Ulrich Becker · Hans-Joachim Reinhard
Editors

Long-Term Care in Europe

A Juridical Approach

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Preface

Long-term care is the most recent branch of social security. It does not form part of ILO Convention No. 102 on Social Security (Minimum Standards) which addresses the traditional field of social security—at least not as a specific social risk. Yet, it is gaining more and more importance in today's social policy and social law due to socio-demographic changes and technical-medical progress as described in many studies. Although the challenge is the same for all European countries, different approaches to social protection for dependent persons have been developed, and the respective national legislations vary greatly.

Within most national jurisdictions, we can observe a situation of inconsistency which is obviously due to an ongoing, only recently started process of institution building. This leads to major problems: the overlap between different national social protection schemes is a cause of inefficiencies and may even cause losses of social rights. Furthermore, the widespread lack of legal coordination not only forms an obstacle to the free movement of dependent persons within the European Union but also impedes the cross-border provision of care services.

We are of the opinion that in this situation, a legal analysis is helpful in order to gain a broad overview, to identify shortcomings and problems and to develop proposals for possible solutions. The aim of this book is to investigate the legal background, the normative guidelines, the legal instruments and the jurisprudence of long-term care in Europe. The study includes a wide range of European country studies from different parts of the continent and from different 'jurisdictional families' with different types of social benefits and different 'social models'. This enables a legal comparison which highlights the principal dissimilarities between European long-term care benefits schemes but at the same time also illustrates the various features that the benefits have in common.

Our special thanks are due to the authors of the country reports, in particular for their fruitful cooperation and their great patience. We are equally indebted to *Christina McAllister* for translations and proofreading. Last but not least, we would like to thank the European Commission for the financial support of this publication.[1]

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Long Term Care in Europe: An Introduction

Ulrich Becker

Contents

1 Introduction

Long Term Care (LTC) has started to become an issue in modern social protection. It means support for those who are not able to independently perform activities of daily living (ADLs).[1] Whereas this support has, even after the introduction of social security in most developed states during the first half of the last century, remained mainly a task of families and social institutions for a long time, more and more states have, over the past decades, started to introduce social benefits for those dependent on care. This is, first, due to the fact that the situation of many persons in need for support calls for professional assistance. Second, there are fewer and fewer

[1] See below, Sect. 2.1.

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persons who might be able to provide non-professional care, such as relatives and neighbours, and fewer reliable social networks are formed that would suffice in order to cover the social needs of dependent persons. The most relevant factor for the growing involvement of public authorities is, third, the demographic development. The populations of most developed states are growing older than ever due to a rising life expectancy.[2] This is a well-known and widely acknowledged development which does not need further explanation at this point. It may, on the one hand, be regarded as good news as it leads to an expansion of our life spans. Yet, medical evidence seems to back the assumption that the growing life expectancy also has, on the other hand, a negative side. Gerontologists tend to differentiate between 'younger' and 'older' elderlies. Wherever the borderline actually has to be drawn, 'older elderlies' run a relatively high risk of becoming dependent on support, and this risk seems to increase with biological age.[3] Taking into account population ageing, it is most presumable that our future societies will consist of a higher percentage of dependent persons than today. A second demographic process has to be taken into account. In many developed countries, the fertility rate is below what demographers call the reproductivity rate.[4] Of course, there are considerable differences between the Member States of the European Union in this respect.[5] But those with a low fertility rate will encounter the problem that the number of persons prepared to provide non-professional care will consistently decrease. At least, more efforts have to be taken in order to stabilise the respective basis for non-professional LTC—which is already weakened as changes in society and labour market participation affect both the attitude towards non-professional care as well as the capacities for making time for such caregiving.

These circumstances have in some countries led to the introduction of specific social benefits schemes, in others to the reform of traditional systems—such as in the Netherlands, where the costs of LTC are expected to become a major burden for the public budget in the foreseeable future.[6] And in all countries, the future architecture and financing of LTC is under discussion.[7] This book does not intend

[2]The average life expectancy in the EU increased from 77.9 years in 2005 to 80.9 years in 2014. Spain is at the top with a life expectancy of 83.3 years, while Latvia occupies last place with merely 74.5 years. Life expectancy strongly varies between women and men. In 2014, it was for women 83.6 years and for men 78.1 years in the EU which is an increase for both sexes compared to 2005 when it was 80.9 years for woman and 74.8 years for men (http://ec.europa.eu/eurostat/de/data/database).

[3]See Baltes and Smith (2003), pp. 123 et seq. Whether or not this will lead to a decrease in disability rates for the young old is disputed, see Jagger et al. (2011), pp. 7 et seq.

[4]This rate of 2.1 children per woman remains unachieved in Europe. The average fertility rate of the European Union adds up to 1.5 children per woman. The country with the highest fertility rate is France with 1.96, the country with the lowest rate is Portugal with 1.31 children per woman (http://ec.europa.eu/eurostat/de/data/database).

[5]And the policy reactions are different; see for a legal comparison Becker et al. (2014).

[6]See the chapter by T. Dijkhoff, this volume.

[7]See Lipszyc et al. (2012).

to take up these discussions as far as the economic aspects are concerned. It takes them as a starting point illustrating the assumption that (1) states need to reorganise the provision of support for those who are not able to perform the activities of daily living, that (2) they have to choose between different types of social benefits schemes in order to implement this provision, and (3) that they have to seek a balance between their own responsibility for the well-being of those in need for support on the one hand, and the respective societal responsibility on the other.

The last point concerns the actual provision, or delivery, of benefits. It deals with the distinction between professional and non-professional care and the situation of the respective caregivers, which is the crucial—yet often underestimated—point for the functioning of LTC systems (below, Sect. 4). Before turning to this point, the different types of social benefits systems which might be used for the organisation of LTC will be described very briefly (below, Sect. 3). This is necessary in order to gain an overview of the potential architecture of systems; and it is useful as various types of systems are being applied in Europe; in fact, it is not uncommon for more than one system being applied in a single country. Lastly, for the identification of the respective benefits systems another step back has to be taken (below, Sect. 2). It concerns the subject of respective benefits. Hence, the specificities of the different LTC benefits shall be described first.

2 Specificities of LTC Benefits

2.1 Care, Cure and Disabilities

If a person is not or no longer able to independently perform the activities of daily living (ADL) or, to put it simply, is helpless or dependent, the situation that has arisen is rather complex. This may be due to various reasons: the person's (bad) state of health may be congenital, it may be the result of an accident or of severe illness, or it may have been caused by a decline in the person's capabilities or in functional status due to ageing. And it can take on various forms. Exactly which ADL are considered as relevant depends on appraisals and valuations. The question has also been a topic for the newly established care (or nursing) science.[8] In order to answer it, the normative background has to be taken into account, in particular the right to human dignity, life and integrity[9]; yet, a more concrete, generally applicable legal definition does not exist. In a recommendation from 1989,[10] the

[8]E.g. Katz (1983), pp. 721 et seq. The debate has also led to more differentiation, especially with the introduction of the term 'Instrumental ADL' (IADL), and it has emphasized the important role of measurement, e.g. Wiener et al. (1990), pp. 229 et seq.

[9]As laid down in Art. 1 to 3 of the EU Charter of Fundamental Rights (CFR).

[10]No. R (98) 9 (https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=532369&SecMode=1&DocId=486242&Usage=2).

Committee of Ministers of the Council of Europe defined dependence as 'a state in which persons, by reason of lack or loss of physical, psychological or intellectual autonomy, require significant assistance or help in carrying out their usual day-to-day activities'; but it did not specify the precise nature of 'usual day-to-day activities' or ADLs. Therefore, it is left to the national legislator to regulate the specificities.[11]

Theoretically, care can be distinguished from cure. The latter comprises all measures and medical appliances which are applied to treat a disease, and the provision of which is a task of the health care systems. In practice, this distinction is far from being clear-cut. First, the concept of illness is an open one which needs to be put into more concrete terms. As in its core it also refers to functional deficits, the main point which draws a line between cure and care lies in the meaning of 'treatment'. Roughly speaking, "to cure" means to alter the state of health of a patient (or at least to prevent it from becoming worse), whereas "to care" does not carry the notion of producing such an effect. Even if one accepts this dissociation, a second problem arises, as very often caring and curing measures overlap, influence each other and sometimes are so deeply intertwined that they cannot be separated from each other. This is the reason why some argue for an integrated system of care and cure.

An even greater overlap can be observed with a view to the notions of dependency and disability. The latter has been comparatively clearly defined by the International Classification of Functioning, Disability and Health (ICF),[12] as well as by the UN Convention on the Rights of Persons with Disabilities of 2006,[13] which has also been ratified by the EU.[14] Art. 1 par. 2 of this Convention reads as follows: 'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.' In the light of this definition, a person who is not able to perform ADLs may, at the same time, be a person with a disability, as it is highly probable that a functional deficit impedes equal societal participation. Consequently, and as far as social policy and social benefits are concerned, measures concerning disabilities on the one hand and measures concerning dependency on the other can only be distinguished from each other in terms of their specific functionality: whereas the former aim to include persons with disabilities, the latter aim to provide support in order to assist dependent persons with the performance of ADLs.

[11]Which might be appropriate as the relevance of functional deficits very much depends on social environment and cultural background.

[12]Which serves as a WHO framework for measuring health and disability at both individual and population levels and has replaced the previous International Classification of Impairments, Disabilities and Handicaps (ICIDH); ICF is available at: http://www.who.int/classifications/icf/en/.

[13]Available at: http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.

[14]See Council Decision of 26/11/2009, OJ L 2010/23, p. 35.

2.2 LTC Dependency as a New Social Risk?

The traditional instrument for promoting social security on a global level is ILO Convention No. 102 on Social Security (Minimum Standards) of 1952.[15] It covers a set of social risks and respective social benefits: health (medical care and sickness benefit), maternity, unemployment, old age, employment injury, family, invalidity and death (survivors' benefit). The need for support with the performance of activities of daily living is not mentioned therein. The same holds true for the EU regulations on the coordination of social security systems.[16] They were the first legal acts on substantive matters of the former European Economic Community,[17] and their drafting was inspired by the ILO approaches to international social security. Thus, it is well understandable that the coordination regulations cover the same set of social risks as ILO Convention No. 102: sickness, maternity and paternity, accidents at work and occupational diseases, death, invalidity, old age (old-age and survivors' pensions), unemployment and family. This set of social risks has remained unchanged over time,[18] it can still be found in Regulation 883/2004 on the coordination of social security systems.[19]

Also in this respect, LTC may be described as a new social risk.[20] It has not been dealt with by the traditional legal instruments developed in the second half of the twentieth century on the international level. It concerns specific situations of need which overlap with already well-known social risks without being congruent with them. And it has caused legislative reactions as new social benefits systems were set up or, respectively, existing systems were extended in order to cover against the risk of LTC dependency. These governmental responses to specific situations of need clearly show the growing awareness of LTC as a social risk and the growing public responsibility for addressing this risk.

As far as EU law is concerned, the ECJ has reacted to this new social risk by extending the scope of application of the coordination regulations. In the *Molenaar* case, the Court has interpreted 'sickness benefits' in a broad way, including all benefits which are 'designed to develop the independence of persons reliant on care'.[21] If LTC benefits are granted without discretion on a legal basis and therefore

[15]Available at: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312247:NO.

[16]Now based on Art. 48 of the Treaty on the Functioning of the European Union (TFEU).

[17]Regulations No. 3 and 4 of 1958.

[18]See also Regulation No. 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community (OJ L 149/1971, p. 2).

[19]OJ L 166/2004, p. 1.

[20]See also Schulte (2013), pp. 207, 213.

[21]ECJ of 5/3/1998, C-160/96 (Molenaar), par. 22 et seq.: 'With regard to the second condition, it appears from the file that care insurance benefits are designed to develop the independence of persons reliant on care, in particular from the financial point of view. The system introduced is aimed at encouraging prevention and rehabilitation in preference to care and at promoting home

have to be qualified as social security benefits,[22] they fall under the scope of the coordination regulations. This jurisprudence has led to the only provision of Regulation 883/2004 dealing with LTC, Art. 34 on 'overlapping long-term care benefits' which contains rules on the concurrence of benefits in cash and benefits in kind for the same purpose.

It has to be noted that the approach of the ECJ towards an extension of social risks covered by the coordination regulations cannot be used for the interpretation of international treaties, as Art. 31 of the Vienna Convention on the Law of Treaties does not allow a similar, dynamic interpretation. Thus, bi- or multilateral social security agreements which include provisions on sickness benefits are not applicable to LTC benefits if they do not make explicit reference to the latter benefits.[23]

3 Organisation of LTC Benefits

3.1 Concept of Social Protection

If the need for LTC can be qualified as a new social risk, it would be natural to come to the conclusion that LTC benefits should be regarded as social benefits. This, however, requires at least a few words of further explanation as the term 'social benefit' is quite open and not often used, at least in English. The term more commonly used would be 'social security'. In its traditional meaning, this comprises benefits or systems set up to secure against the abovementioned social risks that form part of ILO Convention No. 102.[24] In other words, 'social security benefits' mean benefits which aim at protecting the individual against specific

care in preference to care provided in hospital. Care insurance gives entitlement to full or partial direct payment of certain expenditure entailed by the insured person's reliance on care such as care provided in the home, in specialised centres or hospitals, the purchase of equipment required by insured persons, the carrying out of work in the home and the payment of monthly financial aid allowing the insured to choose the method of assistance they prefer and, for example, to remunerate in one form or another the third party assisting them. The care insurance scheme provides cover, furthermore, against the risks of accident, old age and invalidity for some of those third parties. Accordingly, benefits of that type are essentially intended to supplement sickness insurance benefits to which they are, moreover, linked at the organisational level, in order to improve the state of health and the quality of life of persons reliant on care. In those circumstances, even if they have their own characteristics, such benefits must be regarded as 'sickness benefits' within the meaning of Article 4(1)(a) of Regulation No 1408/71.'

[22]See ECJ of 5/3/1998, C-160/96 (Molenaar), par. 20: "The Court has consistently stated that a benefit may be regarded as a social security benefit in so far as it is granted, without any individual and discretionary assessment of personal needs, to recipients on the basis of a legally defined position and provided that it concerns one of the risks expressly listed in Article 4(1) of Regulation No 1408/71". See also ECJ of 10/10/1996, C-245/94 and C-312/94 (Hoever and Zachow), par. 18.

[23]See for the German-Turkish Social Security Agreement of 1964 (revised in 1984) the judgement of the German Federal Social Court of 25/2/2015, B 3 P 6/13 R.

[24]See above, Sect. 2.2.

collective risks. And it means benefits which are granted on a legal basis in the form of individual rights, and which do not depend on specific needs or administrative discretion, as it has been pointed out in the context of the EU coordination regulations.[25]

This definition leaves out social assistance, even though the respective, regularly means-tested benefits appear to be well-established in the European welfare states. As a consequence, two different solutions present themselves for the aim to use a comprehensive concept. First, social security can be understood in a broader way that also comprises social assistance. This solution has been put forward on different occasions.[26] Yet, it has the disadvantage that, against the background of existing legal circumscriptions, it always requires clarification, as the concept is not self-explanatory. Second, a new term can be used, a term with a broader meaning which does not refer to a specific legal instrument or a specific organisational structure of a benefit system. A term of this nature is 'social law', the use of which is rather not advisable as it is mostly found in the German-speaking part of the world.[27] In an international context, and in particular in the European Union, the most comprehensive term which seems to become more and more common in order to describe governmental actions for specific social purposes is the term 'social protection'. Social protection is used as a political objective[28] as well as a category for the survey on existing national instruments.[29] It covers risk-related benefits systems, as well as other systems related to housing and to the fight against poverty. Admittedly, the term remains somewhat blurred as it is being used in different ways, especially as it sometimes comprises social inclusion,[30] and sometimes does not.[31] What is still missing is a more systematic approach based on the specific objectives and functions of benefits.

Despite of these shortcomings, the core of social protection measures lies in administrative systems set up for the implementation of the relevant benefits. Support for persons who are unable to perform activities of daily living is certainly

[25]See above, Sect. 2.2 and footnote 22.

[26]See for example General Comment No. 19 of the Committee on Economic, Social and Cultural Rights on the Right to Social Security, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f19&Lang=en. See also Becker and Pennings (2013), pp. 1, 3.

[27]See Zacher (1989), col. 59 et seq.

[28]See most recently 'Annual Growth Survey 2016 Strengthening the recovery and fostering convergence', COM(2015) 690 fin.

[29]See Mutual Information System on Social Protection (http://www.missoc.org/MISSOC/index.htm).

[30]See the definition on the website of the EU Commission: 'Social protection systems are designed to provide protection against the risks and needs associated with: unemployment, parental responsibilities, sickness and healthcare, invalidity, loss of a spouse or parent, old age, housing, and social exclusion' (http://ec.europa.eu/social/main.jsp?catId=1063&langId=en).

[31]See for example 'Europe 2020: A strategy for smart, sustainable and inclusive growth', COM (2010) 2020 fin.; also on the website of the EU Commission: 'Social Protection & Social Inclusion' (http://ec.europa.eu/social/main.jsp?catId=750).

to be considered as a benefit with a specific social objective—as this is also the case with all benefits intended for the inclusion of persons with disablements and for health protection measures. One point needs to be emphasised though: at least as far as comparative research is concerned, we must not concentrate on public systems only. Instead, we have to take into account that there are also private systems which may pursue the same social objective and which are, in other words, functionally equivalent to the public systems. Also in this regard, it needs to be mentioned once more[32] that the 'continental distinction'[33] between private and public law is getting increasingly blurred. First, social security is a field of law which has a long-standing history of cooperation between public and private actors. This also holds true for the provision of benefits in kind, since physicians, hospitals and other providers are—in most cases—contractual partners of the social security agencies. Thus, phenomena conceived to be of very recent nature and pinned down by the terms 'governance' and 'public private partnership' have in fact been well-known in social law for decades.[34] Second, in all European countries, public social protection schemes are supplemented by private schemes. The latter are sometimes traditional ones, like occupational pension schemes, or they have recently been introduced in order to react to demographic changes, as do some private pension plans. They may have a complementary function, or may partly substitute public security, as is the case, for example, with German LTC insurance.

3.2 Systematisation of Social Protection Systems

Social protection needs to be put into place by way of creating specific institutions. Yet, actual establishment of these institutions and their respective configuration does not simply depend on a specific purpose, or a specific social objective for that matter. It rather depends on a whole set of different circumstances, including the economic situation as well as the institutional and cultural preconditions inherent to a society. Social protection law can be understood as an answer to certain social deficits; yet, the answers given in response to those deficits may vary considerably. This does not only apply to the level of social benefits. It also, and particularly, applies to the architecture or the organisation of each social benefits system. The choices made in this respect follow historical traditions and experiences ('path dependency'), and they are often led by political opportunities and based on political compromises. But they do not go along with a rough socio-political categorisation of social models[35] nor along with the legal comparator's

[32]See already Becker (2010a), pp. 1, 14 et seq.

[33]Cf. Allison (2004).

[34]See also below, Sect. 4.1.

[35]Esping-Andersen (1990). Although Esping-Andersen himself has brought about more differentiation in the meantime, it still serves as a starting point for comparisons in social policy research. See for a categorisation of European countries also Obinger et al. (2005), pp. 1, 23 et seq.

categorisation of so-called 'legal families'.[36] This is particularly reflected in health care, the social protection system which is very close to LTC and is organised, even within the European Union, along very different basic patterns or models: either as a national health system, thus tax-financed and open to the entire population; or in the form of social insurance which is often selective due to its contributory financial basis. The lines between the various models are not always clear[37] and partly blurred.[38]

At least, the existing social protection benefits systems can, on the basis of a systematic comparative analysis, be categorised according to their characteristic features.[39] A very prominent feature which allows a clear distinction between systems concerns their financial sources, and this is mirrored in the differentiation between security and assistance[40] or insurance ('provision', 'Vorsorge', 'previdenza') and assistance.[41] As insurance or 'provisionary' systems are financed from contributions, the granting of benefits is based on specific preconditions; as a consequence, these systems might be selective as far as personal coverage is concerned, on the one hand. But, on the other, the payment of benefits is not dependent on the financial situation of a person covered, and the amount of benefits may rely on the amount of contributions,[42] thus allowing for a differentiation according to the individual standards of living.[43]

Within the category of tax-financed systems, a further distinction can be made between the objective to avoid undesirable situations (especially as regards combatting poverty) and the objective to support persons in situations of specific needs which may be understood as 'desirable situations' (support for families, education, housing, but also measures for the inclusion of persons with disabilities and their integration into labour markets). The payment of the respective benefits may be subject to a means test, especially in terms of, yet not necessarily restricted to, a response to 'undesirable' situations. Payment may also be unconditional, foremost

[36]See for example David and Jauffret-Spinosi (2002). For other approaches for the categorisation of jurisdictions and their significance in the context of social protection Becker (2014), pp. 463, 479 et seq.

[37]See, for the mixed health systems in Central and Eastern European countries Leienbach (2000), pp. 49, 52, 56; Pitschas (2000), pp. 323, 333, 336.

[38]Which also holds true for the mode of financing. The British NHS is partly financed from contributions, whereas the French statutory health insurance receives money from a type of contribution which is very similar to taxes (*contribution social généralisée*).

[39]See Zacher (1987), pp. 571 et seq.; Becker (2010c), pp. 607 et seq.; for a different way of structuring this field see Harris (2000), pp. 155 et seq.

[40]See above, Sect. 3.1.

[41]See for example Art. 38 par. 2 (*previdenza*) und Art. 38 par. 1 (*assistenza*) of the Italian constitution. For a similar distinction in Portugal Vergho (2010), pp. 47 et seq.

[42]Even if not in the sense of the stricter principle of equivalency followed in private insurance law.

[43]Both the selective character and the differentiated level of protection hold true for the Bismarckian type of social insurance, whereas the Beveridgean type aims at ensuring a universal basic coverage, based on flat-rate contributions and benefits.

depending on political decisions and societal valuations. A third sub-category concerns compensation for damages caused by situations which appeal to a more or less tangibly public responsibility (e.g. victims of crimes[44] or of wars); the latter category regards state liability in a broad sense and does not have to be taken into account here.

3.3 Mixed Systems and the Need for Coordination

Over the last years, states have started to introduce specific benefits for LTC. Germany has taken up its tradition as a social insurance country, establishing LTC insurance in 1994[45] which came into force in 1995 and 1996.[46] Using the organisational structure of the existing health insurance, LTC insurance is based on two different pillars: a so-called social insurance and a highly regulated and functionally equivalent private insurance.[47] LTC insurance is a child of its own time and, to some extent, a mixture between the Bismarckian and the Beveridgean social insurance model: it is aimed at covering the whole population, and is thus more universal than traditional German social insurance schemes; and it only grants flat-rate benefits - which do not cover the whole extent of needs of persons who are not able to perform activities of daily living. This insurance approach has served as a model in Japan[48] which, in turn, had some influence in South Korea,[49] but it is still an exception in Europe. Most other countries have introduced tax-financed benefits. And it is still rather the rule that different schemes are being used to supply LTC benefits.

It follows from this situation that it is a very difficult task in nearly all states involved to coordinate the different LTC benefits in an appropriate and efficient way. This even holds true—at least until the most recent reforms will enter into force in 2017[50]—in Germany, where insurance and social assistance benefits coexist side by side.

This need for coordination of the different benefits schemes is substantially increased by the fact that considerable overlaps occur between LTC benefits, sickness benefits and benefits for the inclusion of persons with disabilities.[51] It is nearly impossible to draw clear lines between these categories of social benefits,

[44]See for the different objectives of respective benefits and different arguments for the establishment of a 'public responsibility' *Becker and Körtek* (2010/2011), pp. 169, 171 et seq.

[45]Pflege-Versicherungsgesetz of 26/5/1994 (BGBl. I pp. 1014, 2797).

[46]With a differentiation between ambulatory and stationary benefits.

[47]See the chapter by H.-J. Reinhard, this volume, for more details.

[48]See for the development in Japan and Germany Matsumoto (2007), pp. 59 et seq.

[49]See Sunwoo (2012), pp. 49 et seq.

[50]Zweites Pflegestärkungsgesetz of 21/12/2015 (BGBl. I, p. 2424).

[51]See above, Sect. 2.1.

and in any case it is indispensable to match the different benefits in order for them to accomplish their ultimate goal, that is to effectively support those who need assistance with their daily activities. What makes this coordination so difficult in practice is the fact that very often different administrative entities are involved. If one takes into account that in many states the implementation of LTC benefits causes problems as actors on different political levels are involved (e.g. central government, regions or federal states, local communities), it must become obvious that coordination is one of the major issues of properly working LTC systems.

4 Provision of LTC

4.1 Professional Care and the 'Social Delivery Triangle'

Most professional LTC services that form an integral part of an LTC system are not provided for by the competent authorities, be it a body of governmental administration, an autonomous administrative body following the principle of self-government (*Körperschaften mit Selbstverwaltung*) or a local community. Instead, these authorities involve private actors for the purpose of benefits provision (or delivery).

This model is being used for the sake of efficiency on the one hand, but it also has a normative basis on the other as it leaves space for economic activities of individuals. As already mentioned,[52] this model is a very traditional one which has been practised over decades. Thus, it is not a new element following postmodern developments in governmental action, and it is not an expression of neo-liberalism or economisation, although it has undergone some recent changes. Therefore, the frequently used terms 'privatisation', 'out-sourcing' or 'contracting out' are not suitable to properly describe the cooperation between administrative authorities and private actors, at least as far as this cooperation as such is concerned.[53]

For analytical purposes,[54] it is helpful to stress the connections between the three different actors involved: the administrative authorities, the service providers, sometimes called 'suppliers', and last but not least, the individual in need (entitled person, 'right holder'). There are legal relations between these actors, and these relations form a triangle, the 'triangle of social benefits provision' (or 'social benefits delivery triangle'). Every legal relation follows its own rules, and also has a specific statutory background. Yet, they do not exist to their own ends.

[52]See above, Sect. 3.1.

[53]Example for a misled view: COM(2006) 117 fin., p. 5: 'general aspects of this modernisation process can be seen [. . .] the outsourcing of public sector tasks to the private sector, with the public authorities becoming regulators, guardians of regulated competition and effective organisation at national, local or regional level'.

[54]For a detailed analysis Becker et al. (2011).

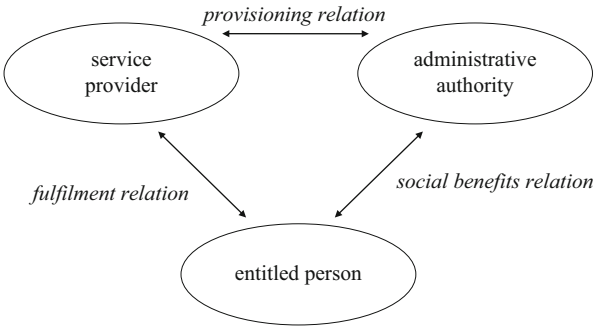

Fig. 1 Social Delivery Triangle

Their common basis is a political decision. The decision of a political community and its government to protect an individual, and this political decision constitutes a public or general interest. Social protection is promised in the form of a social benefit, and a rights-based jurisdiction will consequently create a respective enforceable right of the individual who fulfils the legal requirements ('social benefits relation', *Leistungsverhältnis*). If this right is a right to a service, and if the competent governmental body does not own the necessary institutions or personnel for providing such services, the latter has to make some sort of arrangement in order to ensure that a private provider will take over the duty to fulfil the right. Usually, the competent administrative body does not purchase the service from a private actor in a stricter sense, but it will merely create a legal basis for service provision ('provisioning relation', *Beschaffungs- und Bereitstellungsverhältnis*). The actual fulfilment of the social right will take place on the basis of a legal relation between the private benefit provider and the individual 'right holder' ('fulfilment relation', *Erfüllungsverhältnis*) cf. Fig. 1.

The connections between social benefits relations on the one hand, and the relations between an administrative authority and a social benefits provider on the other (provisioning relations) have led to the jurisdiction of the ECJ according to which EU competition law is not applicable and the competent authority does not act as an undertaking in the sense of the said rules when contracting with a private provider[55]—because, as the Court states, 'the nature of the purchasing activity must be determined according to whether or not the subsequent use of the purchased goods amounts to an economic activity'.[56] It is remarkable that the ECJ uses the term 'purchase' and 'purchasing activity'. It might have understood that term in a rather broad sense, but it is still disputable what forms of legal relation

[55]On the background of the disputable, but standing jurisprudence according to which social activities have a different quality compared to economic ones, see first ECJ of 17/2/1993 Case C-159/91 and C-160/91 *Poucet and* Pistre [1993] *ECR* I-637; most recently ECJ of 5/3/2009, Case C-350/07 *Kattner* [2009] *ECR* I-1513.

[56]ECJ of 11/7/2006, Case C-205/03 *Fenin* [2006] *ECR* I-6295, par. 26. See for an analysis Krajewski and Farley, ELRev. 32 (2007), pp. 111 et seq.

between an administrative authority and a private provider actually fall under this concept.

In any case, the 'provisioning relation' serves as a legal basis for the regulation of three fundamental aspects[57]:

- first, the admission or, generally speaking, the legal involvement of private actors which may also be realised by the way of an administrative contract. Such acts of admission or agreements serve to ensure that the actions of private service providers become subject to all existing laws. In particular, they oblige providers to offer their services under specific conditions, and in this way they allow governments to assume their general responsibility and to guarantee that a sufficient amount of services is being made available;
- second, the setting of adequate prices for the provision of services;
- third, the regulation of an appropriate level of quality and of appropriate instruments in order to assess and ensure the fulfilment of these requirements.[58]

As far as the actual implementation of LTC services is concerned, there is a set of legal principles which needs to be followed by the different actors and which should be understood as legal guidelines for their actions.[59] They partly follow from the general ideas of good governance, partly from constitutional law[60] or other general legal sources.[61] Namely, these principles are:

- security;
- efficiency;
- transparency;
- cooperation;
- individualisation, including freedom of choice.

[57]For details concerning the situation in Germany see Becker et al. (2011), pp. 323 et seq., (2012), pp. 1 et seq. and 103 et seq.

[58]See for a detailed analysis of the use of legal instruments to the abovementioned ends Landauer, 2012, pp. 136 et seq.

[59]See Becker et al. (2011, 2012).

[60]Including the EU Charter of Fundamental Rights (CFR) as a general legal text on commonly acknowledged fundamental rights in the EU; in particular Art. 1 (human dignity), Art. 2 and 3 (right to life and to integrity), Art. 7 (respect for private and family life), Art. 26 (integration of persons with disabilities), and in a positive dimension, but very openly put, Art. 34 par. 1: 'The Union recognises and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case of loss of employment, in accordance with the rules laid down by Community law and national laws and practices'.

[61]See Council of Europe, R (89) 9 (fn. 10).

4.2 Non-professional Care

Some of the aforementioned principles also apply to the actions of non-professional caregivers (or carers without professional status). In most cases, however, these carers will not become part of a legal relationship with administrative authorities, which means that a (formal) provisioning relation will not be established. Yet, in some states they can receive financial support through social cash benefits, e.g. in the United Kingdom, Ireland and Denmark.[62] In other states, general rules on quality standards also apply to care provided by relatives and other non-professional carers.[63]

In practice, and notwithstanding the rather informal involvement in care arrangements, non-professional caregivers play a major role for the functioning of LTC systems all over the world. A system may set specific incentives in order to strengthen this role, particularly by granting cash benefits. Yet, even if it does not do so,[64] it regularly leaves room for at least additional services to be performed by relatives, neighbours or other non-professional caregivers. The extent of such services is of substantial size, and it can be assumed that no LTC system can work without those services. As in the case of professional care, the involvement of non-professional care may also be based on a normative fundament as it is capable of enhancing the autonomy of persons in need.

The important role of non-professional caregivers explains why it must be one of the major tasks of governments to enable them to provide their services.[65] The respective measures may cover very different aspects: information and counselling in order to improve the quality of the care services and to reduce personal responsibility; social security coverage, especially with a view to accidents and old age; provision of substitutes for vacation periods. And there might be a growing interest in concluding formal and legally binding agreements with non-professional caregivers in order to establish a provisioning relationship as well as a stable legal basis for their work. One aspect must be stressed in particular: as it is mostly women who take care of their relatives, even among parents-in-law, it is always—and for as long as existing role models do not change profoundly—a task of great importance in terms of gender politics to improve the situation of non-professional carers and reinforce the efforts to extend the group of persons interested in providing care.

But it is not enough to take better care of non-professional caregivers as far as the social benefits administration is concerned. It is also essential that non-professional carers be given the opportunity to actually provide care. Taking into account that the employment strategies presently followed in Europe are aimed at putting more

[62] See for an overview Becker and Lauerer (2011), pp. 121, 133 et seq.

[63] See Urban (2016).

[64] As it is the case in Japan for example.

[65] See for Germany Becker and Lauerer (2011), pp. 121, 138 et seq.

and more people into formal employment relationships,[66] reconciliation of work and family life becomes an increasingly urgent issue. In particular, it is necessary to regulate labour relationships in a way that allows gainfully employed persons to take time off and get leave for caretaking purposes, at least for a certain period of time. The most effective way may be to confer a right of care leave on gainfully employed persons, which would imply that employers are to grant this right accordingly. Another way is to rely more on voluntary action and to leave the regulation of care leave to collective bargaining.

4.3 Mixed Provision and the Need for Coordination

Ultimately, effective LTC systems will, also with regard to the role of benefits providers, need to be based on a balanced mix of different forms of benefits. Non-professional carers will not be willing to work without societal support and without a certain personal scope of action, and the LTC system must offer incentives for non-professional care. At the same time, non-professional caregivers will not be able to perform well without having the possibility to also resort to and to rely on professional care provision.

In ageing societies, both labour supply and caregiving opportunities must be promoted.[67] For this reason, a balanced mix of LTC provisions seems to be the best option in order to meet the present challenges.[68] This suggestion is strongly supported by the finding that relatives and other members of society are much more ready to assume care obligations if professional carers and care facilities stand by to help out and to reduce the workload of non-professional caregivers.

5 On the Outline of the Project

As far as the state of research is concerned, various publications on LTC benefits in Europe exist.[69] Probably the most comprehensive ones are the OECD studies on the challenges of providing and financing LTC,[70] and on evidence and good examples

[66]See Council Decision of 5/10/2015 on guidelines for the employment policies of the Member States for 2015 (OJ L 268/2015, p. 28), Guideline 6: 'Enhancing labour supply, skills and competences', including the following paragraph: 'Female participation in the labour market should be increased and gender equality must be ensured, including through equal pay. The reconciliation between work and family life should be promoted, in particular access to affordable quality early childhood education, care services and long-term care.'

[67]See also Scheil-Adlung and Bonan (2013), pp. 25 et seq.

[68]See Laferrère and Van den Bosch (2015), pp. 331 et seq.

[69]See also for an overview on existing national legislation in the EU: Mutual Information System on Social Protection, Comparative Tables, XII (http://www.missoc.org/MISSOC/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp).

[70]OECD (2011). See also the articles in Eurohealth (2011), no. 2–3.

of how to meet these challenges.[71] There are also different studies on very recent LTC reforms.[72] Nevertheless, what is missing is a detailed analysis of the legal background, the normative guidelines[73] and the legal instruments for LTC in Europe,[74] which would combine detailed descriptions with specific insights into the above-mentioned problems of coordination from multiple perspectives.

In order to provide a broad overview, this collection includes a wide range of European country studies[75] from different parts of the continent,[76] from different 'jurisdictional families' with different types of social benefits[77] and different social models.[78] This allows for a macro-comparison which clearly shows the landscape of different social protection systems relevant for the support of persons dependent on care.

As far as the method is concerned, it is true that our comparison starts from the observation of specific legal problems, namely the overlap between different social protection schemes and the need for coordination of the latter. One may object to the supposition that legal comparisons still have to follow the functionality approach,[79] as a comparison may come into conflict with the postulation that the comparator of laws 'must rethink the original question and purge it of all the dogmatic accretions of one's own system.'[80] Yet, every problem that calls for solutions is, as a rule, only recognised as such as a result of the study of certain legal systems.[81] What is important is to subsequently formulate this problem in such a way that it is freed from its embedding in positive law and raised to a more abstract level. In this regard, social policy is a very helpful discipline even for a comparison concentrating on social law as it sheds light on the functional background of this law and may help to understand the social deficits to which law should give an answer.[82]

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[71] OECD (2013).

[72] Costa-Font (2011) and Leichesenring et al. (2013).

[73] See for the UN Convention on the Rights of Persons with Disabilities above, Sect. 2.1; for the constitutional background and the EU CFR above, Sect. 4.1.

[74] See for economic aspects Costa-Font and Courbage (2012); De La Maisonneuve and Martins (2013).

[75] See for outside Europe WHO (2003).

[76] See for Southern Europe Da Roit et al. (2013), No. 4, pp. 577 et seq.

[77] See above, Sect. 3.2.

[78] See for the very restricted meaning of these models above, Sect. 3.2.

[79] The current debates on the comparative method, which continues to focus on the principle of functionality, essentially deal with two different issues: for one thing, they deal with epistemological requirements which mainly regard the finding of the subject that forms the basis of a comparison, i.e. which regard the locating of the relevant law. For another thing, they deal with the function and the functioning of the law and, in doing so, address the objectives of the comparison of laws, Becker (2010b), pp. 11, 20 et seq.

[80] Zweigert and Kötz (1998), p. 35. For the relevance in social law research Pieters (1998), pp. 715, 726 et seq.

[81] See Esser (1972), pp. 97, 103 et seq., 110 et seq.

[82] See above, Sect. 3.2.

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Benefit Structures for Persons Dependent on Long-Term Care in Austria

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Contents

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1 Synopsis

Long-term care dependency in Austria has been recognised as an independent social risk (only) since 1993. Up to then, only isolated and rather dissimilar benefits and services existed which were partly based on the causality principle or which were granted within the context of social assistance (Sozialhilfe)—and here particularly in the form of benefits in kind. The most commonly paid cash benefit related to long-term care at the time was referred to as "helplessness allowance" within the context of the statutory pension insurance. This was an allowance in addition to the monthly pension that was granted in the case of a certain minimum need for "maintenance and help"; the amount (of a converted monthly sum of approx. € 217 in its latest figures) was, however, independent of the actual need.[1]

These and other cash benefits related to long-term care were replaced as of 1 July 1993 by the care allowance according to the Austrian Federal Long-Term Care Allowance Act (*Bundes-Pflegegeldgesetz, BPGG*[2]) which, by way of its seven levels, is geared at a particularly strong needs orientation. Due to the (then) constitutional distribution of competences in the context of the federal structure of Austria, this benefit could only be addressed to persons who were already entitled to a separate benefit regulated under federal law. The group of persons entitled to these benefits according to BPGG initially only included the recipients of a basic allowance paid under federal law, i.e. particularly of a pension paid out of the statutory pension insurance, a full pension paid out of accident insurance or a benefit paid out of the pension system for federal civil servants and their surviving dependants.

According to the constitutional distribution of competences, however, cash benefits related to long-term care for civil servants of the Austrian provinces and municipalities who are subject to public law were the responsibility of the provinces.[3] At the time, the latter enacted province-specific long-term care allowance acts which also included entitlements for other persons who were not, or could not, be accounted for in BPGG for lack of regulatory options at the federal level. Province-based long-term care allowance therefore also came into consideration for persons dependent on long-term care who were not entitled to a pension or the like, i.e. especially persons in their role as "mere relatives", but also gainfully employed persons and persons dependent on social assistance.

As to its content, the long-term care allowance acts defined for the provinces were mostly patterned on BPGG, since the provinces had concluded a treaty with the Federal Government—the agreement between the Federal Government and the provinces according to Art 15a B-VG (BGBl 1993/866), mainly abbreviated as

[1] Cf. overview in Pfeil (1994), pp. 53 ff.

[2] Austrian Federal Law Gazette (Österreichisches Bundesgesetzblatt, BGBl) 1993/110, as amended by BGBl I 2016/116.

[3] Cf. Art. 21 Austrian Federal Constitution Act (Bundes-Verfassungsgesetz, B-VG), BGBl 1930/1 as amended by BGBl I 2017/138.

"Long-Term Care Agreement"—committing themselves to enact long-term care allowance regulations "with the same objectives as those on federal level". This coexistence of ten long-term care allowance acts and regulations based thereon, with a multiplicity of decision-makers to implement the former,[4] had always been viewed critically. Only in 2012 could a standardisation be effected by passing the Long-Term Care Allowance Reform Act (*Pflegegeldreformgesetz*) (BGBl I 2011/58): by way of a constitutional amendment with regard to the matter of "long-term care" the sole responsibility of the Federal Parliament was determined and standardised[5] and all long-term care benefit entitlements were reassigned to BPGG. As for the definition of the category of persons eligible for benefit, § 3 of the latter still primarily focuses on recipients of a basic allowance regulated by federal legislation. However, according to § 3a BPGG this now also includes all other persons who have their habitual residence in Austria and who are Austrian citizens or are considered equivalent thereto.[6]

The main task that the Austrian provinces adopted in 1993 by way of the Long-Term Care Agreement—according to the constitutional distribution of competences that continued to be applicable—concerned, and still concerns, the provision of benefits in kind for persons dependent on long-term care. Yet, the relevant regulations continue to be related to social assistance or to the disability law of the respective province, the latter of which has partly evolved from this field as a form of "special social assistance".[7] This means, in particular, that the use of long-term care services—usually organised by the provinces and/or the municipalities—at home or in a facility designated for this purpose (mostly called "Heime") is often based on a strict subsidiarity principle, and that contributions or co-payments are to be borne by the benefit recipients, certain relatives or even by particular third parties.[8]

Apart from that, both cash benefits and benefits in kind for persons in need for long-term care are financed from general tax revenues. The introduction of a long-term care insurance was, at first, not up for discussion. Meanwhile a changeover has been urged—not least by the provinces and municipalities that are increasingly reaching their budgetary limits—to a system financed at least in parts from

[4]The number of responsible funding bodies, amounting to up to 303 before the reform of 2013, has meanwhile decreased to only six; see also below B I 6.

[5]Cf. Art. 10 Para. 1 Z 11 B-VG.

[6]This particularly includes persons whose equal status can be derived from treaties or European Union law, who were granted asylum or who were legally entitled to reside within the EU or who have a comparable residence permit; cf. for details § 3a Para. 2 and 3 or, respectively, § 3b BPGG; see also below B I 1.

[7]Cf. on this Mayer and Pfeil (2012a), pp. 385 ff.

[8]Some changes have to be expected in this respect since the Federal Parliament has passed a constitutional law (laid down in § 330a ASVG) that will be effective from 2018 and will ban any kind of compensation that would have to be paid by persons claiming stationary care (or their relatives) who own certain properties; see below Sect. 2.2.2.