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How does the introduction of 'choice' affect the pooling of risks in European welfare states? The case of long-term care

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Abstract: Ongoing reforms of European welfare states that aim at increasing 'choice' for patients, clients, and beneficiaries provide a unique opportunity to explore what exactly drives these reforms and how they reconstitute communities of economic risks. Traditionally, the solidaristic bargain underpinning European welfare states revolved around the twin objectives of a redistribution of resources and a pooling of risks (Baldwin, 1990). Much of the retrenchment literature to date has focused on the income distributive effects of dwindling resources to explain changes in European welfare states. We postulate that more profound changes in welfare arrangements are being driven by the introduction of 'consumer choice' which is compatible with welfare expansion of new welfare state pillars. Our case study on long term care explores in particular, what choices users get and whether this allow us to infer the thrust behind 'choice' reforms as well as the effects on the pooling of risks in European welfare states. We find that welfare state expansion in long-term care has responded to growing demand and that there is a great variety in the cost-sharing arrangements which cannot all be subsumed under the imperative of cost containment.

1 Introduction

Choice is an element of welfare state reform in many European member states. However, the drivers of this 'choice agenda' are not well understood. Our argument and point of departure in this paper is that potentially profound changes in welfare arrangements are driven by the introduction of 'consumer choice'. This is in contrast to the literature on welfare retrenchment, most prominently the 'new politics of the welfare state' (Pierson 2001), which to date has focused on the income distributive effects of dwindling resources to explain changes in European welfare states. Our reasons for this different starting point are threefold: First, in welfare economic terms the choice agenda breaks with the time-honoured equity-efficiency tradeoff and thus comes with a novel and robust justification for social policy interventions which relies less on solidaristic motives. Second, in political terms the involvement of the private sector creates its own dynamic of support and demand for more choice. And third, European integration is a complementary driver and supporter of the choice agenda at the member state level and, in turn, the EU has strong motives for

supporting the choice agenda.[1] In particular, the more member states introduce choice reforms, the more the EU gets a regulatory mandate for 'social services of general interest' in the context of the Single Market Programme, if only to scrutinise their claim of general interest and exempt such services from competition law (Huber 2007: 5-8).

Before we expand on these reasons in the next section, a brief clarification of what choice in welfare means may be in order. In principle, choice can extend to at least five dimensions of a social service (Le Grand 2007: 39-40): where, who, what, when, and how. *Where* relates to the choice of provider (eg which care home?), *who* to the choice of the professional (eg a one day care centre or another?), *what* to the choice of the service or treatment (eg residential or home care?), *when* to the choice of timing (of an appointment or a treatment) and *how* concerns the choice of access and communication (eg consultation face-to-face, over-the-phone or web-based). In practice, there is an important sixth dimension, namely the question of '*who does the choosing*?': the individual user, an individual agent (a relative, the GP) who represents the user, or perhaps a collective like a Social Care Trust contracting with hospitals on behalf of a group of users? The most relevant choices in practice seem to be the choice of providers or of services and whether this is done by the individual user or by a collective on behalf of the individual (Williams and Rossiter 2004: 6).

Introducing choice of providers does and did not necessarily mean privatization of services; it can be between public providers that are given financial incentives to compete.[2] Furthermore, a very important dimension to delimit privatisation is to distinguish the important role of non-profit private organisation in complementing public coverage which cannot be confused with marketisation of welfare. But '*who pays*?' can be seen as a seventh dimension of choice if it is related to privatizing social services. Various forms of cost sharing for basic services and co-payments for additional services allows monitoring demand in line with individual's capacity and willingness to pay. A related dimension, finally is the territorial one, namely the assignment of decision making authority and its financing. For instance, it is well-known from the literature on federalism that decentralisation to the lowest level of authority (local level) without providing full federal funding is likely to make local authorities ration services and introduce stricter means or needs-testing.

This leads to a more general point: Choice is not quite as new a feature of the welfare state as its proponents sometimes make us believe. But the interesting point for us is that this has become a 'selling point' for welfare reforms. While additional services against co-payment have been a time-honoured item in many insurance contracts, notably health care, the fact of additional services was often neglected while co-payments were understood and justified as a means of containing moral hazard and thus the 'cost explosion' in health care. The

[1] The OMC on health and long-term care stresses three goals, in this order: access for all, high-quality adapted to changing needs and preferences, and financial sustainability (CEC 2006, Huber et al 2007:3-4). This is a typical 'motherhood and applepie' formulation of an EU policy document and our paper tries to identify which goals are institutionalised in practice.

[2] "It is the presence of competition that matters, not the ownership structure of providers [..]." (Le Grand 2007: 42)

choice agenda can turn this on its head: that the co-payment is unrelated to the likely cost of the additional service may be downplayed or ignored altogether while the availability of more services becomes the centre of attention. It is exactly this shift of emphasis and what drives it politically and economically that interests us here.

As will be argued in the next section, we have strong reasons to believe that the thrust of European welfare reforms is no longer on retrenchment but has moved on to a more positive (sounding) agenda of choice. But in practice quite a few tensions arise and they affect the pooling of risks between citizens which will be outlined in the third section and later highlighted in our case study. In the fourth section, the research design will be explained: We try to identify patterns of choice elements that can be interpreted in favour of particular motivations for introducing choice, such as middle-class electoral politics, legitimising public welfare or, indeed, cost containment. Our case study of long-term care in France, Germany, Italy, the Netherlands, Spain and the United Kingdom tries to identify these motivations in the fifth section. We have chosen this case study because it provides the greatest challenge for our hypothesis that it is not primarily retrenchment that drives welfare reforms in Europe – if we can show that even here, cost containment cannot explain major features, then we would consider this to be evidence for our starting point. We conclude with some pointers to further research, in-depth qualitative case studies that are necessary since not all hypotheses about motivations can really be distinguished at this general, bird's eye view which our paper casts on long-term care.

2 Why 'choice' is relevant in European welfare reforms

Our first reason for the hypothesis that the choice agenda is a potentially more profound and powerful determinant of welfare systems and their change than 'permanent fiscal austerity' is its more appealing, legitimate economic foundation. The economic rationale for choice in welfare presupposes that there is a wide range of social policies to which the equity-efficiency trade-off does not apply, opening up opportunities for economically equivalent choices. The new economics of the welfare state (Barr 1992, 2004; Sinn 1995) supports this view that social policy can act 'as a productive factor', to paraphrase the Social Agenda of the EU. It has identified two routes through which social policy interventions can make the market economy work better: either by compensating for market failures such as adverse selection or negative externalities or by allowing individuals to take riskier choices that will, on average, yield higher returns. The economic literature on user choice and provider competition added to this reconciliation of markets and social policy by studying how, in turn, social policy can emulate market mechanisms to improve welfare provisions (Le Grand 1991, Le Grand and Bartlett 1993).

The concept of 'quasi-markets' captures arrangements in which providers on the supply side compete just like in commercial markets. But the users on the demand side make their choice without being constrained by unequal purchasing power, ie the service is paid for by the state following the user's choice, for instance through vouchers or a funding formula that responds to demand. "The quasi-market is thus a fundamentally egalitarian device, enabling public services to be delivered in such a way as to avoid most of the inequalities that arise in normal markets from differences in people's purchasing power." (Le Grand 2007: 41) This redistribution through market mechanisms, ex ante (from the rich to the

poor) and ex post (from the lucky to the unlucky), seems to combine the best of both worlds: the efficiency of markets with the equity of welfare. Its appeal to users depends less on solidaristic motives than on improved satisfaction with the individual service that taxpayers or contributors collectively finance (CEC 2008: 63-64). However, we will argue below that other tradeoffs may be involved in the reconstruction of risk communities implied by user choice and provider competition.

Second, the political dynamic that the choice agenda creates is likely to be self-perpetuating (Blomqvist 2004: 152). For one, it tends to be supported by those who are actually interested and able to make choices and these tend to be the more resourceful members of society. To the extent that choice does indeed lead to the involvement of private providers, there will also be political support from the supply side of a quasi-market. Moreover, the development of ever more diversified and tailor-made social services could feed on itself if 'the logic of stratification (that social groups seek to define themselves by separation from others and continuously invent new ways of doing so) is likely to create ever-increasing demands for more exclusive and culturally "distinct" service alternatives.' (Blomqvist 2004: 152) Distinct services may again be provided more for the resourceful and articulate members of society who are willing and able to demand them politically. Finally, the provision of user choice in quasi-markets may lead to the privatisation of financing them, fully or in parts, because the beneficiaries do not want to wait for authorities to purchase them on their behalf. The privatisation of welfare finance would again create political support among providers and the beneficiaries of tailor-made services.

Third, the choice agenda gets some of its impetus from European integration. We have already indicated that the mantra of the EU's agenda, 'social policy as a productive factor', fits the welfare economic rationale of the choice agenda perfectly. 'Modernisation' is another catchword by which the Commission identifies a trend that involves more choice for users.[3] Moreover and less obviously, it may affect the democratic consensus as enshrined in national welfare state arrangements. For instance, EU competition law threatens national monopolies in service provision and grants worker, patient and student mobility in the European Union that can thus put pressure on national welfare arrangements in EU member states (Leibfried 2005). Different conceptions of democracy in the EU would each justify the reconstruction of risk communities at the national, supra- and even subnational level through choice. The EU therefore has an inherent interest in this agenda even though it sees not itself, but forces at the member state level as the main driver of a more consumerist orientation in welfare (CEC 2008: 61-64).

[3] 'Modernisation is a response to the main social and economic challenges EU societies are facing (ageing, gender equality, social integration, labour market flexibility and efficiency, etc). The necessity to adapt to changing needs, which cannot be dissociated from the search for quality improvement, efficiency and cost containment, is amongst the most important drivers of modernisation. In a context where the services needed are becoming more sophisticated and complex, the need to develop a stronger user orientation, to increase user empowerment and to promote access to social rights also play a role in this process.' (CEC 2008: 61) A substantial study for DG Employment identifies user orientation ('more choice') as one of six drivers of modernization of social services and healthcare systems (Huber et al 2008: 16).

3 Why tensions arise in 'choice' reforms

The economic rationale and the likely political dynamic outlined above indicate that the choice agenda may involve some tensions, other tradeoffs or perhaps the old equity-efficiency tradeoff in a new guise. As indicated, choice may be politically more attractive for resourceful members of society, educated middle-class households, rather than for the less well-off (as much as they may like choice as well), and hence be economically regressive. This would also affect the image of the EU as a destroyer or a rescuer of the European welfare state. The following is a general outline with a few examples; but we must leave it to future research to specify some of these tradeoffs.

Even strong proponents of user choice and provider competition in welfare economics concede that a number of preconditions have to be fulfilled for quasi-markets to deliver on their promise of improving the quality of social services "without adverse consequences in terms of increased inequity" (Bartlett and Le Grand 1993: 19, cf.19-33 for the following).

1. First, the *market structure* will never follow the ideal atomistically competitive model of an economics textbook since the price mechanism will not fully reflect individual user preferences but decisions of the funding public agency. Hence 'voice' or political mechanisms of user involvement need to be put in place so as to make up for this relative deficiency of the price mechanism. The voice of users may also help to compensate for some loss of control over the supply side, ie the social service professionals and the cost of their labour, which was "one of the major virtues of a monopsonistic public sector" (Bartlett and Le Grand 1993: 23). Note also that competition between providers may come at the cost of driving out cooperation between providers, eg hospitals, which may generally not be desirable (Williams and Rossiter 2004: 12).
2. Second, with a multitude of providers, the problem of *asymmetric information* is likely to get worse: "[T]hese include the likelihood that providers will adopt opportunistic strategies in the face of incomplete information; the increased risk premia required by the risk-averse providers of services; and the increased administrative costs of fully specified cost-per-case contracts." (Bartlett and Le Grand 1993: 26) On the demand side, this is the notorious problem of quality uncertainty (Akerlof 1973). Clients will need help and advice to make choices between providers or treatments efficiently. This is the basic rationale for having intermediaries making the choice on behalf of the individual user but it also implies that choice is actually confined.
3. Third, as we know from Coasian institutional economics, market coordination has considerable *transaction costs*, especially under conditions of uncertainty when it is not possible to specify future contingent prices fully in advance. Under these conditions, hierarchies in the public sector or in firms can be less costly allocation mechanisms. Transaction costs also figure on the demand side in that exercising choice effectively requires clients to incur some costs and search actively for information (Williams and Rossiter 2004: 5).
4. Fourth, the *motivation* of market actors and social service providers is not necessarily compatible. For providers being responsive to (quasi-)market signals, they must be driven, at least to some extent, by financial considerations. Yet, the clientele may be vulnerable and incapacitated, and the services they

need are typically more vital than a haircut. In order to avoid that commercially driven providers exploit the power asymmetry in the relationship, the public sector purchasers need to be strong advocates of user interests still. Moreover, some excess capacity is a necessary cost of choice for providers to be able to respond flexibly to demand (Williams and Rossiter 2004: 10).

5. Last but not least, a particular form of *adverse selection or discrimination* is likely to become a problem with market provision, namely cherry picking or cream skimming. It means that the least needy clients get the best services because they are less costly to serve. "Only if the contract price varies in an appropriate fashion with the needs of the client will cream-skimming not be a problem." (Bartlett and Le Grand 1993: 33) However, even if a highly geared pricing formula can incentivize providers to serve 'difficult' clients, this may lead to mistrust between purchaser and providers as they will have opposite incentives to downplay or overstate, respectively, the real need of clients (Bredgaard and Larsen 2008: 349).

The most fundamental tension or tradeoff becomes obvious if we take the political dynamic into account. Above all, the prediction that resourceful clients will take up the offer for choice more effectively than the less well-off households suggests that any assessment has to look at both choosers and non-choosers (Williams and Rossiter 2004: 18). The *negative externality* of providing choice for some on those who do not take it up or are not choosers is aptly illustrated by Bartlett and Le Grand (1993: 17): granting choice for users to get (support for) residential care may reduce choice for carers on whom there is now moral pressure to care at home. Generally, there is a danger that public services, for instance state schools, deteriorate because private alternatives are taken up selectively, leading to segregation into poor public and well-endowed private services. However, in theory there may also be a 'leveling-up effect' on public provisions because competition puts healthy pressure on bureaucracies to improve their ways (Williams and Rossiter 2004: 9). The level in take-up rates as well as the share of different user groups in take-up are indicators of this effect on social service provision that can go either way: undermine public services as we know them or improve them by providing competition and more choice. For the European Union and its inadvertent as well as explicit support for the choice agenda it is a vital question which effect prevails.

All these tensions affect the amount of risk pooling and segregation that results from introducing choice into welfare systems. In theory, it is not always clear whether this works out in favour of more or less social security, or which user groups are exactly affected. For instance, does the imperfection of quasi-market structures – given the atomistic competitive market as the benchmark – lead to better insurance of so far neglected risks because users are allowed now to choose according to their preferences and constraints? Or does the loss of control over the supply side lead to cream-skimming and other forms of segregation, of the less well-informed or those less inclined to incur all the search costs involved in making choices? Or, to take another example, does the negative externality from providing private alternatives lead to less insurance/ lower quality of services for those dependent on public risk management of last resort?

In our research, we will address these tensions and the reconstitution of risk communities involved in the following questions:

1. Does the introduction of choice elements lead to larger pools or more separated pools of risk? In our case study of long-term care, we will look at coverage and access to services.
2. Is the risk pooling/ separation potentially welfare-enhancing because the pooling/ separation follows different preferences, not different risk levels of the users? In our case study, we will inquire whether use of nursing homes and community services is characterized by take-up rates that vary strongly with the income level of households.
3. Was this explicit in the original proposal and intended or does it look like an unintended consequence that puts pressure on reformers to adjust the original policy design? For our case study, this means to watch out for corrections of original reforms and/or salient political debates about reforms between government and opposition.
4. Did the introduction of choice lead to higher risks for the non-choosers and/ or less choice for those not targeted but affected by a scheme? For a preliminary answer, our case study can draw on surveys and polls that reveal how satisfied individuals in different circumstances are with long-term care arrangements.

4 What motivations potentially drive 'choice' reforms

The literature on welfare reforms in general and choice in particular has in theory established a number of motivations behind the introduction of choice in welfare systems. In our empirical case study, we will make an effort to identify these motivations by looking at patterns of choice elements. Table 1 gives an overview of our reasoning.

Cost containment is one motivation that comes closest the theme of retrenchment under 'permanent fiscal austerity' in the new politics of the welfare state (Pierson 2001). A problem with this motivation is that it is both omnipresent and yet hard to pin down. It is always present since even governments with traditionally soft budget constraints have become rather cost-conscious, if only because EU fiscal surveillance keeps on asking them to justify unsustainable spending paths. Politically, however, it is hard to pin down and, except for instances of fiscal crisis management, can easily be overestimated as a motivation. If it were dominant, we should see more cuts in the big spending programmes of health and pensions but, one the whole, we do not. Our approach here is to look at the financing arrangements for a particular scheme: cost containment is likely to be at work if means-testing that restricts entitlement is combined with decentralised financing, for instance by local authorities, which creates disincentives for generous funding, and if private for-profit alternatives are rather restricted because they tend to be expensive (OECD 2005: 28).

Commercial interests of for-profit providers can be the driving force behind choice reforms which is what many social policy scholars suspect behind a 'privatization of risk' strategy (Hacker 2004). We would locate them in the fact that for-profit providers actually play a prominent role in social service provision, that the authority over financing is quite

fragmented (thus increasing the availability of resources) and that users are given the option to substitute a public for a privately funded scheme. It should be noted that commercial interests as the driving force make cost containment quite difficult because the government loses control over finances.

Middle-class electoral politics is the motivation that political scientists like Blomqvist (2004) put forward as the thrust behind choice reforms in Sweden. We would see this motivation at work if contribution-based entitlement is combined with choice of private outside options, either as a top-up (supplement) or for complete opt-out from the private alternative (substitute). The attempt at enticing middle-class voters could also be seen in providing maximum choice of providers, including private for-profit providers, which cater tailored services to well-informed and otherwise resourceful clients.

Family policy is a related motivation. It can only be distinguished as separate from middle-class electoral politics if it addresses the specific needs and interests of (female) carers. We would see this at work if universal entitlement financed out of general taxes (ie no means test or contributions as basis of entitlement) is combined with choice among non-profit providers. In this, we would see the attempt to allow women to reconcile career and care obligations even if their work does not provide ample resources to pay relevant amounts for the opportunity of choice. If family policy is mainly directed at raising female employment rates, we would expect to find the same pattern as in middle-class electoral politics, namely contribution-based entitlements and choice among providers that includes for-profit agencies.

Administrative modernisation is a motivation that clearly comes out of the literature on quasi-markets; and scholars who adhere to this approach have advised governments to that effect (Le Grand 2007). The modernisation aspect is discernible in the attempt to foster competition between public and non-profit providers while there is centralised authority over the financing of the choice scheme. If this motivation is prevalent, existing institutions are largely preserved, such as contribution-based or means-tested entitlement. We would also not expect an emphasis on for-profit providers which do not compete on a level-playing field and their involvement (beyond some trial schemes) may be too disruptive if gradual modernisation is the driving force.

Legitimising public welfare is another motivation that can be discerned in the early quasi-market literature (Le Grand and Bartlett 1993). It is related but possibly different from administrative modernisation insofar the basis of entitlement tends to be universal, ie services over which choice is given are financed out of taxes, non-profit providers are co-opted as advocacy groups and outside options can be chosen as a complement. This motivations shares with administrative modernisation that the central control over finances is not relinquished.

Given the complexity of motivations, our strategy is specifically to see to what extent we can exclude cost containment as the primary motivation and then discern other motivations in line with our research design summarized in table 1. *Cost containment* strategies in LTC would give limited support for formal residential care (eg communal day care) but not

allow private institutional care, favours means-testing and local authority over financing because that tends to keep costs down. *Commercial interests* as the driver, characterized by the option of private nursing homes, massive involvement of for-profit providers and the possibility to opt out of public schemes altogether (ie substitute) would be at odds with cost containment. Similarly, free choice between supported residential care and nursing homes of a good quality, ie between a relatively 'cheap' and the expensive option of institutional care, and the option to pay for additional services (supplement) or even an opt-out (substitute), would suggest that *middle class voters* and 'productivist' (work-oriented) family policy are drivers, incentivising women to enter employment. *Care-oriented family policy* is distinguishable in that it does not give expensive institutional care options but in contrast to cost containment gives generous support to formal residential care and provides universal entitlements. *Administrative modernisation*, including better pay and career opportunities for staff in institutional care, and more tailored, decentralised provision combined with central finance (quasi-markets) is also incompatible with prioritizing cost containment. Finally, *legitimizing public welfare*, can be discerned in universal entitlement, in complementary and supplementary financing of services, and in the attempt to co-opt non-profit providers, largely for political reasons.

But we are also interested in how cost containment is done exactly: mainly through limiting the choice on institutional care; decentralisation with limited central funding; or restriction of access through high co-payments? The political implications of each of these options are different because they are more or less visible and are to different degrees regressive in their impact on households with different incomes.

Table 1: Choice elements and their hypothetical motivations

Which features (columns) speak in favour of which motivation (rows)?	**Care service**		**Finance**			**Provision**	
	residential	*institutional*	*Basis of entitlement*	*Level of authority*	*Nature of outside options*	*Public*	*Private*
	formal, informal	*public, private*	*means-tested, contribution-based, universal*	*central, decentralized, fragmented*	*complement, supplement, substitute*	*centralized, de-centralized*	*non-profit, for-profit*
Cost containment	limited support for formal care	private not an option	means-tested	decentralized		decentralized	
Commercial interests		private as an option		[fragmented]	substitute		for-profit
Middle-class electoral politics		private as an option	contribution-based		supplement, substitute		
Family policy (care-oriented)	generous support for formal care		universal (needs-testing only)				non-profit
Administrative modernisation		generous support for public		central		de-centralized	
Legitimising public welfare			universal (needs-testing only)		complement, supplement		non-profit

see text for elaboration

5 The introduction of long-term care in six European countries

Table 1 indicates that we found it useful to boil down the opportunities for choice to three dimensions:

- Choice of service: The relevant choice here is between care that takes place in a nursing home or in the residence of the old age dependent, the latter typically provided by relatives but with different degrees of support, say by care assistants or community day-care services. The less restricted this choice between institutional and (various option of supported) residential care is, the less we consider cost containment to be the driving force.in particular if more expensive private institutional care is covered. To what degree this goes hand in hand with administrative modernisation or private sector pressures can be distinguished according to what extent public rather than private institutional care is the focus of attention.
- Choice of financing: The question of financing has two main aspects in long-term care. First, is there a choice of opting out or paying into an insurance scheme so as to be covered at all or is every resident automatically covered by a universal public scheme? Second, is there only needs-tested access of services (universal) or does the choice over the full range of treatments require individuals to share the costs (in the form of co-payments, co-insurance or deductibles, ie means-tested or based on prior contributions)? We contend that means-testing and strict targeting is necessary for identifying cost containment as the primary driver while insurance-based coverage suggests that upper and middle-class voters are targeted (without necessarily compromising means-tested support for the less affluent). In addition, the centralisation of finance is an indicator to what extent different schemes exist that can be chosen, but also to what extent competition between them exists that keeps costs down. Finally, these schemes may require some complementary co-payment, allow for supplementary top-ups or can be actually substituted by some private arrangement.
- Choice of provider: The choice of provider may be offered, normally dependent on the degree of need and te intensity of care required. Basic choices concern the choice between public providers, on the one hand, and private for-profit and non-profit providers, on the other. With respect to public providers there is a question of how centralised and uniform or decentralised and diversified they are organised and hence offer choice within the public sector. Decentralisation is compatible with cost containment; but it depends on the type of funding of the system and the level at which decentralisation takes place (regional or local, the latter being more costly) and on the extent to which central public funds are available whether this should be considered the dominant factor or, for instance, administrative modernisation. An important role of for-profit providers is not easily reconciled with cost containment, but indicates the influence of commercial interests. An important role of non-profit providers suggests either family policy targeting care givers, especially if combined with some individual co-payments since this is an affordable private source of formal care. Or it indicates legitimising strategies for public welfare since non-profit providers represent important political stakeholders of a particular social policy.

As mentioned above, we have chosen long-term care (LTC) for elderly people as our first case study because it is the most challenging for us in terms of our overall hypothesis that retrenchment is an overstated driver of welfare reforms. Cost considerations here seem to be overwhelming: An OECD (2005: 20) study notes that demand for LTC increases exponentially in the age group of 80 years and older and this is the fastest growing segment of the population. According to Eurostat projections, the number of this age group will rise by 50% and more than double in all EU-25 countries except Sweden which already has the highest share of very old people in the world (Huber et al 2008: 93). In all European countries, expenditure on LTC is expected to grow markedly (Pickard et al, 2007). In Spain, the introduction of a new package to cover LTC implies that public expenditure on LTC will rise from 0.3% GDP to 1% GDP (Costa-Font and Gonzalez, 2000). Yet, this also suggests that outright retrenchment is not really an option, on the contrary, an ever rising amount of fiscal areas will have to be devoted to LTC for older people.

In other words, cost containment may be possible at best. And there are other motivations that may make even that difficult. A study for the Commission notes 'dissatisfaction of citizens with the number and quality of available public services will keep growing.' (Huber et al 2008: 93) In particular middle class households will be able and willing to pay for better long-term care, either for themselves or for an elderly relative as this allows them to maintain a higher living standard and a life style of independence. Another driver seems to be staff shortages which are a great and rising concern of public LTC providers, due to low pay, high staff turnover and difficult working conditions (Huber et al 2008: 95). Hence, there is a prima facie case for administrative modernization and improving/ legitimizing public welfare so as to retain and attract staff.

In a number of OECD countries, there is a move towards allowing users more choice as regards residential care, among care providers and flexibility with regards to the way care is provided (OECD 2005: 50; Lundsgaard 2005: 12).[4] Choice typically means that a user in need of care is given a personal budget, ie a person found eligible is given a certain amount of support, specified as a particular set of services, a number of hours per week or an amount of money. Out of this budget, 'the person needing care can choose how to obtain care and how to "spend" the support for which she/he has been found eligible; either from an agency designated by the public authorities or insurance programme, from an alternative agency or self-employed care assistant, by employing a personal care assistant her/him self or possibly receive a cash allowance to support informal care. The German long-term care insurance comes close to this description.' (Lundsgaard 2005: 21).

This trend holds for very different models that exist and there is quite a lot of diversity in LTC, more than in health care generally.[5] In our country sample, Italy and Spain is representative of Southern European countries where it is largely provided informally even

[4] The United States, more precisely the states, have the longest experience with 'consumer-directed' LTC, lasting for more than 20 years, where it means choice over a particular form of residential care services (OECD 2005: 51).

[5] 'Even where seemingly similar arrangements have been put in place, the underlying policy goals for their introduction may not have been the same, taking into account different starting positions and policy context.' (Lundsgaard 2005: 20)

though institutional care is predominantly funded publicly. Germany and the UK represent countries that have considerable more public resources spent on LTC; a significant share goes into support of informal care, allowig care recipients either to get formal care or share it with the informal care giver (Germany), or granting LTC allowances to relatives providing informal care (UK). The Netherlands is representative of other Nordic countries in that it spends considerable amounts on LTC but channels these public funds largely to formal residential care or to institutional care (Lundsgaard 2005: 12). France is similar in its focus on formal, in particular institutional, care but is not as generous as the Netherlands, in that respect more similar to Germany and the UK. Services have been expanding strongly in four out of the six countries, including France, Germany, Spain and the UK (Huber et al 2008: 106)., although this does not show up in the figures from 2000 in Table 2.

Table 2: Financing and provision of LTC in 2000

	Financing (as % of GDP)		Provision (as % of 65+)	
	Total expenditure	Public expenditure	in nursing homes	in residential care
France	0.5	n.a.	6.5	./.
Germany	1.3	0.9	4.0	9.0
Italy	1.0	n.a.	2.0	2.0
The Netherlands	2.7	1.8	2.4	12.0
Spain	0.6	0.2	4.0	4.0
United Kingdom	1.4	1.0	4.0	20.0

Source: OECD, AARP European Leadership Study, Costa-Font *et al* (2008).

Table 3 specifies what we have found for the six large EU countries that we have chosen for our case study on LTC. The cost-containment motive is noticeable if one concentrates on cost-sharing arrangements: there is practically no LTC system that would not means-test the access to care and co-payments are used to moderate demand (in Germany and the Netherlands, means-tested benefits cover those that do not have contribution-based entitlements). In three of these countries (Italy, Spain and the UK), we also find a combination of decentralized finance and decentralized provision, which restricts local authorities. But the slight privilege that benefits extend to institutional care in Italy and the role of for-profit providers in the UK suggest that even here a few other motives, such as professional or commercial interests, may play a role. Spain stands out as a relatively clear case where choice is driven by cost containment, along with some influence of commercial interests. They have managed to instrumentalise decentralisation so as to prevent a uniform level of services, to create a market for financial complements to public coverage and allow a role of market providers to emerge.

Table 3: Features of long-term care services in six European countries

	Care service		**Finance**			**Provision**	
	residential	*institutional*	*Basis of entitlement*	*Level of authority*	*Nature of outside options*	*Public*	*Private*
France	Cash benefit is fungible	Cash benefit is fungible	Means-tested co-payments	Central gov't (social insurance)	Complement	Central and regional governments	For-profit
Germany	In kind support of formal care plus lower cash benefit for informal care	Lower cash benefit	General coverage after needs-test (contribution-based, means-tested for non-contributors)	Central gov't (social insurance)	Substitute	Regional governments	Mixed for- and non-profit
Italy	Cash benefit is very limited for formal care	Cash benefits	Partial and means-tested entitlement to annuity	Central gov't grant and local taxes	Supplement	Central and local governments	Non-profit
The Netherlands	In kind and cash benefits	In kind and cash benefits	General coverage after needs-test (income-related, contribution-based coinsurance)	Central gov't (social insurance)	Substitute (?)	Central and local governments	For-profit
Spain	In kind	In kind and cash benefits	Means-tested co-payment	Equal share of central gov't, regional gov't and individual	Complement, supplement	Regional governments	Non-profit
United Kingdom	In kind and cash benefits	In kind and cash benefits	Universal access in Scotland but means-tested in England and Wales	Central gov't grant and local taxes	Complement, supplement	Local governments	For-profit

What about the others? France, another country with conditional, means-tested coverage, does not show a clear pattern. A new autonomy pension system, introduced in 2002, provided only a limited entitlement but even so the system soon ran into budget deficits because of unexpectedly high demand. The attempt at cost-containment is discernible in the fact that no universal entitlement was granted and no earmarked tax was to pay for benefits, unlike in Germany and the Netherlands. Yet the role of for-profit providers with centralized financing and a relatively high share of institutional care does not suggest an overriding motivation of cost containment because all of these features make care services expensive. This shows some relevant impact of commercial interests.

Germany's LTC system has a discernible emphasis on family policy that is supportive of residential care. Access and coverage is general or universal and it nurtures a 'mixed economy of welfare'. The Netherlands looks like a case of middle-class electoral politics with its fungible benefits that leave individuals the choice of service, general coverage but for the majority contribution-based, and the possibility to opt-out altogether. Both countries allow some choice of in kind/cash transfers or a combination of both, but cash transfers are less generous (do not have the same value as the equivalent in kind transfer). The official rationale for this is prevention of moral hazard, eg relatives claiming a cash benefit for an elderly person living in the household. But there was also considerable lobbying of formal, both non-profit and for-profit, providers who saw their markets undermined by generous support of informal carers.[6] It can be generally observed that countries allowing in kind benefits provide for more choice and support subsidised informal care by household members (Lundsgaard 2005). This seems to be a successful political strategy of co-opting commercial interests for a middle-class/ family-friendly policy that mobilises both formal and informal private sources of care. But it raises the question – which we need to follow up in future research– whether more choice of this kind for the elderly dependant reduces choice for carers.

Another general observation to add is that the availability of private alternatives, ie choice in this specific sense, may be partly or largely a result of time. Countries in which formal LTC has been introduced only recently, to support informal care in the family, tend to give a larger role to non-profit organisations in delivering care for the elderly. Countries with a longer tradition of LTC coverage, like the UK, the Netherlands and Germany, markets for financing care and a bigger role of for-profit organisations appear to have developed over time. This also holds for the financing side of care. A choice of financing mechanisms can entail that individuals may opt out of the system which is the case in Germany (where the public scheme covers just over 70 million people and a private scheme about 8.5 million, cf OECD 2005: 81). Complementary private instruments have been developed in France, the largest private LTC insurance market in Europe, covering 1% of the old age population. Private alternatives were developed in the UK but with not much success (Barr 2004). Italy and Spain do not have developed financial markets for LTC insurance. Hence, it is conceivable that some of the differences in this respect are not so much evidence of

[6] 'Developing a more diversified sector of formal care providers and creating care jobs has, in some cases, been an important secondary objective when expanding choice in connection with the expansion of public or insurance-based funding for long-term care' (Lundsgaard 2005: 25, with respect to Germany).

different political strategies but a result of different stages of development in LTC systems. If so, the latecomers are bound to 'catch up' and more choices will become available through an emerging private care sector, presumably strengthening commercial interests in maintaining more choice.

What can we at this stage say about the reconstitution of risk communities? Our answers are rather tentative and more research is needed.

- Does the introduction of choice elements lead to larger pools or more separated pools of risk? In our case studies of long-term care, coverage has been general only in Germany and the Netherlands, we think because these countries were able to introduce extra financing for LTC insurance (with means-tested assistance for those not covered). But access to services is an entitlement in all, ie every resident is, in principle, entitled to care services if needy. It depends on the private resources that the needy person can bring to bear which decide on whether this entitlement actually materialises. This 'affluence-testing' can leave some groups, for instance low middle income households, effectively uncovered as they are above the threshold to qualify for public assistance but do not have enough resources to buy private alternatives or make th required co-payments.
- Is the risk pooling/ separation potentially welfare-enhancing because the pooling/ separation follows different preferences, not different risk levels of the users? We cannot answer this question at the moment because we do not have data on take-up rates between different optional services and what possibly determines them.
- Was this explicit in the original proposal and intended or does it look like an unintended consequence that puts pressure on reformers to adjust the original policy design? In our case study, evidence so far suggests that choice has been introduced in response to particular demand pressures, for instance choices in residential care in response to quality deficits of nursing homes or support for informal care so as to help care givers to improve their labour market attachment. In some countries, eg France and Germany, there is also evidence for considerable supply-side pressure for the introduction of choice elements, ie private insurers or formal care providers, both for-profit and non-profit, wanted to expand their markets.
- Did the introduction of choice lead to higher risks for the non-choosers and/ or less choice for those not targeted but affected by a scheme? We did not find surveys for our countries so far but it seems likely that the needs of informal care-givers, mostly middle-aged women, will only be met in that they get more options for support of their work but not the choice of opting out. Fiscal pressures will be most felt here and it is inconceivable that formal providers will meet the growing demand for LTC predominantly. Even full compensation of informal carers is unlikely.[7] We cannot provide evidence for what happens

[7] Even if we take the highest spenders on LTC as a benchmark (Denmark, the Netherlands, and Sweden), 'the total volume of long-term care provided by agencies, care assistants and relatives corresponds to 7 - 9% of GDP currently in these countries but may grow to 13 - 16% of GDP by 2050 merely to maintain current service standards. This is more than *twice* the total public spending on education from nursery schools through to universities which typically accounts for 5 - 7% of GDP in OECD countries.'

to non-choosers, who may fall into this category quite involuntarily, given that means-tested coverage in four of our six countries suggests that these LTC systems do fail a significant group of households with care needs. This needs further follow-up in future research.

6 Conclusions

This paper tried to identify institutional patterns in social policies that would allow us to infer the driving motivations behind the introduction of choice in these policy areas. This research design was applied to long-term care in the six largest EU countries. We do find that even in an area where cost considerations are imperative, retrenchment appears not to be the main concern of governments. They expand services in this area despite the potentially massive fiscal consequences, both due to growing demand for better quality and easier reconciliation of care and paid work for care-givers, and due to noticeable supply-side pressures in some countries. The milder form of retrenchment, cost containment, was discernible in four out of six countries we looked at but only in Spain did we find a coherent thrust to that effect. Others had too much leeway for private for-profit providers and institutional care to be credibly focused on cost containment. Our findings resonate with more general statements in the policy-oriented literature.

We could not fully answer the question of how choice affects the reconstitution of communities of risk for the area of long-term care. But it seems that coverage seems to be still patchy in many countries while access is, in principle, guaranteed for all residents, although they may have to be poor enough to actually get public support. This may lead to a separation of risk pools; but at least they become now identifiable while without the entitlement, they were not identifiable before. Another area of concern is that potential informal care-givers may incur higher risks of ending up doing long-term care work, somewhat paradoxically because they receive now more support for their care work. The benchmark for comparison is again important, however. In many Southern European countries, Italy and Spain in our sample, this form of choice in residential care may actually allow female relatives to reduce their input compared to their lone responsibility before a public scheme was introduced; in continental European countries it may put more pressure on potential care-givers and therefore actually reduce their choice.

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(Lundsgaard 2005: 40) This study therefore suggests that it is fiscally not affordable to compensate informal carers fully, let alone let them opt for not caring.

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