Reforms in Long-Term Care Policies in Europe

Investigating Institutional Change and Social Impacts
Reforms in Long-Term Care Policies in Europe
Reforms in Long-Term Care Policies in Europe

Investigating Institutional Change and Social Impacts
We became interested in long term care reform for many reasons, the most intriguing of which was that Long Term Care has been one of the few welfare policy areas in which radical, expansive changes and new reforms have taken place in the last years, in contrast with the inertia and tendency towards retrenchment affecting mainstream welfare areas such as pension systems. Yet, in spite of the dramatic changes in the field, and the increasing relevance of long-term care in our aging societies, we realized that no book till date had set out to explain these trends.

We did not want to just give a description of the changes that have taken place in Long Term Care, but also to provide a general interpretation of the broad trends now shaping the field. We wanted to understand how these changes developed; which social and political actors played a significant role in bringing them about; and what institutional mechanisms contributed to the de-freezing of this increasingly relevant policy field. Lastly, we wanted to take into account not only the social and economic drivers for reform, the institutional process and the policy design, but also the social impact of these reforms. By analyzing and explaining how these changes developed throughout Europe, we also wished to contribute to the ongoing discussion about the limits and potential for innovation of current welfare states.

In order to avoid a mere collection of national case studies, we decided to bring together some of the best academic expertise in this policy field, and so asked our colleagues to work with us to build a common analytical framework for the study and subsequently to engage in the analysis of our collective preliminary results. The research group for the study had the opportunity to work together at a series of seminars-funded by SPI-CGIL (the most important Italian trade union including workers and pensioners)-which were held in Milan (2009) and Rome (2010).

We thus first wish to sincerely thank SPI-CGIL, particularly Riccardo Terzi (Director of the SPI-CGIL Research Unit), for sharing our aims and supporting this research project by providing all the funding necessary to organize the seminars and to sustain the national research groups involved in the research. IRES (Istituto di Ricerche Economiche e Sociali), and especially Maria Luisa Mirabile, Director of Research in the Social Policy department and editor of La Rivista delle Politiche Sociali (Italian Journal of Social Policy), also played a relevant role in the organization and the scientific coordination of the research and seminars.
Acknowledgments

Preliminary versions of this study were presented and discussed at many international conferences. As we are not able to list all the people who gave us valuable comments and feedbacks in these discussions, we would like to thank them all collectively. Special thanks to Joakim Palme, Tine Rostgaard and Birgit Pfau-Effinger for their helpful comments on preliminary drafts of the concluding chapter. We would like also to thank the authors of the country chapters for their invaluable suggestions on the introductory and concluding chapters. We also thank Teresa Krauss and Morgan Ryan from Springer for their continual support and Ciara O’Dwyer for her careful proofreading of each chapter. We also appreciate the financial and organizational support of the Social Policy Lab at the Polytechnic of Milan, especially the great assistance of Laura Di Maria. Without their support this project would not have been feasible.

Costanzo Ranci
Emmanuele Pavolini
# Contents

**Part I  Concepts and Measures**

1. **Reforms in Long-Term Care Policies in Europe: An Introduction**  
   Emmanuele Pavolini and Costanzo Ranci  
   3

2. **Long-Term Care Systems in Comparative Perspective: Care Needs, Informal and Formal Coverage, and Social Impacts in European Countries**  
   Francesca Carrera, Emmanuele Pavolini, Costanzo Ranci and Alessia Sabbatini  
   23

**Part II  Country Analysis**

3. **Long-Term Care in Sweden: Trends, Actors, and Consequences**  
   Gabrielle Meagher and Marta Szebehely  
   55

4. **Trajectories of Change in Danish Long Term Care Policies—Reproduction by Adaptation through Top-Down and Bottom-Up Reforms**  
   Viola Burau and Hanne Marlene Dahl  
   79

5. **Long-Term Care Reforms in the Netherlands**  
   Barbara Da Roit  
   97

6. **Radical Institutional Change and Incremental Transformation: Long-Term Care Insurance in Germany**  
   Hildegard Theobald and Sarah Hampel  
   117

7. **Steps Toward a Long-Term Care Policy in France: Specificities, Process, and Actors**  
   Blanche Le Bihan and Claude Martin  
   139
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Long-Term Care Reform in Austria: Emergence and Development of a New Welfare State Pillar</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>August Österle</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Long Term Care Reform in England: A Long and Unfinished Story</td>
<td>179</td>
</tr>
<tr>
<td></td>
<td>Caroline Glendinning</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Long-Term Care in Spain: Between Family Care Tradition and the Public Recognition of Social Risk</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>Gregorio Rodríguez Cabrero and Vicente Marbán Gallego</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Long-Term Care Italian Policies: A Case of Inertial Institutional Change</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>Giuliana Costa</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Long-Term Care Reform in Central–Eastern Europe: The Case of the Czech Republic</td>
<td>243</td>
</tr>
<tr>
<td></td>
<td>Jana Barvíková and August Österle</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Part III  Conclusions</strong></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Institutional Change in Long-Term Care: Actors, Mechanisms and Impacts</td>
<td>269</td>
</tr>
<tr>
<td></td>
<td>Costanzo Ranci and Emmanuele Pavolini</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Index</strong></td>
<td>315</td>
</tr>
</tbody>
</table>
About the Author

**Jana Barvíková**  works as a researcher at the Research Institute for Labour and Social Affairs. Her professional background is in social work and in 2011 she defended her PhD thesis in sociology (Charles University, Prague). Her broad research interests include intergenerational solidarity, family informal care, social and legal protection of children and family policy.

**Viola Burau**  is Associate Professor in Public Policy at the University of Aarhus in Denmark. Her main research interests lie in the politics and policies of welfare services, the governance of expertise and cross-country comparison. She has published widely, including a co-edited book on ‘Governing home care’ (Edward Elgar 2007) and a co-edited special issue on ‘Shifts in Nordic welfare governance’ (International Journal of Sociology and Social Policy 2011).

**Gregorio R. Cabrero**  PhD in Economics, is Professor in Sociology at University of Alcalá (Madrid). He is member of EU network of independent experts on social inclusion. He has coordinated the research group that has evaluated the Spanish system for autonomy and care for dependency (2011). He has published several books and articles on the Spanish Welfare State, nonprofit sector, personal social services and public spending.

**Francesca Carrera**  is senior researcher at IRES—Economic and Social Research Institute—in the research area “Welfare and rights of citizenship”. She has conducted numerous researches on issues of social policy, local welfare systems, immigration and immigration policies, active aging. She is a member of the editorial board of “la Rivista delle Politiche Sociali”.

**Hanne Marlene Dahl**  is a professor at Roskilde University at the Dept. for Society and Globalization. Her main research interests are in the governance of care, the relationship between the state and care professions in an era of Europeanization and globalization and from a gender perspective. She has co-edited two books for international audiences ‘Dilemmas of Care’ (Ashgate, 2005) and ‘Europeanization, Care and Gender’ (Palgrave Macmillan 2011) as well as published extensively in international journals.
Barbara Da Roit  PhD in Sociology and in Urban and Local European Studies, is Assistant Professor at Utrecht University (NL), Social Policy and Intervention Studies. She recently published the book *Strategies of Care. Changing Elderly Care in Italy and the Netherlands* (Amsterdam University Press 2010) and several articles in international journals over care systems and transformation.

Vicente Marbán Gallego  PhD in Economics, is Lecturer in Sociology at University of Alcalá (Madrid). He was Associate-Director of the Third Sector Spanish Journal (2006–2011). He has participated in different national and European researches and in the evaluation of the Spanish LTC reform. He has published different articles and chapters in a book on the Third Sector and LTC policies in Spain.

Caroline Glendinning is Professor of Social Policy in the Social Policy Research Unit, University of York, England. She is also an Associate Director of the National Institute for Health Research’s School for Social Care Research. She has conducted numerous research studies relating to social care, including studies of family carers, personalisation, reablement and social care outcomes; and has contributed to a number of international comparative studies on these topics.

Sarah Hampel  M.A. Gerontologist, completed her studies in Gerontology in 2010. Since 2011, she works as a research fellow at the Institute of Gerontology at the University of Dortmund. Her main research areas are social gerontology, long-term care policies and provision and dementia illness.

Blanche Le Bihan is a political scientist, assistant professor at the EHESP School of Public Health in France. Her researches concern Social Care in France and Europe. She has recently published “Cash for Care Schemes and the Changing Role of Informal Caregivers in France and Italy”, in B. Pfau-Effinger and T. Rostgaard (ed), Care between Work and Welfare in European Societies, London, Palgrave, 2011, p. 177-203 (with Barbara Da Roit).

Claude Martin is a sociologist, research professor at CNRS (National Centre of Scientific Research), director of the Research Centre on political action in Europe (University of Rennes 1, Science Po Rennes and EHESP). He occupies the Chair on “social care” at the EHESP School of Public Health. He recently edited with Robert Castel, Changement et pensée du changement (Paris, La Découverte, 2012).

Gabrielle Meagher  is Professor of Social Policy at the University of Sydney, Australia. Her research explores the impact of marketization on care work and on social service organizations. She is co-convenor of the Australian Paid Care Research Network and of the Nordic Research Network on Marketisation in Eldercare.

August Österle  is Associate Professor at the Institute for Social Policy, Department of Socioeconomics, WU Vienna University of Economics and Business, and is Visiting Professor at the Corvinus University Budapest. His research interests include comparative welfare state research and the socio-economics of health and long-term care policies, with a thematic focus on comparative and cross-border issues in health and long-term care.
Emmanuele Pavolini is an economic sociologist, associate professor at the University of Macerata in Italy. His main research interests have been connected to Social Care and in particular Long Term Care in Europe. He is also studying Health Care reforms in Europe and the impact of decentralization of the Welfare State and social inequalities. He has recently published (with G. Vicarelli) an article on Current Sociology on the impact of decentralization on the Italian Health Care System.


Alessia Sabbatini PhD in Social work, is researcher at ISTAT—Italian National Institute for Statistics. She worked at IRES—Economic and Social Research Institute—in the research area “Welfare and rights of citizenship”. Her main research interests are social policy, local welfare systems, care and reconciliation policies and long-term care, social capital. She is a member of the editorial board of “la Rivista delle Politiche Sociali”.

Marta Szebehely is a professor of Social Work at Stockholm University, Sweden. She has been studying care services, in particular eldercare, since the mid 1980s and has been involved in several comparative projects on care from social policy and gender perspectives. Within the Nordic Centre of Excellence ‘Reassessing the Nordic Welfare Model’ she is responsible for research on Care in Ageing and Diversifying Societies.

Hildegard Theobald is a professor of Organisational Gerontology at the University of Vechta. Her research focuses on international comparative research on long-term care policies, policy development and transnationalisation, care organisations and professionalisation of care work.
List of Figures

Fig. 2.1 The proportion of the population more than 65 years old with strong limitation in activities due to health problems for at least the last 6 months (2008) ................................... 27

Fig. 2.2 Preferences for type of care desired in the case of parents becoming dependent in old-age—EU-27, 2007 ................ 29

Fig. 2.3 Percentage of individuals who believe that adult children must care for their disabled parents even if this means sacrificing their career—2007 ........................................ 30

Fig. 2.4 Percentage of individuals who believe that children should provide care to dependent parents even if it means renouncing their career—2007 ........................................ 31

Fig. 2.5 Amount of public spending on LTC in PPS (purchasing power standard) euros per capita 2008 ........................ 32

Fig. 2.6 Amount of public spending on LTC allocated to services; as a proportion of total LTC spending (GDP per capita), 2008 ........ 34

Fig. 2.7 Rates of coverage for LTC services for the population aged 65± mid 1990s—mid 2000s .............................. 36

Fig. 2.8 Overall rates of coverage of LTC services for the older population (65+ years) and the rate of coverage provided through home care services—mid-2000s .......................... 37

Fig. 2.9 Rates of coverage for home and residential care services—mid-2000s .................................................. 38

Fig. 2.10 Rates of coverage for home and residential care services—mid-1990s .................................................. 39

Fig. 2.11 Total rates of coverage for the older population (mid-2000s) and level of spending on LTC (GDP per capita—2008; ESSPROSS data, Eurostat 2010) ................................. 40

Fig. 2.12 Percentage of citizens who report that they currently pay, or have in the past paid, for care services for their parents (percentage calculated among respondents aged 40+), 2010 .... 41

Fig. 2.13 Percentage of citizens dissatisfied with the performance of their LTC system ................................................. 41
List of Figures

Fig. 2.14 Percentage of women who have withdrawn (partially) from the labor market to take up caring responsibilities (for disability) to close family members including older relatives—2007 (only women aged 40+ with an older or disabled relative) ............ 47

Fig. 2.15 Relationship between the percentage of women that have withdrawn (partially) from the labor market to take up caring responsibilities for a dependent family member (young adult or older person), and the percentage willing to sacrifice their career for caring responsibilities—2007 (sample made up of women more than 40 years with a dependent family member) .......... 48

Fig. 10.1 Evolution of the proportion of cash benefits and services in relation to the total amount of benefits 2008–2010 (%) ............ 215

Fig. 11.1 Evolution of new yearly provisions per gender and age at the beginning of provision ........................................ 233

Fig. 11.2 In-kind services and cash programs for frail older people in Italy 1984–2011 ............................................................. 233

Fig. 13.1 The impact of LTC reforms on coverage and public expenditure: retrenchment, restructuring and expansion .................. 301

Fig. 13.2 The drivers of beneficiaries increasing autonomy ............ 306
List of Tables

Table 1.1  An explanatory framework for analyzing policy change ........ 5
Table 1.2  The actors potentially involved in the LTC policy arena ......... 16
Table 2.1  Percentage of the population aged 65+ and 80+ in 1970, 1990, and 2010 (ranked by percentage of the population aged 65+ in 2010) .................................................. 25
Table 2.2  Informal caregivers: percentage of the population reporting to be informal carers to people with strong limitations in daily living, different years 2004–2006 ........................................ 27
Table 2.3  Trends in spending on disability, PPS euros per capita, 1990–2008 .......................................................... 33
Table 2.4  Satisfaction ratings for various aspects of the public LTC system, 2007 (the data refer only to those with prior experience of the issues of dependency) ......................... 42
Table 2.5  Probit regression of the role played by the health status of older people on the lack of access to health services: marginal effects (category reference: individual in good health) ................. 45
Table 2.6  Difference between carers and noncarers according to employment status before taking up caregiving duties (percentages in relation to specific population groups) .......... 49
Table 6.1  Overview of long-term care insurance (LTCI) and reforms in Germany .......................................................... 118
Table 6.2  Social long-term care insurance (in billion euros) .................. 134
Table 6.3  Private long-term care insurance (in billion euros) ............... 134
Table 6.4  Long-term care assistance (Hilfe zur Pflege) within the federal law on social assistance: expenditure and number of beneficiaries ........................................ 134
Table 6.5  Number of votes and majorities ..................................... 135
Table 6.6  Increase of benefits .................................................. 136
Table 7.1  Average amount of APA depending on dependency level ........ 147
Table 7.2  Number of APA recipients (in thousands) by dependency level in September 2010 ........................................ 148
Table 7.3  Dependency accounts (in billion € 2010) .......................... 150
Table 8.1  Long-term care allowance: benefit levels and benefits
Table 8.2  Changes in the Austrian long-term care system 1993–2011 ..... 166
Table 10.1  Beliefs, interests, and resources of the main social actors
involved in the LTC reform ........................................ 207
Table 10.2  Levels of protection, system of benefits and support
for autonomy, financing, governance, and quality
checks in the dependency act 39/2006 ............................ 211
Table 10.3  Changes in the Spanish LTC system (2005–2011) ............. 213
Table 10.4  LTC services’ coverage before and after the 2006 reform
and the diffusion of cash benefits .............................. 214
Table 11.1  Percentage of Italian families with older people per type of
help received (2009) ............................................... 223
Table 11.2  Caring arrangements of severely dependent older people
receiving the IdA living at home and number of hours per
week of care (2008) .............................................. 223
Table 11.3  Coverage by the Italian LTC system (2008–2011) ............. 226
Table 11.4  Ageing and dependency in Italy ................................ 229
Table 11.5  Projected indicators for three generations of women at
40 years old. .......................................................... 229
Table 12.1  Basic long-term care data, 1995–2005 .............................. 251
Table 12.2  Community care services, 1995–2010 .............................. 253
Table 12.3  Care allowance provision according to four levels of
dependence, 2012 .................................................. 254
Table 12.4  Care allowance beneficiaries according to four levels of
dependencea and total care allowance expenditure,
2007–2010 .......................................................... 255
Table 13.1  LTC policies: the scenario at the beginning of the 1990s ...... 271
Table 13.2  Percentage variation in the public per-capita expenditure on
healthcare in the 1990s and in the 2000s (constant prices at
2000 level) .......................................................... 273
Table 13.3  Fiscal constraints on welfare reforms in Europe: gross debt
and deficits in the last two decades .............................. 275
Table 13.4  LTC reforms in Europe, 1970–2012 ............................... 281
Table 13.5  LTC regimes and types of institutional change in the last two
decades ............................................................. 294
Table 13.6  LTC reforms: the effects on public financing, beneficiaries,
the labor market and regulation ................................. 304
Part I

Concepts and Measures
Chapter 1
Reforms in Long-Term Care Policies in Europe: An Introduction

Emmanuele Pavolini and Costanzo Ranci

1.1 Introduction

Long-term care (LTC) is one of the most rapidly developing policy areas in Europe, where significant institutional change and innovation have taken place over the last two decades throughout the continent. In contrast to mainstream policy fields (e.g., pensions, labor market policies, and health care), where attempts to reduce public intervention has been the most common trend (Castles 2004, 2005; Korpi and Palme 2003; Pierson 2001), LTC has seen a broader scope of transformations, ranging from retrenchment and cost containment to a growth in public financing and an expansion of coverage. In many European countries, LTC policies over the last two decades have been characterized by a recognition of social rights on the one hand and yet increasing social responsibilities on the other (Morel 2006). This book is aimed at describing these general trends, identifying the factors, which explain these broad developments, highlighting both the main differences between European countries and outlining the main consequences of the various policy developments that have taken place.

1 We use here a broad definition of LTC, namely, as “a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL), such as bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom. This personal care component is frequently provided in combination with help with basic medical services such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care. LTC services can also be combined with lower-level care related to help with instrumental activities of daily living (IADL), such as help with housework, meals, shopping and transportation” (OECD 2011). This definition, however, fails to consider income scarcity, material deprivation, poverty, and housing distress, factors, which are often related to dependency.

E. Pavolini
Dipartimento di Studi Sociali, Macerata University, via D. Minzoni, 2, 62100 Macerata, Italy
e-mail: e.pavolini@unimc.it

C. Ranci
Department of Architecture and Urban Studies, Polytechnic of Milan, Milan, Italy
e-mail: costanzo.ranci@polimi.it
As outlined in greater detail below, our approach to LTC policies is characterized by an institutional perspective. In this book, LTC is seen as one of the main grounds to test the innovative capacities of European welfare systems. Contemporary welfare systems have historically failed to fully recognize the need for care as a social risk, and care as a social activity that has to be supported and promoted. For many decades, care has been mainly considered either as a private obligation or as an individual (or community-based) activity, which has to be replaced by public intervention only in very limited circumstances (lack of family ties, loneliness, poverty, very high degree of disability; Daly and Lewis 1998; Finch 1989; Leira and Saraceno 2004). Institutional changes in LTC policies in the last two decades have brought about a clearer and broader recognition of care as a basic need of citizens and as a social right in many countries. This is a paradoxical result if we consider the timing and the specific conditions under which this process has taken place. The 1990s and the last decade will be largely remembered as an historical phase characterized by welfare cuts (or attempts to do so) and a narrow reorganization of the service provision. However, the trends, which occurred in the LTC field, stand in stark contrast to this general trend within a large number of countries. Yet, how was this possible in a time of cost containment and welfare retrenchment? Furthermore, what were the main driving forces and the most prominent obstacles in this process? What social and institutional forces were activated in order to obtain, or prevent, this result? How has innovation been shaped and what were the institutional mechanisms? What has been the impact of these changes on entitlements to care, on the organization of care provision, and on the care labor market?

We also envisage that our study of the transformations that have occurred in LTC policy in various European countries can help to identify the conditions and social and political processes through which contemporary welfare systems have a chance to change in the attempt to respond to emerging new social needs in a time of strong budgetary restrictions (Bonoli 2006; Taylor-Gooby 2004). Institutional change in LTC policies is not a unidirectional process, but it has taken manifold configurations and has triggered diverse impacts in different countries. While some countries have completely redesigned the setting of their LTC policy, other countries have changed few aspects, or they have just reduced or increased the generosity of previous programs. Even the classic categorization of European countries into distinct care regimes (see below) has partially come under question as a consequence of these changes (Rauch 2007). The purpose of this research is to identify both the commonalities and the specificities of the process of change, and to provide a general interpretation of the direction taken by these changes in Europe.

The countries, which we included in our study, belong to different “welfare regimes” in Europe. Spain and Italy constitute the Southern European regime, France, Germany, and Austria the Continental regime, the United Kingdom is part of the Anglo-Saxon regime, and Sweden and Denmark are part of the Scandinavian regime. The Netherlands is a special case, characterized by a combination of Nordic and Continental patterns. The Czech Republic is also included as it belongs to the Central-Eastern European countries, which we also wished to analyze. In order to avoid a mere collection of national case studies, the analysis has consisted of
Table 1.1 An explanatory framework for analyzing policy change

<table>
<thead>
<tr>
<th>Characteristics of the LTC policy field (institutional setting and level of integration)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why</strong></td>
</tr>
<tr>
<td><strong>Who</strong></td>
</tr>
<tr>
<td><strong>How</strong></td>
</tr>
<tr>
<td><strong>What</strong></td>
</tr>
</tbody>
</table>

comparative research carried out by an international group of scholars who are experts in LTC policies in their respective countries. This group of scholars used a common framework for analyzing the transformations in the LTC policies in each country. This framework was based around responding to four key questions:

1. **The “why” question**: What are the causes or factors associated with the development of a specific LTC policy change?
2. **The “who” question**: Who are the coalitions of actors who push for change or stability, what are their values, interests, and resources and their internal composition?
3. **The “how” question**: What are the concrete mechanisms that allow institutional change or stability (inertia)?
4. **The “what” question**: What have been the main impacts of these changes on those with LTC needs, the (formal and informal) organization of care and the working condition of care workers?

This framework was developed by adapting existing frameworks from the academic literature. Indeed, in the literature, there are different approaches to explaining the different institutional settings for social change: from economic to cultural explanations, from political power to a neoinstitutionalist approach (Hacker 2004). Some scholars have tried to adopt multicausal explanatory models of welfare institutional settings configuration. For instance, in their studies on welfare policies in western countries, Esping-Andersen (1990) and Ferrera (2005) developed frameworks in which different explanations are considered and mixed. In order to answer our key research questions, we have adopted the explanatory scheme outlined in Table 1.1, partially based on Ferrera’s (2005) framework.

As the main focus of the book is the changes that have occurred in LTC policies, the first point is the reconstruction of LTC as a policy field. This issue is discussed in the next section of this chapter, with special focus on the institutional characteristics of this policy field. The following section (Sect. 1.3), discusses our institutionalist perspective in respect of the current literature on care regimes. Our goal is not to provide a further typology of care regimes, but to grasp from this discussion the most
important elements characterizing a care regime as an institutional setting wherein change and reforms take place. In Sect. 1.4, we develop our analytical framework for our study of institutional change in the LTC sector in Europe, starting with the “why” question. We argue that the innovation process in the LTC sector begins with a “problem pressure” or a “public policy crisis” that takes place when “old” institutional solutions no longer fit new needs and problems. As a consequence, new solutions must be adopted. Often, old and new actors with specific stakes in LTC policy start to mobilize and reciprocally interact. Through their actions, specific diagnoses and solutions are proposed and discussed. Institutional change can therefore be described as the result of a complex mechanism whereby institutional preconditions lead to the mobilization and intermediation of actors, leading in turn to coalition building. Indeed, the “agency” factor is one of the most relevant aspects that will be investigated in our research in order to answer the “who” question.

Next, we will address the “who” and “how” questions in Sects. 1.5 and 1.6, respectively. Indeed, the overall logic of institutional change can assume different shapes (Streeck and Thelen 2005), ranging from abrupt change to incremental innovation or simple adaptation in continuity with the previous situation. In order to evaluate the continuity/discontinuity of this change, we consider the outcomes, or impact of these policies in Sect. 1.7, looking at the impact of reforms and innovation on the care system, with special attention to funding and coverage level, public regulation, and the working conditions under which care is provided.

1.2 LTC Policies: A Traditionally Low Institutionalized Policy Field

While it is relatively easy to define LTC activities, it is more difficult to define what exactly an LTC policy is. However, the issue is important both for theoretical and empirical reasons. As already noted by Heclo and Wildavsky (1974), more than 35 years ago, a policy is a “variable,” not a constant: the boundaries of a policy field shift over time; they are controversial and in themselves are contested among different actors. Taking a neoinstitutionalist approach (March and Olsen 1989), we expect that, once the LTC policy field has been framed in a specific country in a certain way by a series of actors and acts, unless something relevant happens (e.g., a broad change in people’s needs), the specific definition will have an impact on the way LTC policies develop: the prevailing conditions of various dimensions of LTC (such as health care, work-life balance policies) affect the way in which issues are determined, actors play in the field, rules are applied, and, mainly, solutions are proposed and adopted to avoid the onset of inertia.

LTC has historically been a less “institutionalized” policy field than other welfare policies such as health care, education, and social security. The need for care is a relatively “new social risk” compared to relatively “old social risks” such as poverty or unemployment (Ranci 2010; Taylor-Gooby 2004). LTC emerged in the public discussion only in the 1990s, when population ageing became a more widespread
and growing problem (see Chap. 2 for further details). For a long time, people whose care needs made them dependent on others were not acknowledged the basic rights of citizens (Leira and Saraceno 2004). Instead, they were considered as “dependent family members” or as social assistance recipients. As Saraceno (2008a) articulates, “entitlement to receive care was framed implicitly as an entitlement to be cared for by a female family member. It certainly did not result in a social right.” On the other hand, caring for frail older people was not only considered a moral obligation to be shared by families and society, but it was also constructed as the responsibility of women rather than men. Furthermore, responsibilities to care for older relatives do not allow for the same social entitlements such as paid leave, income support, or pension contributions that are associated with maternity leave. Finally, it is only recently that care policies in some countries have recognized not only the care problems of the dependent but also the material and psychological vulnerability of informal caregivers (Costa and Ranci 2010).

For a long time, therefore, care has been considered as an informal activity that is part of family-based reciprocal obligations, and it has not developed as a professional field characterized by standardization (Ungerson 1997). The relational nature of care as an interpersonal activity implying only a basic professional competence has meant that LTC services are not heavily formalized and has also prevented the rationalization of professional skills and services as it has occurred in the health care domain, where technical and professional skills are more widely recognized. This fact explains why, in contrast from what happened for health care rights, social care rights have been very poorly defined both in terms of service provision and quality requirements. In many countries, care services still have a vague and broad definition, ranging from social assistance to personal help. Professional care workers and care recipients have few uniform criteria that can be used to assess the real contents of care services as well as their quality. The high labor intensity of care services also explains why care is a field highly affected by cost increases and low productivity, preventing the development of a professional market-based provision of services (Baumol 1996).

The most relevant consequence of the lack of formalization of LTC services is that normative definitions and official statements about eligibility criteria do not automatically get put into practice (Leira 1992). Often, there is a great deal of uncertainty about care entitlements. First, the multiple dimensions attached to providing “care” (personal help, social interaction, support for mobility or basic everyday life activity, and so on) have made it relatively difficult to develop specific technical protocols. The needs’ assessment of the dependent is complex in itself as it encompasses multiple aspects, some of which are subject to subjective interpretation. Second, care has been perceived as a relational activity implying a specific adaptation to the needs of the recipient. Notwithstanding this, much effort has been made to provide professional care workers with standardized protocols, of which flexibility, listening capacity, sensitivity, and personal confidence are considered as valuable requirements (Malley and Fernández 2010). As care is still considered a “labor of love” (Finch and Groves 1983; Ungerson and Yeandle 2007), standardization and technical specifications have been very difficult to implement.
Further problems emerge in the organization of care services. Low productivity and high exposure to cost increases (every improvement in the efficiency would imply a significant deterioration in quality) have historically paved the way for a very low growth of private care services (Pauly 1990). Care services have been hugely based on public financing and more recently on the presence of nonprofit providers (Ascoli and Ranci 2002). Only lately new private actors (such as private insurances) have entered the field, attracted by the huge increase in demand for care and the availability of public funds (OECD 2011). In the public sector, the low qualification of care workers and the shortage of qualified providers that operate in the care sector have curbed the growth of care services. The more recent turn to the principles of “ageing in place,” stressing the convenience of care policies focused on domiciliary help rather than the supply of residential facilities, has had further implications for this aspect. On the one hand, as home care services cannot be delivered on a 24 hour basis, they need to be supplemented with additional forms of private or informal domiciliary help. On the other hand, the increasing combination of care and cash measures has been developed on the implicit assumption that an informal, semiformal, or formal caregiver is available to meet the beneficiaries’ need for care (Evers et al. 1994; Pfau-Effinger et al. 2009). Whatever is the level of standardization of professional care, therefore, a relevant part of the responsibility for care is still shared by recipients or their informal care network (if they have one; Österle 2001).

As a consequence of both the weak legal status of social rights to care and the difficulties of implementing a complete care service organization, care can be defined as a supply-conditioned right even in the most generous welfare states, “expressing the intention of government, but not necessarily establishing an entitlement to be claimed here and now. To a considerable extent, the needs of the care dependent are met outside public budgets, by nonpublic bodies or by private individuals, who by necessity or choice accept the responsibility for care provision” (Leira and Saraceno 2004, p. 26).

The gap between official statements regarding the social right to be cared for and the actual organization of the care service system constitutes a peculiar characteristic of care policy, and of the LTC policy field more specifically. Care provision must follow requirements that have been officially stated in the entitlements structure, but it also requires specific organizational conditions that are very often difficult to guarantee for the reasons outlined above. This fact can be understood in terms of Dahrendorf’s (1988) classic distinction between entitlements and provision. Entitlements are defined by Dahrendorf (1988), and also by Sen (1981), as “socially defined means of access” or “entry-tickets” (Sen 1981, p. 11). Provisions are those “things one is entitled to,” “the whole range of material or immaterial choices that may be open up by entitlements” (Sen 1981, p. 12). It is exactly in the space between what is stated about an individual’s basic entitlements to be cared for and the provision of care services on the ground that a relevant part of the problem pressures affecting LTC systems has emerged. The “care deficit” problem emerged in Europe as a critical problem in the early 1990s and it revealed not only the weak status of social rights related to care, but also the poor development of the care service infrastructure. Waiting lists; a high level of rationing, combined with the poor quality of existing
Reforms in Long-Term Care Policies in Europe: An Introduction

Care services; a high reliance of charity or philanthropic institutions providing care; increasing costs shifted on patients and their relatives; and the lack of domiciliary help: all these aspects resulted not only in a limited expansion of the care delivery systems, but also in the weak capacity of European welfare states to better organize service provision. On the other hand, in Scandinavian (and partially Anglo-Saxon) countries where a service-led approach to LTC was already developed (Pavolini and Ranci 2008), care services showed a strong trend toward increasing costs due to low productivity and cost disease, asking for a significant reduction in their provision. In both cases, therefore, a tension between the declared level of entitlements and the actual level of provisions emerged. Also, it is mainly in that space that institutional change has occurred over the last two decades as we will see below.

1.3 Varieties of LTC Regimes

We limit our study of changes in LTC in Europe to the last two decades, when most of the major transformations in LTC policies have taken place. The early 1990s therefore constitute our starting point. At that time, the LTC policy field was structured differently throughout Europe. Two aspects are relevant in this perspective: the institutional setting and the level of integration of the policy domain. By the former, we refer to the policy legacy shaping the institutional field of LTC in each country. Policy legacy deals with the type of welfare state tradition (residual, universalistic, etc.) that was specifically dominant in the LTC policy field before reforms started. Policy legacy usually plays a big role in policy reforms due to the fact that it is one of the most influential “structuring” forces in the debate, particularly in determining which direction the reforms should take: actors used to a specific type of welfare state setting will try to apply or to adapt this traditional setting to “new” or less institutionalized policy fields (such as LTC). More specifically, the organization of care in the private or public spheres (e.g., by churches, nonprofit care institutions, care professionals hired by public authorities or by private providers) might create the basis for different perceptions and options of solutions. For instance, the spread presence in Italy of a care gray market run mostly by migrant women, independent from public policy supply, has been and is still nowadays a very relevant sociostructural phenomenon taken into consideration in the LTC policy arena. The opposite situation takes place in Scandinavian countries where there is a strong and consolidated presence of public professional care supply, which is organized and tends to be considered when discussing issues such as “freedom of choice for the dependent person.”

By the latter, we refer to the level of integration of the LTC policy field in each country. An “integrated” policy field is characterized by the existence of a recognized policy field and by joint packages and agencies of intervention. In contrast, we have a policy field structured through “loosely” connected domains. While there is some overlap in organization by different government departments, there is little integration overall, and so intervention runs through separate and parallel institutions and organizations, often with juxtaposed logics of functioning and levels of coordination.
Whether the level of integration of the policy field facilitates or does not facilitate policy change is hardly debatable. The more integrated a policy field is, the more common definitions of problems and solutions are shared by the different policy actors, and the more likely is the formation of strong policy coalitions forwarding or opposing new reforms in the public arena. On the other hand, the more fragmented the LTC policy field, the more contrasting interests shape the policy arena, and the more difficult the introduction of radical changes becomes. A certain level of integration in the LTC policy community therefore seems crucial to allow an appropriate change to this policy field.

The concept of care regimes can be fruitfully used to synthesize the two dimensions just considered. This concept has been proposed as a reaction to the well-known concept of “welfare regimes” of Esping-Andersen (1990), and it reflects the critics advanced by many scholars, mainly feminists (O’Connor 1993), to an analytical perspective only focused on the state and market and the relationship between these two institutions, not paying attention to the role played by the family and gender relationships in the practical provision of welfare services (Alber 1995). Therefore, new typologies of “regimes” have been developed in the attempt to incorporate the state–family nexus in the cross-national comparative analysis. In our perspective, care regimes are to be considered as institutional forms codifying peculiar social entitlements (i.e., social right to be cared in the case of need) and related forms of service provision or support (Anttonen and Sipila 1996; Bettio and Plantenga 2004; Rostgaard 2002). In the present study, the point in question is not related to the classification of specific countries, or the identification of the “right” number of clusters, in order to distinct such regimes. Rather, our use of the concept of “care regimes” is aimed at identifying the main factors explaining cross-national variations in the distribution of caring responsibility among the different actors of the care system (State, family, voluntary sector, market) in order to identify the institutional setting and the level of integration of this policy field in the different countries considered.

Care regimes have been firstly defined in relation to the extension of State responsibility to provide care in contrast with family obligations. This is the approach suggested in a seminal paper by Daly and Lewis (1998), where the authors distinguished between Scandinavian countries (where care is made available to people by the State on a universal basis) and continental countries (characterized by the privatization of care, via family or voluntary provision). Anttonen and Sipila in their well-known paper on European social care services (1996) honed this framework, adding two aspects:

1. the difference between State and family care responsibility is associated with a higher or lower activity rate of women in the labor force;
2. between the State-based model and the family-based model lies an intermediate model (a central European subsidiarity model), where responsibility for care lies with the family but the volume of social care provision is at an intermediate level.

More recently, empirical studies of national care systems and the development of comparative analysis have contributed to an attenuation of the strong contrast
between state-led regimes and family-led regimes. Still in the feminist perspective, care regimes have been identified by considering to what extent they contribute to the degendering of welfare states (Knijn and Ungerson 1997), so identifying care regimes in respect of the strength of the so-called male breadwinner/female caregiver model.

In the same perspective, Burau et al. (2007) introduced the concept of “predominate support strategy” distinguishing between public (universalistic), targeted, and family models. Analyzing home care, they found that public support can be either formal care service provision or economic support for informal caregiving. The former is predominant in countries adopting a public strategy (Sweden, the Netherlands) and the latter is predominant in family care-based countries (Germany, Italy).

In a different perspective, focused not on familialism but on the tradeoff between work and care, care regimes have been identified according to the extent to which women have the right to choose between working and caring. According to Rostgaard (2002), the main policy factor is not the distinction between in-kind service provision and cash benefits distribution, but the extension of public intervention. She identifies three models: a female care giver model (women stop working in order to provide care, public provision is mainly through cash benefits); a dual breadwinner model (extensive public provision of care, women mostly at work), and a family–work model (abundant supply of public services, an elevated compensation rates of cash benefits, and flexibility in the labor market, allow families to choose their own preferable care arrangement).

A different perspective has been developed by scholars who took into account not gender relations, or the care/work tradeoff, but the institutional setting within which public care is provided, i.e., the institutional logic according to which care services are organized and provided to the population (Bettio and Plantenga 2004; Jensen 2008). In this respect, care regimes should be considered as further developments of traditional welfare regimes, from which the new programs take the basic regulatory and institutional setting. From this perspective, three main systems have been identified: a Beveridgean approach (where LTC has been integrated within the existing public regulatory system for health and social services, based on universal principles); a social risk approach (LTC has been recently recognized as a new “incomplete” social right); and a social assistance approach (services are provided on the basis of assistance principles, and public care is considered as a means-tested, complementary solution). A similar analysis is proposed by Simonazzi (2009), who identifies care regimes on the basis of their entitlement structure. Simonazzi distinguishes a Beveridge-oriented system (care services are universally defined but are means-tested or income-related), a Bismark-oriented system (a universal scheme is aimed at avoiding social assistance), and a Mediterranean model (based on the principle of social assistance). France is considered as a mixed case between the Beveridgean and Bismarkian systems.

In a similar neoinstitutionalist perspective, Alber proposed to look at the institutional organization of social service provision. Indeed, the public intervention in this field is often characterized by a high level of vertical and horizontal subsidiarity: local public administrations, voluntary and church-related organizations each take a relevant part of the responsibility to provide care (Alber 1995). Therefore,
cross-national variations should be explained by paying attention to the institutional and organizational features of the national social services systems, with special attention paid to intergovernmental relations.

This institutionalist approach seems relevant as it is focused on both the recognition of social care as a social right and the organization of care provision. As already explained, LTC regimes are organized on two levels—entitlements and provisions—among which there are relevant gaps and tradeoffs. Care regimes identify not only different forms of care provision, but also specific forms of recognition of care as a social right. Entitlements have been established in order to select the right to access to services and provision, to limit opportunistic behaviors, to control costs and quality of services. It is highly probable that the institutional setting has been inspired by previous knowledge and experience in similar policy fields, such as care for older people, health care, and income support benefits. Thus, the new entitlements to LTC can be variously related to other rights that had previously been recognized. The entitlement structure requires that some form of public responsibility (both to cover cost and provide services or support) should be developed and institutionalized. This is exactly the focus of our research. In our perspective, therefore, care regimes are to be considered as institutional forms codifying particular social entitlements (i.e., the social right to receive care in the case of need) and related forms of service provision or support (including coverage of costs of care).

1.4 The “Why” Question: Opportunities and Constraints of Long-Term Care Policy Change

A series of factors have contributed to the path for institutional change in LTC policy. In comparative social welfare theory, this aspect is commonly considered in terms of problem pressure. Problems may rise from the outside as well as from the inside of the welfare state: on the one hand, social and economic transformation can create new social needs that are not adequately addressed by the existing measures, while on the other hand, inner financial or political constraints can call for a change in the previous institutional setting. Therefore, problem pressure can be considered as a window of opportunity for enlarging public intervention, but also as a new constraint requiring significant reduction in the existing public programs.

A problem pressure can be understood, according to Ferrera (2005), as an increasing gap between (emerging) social needs and the preexistent repertoire of policy measures aimed at addressing these needs. Conventional social programs can be understood as policy solutions that were found to solve previous problems: but social and/or institutional new situations can make the traditional repertoire of solutions obsolete, or inadequate. A new response is therefore needed, even though this is not always recognized. Only when this gap is recognized in the public arena, then a “public policy crisis” may be opened, and innovation has some chance of taking place. In this process, therefore, problem pressure is a necessary, though on its own insufficient, condition for institutional change and policy innovation.
Assistance for frail (older) people has historically been one of the first and most widespread forms (since the Middle Ages) of social aid through the use of shelters for the (older) poor. After World War II and until the 1980s, there were policies that we can define as “elder care” with a definition that is, however, partially different from the one adopted today for LTC. Those policies were less directed to persons with a reduced degree of functional capacity and more to older people with limited means. The typical policy instrument of traditional care policies until the 1980s was residential institutions for the poor, or lone older people, sometimes (but not necessarily) dependent, whereas nursing homes (designed for people with a mix of health and social care needs) were less diffuse.

From the 1970s, under the pressure of specific interest groups, new public programs were introduced in many European countries to address the need for care and social reintegration of adults with disabilities. Scandinavian countries also developed a generous supply of care services for older people as part of their generous approach to welfare (Anttonen and Sipila 1996). With the relevant exception of adults with disabilities, chronic diseases, and heavy dependence were not wholly recognized as particular social risks in other European countries. Services such as nursing, long-term rehabilitation, and social care were considered as residual, mainly provided by families, voluntary organizations, public or religious institutions specialized in humanitarian help and social assistance. Until the beginning of the 1990s, only few European countries had introduced a nation-wide program recognizing LTC as a clear social right. Public programs were mainly aimed, at that time, at supporting the income, and only indirectly the care needs of dependent people: poverty, not care needs, was considered the real social risk, which people had the right to be protected against.

The 1990s were the turning point for LTC policies in many European countries. Many relevant social changes had put renewed pressure on the existing systems of LTC. The demographic structure of the population begun to change all over Europe as a consequence of the ageing process: an effect of the improvement of the material living conditions of the middle classes but also of the better quality of health care (see Chap. 2). Contrary to many pessimistic predictions, the higher number of old people has come with a reduced relative degree of morbidity and dependency, therefore increasing only moderately the number of people in need of care (Lafortune and Balestat 2007). However, if not the quantity, it was the quality of care that increasingly became significant: the higher percentage of dependent older people increased the need for multidimensional care, with the social and health aspects of care becoming strongly interrelated. If demographic trends only partially contributed to increasing the pressure for change, it was the transformations occurring in the social organization of care that hugely changed the situation. For many decades, the provision of care had been mainly granted by family networks in most of European countries. In 2001, Österle estimated that informal care still covered around three quarters of the total care for people with disabilities in western European countries, attributing a very secondary role to public protection. Starting from the 1990s, this (either implicit or explicit) intergenerational reciprocity system has been increasingly weakening for a number of reasons (Österle 2001; Saraceno 2008b), as outlined below.
First, the transformations in the forms of households helped to increase the demand for care, which could not be satisfied by members of the same household: the numbers of older people living alone has in fact been increasing in all European countries, while the number of those living with their children has been decreasing (see Chap. 2 for details). This was set against a progressive decrease in the potential for support from kinship networks. A first factor was the worsening of the old-age dependency ratio as a consequence of the reduction in the effect of the generation turnover. The rise of the older population, joined with the progressive reduction in the fertility rate, has reduced, and is still progressively reducing, the availability of family caregivers. A second factor, which has weakened the caregiving capacity of informal networks, is the increase in female participation in the labor market. The effects of higher female employment on informal care for older people are not clear. According to some research (Costa and Ranci 2010; Lamura et al. 2003), the increase in female employment rates does not significantly reduce caregiving activity when it is only for a few hours per week, while it has an appreciable effect on caregiving for those who require continuous assistance, making home care services or institutionalization in residential facilities necessary. Generally, while there is uncertainty over the decline in the number of informal caregivers, it is likely that the total time spent on caregiving has been constantly decreasing over the last few decades.

Therefore, the persistent increase in female participation in the labor market (especially of women aged between 40 and 60 years), and the corresponding increase in the number of dependent aged people, have conjured together to bring the dominant traditional, family-based care system close to a collapse. The organization of families and the integrity of relations between generations were put under pressure. Moreover, the presence of a dependent person in low-income families increased the risk of poverty, and the augmented use of private care services by the most dependent exposed the poorest groups in the population to further risk of poverty. In other words, a social reorganization based on dependency has been taking place in the last two decades. Dependency therefore challenged the integrity of relations between generations within families. Alternative solutions were not readily available. The traditional response to the lack of family care was the institutionalization of dependent older people in residential facilities: a solution increasingly too expensive as the quality standards of these structures improved. Such facilities were also less accepted as a viable solution, as the type of care provided can often compromise resident’s independence.

The reduction in family care obligations and the subsequent increase in care requirements have together created a strong pressure on public health care systems, on the cash programs aimed at supporting the income of the dependent, and on the local assistance programs providing the dependent with residential institutions, home care, and daily services. The demand for these services increased at a time when cost containment, rather than service expansion, was the issue most at stake (Pierson 2001). The highest pressure came from the rising costs of hospitals and high-intensity caring needs, but also local assistance programs were increasingly under pressure because of the growing number of people requiring home care and daily care services. Therefore, many countries had to reduce their health care system’s
operating costs and local social assistance by redirecting the rising demand for care to less expensive care options, or by reshaping the preexisting care programs.

As a consequence, a tradeoff emerged between the need to provide more and more people with care not supplied by families on the one hand, and the need to control the huge increase in public costs, mainly weighting on public health systems on the other. This problem went unresolved for many years as no suitable solution could be found. However, this was, in our view, a good condition to foster institutional change in many countries. The Nordic and Anglo-Saxon countries, which had already developed an extensive public structure of social services, had to adapt their care provision systems to the new situation. The Mediterranean and Central-Eastern countries, in contrast, could enjoy a stronger support provided by family solidarity even though the tendency of women to participate in the labor market had become very high, especially in latter countries. Continental countries were much more deeply affected by the ageing process and the weakening of family ties than other countries on the one hand; and at the same time they could not rely on an already established structure of public care services, on the other. Therefore, they had to create innovative solutions in order to find a way to get through the Scilla of enlarging entitlements and care provision and the Cariddi of cutting public expenditures.

As already stated, an increasing gap between problems and solutions does not necessarily lead to policy innovation (Ferrera 2005). However, the gap can lead to a public crisis, encouraging new actors to bring new ideas and solutions to the policy arena. Counterforces will often resist change and therefore a collective decision-making process will be required. In the field of LTC policy, the absence of the definition of “long-term care” in many countries created additional problems. In contrast, in the countries where a working definition of care for the dependent was already in use, a redefinition of the term had to take place in order to facilitate the operation of new policies. In countries where LTC was nonexistent, a new policy field had to be invented and new political and technical definition of “long-term care” had to be agreed about among the relevant policy actors.

1.5 The “Who Question”: The Role of Actors in LTC Policies

An analysis of LTC policies and institutional change cannot avoid the issue of agency: as Lundquist (1980) wrote many years ago, the policy actors are those who make policies, not contextual factors. Capano and Howlett (2009) underline the importance of agency and, in particular, of policy leadership in the event of significant changes: “radical changes develop through a complex process in which focal events, critical junctures and policy windows offer opportunities for change. Therein lies the case for the strategic role of agency; the ongoing momentum has to be taken advantage of ( . . . ). Policy entrepreneurs are those capable of discovering new needs and solutions, of dealing with a high degree of uncertainty, and of resolving the problem of collective coordination” (Capano and Howlett 2009, pp. 225–226). The same scholars also argue that policy leadership is not necessarily an individual mission, but a collective
Table 1.2 The actors potentially involved in the LTC policy arena

<table>
<thead>
<tr>
<th>Public actors</th>
<th>Private social actors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National level</strong></td>
<td><strong>Actors with direct interests in provision</strong></td>
</tr>
<tr>
<td>National governments (role of ministries of finance vs. other “welfare” ministers)</td>
<td>Trade unions representing care workers</td>
</tr>
<tr>
<td>LTC ministry or the main ministry formally in charge of LTC policies (if present)</td>
<td>Private welfare-related enterprises (e.g., health insurance companies, etc.)</td>
</tr>
<tr>
<td>Other welfare sectors institutional actors/stakeholders (health care ministry, etc.)</td>
<td>The Church or other (nonprofit) delivery agencies</td>
</tr>
<tr>
<td>Top civil servants working in the LTC policy area</td>
<td></td>
</tr>
<tr>
<td><strong>Subnational or supranational level</strong></td>
<td><strong>Actors with a more general interest in LTC</strong></td>
</tr>
<tr>
<td>Local governments</td>
<td>Trade unions in general</td>
</tr>
<tr>
<td>The European Union</td>
<td>Representatives of private economic enterprises</td>
</tr>
<tr>
<td></td>
<td>Intellectuals/experts (economists, etc.)</td>
</tr>
<tr>
<td></td>
<td>Carers/users’ associations</td>
</tr>
<tr>
<td></td>
<td>Mass media</td>
</tr>
</tbody>
</table>

undertaking, involving different people at different institutional levels and policy stages: “to produce effective policy change, simply changing the agenda (matching new solutions to old problems or reframing the meaning of policy) is not enough: the ‘new’ solutions must pervade all policy domains, and leadership must be provided at different institutional levels and areas of policy” (Capano and Howlett 2009, p. 227).

Given the policy field analyzed, the main actors playing a role in the LTC arena can be divided into two broad categories: public and private actors (see Table 1.2). Of the public actors, there is a first set working mainly at the national level: governments (with possible internal conflicts among ministries in charge of the budget—Ministry of Finance—and welfare ministries always seeking more resources), the specific Ministry formally in charge of LTC issues (if there is one), other welfare policies actors with their own agenda and interests in LTC policies (e.g., to shift burden and costs from their own policy field to LTC), and the top bureaucracy dealing with the LTC policy area. A second set of public policy actors are those coming from local governments (given the importance of these actors in many countries for LTC policies) and from the European Union (through directives, benchmarking, etc.).

The private actors can also be divided into two broad subsets on the basis of their type of interest. We can differentiate between actors primarily interested in influencing LTC policy, because they have a direct stake in LTC provision (trade unions on behalf of workers in the sector; private enterprises providing care services; the Church; health insurers willing to open up new markets; and other, often nonprofit, delivery agencies as direct providers of services) and actors with a more general interest in the development of LTC policies (from users’ associations to experts, mass media and representatives of private economic enterprises, and again, trade unions), where the concept of development can point to possible different ideas about reform (either improving public financial support as in the case of users’ associations, or cutting down welfare costs as in the case of the representatives of private economic enterprises).