Organization and Supply of Long-term Care Services for the Elderly: A Bird’s-eye View of Old and New EU Member States

Monika Riedel, Markus Kraus and Susanne Mayer

Abstract

This article provides an overview of the organization of formal long-term care (LTC) systems for the elderly in ten old and eleven new EU member states (MS). Generally, we find that the main responsibility for regulating LTC services is centralized in half of these countries, whereas in the remaining countries, this responsibility is typically shared between authorities at the central level and those at the regional or local levels in both institutional and home-based care. Responsibilities for planning LTC capacities are jointly met by central and non-central authorities in most countries. Access to publicly financed services is rarely means tested, and most countries have implemented legal entitlements conditional on needs. In virtually all countries, access to institutional care is subject to cost sharing, which also applies to home-based care in most countries. The relative importance of institutional LTC relative to home-based LTC services differs significantly across Europe. Although old MS appear to be experiencing some degree of convergence, institutional capacity levels still span a wide range. Considerable diversity may also be observed in the national public–private mix in the provision of LTC services. Lastly, free choice between public and private providers exists in the vast majority of these countries. This overview provides vital insights into the differences and similarities in the organization of LTC systems across Europe, especially between old and new MS, while also contributing valuable insight into previously neglected topics, thus broadening the knowledge base of international experience for mutual learning.

Keywords
Formal long-term care; Governance; Organization; Supply; Old EU member states; New EU member states

Introduction

At the country level, the development of long-term care (LTC) systems is affected by a complex interplay of internal (ideas, actors, interests, institutions)
and external (transnational policy transfer) factors (Theobald 2011). Thus no single history can explain the evolution of LTC systems in Europe. The result of these combined internal and external factors forms a rich variety of approaches and strategies for organizing and funding formal care services across the continent.

Meanwhile, European countries are uniformly aware of the importance of providing frameworks for both formal and informal care services for those in need, especially for elderly people (OECD 2005b; Colombo et al. 2011). The precise design of these systems, however, varies between countries. For example, in many eastern EU member states (EU MS), home care is not yet fully developed, whereas in some northern MS, informal care is comparatively less pronounced (Riedel 2013a). Overall, such national differences in LTC organization can be explained by these countries’ differing histories, inherited levels of provision, and the traditional roles of state and civil society (WHO 2008).

In previous research, little attention has been devoted to the commonalities of European LTC systems, especially at a comprehensive level. Thus, this article aims to portray and compare the organization of formal LTC systems for the elderly population (defined as those aged 65 and above) in 21 EU MS. Focusing also on potential discrepancies between old and new MS, we address the following research question: How do the organization and supply of LTC systems differ between old and new EU MS? A descriptive approach is used to explore three hypotheses. First, LTC regulation in new EU MS is more centralized than that in old EU MS. This hypothesis is grounded on the more centralized organization generally found in post-socialist countries. Second, new EU MS restrict access to LTC services more tightly because their economic performance presumably allows for focusing on certain population groups only. Third, in new EU MS, capacities to provide formal LTC services are lower and less frequently located in the private sector compared with old EU MS. We hypothesize this difference primarily because responsibilities for LTC provision in most new EU MS have traditionally been with family and public providers. Likewise, the development of the formal home-based care sector in such countries has only recently begun. Indeed, focusing on the differences between old and new EU MS does not suggest that each of these groups is homogenous in itself. For example, among old EU MS, the level of institutional LTC capacity is higher in Scandinavian states and lower in southern states. We also expect a range of higher to lower capacities in new EU MS, but with this range being at a generally lower level.

Overall, this article differs from prior research in two important dimensions. First, we do not limit our focus solely to the countries typically selected for such studies (e.g. England, Germany, the Netherlands and Sweden). Rather, by including states that joined the EU in 2004 or 2007 (new EU MS) in addition to old EU MS, we strive to provide a more complete representation of Europe to offer a broader set of international experiences for mutual learning. Second, a growing body of research focuses on selected aspects of LTC, such as funding issues (Karlsson et al. 2007; Fernandez et al. 2009; Costa-Font and Courbage 2012), cash-for-care programmes and cash benefit schemes (Timonen et al. 2006; Da Roit et al. 2007; Arksey and Kemp 2008;
Da Roit and Le Bihan 2010), the impact of population ageing on public spending (European Commission 2012; Comas-Herrera et al. 2006; Costa-Font et al. 2008), LTC patients’ rights (Le Bihan and Martin 2006) and reforms of LTC systems (Pavolini and Ranci 2008; Glendinning and Moran 2009; Österle 2010; Rostgaard 2011; Simonazzi 2012). However, a combined overview of several organizational features of LTC systems (other than financing issues) has not yet been featured in the literature. In the context of health care systems, provision of, and access to, services are considered areas of fundamental importance (Wendt 2009) that have been studied extensively. By focusing on these topics in relation to LTC services, our overview helps bridge this crucial gap in a largely understudied area of research.

Data

The information presented in this article is primarily drawn from a set of country reports on national LTC systems published in 2010 in the context of a project funded under the 7th Framework Programme (FP7 Health-2007-3.2.2, Grant no. 223483). This set of reports comprises the following countries: Austria, Belgium, Bulgaria, the Czech Republic, Denmark, England, Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Lithuania, the Netherlands, Poland, Romania, Slovakia, Slovenia, Spain and Sweden.

In collecting country-specific information, we aimed to apply uniform definitions of key concepts for all countries. We revalidated the collected information and checked for consistency with the definitions to ensure a high degree of data quality and comparability. These synthesized findings were then sent back to the country reports’ authors for verification. When necessary and possible, the resulting data were subsequently complemented with additional information from the literature.

Consistent with the Organisation for Economic Co-operation and Development (OECD 2005b), institutional care was defined as LTC provided in an institution that also serves as the residence of the care recipient. Additionally, following the OECD (2005b), home-based care was defined as care provided in the home and related to daily functioning, such as personal care (eating, bathing and dressing) and homemaking. This type of care includes both home-nursing care and social care but excludes informal care.

Conceptual Framework

The conceptual framework used in the analysis in this article is based on a supply and demand perspective on LTC, as illustrated in figure 1. However, heavy regulation in the LTC market also assigns an important role to governments, sometimes throughout the national, regional and local levels. Social insurance (including accordingly regulated private insurance) may additionally have some responsibility for such services, especially regarding medical and nursing care. Lastly, in several countries, certain regulatory tasks, such as the licensing and monitoring of providers, are outsourced to quasi-autonomous institutions.
On the demand side, not all persons in need of care are actually in a financial, emotional or intellectual position to acquire the LTC services that they need. Typically, government and/or social insurance assume the task of lowering financial barriers, for example, by (co-)financing services. Alternatively, other persons may want such LTC services and are in the financial, emotional and intellectual position to acquire the desired services, and in some cases, an objective need could be debated, especially in times of financial austerity. In sum, the demand and need for (publicly financed) care need not coincide.

Therefore, the level of government responsible for such care typically attempts to design a framework for interactions between demand and supply in a way that achieves the largest possible overlap between them using several avenues of regulation: governments can define entitlements for specific LTC services (or avoid doing so) and can link entitlements to certain conditions relating to financial, social (e.g. family status) or care-related needs. Regardless of entitlements, cost sharing can be required, particularly for institutional care and home care. Although these regulations may be summarized under the heading ‘access to LTC’, other regulations imposed on the providers of care services that aim to foster high-quality services may thus influence the supply of services. This influence may in turn have repercussions on the demand and need for care if higher-quality services result in reducing, avoiding or postponing care needs. Lastly, assistive technology increasingly has the potential to
change the relationship between care demand and supply. If technology helps ensure that persons in need of care are in a better position to cope on their own (or with the help of family members) at least in performing certain care tasks, the need for professional carers can be reduced, thus changing the structure of supply that is required to cover the aggregate care needs of a population.

The formal supply of care services is highly heterogeneous. First, it can be differentiated by the location of service provision, resulting in a distinction between institutional care on the one side and the private homes of persons in need of care on the other side. Increasingly, semi-institutional care forms are emerging, and they often enable informal carers to remain the primary provider of care while avoiding the often disliked transfer to a nursing home. Second, the supply of care can be distinguished by the type of provider: public, private not-for-profit and private for-profit providers. An additional differentiation (not reflected in figure 1) refers to the types of care tasks: in several countries, medical or nursing care and social care are separated with regard to governance, provision or financing.

A specific characteristic of the market for care is that the supply of services may also come from non-professionals (informal carers), and in fact, such professionals provide a major share of care in most countries. In this study, however, we restrict our focus to the organizational aspects of formal LTC provision. Furthermore, regarding the interplay between the supply and demand/need for care, we limit our analysis to the issue of access. We do not assume that other aspects are less significant; rather, regarding LTC quality, we refer to a comprehensive report published recently (OECD 2013). With regard to technology, we do not yet see how such a complex and difficult-to-confine topic can be integrated into a synthesizing approach such as that assumed in this study, and we thus chose to leave this possibility open to future research.

Selected Aspects of Governance

LTC policies differ considerably between countries according to their national governmental systems, histories, culture and economic performance (Daatland and Herlofson 2003; Bettio and Plantenga 2004; Yoo et al. 2004; European Commission 2007; Reimat 2009). These differences are also mirrored in two organizational aspects of the general LTC system as described in this section: first, the main level of government for fundamental decision making (national, regional and local) and, second, the main governmental level for capacity planning.

Main level of decision making

LTC systems are typically not regulated by only one level of a governing body: several tiers frequently share responsibilities, even in small economies. Although the actual scale of influence is shaped by the legal and financial incentive structure within a country, these parameters also determine the functional advantages and disadvantages associated with the respective degree of (de)centralization. In technocratic terms, such costs and benefits
potentially result from scale effects, transaction costs, territorial responsiveness, democratic accountability and other factors (Costa-Font and Greer 2013). The level of government may thus significantly affect the success of LTC policies.

As table 1 demonstrates, the main responsibility for regulating LTC is at the national level in nearly half of the countries investigated. In the other half, this responsibility is typically shared between different levels. This proportion holds for both institutional and home-based care; in all but one country (Slovenia), responsibilities for both care settings are allocated in a parallel manner (i.e. in both care settings, responsibility is distributed across levels, or the national level is allocated a dominating role).

Belgium represents a typical example of shared responsibility: the federal Ministries of Health and Social Affairs together with the National Institute for Health and Disability Insurance are responsible for the overall LTC budget, capacity planning and fees. National and regional authorities are jointly responsible for the certification, monitoring and quality control of residential care services, while regional authorities regulate home-based care services, and the local levels organize these services (Willemé 2010).

Finland and France are the only countries reported to have a high degree of non-centralization in both types of care settings. Note, however, that the non-centralization in both countries results in quite different sizes of the average catchment population: in Finland, more than 300 municipalities are responsible for approximately 5 million inhabitants in total, whereas in France, approximately 100 departments are accountable for 66 million people. Whereas more centralized authorities may benefit from economies of scale, smaller and non-centralized authorities facilitate attention to regional needs.

**Capacity planning**

LTC capacity planning may occur at three different levels. In practice, in the majority of countries, authorities at the central and regional and/or municipal levels share planning responsibilities. Only Hungary administers capacity planning for both care settings by central authorities, whereas Denmark, England, Italy, Poland, Romania and Sweden exclusively delegate this task to non-central authorities. Generally, the responsibility for capacity planning appears to be less centralized than the responsibility for overall LTC regulation, as shown in table 1.

Austria is representative of the implementation of joint responsibilities. At the national level, the government establishes general rules for capacity planning. At the regional level, each province is obliged to draft plans for a comprehensive net of institutional, semi-institutional and home-based care services to ensure full geographical coverage (Riedel and Kraus 2010).

Exceptional cases are found in Germany and the Netherlands, as neither country relies on any government instruments to steer the care supply. In Germany, the practice is grounded in LTC insurance law following the principles of fair competition and market deregulation to ensure a plurality of providers (public, private not-for-profit and private for-profit providers). This open-market policy limits the political impact and public planning possibilities and allows for over-capacities (Klie 2005). In 2011, for instance,
Table 1

Main levels of decision making and capacity planning

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*Note:* *public accreditation but no public capacity planning.*
the degree of capacity utilization in residential and nursing homes amounted to 88 per cent (Statistisches Bundesamt 2013).

In the Netherlands, the initial aim behind central planning had been to facilitate expenditure control. However, this strategy was actually found to hinder improvements in efficiency in institutional care and was hence abandoned in 2009. Since that time, individual LTC facilities have had the responsibility of planning their own capacity and adjusting to current demand. The government thus aims to increase freedom and responsibility for planning and investments (Ettelt et al. 2008; Mot 2010).

**Comparison between old and new EU member states**

The findings support our hypothesis regarding the basic structure of governance (i.e. that LTC regulation is more centralized in new EU MS than in old EU MS). This hypothesis applies to five of the ten new EU MS: the Czech Republic, Hungary, Lithuania, Poland and Romania. By contrast, in Bulgaria, Estonia, Latvia, Slovakia and Slovenia, authorities at both the central and non-central levels share these responsibilities. However, we do not find a clear difference between former MS of the USSR and other post-socialist MS of the EU. In the old EU MS, the central level has a dominating role less frequently (three of 11 countries, i.e. Italy, the Netherlands and Sweden). Only two old EU MS, Finland and France, and no new EU MS attach greater importance to the non-central level.

With regard to capacity planning, differences between the two groups of countries are less pronounced. The only two countries ascribing responsibility to central governments in planning institutional care, however, are again the new EU MS. In the majority of countries, authorities at both the national and regional levels have some importance. Where responsibilities are shared, national bodies typically establish the general framework for planning, financing and monitoring services, while regional or local authorities are often responsible for fine-tuning governance and executing established regulations. In some countries, regional authorities are more relevant for home-based care than for institutional care, but responsibilities for both types of care settings are generally attached to the same level of government. This also applies in cases in which public capacity planning has been replaced by self-regulation via market forces, such as in Germany and in the Netherlands. In several countries with a strong social insurance system, health insurance or LTC insurance rather than a governmental body has assumed governance responsibilities, particularly with regard to institutional care or home nursing care.

**Organization of Access**

In analyzing the organization of access to publicly (co-)financed LTC services, we follow the World Health Organization’s approach that addresses two key questions regarding the design and layout of LTC systems (WHO 2003). The first concern addresses whether the LTC system targets the total population or parts of the population only, and the second question explores whether legal entitlements define access to LTC services.
Access to long-term care services

An LTC system that exclusively targets the poor population requires some form of means testing. However, in LTC systems that include both the poor and the non-poor, some degree of means testing may also be implemented, for example, to exclude the very high-income population or to vary the scale and scope of benefits across different socio-economic groups (WHO 2003).

In our sample, two-thirds of the countries provide access to publicly funded LTC services without means testing. These countries are clustered neither geographically (e.g. West or East European countries, Scandinavian or Mediterranean countries) nor along the lines of traditional welfare models (e.g. formal versus informal care-oriented LTC systems) (table 2).

Entitlement to long-term care services

Entitlement to LTC services implies that everyone fulfilling the eligibility criteria must be granted access to these services. Established through specific legislation, such a system protects the retention of LTC services in the political process. Costs can be limited only through changes in eligibility criteria, which would likely be subject to public debate. By contrast, non-entitlement allows for controlling expenditures, as services do not need to be provided once the budget is exhausted (e.g. even those meeting the eligibility criteria could then be placed on a waiting list). Consequently, budget allocation can be more flexibly adjusted to fit the current fiscal situation (WHO 2003).

Nearly all countries have established entitlements to publicly financed LTC services (benefits in kind). Notable exceptions are Austria, England and Romania (table 2). In Austria, the question of entitlement depends on the type of benefit. Although persons in need of care have a legal entitlement to care allowances (i.e. the main pillar of the Austrian LTC system), this does not apply to benefits in kind (Horvath and Mayer 2010; Riedel and Kraus 2010). In England, entitlement to LTC services is granted for home nursing care but not for institutional care and home care (Comas-Herrera et al. 2010), whereas in Romania, entitlements do not apply to any care setting (Popa 2010).

At the same time, the validity of entitlements as a proxy for access to care is potentially limited by the co-existence of entitlements with cost sharing, geographical disparities and low capacities (e.g. Golinowska 2010; Marcinkowska 2010; Sowa 2010; Ilves and Plakane 2011). In fact, for institutional care, cost sharing is common in virtually every country (table 3), but the extent of cost sharing differs considerably. In England, for instance, nursing care services (but not living costs) are entirely covered by the National Health Service. In Austria, by contrast, both living costs and nursing care services must be borne privately. To help fund these expenses, persons in need of care are supposed to use care allowances, and social assistance becomes involved if individual means are not sufficient (Riedel and Kraus 2010). Cost sharing is income dependent in more than half of the countries examined.

For home care, all but three EU MS (Denmark, Germany and Latvia) apply some type of cost sharing, and many countries differentiate by income levels. By contrast, for home nursing care, cost sharing is far less frequent across Europe.
Regional disparities in access to LTC services were reported for all but one of the new EU MS (Estonia), whereas such disparities were reported for approximately half of the old EU MS (Belgium, England, Finland, France, Italy and Spain). In addition, only one new EU MS and four old EU MS (England, Finland, France, Germany and Romania) do not declare considerable waiting times for institutional care. Although the existence of waiting times often relates to low capacities, it must also be considered in the context of the local population’s expectations based on different traditions and historically grown supply patterns.

**Comparison between old and new EU member states**

Our second hypothesis focuses on access to LTC services and posits that access is more tightly restricted in new EU MS than in old EU MS. In fact,
regulations concerning means testing and entitlements to LTC services do not support this hypothesis, as LTC governance in both the new and old EU MS aims to ensure low organizational barriers to access. Of the seven countries with means testing, four are new EU MS (Latvia, Lithuania, Poland and Romania) and three are old EU MS (England, Italy and Spain). In all but two LTC systems (Austria and Romania), legal entitlements have been implemented for neither institutional nor home-based LTC services. Easy accessibility along both lines, legal entitlements with no means testing, can be found in six new EU MS (Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania and Poland) and seven old EU MS (Belgium, Denmark, Finland, France, Germany, the Netherlands and Sweden). By contrast, access to publicly financed LTC services appears to be most difficult in England and Romania.

Table 3
Cost sharing in long-term care services

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Organization of Supply

The importance of the cultural and historical context for the design of national LTC systems has been emphasized previously (World Bank 2010). This diversity is also reflected in the organizational patterns of LTC supply. In this line of reasoning, this section aims to answer two questions: First, where is care predominantly provided, in institutions or at home? Second, who provides care: public or private entities?

**Institutional versus home-based care**

Across Europe, the relative importance of institutional compared with home-based LTC services differs significantly. For instance, the availability of beds in institutional care facilities ranges from 3.3 (Bulgaria in 2011) to 75.0 (Sweden in 2011) beds per 1,000 inhabitants aged 65 or older, as displayed in figure 2.

Partly resulting from shifts in demography and partly resulting from changed capacities or policies, several countries have exhibited upward or downward trends in these numbers. Among the old EU MS, these shifts have resulted in a slight convergence in the relative availability of beds in recent years. Consequently, two different groups of countries can currently be distinguished (figure 2). The first group scaled back institutional care in favour of home-based care with the underlying aim that such a policy may help serve

**Figure 2**

Provision of institutional care in selected old and new EU member states


Note: solid lines = old EU MS; dashed lines = new EU MS.
two objectives simultaneously. First, in many countries, home-based care is favored over institutionalized care by the persons in need of care (European Commission 2007). Delaying institutionalization would therefore better match the preferences of the elderly population. Second, institutional care is perceived to be more costly than home-based care, especially for those whose care needs are less severe. Restricting publicly (co-)financed institutional care is thus regarded as an avenue towards higher long-term sustainability of LTC financing systems. In fact, such a declining trend in institutional care is especially evident in countries where this sector is most developed and widely used, namely, the Netherlands and Scandinavian countries (Simonazzi 2009). In Denmark, for example, this trend can be attributed to the 1987 Act on Housing for the Elderly, which completely abolished the erection of new conventional nursing homes. Since then, no nursing homes have been built (Karlsson et al. 2012). By contrast, declining institutional capacities are not yet visible in countries such as Austria, Belgium, France and Germany. However, it seems noteworthy that Austrian and German policymakers explicitly state the objective of favouring home-based care over institutional care, which in Germany also corresponds to greater increases in care allowances for home care compared with allowances for nursing homes.

In a second group of countries, we observe increasing institutional care capacities both in absolute terms and relative to the elderly population. This trend can be observed in countries that previously lagged behind in this respect (i.e. the Mediterranean countries).

In the new EU MS, far lower capacities of institutional care are found (figure 2), and only some countries, such as Hungary and Slovakia, appear to be converging to levels comparable to the old EU MS. In this context, note that both countries began with comparatively high nursing home capacities, whereas countries with relatively low availability exhibit rather stable levels. This pattern is found, for instance, in Bulgaria and Poland, where informal care has traditionally played a vital role (Golinowska 2010; Mincheva and Kanazireva 2010). In several new EU MS, LTC was commonly provided in institutions or by family members at home but was rarely provided in the form of professional home care. Recent efforts have therefore been increasingly directed towards establishing professional home care systems rather than extending institutional care capacities (Riedel 2013a).

Public versus private provision of services

An ongoing issue in LTC system reform is whether to ‘make or buy’ LTC services, which refers to how much care should be provided by the public sector and how much should be contracted to private (not-for-profit and for-profit) providers (World Bank 2010; OECD 2005a). Increased reliance on market mechanisms is linked to efficiency considerations as well as increased consumerist values and interest in user empowerment, weakened trust in professionals and questioning of the adequate size of the state in general (Rodrigues et al. 2014; Greener 2008). However, private LTC service provision is accompanied by issues such as cream-skimming (by for-profit institutions) – where private nursing-homes may prefer individuals with lower
or less labour-intensive care needs, even within defined care-levels – and requires performance monitoring, while private non-profit organizations are theoretically associated with higher quality (WHO 2003; Lundsgaard 2005; OECD 2005a). In practice, quite different views on the optimal (or at least the best feasible) public–private combination in the provision of LTC services are found across Europe, as shown in figure 3.

Of all countries, the Dutch LTC system ranks in the most extreme position, with virtually all LTC services provided by private organizations: institutional care is supplied by private not-for-profit facilities, and home-based care is offered by both private for-profit and not-for-profit providers (Mot 2010). In Germany, the market for LTC services in both care settings is also dominated by private for-profit providers, although the not-for-profit sector has traditionally been larger (Schulz 2010; Statistisches Bundesamt 2011). The significant increase in private for-profit providers can be ascribed to the German New Public Management measures, including the opening of the care market and the restructuring of modes of coordination related to contract management (Theobald 2012).

In Scandinavian countries, public entities remain the predominant providers of social services including LTC. As in Germany, however, the care market has also been opened for private entrepreneurs, resulting in rising

Figure 3

Estimated share of public versus private provision of formal long-term care services and institutional care versus home-based care

Note: if no precise data were available, the country reports’ authors provided an approximate estimate (0–20%, 21–40%, 41–60%, 61–80% or 81–100%). In the figure, the mean of the respective interval was then used (e.g. 10% rather than 0–20%). Note, however, that no information on public/private shares could be obtained for seven countries.
proportions of private care supply. In Sweden, for example, the share of private caregiving (both institutional and home-based care) has more than tripled since 1993 (Karlsson et al. 2012). In 2012, 23 per cent of home-based care was already delivered by private companies, and 21 per cent of institutional care (special housing) users lived in a facility operated by a private company (Riedel 2013b).

The Austrian, Belgian, French and Spanish LTC systems hold an intermediate position: we estimate that at least 40 per cent of the market share is claimed by private providers in both care settings.

Generally, private (for-profit and not-for-profit) providers play a larger role in the provision of home-based care than in institutional care provision. This statement also appears to be true for the new EU MS, where private, largely non-profit organizations are often more important in social care than in health care. Already during communist times, social care providers in the community had been far less developed – if existent at all – in these countries (Österle 2010). In our sample of countries, the evolving role of the private sector in the provision of home care is most notable for Slovakia and Estonia. A particular case is Hungary, where a special distinction is made between public and private ownership for the provision of home-based care: most home care facilities are publicly owned, whereas most home nursing care facilities are privately operated (Czibere and Gal 2010).

Comparison between old and new EU member states

Our third hypothesis claims that institutional capacities in the new EU MS are lower than in the old EU MS and that the private sector has not yet achieved comparable ‘market shares’ in the overall provision of LTC. Indeed, in terms of lower capacities in the new EU MS, the hypothesis is clearly supported by our findings on institutional care and tentatively also for home care. For institutional care, we do not observe any convergence between the two country groups, and we find only some degree of convergence within the group of old EU MS. In home-based care, several new EU MS are in the process of building their capacities, thus catching up to the old EU MS to some degree.

With regard to the public–private combination in institutional care, the results underline that private provision remains much less important in the new EU MS than in the (non-Scandinavian) old EU MS. For home-based care, the hypothesis cannot be supported. Among the new EU MS, the share of private provision ranges from approximately 10 per cent to approximately 90 per cent, and data are available for only a small number of countries.

Discussion

This article presents an overview of selected organizational and supply aspects of LTC systems in 21 EU MS. This study focuses on three domains – the basic structure of governance, access to LTC service and basic supply characteristics – with a special emphasis on comparing old and new EU MS. This research cannot, however, provide an in-depth analysis for each individual aspect, which is a limitation of this article. For instance, we illustrate which countries use means testing but are unable to analyze the relative generosity
of specific income limits. Another limitation is that the data used were from 2010; however, when possible, we updated these numbers with more current information. In general, this article extends the literature by exploring rather unfamiliar territory in terms of both countries – by highlighting differences and common features between the old and new EU MS – and content – by discussing previously neglected facets of LTC organization and supply.

In interpreting these findings, we observe a more pronounced centralization of LTC governance in the new EU MS from a historical perspective. This finding also partly reflects the lower population size in these countries. Centralized governance in small countries may allow for a similar degree of responsiveness relative to that in larger countries with non-centralized governance structures. Thus, we do not necessarily expect new EU MS to reallocate such responsibilities to lower hierarchical levels.

In the area of capacity planning, Germany and the Netherlands not only sought to improve responsiveness by emphasizing private provision but also opened access to their LTC markets for suppliers by refraining from public capacity planning. In the new EU MS, we do not yet observe such a tendency, as Germany and the Netherlands began with far higher capacities and sought to use market pressure to improve allocative and technical efficiency.

Based on the entitlement to services and means-testing indicators, our results suggest easy accessibility to LTC services across the EU. This observation, however, must be interpreted with some scrutiny, as the absence of these organizational barriers alone does not necessarily translate into easy and timely access in practice. For instance, cost sharing is quite common in both country groups (institutional care: all countries; home care: nine new and nine old EU MS; and home nursing care: five new and four old EU MS), and only four countries do not report problematic waiting times for institutional care. Quantitative and comparable evidence on these two aspects is scarce, but the large differences observed in supply capacities in both country groups indicate that the factual availability of formal LTC might pose more severe challenges in the new EU MS than in the old EU MS. Furthermore, little is known about the concrete forms and amounts of cost sharing in LTC, but income-dependent forms of cost sharing are generally more widely applied in old EU MS. Recognizing that income levels in these countries are generally higher than in the new EU MS raises concerns regarding whether the older population in new EU MS is more severely affected by cost sharing for LTC services than that in old EU MS.

Generally, the private sector is on the rise in both types of care settings across Europe, especially in home-based care. Notably, the private provision of LTC services is dominated by not-for-profit firms in most countries. However, some countries, such as Germany, show a substantial and increasing share of for-profit providers.

Privatization in several countries is associated with an increasing patient orientation in care, as can be observed in Sweden, for example. Such a consumer orientation entails that persons in need of care should be in a position to choose both their preferred care setting and their preferred provider or provider type (e.g. public or private). In the vast majority of LTC systems, care recipients can choose their provider freely, and some countries already
support such opportunities for choice with regulations prescribing diversity of providers. In several countries, theoretically available options are negated by limited care capacities in terms of nursing homes or care workers. From an optimistic perspective, such legal encouragement of choice demonstrates that these typically relatively poor countries acknowledge the necessity of patient orientation in care but have not yet found strategies to raise the necessary funding to ensure sufficient capacities. Furthermore, critics in both rich and poor countries state that transparency and information on available choices must be improved to empower persons in need of care to actually execute their right to choose (OECD 2013).

Considering the economic crisis and its impact on public policies, some states have already tightened access criteria; for example, in Spain, the planned step-wise reform of care allowances was gradually postponed, and financial support for home-based care was reduced (Patxot 2014). In reviewing LTC policy changes since the onset of the economic crisis in Finland, Spain and the UK, Waldhausen (2014) concludes that cutbacks are increasingly occurring, often by local governments and especially with regard to the granting of benefits and increases in cost sharing. Whereas changes in reform plans were clearly triggered by changes in economic background in countries such as Spain, other countries also recently tightened access, but their actions appear to be related to concerns regarding long-term fiscal sustainability rather than sluggish short- or medium-term economic growth. Examples include Austria, where eligibility rules for care allowances were recently tightened twice, and the Netherlands, where access to personal budgets was severely restricted in 2014. Furthermore, we expect that the observed shifts in the supply structure of care (more private, less institutionalized) will continue or even accelerate. For instance, the shift from institutional care to home-based care and the resulting delay in institutionalization will require a reorganization of the entire care chain in old EU MS, including the redirection of a considerable amount of investment (Simonazzi 2009; OECD 2005a).

In the longer term, further shifts in organizational structures will be likely if care organization increasingly aims to exploit process innovations (including those resulting from information and communication technology) to make better use of increasingly scarce human resources. Such endeavours could, for instance, lead to the recentralization of care providers if sufficient evidence for the frequently promised efficiency gains can be delivered (Carretero et al. 2012).

Some new EU MS, which are to some degree ‘late-comers’ in implementing a defined LTC sector, could make use of the experiences of countries with more advanced systems: rather than building large institutional capacities and subsequently reducing them in favour of more efficient care settings, those countries can – and some already do – immediately aim for the latter (for examples, see Riedel 2013a). By more directly developing diverse forms of home care, new EU MS may be in a position to avoid efficiency losses resulting from transitional processes. For years, reforming the LTC sector has been hampered by low LTC budgets, which raises concerns that the financial crisis may decelerate such processes even further (Österle 2014).

In this overview, we strived to include comparable information on the organization and supply of LTC systems in both old and new EU MS.
Additional research is necessary in several areas. For instance, researchers have observed (Pavolini and Ranci 2008) that cost sharing is highly important in the LTC sector. However, comparable cross-country information is difficult to obtain, thus impeding thorough analyses on such topics as the distributional aspects of public versus private LTC provision. Furthermore, future research should also conduct multi-country analyses that actually include both new and old EU MS. Truly intra-European comparisons have been scarce in previous analyses, which tend to be limited to one group of countries or the other (Costa-Font et al. 2008; Pavolini and Ranci 2008; Österle 2010).

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Notes

1. Monika Riedel and Markus Kraus contributed equally to this work.
2. Among the countries discussed in this article, the average population size in the old EU MS is more than three times the average population size in the new EU MS. Only one new EU MS (Poland) has a higher than average population size than the old EU MS, and five new EU MS are smaller than the smallest old EU MS.

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