institution of Finland (KELA) and not by the municipalities (Johansson, 2010).

In the German LTC system, care recipients can choose between in-cash and in-kind benefits for home-based care. Benefits are available for all insured persons in the long-term care insurance (LTCI) depending on the extent of the need for care, but irrespective of age, income or wealth. The German long-term care system distinguishes between three care levels. While most often care recipients choose benefits in cash to reimburse their informal caregiver, they choose benefits in kind when obtaining formal home-based care. When choosing cash benefits, these are given directly to the recipient. To improve the quality of caregiving, the recipients of cash benefits have to contact a professional caregiver twice a year for a review. Furthermore, cash and in-kind benefits may be combined. If, for example, the informal caregiver is on vacation, LTCI will cover the expenses of a professional carer for a period of up to four weeks – up to a ceiling of €1,470. The cash benefits range from €225 (Care level 1) to €685 (Care level III) in 2010. The cash benefit scheme in funded by the LTCI (Schulz, 2010b).

In general, all benefits are capped or given as lump sums in the German LTC system. In institutional care expenses are only co-financed. The LTCI funds reimburse caregiving costs depending on the care level up to a fixed amount (Care level I €1,023, Care level II €1,279, Care level III €1,510); the so-called “hotel costs” (board and lodging) are not covered. Uncovered costs have to be paid by the persons in need of long-term care themselves. In formal home-based care the LTCI funds reimburse caregiving costs up to the following fixed amounts: Care level I: €440, Care level II: €1,040 and Care level III: €1,510. Similar to institutional care, uncovered costs have to be paid by the persons in need of care themselves (Schulz, 2010b).

The Italian cash benefit scheme is a universalistic intervention, neither linked to the payment of social security contributions nor means-tested. A person’s eligibility for cash benefits must be assessed: He or she must be 100% disabled and in need of continuous care on the one hand and must not be in residential institutions with costs charged to the public administration on the other hand. The cash benefit is provided every month and recipients are free to use it to purchase LTC services or not. In 2009 the monthly benefits amounted to €472.04. The national cash benefit scheme is funded by the central government out of general taxation (Da Roit et al., 2007; Tediosi & Gabriele, 2010).

In the Dutch long-term care systems the persons in need of care can choose between benefits in cash and in kind the home-based care. Persons in need of care who choose the cash-reimbursement scheme receive a personal budget that is 25% lower than the costs of in-kind care. The assumption is that they can buy care more efficiently. They are free to choose who should deliver their care: an official institution, an independent care worker, a family member, friend, neighbour etc. For most of the budget, patients have to be able to show that they did spend the money on care (Mot, 2010). In the current reform discussion this question is getting much attention, i.e. how much can be gained by purchasing informal care individually.

Table 7. Availability of benefits

Country	Institutional care		Home care			Home nursing care		
	Only benefits in kind	Benefits in kind and in cash	Only benefits in kind	Benefits in kind and in cash	Choice between benefits in kind and in cash	Only benefits in kind	Benefits in kind and in cash	Choice between benefits in kind and in cash
Austria		X		X			X	
Belgium		X		X		X		
Bulgaria	X		X			X		
Czech Republic	X			X		X		
Denmark	X		X			X		
England		X			X	X		
Estonia		X		X			X	
Finland		X			X			X
France		X	X			X		
Germany	X				X			X
Hungary	X		X			X		
Italy		X		X			X	
Latvia	X			X		X		
Lithuania	X			X			X	
Netherlands	X				X			X
Poland	X				X	X		
Romania	X		X			X		
Slovakia	X				X		X	
Slovenia		X		X		X		
Spain		X		X		X		
Sweden	X		X			X		

Source: IHS HealthEcon compilation 2010 based on country experts' data collections.

Concluding this chapter, we need to add another caveat on the merits of choice: It goes without saying that a comparison between benefits in cash and benefits in kind is to be made *ceteris paribus*: A rational care recipient will favour benefits in cash over those in kind if and only if the amount of cash granted allows him or her to purchase a similar amount of comparable care as the respective benefit in kind. This proposition, however, is far from being redundant. The 1993 reform of the Austrian LTC system, for instance, united several benefits under one major cash benefit – *Pflegegeld* – last but not least in order to support care recipients' autonomy and independence. Since then, the granted amounts lost much of their purchasing power due to too infrequent and too low adjustments of the monetary value. In combination with the complete absence of any legal entitlements for services in kind, the theoretically enhanced possibilities for choice lost much of their value. In Germany, critics also complain about the devaluation of cash allowances. But while cash allowances lost much of their value, there is some kind of 'safety net' for persons in need of care as there are entitlements for services in virtually all settings of care, which perhaps makes the situation more favourable for prospective care receivers than in the Austrian system. Most persons, however, might favour the Danish situation, with a complete absence of cash benefits, but a broad spectrum of benefits in kind for which legal entitlements

and mandatory quality assurance were implemented. The Danish high-quality system, however, comes at considerable cost for public purses.

5. Summary

In the future, formal care provision will gain more importance due to demographic shifts (increase of old and very old people, decline of young people and young adults) and social changes (female labour force participation, higher internal mobility across Europe). This increasing importance of formal care goes hand in hand with an increasing burden of LTC financing which emphasises the importance of the question of exactly how access to publicly financed services is regulated. In this context, we focus on two questions:

1. Are national LTC systems in the EU targeted at the poor only or do they also include the non-poor population?
2. Is the provision of services based on a legal entitlement or not?

The review of the LTC systems shows that two out of three LTC systems do not concentrate public support on the poor population only, i.e. access to services is managed without implementation of a means-test. Among the LTC systems targeted at the poor only, neither a geographical cluster nor one along the lines of traditional welfare models can be observed. Furthermore, the review reveals that almost all LTC systems have implemented entitlements for LTC services. Summing up, about half of the analysed LTC systems offer the highest possible level of access with regard to our two variables of interest: access to LTC services without means-testing but based on entitlements. But this easy access in theory does not necessarily translate into easy (and timely) access in practice: 16 out of the 21 studied countries report limited access to publicly financed LTC services due to geographical (e.g. rural vs. urban) or organisational (e.g. waiting times) barriers.

The structure of LTC systems differs considerably between countries. This is a result of the national structure, history and culture as well as of the economic performance of the individual countries. To reveal some differences, we investigated several organisational features and asked for the most important entities for decision-making, the responsible entities for capacity-planning and whether quality assurance is voluntary or mandatory. The analysis reveals that both centralised and shared decision-making can be found in Europe with a roughly similar frequency: In about half of the LTC systems the main responsibilities for regulating LTC are on the national level, while in the other half this responsibility is shared between national, provincial and municipality levels. This proportion is true for both institutional and home-based care. In contrast to our expectations, not all Eastern European LTC systems are organised in a central way. In the Bulgarian, Estonian, Latvian and Slovakian LTC systems, decision-making falls under the responsibility of both the centralised and decentralised levels. In addition, the review shows that capacity-planning also takes place at national, regional and local levels, even though we could not always define this distinction with sufficient clarity. In the majority of the analysed LTC systems, capacity-planning is consigned to both the centralised and the decentralised levels. In these countries, the legal framework is usually defined at the centralised level while regional or local bodies are entrusted with deciding on details and the execution of those regulations. Only Hungary handles capacity-planning for both settings centrally, and Slovenia handles it for institutional care at the centralised level. Furthermore, the examination reveals that in two of three LTC systems, quality assurance is mandatory. OECD and WHO have reported on the frequency of inadequate care in institutional as well as home-based care. Thus, many recent LTC reforms included aspects of quality assurance and improvement.

Another point that is determined mainly by history is whether the LTC services are provided publicly or privately. The public-private mix in the provision of LTC systems is quite different.

Scandinavian welfare systems like those in Denmark, Finland and also Sweden have a strong tradition of public provision of such services. Slovenia is the only non-Scandinavian country where the public sector plays as important a role in the provision of LTC services as in Scandinavia. On the other end of the scale are England, Germany and the Netherlands. In these countries LTC services are almost exclusively provided by the private sector. In this group of countries, the Netherlands occupies the most extreme position, with LTC services being provided exclusively by private entities. In general, the private sector is more important in the provision of home-based services than of institutional ones. This is especially true for the new EU member states.

We find that the public-private mix of LTC service provision goes hand in hand with the possibility to enable care recipients to choose from among alternative providers. The vast majority of the LTC systems analysed offer free provider choice in both settings of care, institutional care and home-based care. Apart from Italy and Spain, where free provider choice is limited to home-based care, we find the most restrictions in Scandinavian countries. These have a strong tradition of public provision of LTC services with no or limited possibility to choose the provider freely. Finland does not offer the care recipients any possibility to choose their providers. Denmark opened the market for private providers in home-based care in 2003, but only 1 out of 5 care recipients made use of private providers in practical help and hardly any care recipients sought private help with personal care in 2006. Sweden allowed private providers to enter the market in the beginning of the1990s. Even until now the emergence of private providers is restricted to less than 15% of the local authorities, mostly in metropolitan areas and larger towns. Thus, to ensure that a care recipient can exercise choice in selecting his or her care provider, it is not sufficient simply to legally allow private entities to provide services. In short, the possibility to freely choose one’s provider is only valuable as long as there is also sufficient service capacity available. This, however, is closely connected to questions of how much public and private money is available to finance LTC services.

References

BMASK (Bundesministerium für Arbeit, Soziales und Konsumentenschutz) (2011), Höhe des Pflegegelds [Online] (retrieved 4 April 2011).

CASE (Center for Social and Economic Research) (2009a), ANCIEN questionnaire Lithuania [internal data collection for the ANCIEN project, not publicly available].

——— (2009b), ANCIEN questionnaire Romania [internal data collection for the ANCIEN project, not publicly available].

Comas-Herrera, A., L. Pickard, R. Wittenberg, J. Malley and D. King (2010), "The Long-Term Care System for the Elderly in England", ENEPRI Research Report No. 74, CEPS, Brussels (www.ceps.eu).

Costa-Font, J., O. Mascarilla-Miró and D. Elvira (2006), "Means Testing and the Heterogeneity of Housing Assets: Funding Long-Term Care in Spain", *Social Policy and Administration*, Vol. 40, pp. 543-559.

CPB (Netherlands Bureau for Economic Policy Analysis) (2009), ANCIEN questionnaire The Netherlands [internal data collection for the ANCIEN project, not publicly available].

Da Roit, B., B. Le Bihan and A. Österle (2007), "Long-term Care Policies in Italy, Austria and France: Variations in Cash-for-Care Schemes", *Social Policy and Administration*, Vol. 41, pp. 653-671.

DIW (German Institute for Economic Research) (2009), ANCIEN questionnaire Denmark [internal data collection for the ANCIEN project, not publicly available].

Ettelt, S., E. Nolte, S. Thomson and N. Mays, International Healthcare Comparisons Network (2008), "Capacity planning in health care: A review of the international experience", Policy Brief, WHO on behalf of European Observatory on Health Systems and Policies.

FEDEA (Fundacion de estudios de economia aplicada) (2009), ANCIEN questionnaire Spain [internal data collection for the ANCIEN project, not publicly available].

Joël, M.-E., S. Dufour-Kippelen, C. Duchêne and M. Marmier (2010), "The Long-Term Care System for the Elderly in France", ENEPRI Research Report No. 77, CEPS, Brussels (www.ceps.eu).

Johansson, E. (2010), "The Long-Term Care System for the Elderly in Finland", ENEPRI Research Report No. 76, CEPS, Brussels (www.ceps.eu).

Karlsson, M., T. Iversen and H. Oien (2010), "Scandinavien long-term care financing", Health Economics Research Programme at University of Oslo, HERO 2010, Working Paper 2010:2, Oslo.

Klie, T. (2005), Pflegeversicherung. 7. Auflage, Vincentz Network, Hannover.

Konetzka, R.T. (2006), "Changing Economic Incentives in Long-Term Care", Policy Brief 32/2006, Center for Policy Research (CPR) at the Maxwell School of Syracuse University, Syracuse, NY.

Kraus, M., M. Riedel, E. Mot, P. Willemé, G. Röhrling and T. Czpionka (2010), "A typology of systems of long-term care in Europe", ANCIEN project, Research Report, Institute for Advanced Studies, Vienna.

Lundsgaard, J. (2005), "Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care. How Can it Help Improve Care Outcomes,

Employment and Fiscal Sustainability?", OECD Health Working Paper No. 20, OECD, Paris.

Mot, E. (2010), "The Long-Term Care System for the Elderly in The Netherlands", ENEPRI Research Report No. 90, CEPS, Brussels (www.ceps.eu).

OECD (Organisation for Economic Cooperation and Development) (2005), "Long-term care for older people", Paris.

——— (2008), "OECD Economic Survey, Denmark", Vol. 2008/2, Paris.

Pickard, L., A. Comas-Herrera, J. Costa-i-Font, C. Gor, A. di Maio, C. Patxot, A. Pozzi, H. Rothgang and R. Wittenberg (2007), "Modelling an entitlement to long-term care in Europe: Projections for long-term care expenditure to 2050", *Journal of European Social Policy*, Vol. 17, pp. 33-48.

Prevolnik Rupel, V. and M. Ogorevc (2010), "The Long-Term Care System for the Elderly in Slovenia", ENEPRI Research Report No. 87, CEPS, Brussels (www.ceps.eu).

Riedel, M. and M. Kraus (2010), "The Long-Term Care System for the Elderly in Austria", ENEPRI Research Report No. 69, CEPS, Brussels (www.ceps.eu).

Schneider, U., A. Österle, D. Schober and C. Schober (2006), "Die Kosten der Pflege in Österreich, Ausgabenstrukturen und Finanzierung", Institut für Sozialpolitik, Forschungsbericht 02/2006, Wien.

Schulz, E. (2010a), "The Long-Term Care System for the Elderly in Denmark, ENEPRI Research Report No. 73, CEPS, Brussels (www.ceps.eu).

——— (2010b), "The Long-Term Care System for the Elderly in Germany", ENEPRI Research Report No. 78, CEPS, Brussels (www.ceps.eu).

Statistisches Bundesamt (2011), Pflegestatistik 2009, Pflege im Rahmen der Pflegeversicherung Deutschlandergebnisse, Wiesbaden.

TARKI (Social Research Institute) (2009), ANCIEN questionnaire Hungary [internal data collection for the ANCIEN project, not publicly available].

Tediosi, F. and S. Gabriele (2010), "The Long-Term Care System for the Elderly in Italy", ENEPRI Research Report No. 80, CEPS, Brussels (www.ceps.eu).

Willemé, P. (2010), "The Long-Term Care System for the Elderly in Belgium", ENEPRI Research Report No. 70, CEPS, Brussels (www.ceps.eu).

WHO (World Health Organization) (2003), "Key Policy Issues in Long-Term Care", Geneva.

——— (2008), "Home care in Europe: The solid facts", Milan.

World Bank (2010), "Long-term care policies for older populations in new EU member states and Croatia: Challenges and Opportunities", Europe and Central Asia Region, Human Development Department, Washington, D.C., November.

INSTITUT FÜR HÖHERE STUDIEN
INSTITUTE FOR ADVANCED STUDIES
Vienna

The Institute for Advanced Studies (IHS), Austria's premier post-graduate research and training institute, combines theoretical and empirical research in economics and other social science disciplines. It was founded as a private non-profit organization by Paul F. Lazarsfeld and Oskar Morgenstern in 1963. From its very beginnings, the IHS has operated on the principle that scientific enterprises, scientific co-operation and scientific problem solutions offer a platform for critical discussions, an opportunity for consensus formation, and an open and interdisciplinary arena for scientific research and critical scientific expertise. The Institute's Board of Trustees is composed of leading figures in politics, science, and economics. In addition there is an international Scientific Advisory Board. The Institute is financed by subsidies from federal ministries (Federal Ministry of Finance and Federal Ministry of Education, Science and Culture), the Austrian Central National Bank, the City of Vienna and other institutions. More than 40% of the Institute's budget is earned from research contracts. The Institute for Advanced Studies is divided into three departments: 1) Economics and Finance, 2) Political Science, and 3) Sociology. The institute has approximately 60 scientific employees and 23 administrative employees. There are about 50 students.

The Team IHS HealthEcon at the Department of Economics and Finance (EcoFin) is one of the leading research groups in the field of applied health economics in Austria. Reflecting the requirement for a multidisciplinary approach, its members stem from a variety of different fields like economics, business administration, statistics, medicine and pharmacy; currently, there are also three young economists working as part of the team. IHS HealthEcon explores topics as diverse as the future of financing healthcare and long term care, efficiency studies and evaluation, equity in healthcare, healthcare systems comparisons, national and international health policy analysis, health services research and interactions of healthcare with other sectors.

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).