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Equity and Long-Term Care Policies: A Framewok for the Comparative Analysis

AUGUST ÖSTERLE

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Adopting a broad, long-term and comparative perspective, the Forum will aim to:
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· identify the various options for, and constraints on institutional reform;
· discuss the role of the various actors in promoting or hindering this reform at the national, sub-national and supra-national level;
· and, more generally, outline the broad trajectories and scenarios of change.

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Equity and Long-Term Care Policies: A Framework for the Comparative Analysis

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ABSTRACT

This paper develops an analytical framework for the systematic comparative analysis of equity approaches in long-term care policies. Equity is at the core of welfare state objectives, but there is a lack of systematic conceptualisation in many areas of social policy. This is particularly true for long-term care. This paper attempts to clarify the 'elusive' issue of equity by systematising the wide range of interpretations of equity in the provision and in the finance of long-term care, focusing on care-receivers and informal care-givers, respectively, as the target group of equity policies. This methodological approach will help to improve the understanding of equity in long-term care and to further develop comparative analysis in this policy field.

INTRODUCTION

It is only recently that long-term care became a major social policy issue in all welfare states. The debate on how to redesign long-term care policies is shaped by an increasing demand for care, a decrease in the care-giving potential in the informal sector, changing values and attitudes towards informal care-giving and the division between private and public responsibility, as well as incentives and challenges from the social, political and economic environment.

Parallel to the novelty on the top-agenda of social policy, long-term care is one of the less researched areas in social policy. In analysing the issue, long-term care has often been equated with care in nursing homes, reflecting the fact that public expenditure first of all was directed at this type of care setting. More recently and parallel to the emphasis on care in the community, long-term care is more often equated with social services for the elderly. However, both aspects only represent – an important – part of the wider long-term care issue. Apart from the provision of in kind services, some countries nowadays regard payments for care as the key to their long-term care systems. In most countries there is a slowly growing awareness of the gendered issue of informal care-giving. Overall, considerably less emphasis in research has been put on the long-term care system as a whole, which is even more true for cross-country comparative research.

Only in the 1990s is there an increase in comparative research on long-term care. The OECD has produced a series of publications on the topic (e.g. OECD 1996 and 1994) and the issue was addressed by the EU in the European Observatory on Ageing (e.g. Walker, Guillemard and Alber 1993). A number of comparative studies have looked at home care and social services (Weekers and Pijl 1998; Hutten and Kerkstra 1996; Jamieson 1991), payment for care programmes (Weekers and Pijl 1998; Evers, Pijl and Ungerson 1994; Glendinning and McLaughlin 1993), family care (Jani Le-Bris 1993), gender issues in care (Knijn and Kremer 1997; Ungerson 1995), or a variety of specific questions (e.g. contributions in Eisen and Sloan 1996). Many of these studies include detailed descriptions of the respective elements in the national long-term care systems, offering a most valuable basis for any further research. However, efforts in cross-country comparative research are only at the beginning and have been hindered by considerable policy variations – even within countries –, problems and constraints in data availability and comparability (Edvartsen 1996), as well as the lack of conceptual and analytical frameworks considering the specific characteristics of long-term care (an important exception is Alber 1995). The latter issue of missing analytical tools will be addressed here.

It is the objective of this paper to conceptualise an analytical framework for the comparative analysis of equity in long-term care. The focus is on equity as a social policy objective, on how public policies interfere in long-term care systems by providing, financing, and regulating long-term care and how this affects care-receivers and informal care-givers in terms of equity. It is not the objective of this study to analyse the normative question of how equity should be defined in long-term care or to analyse one interpretation of equity in long-term care, but to develop a framework covering the range of interpretations of equity. This will contribute to a better understanding of the operationalisation of equity in long-term care policies and to a more systematic approach in the comparative analysis of equity issues.

First of all, this paper outlines the growing importance of long-term care issues, clarifies the concept and attempts to map the institutional and the policy mix in long-term care. In the following chapter the concept of equity will be introduced, and dimensions and interpretations of equity will be specified and discussed with regard to their relevance for long-term care. The analysis follows the distinction between the provision of long-term care focusing on care-receivers, and the finance of long-term care focusing not only on monetary contributions, but also on informal care-givers in their role as in kind contributors.

LONG-TERM CARE AND THE WELFARE STATE

There are at least four sets of arguments that make long-term care a major welfare state issue: changes in the number of people in need of long-term care, changes in the traditional support systems and the role of informal care-giving, social, political and economic factors influencing the support structure, and the overall economic situation.

Older people are most likely to need long-term care, especially those 80 years and older. As this is the fastest growing age-group the number of dependent older people will grow substantially. In the OECD countries the share of the population aged 65 and over to total population will have more than doubled between 1960 (9.4%) and 2030 (22.5%). The share of those aged 75 and over to total population will increase from 5.5% in 1990 to 10.4% in 2030 (OECD 1996). There is no consensus among experts as to whether and to what extent the dependency ratio – the number of people in need of care related to the total number of people in a certain age-group – will change as a consequence of higher life expectancy and progress in medicine. The expansion of morbidity thesis, the compression of morbidity thesis, and the dynamic equilibrium thesis are all supported by empirical work (Cambois and Robine 1996). But even if a

decline in the prevalence of disabilities is assumed, there will be an increase in the absolute number of people in need of long-term care because of demographic trends (e.g. Badelt, Holzmann, Matul and Österle 1996; or Manton, Corder and Stallard 1993).

The majority of frail elderly people live in private households with their close relatives, in particular their partners and their daughters or daughters-in-law, who fulfil the role of carer. In the majority of these caring relationships the bulk of long-term care-giving is done by only one person. And even in Scandinavian countries with a high level of social service provision, in the majority of cases informal care-givers have to be seen as the main care-givers (Hennessy 1997). However, there are changes in the family and household structure, such as an increase in the number of persons living alone, a smaller number of children per family, changes in labour force participation or higher mobility which tend to reduce the potential for informal care-giving (for more details see Sundström 1994). Even if people find arrangements to care for a close relative not living in the same household, as well as arrangements to combine work and care, there certainly is a decrease in the amount of time that will be dedicated to informal care-giving under these circumstances.

The ability and the willingness to care for a person in need of long-term care living in the same household or being part of the family depends on changing values and attitudes towards informal care-giving and different forms of care. Additionally, it is determined by the design of welfare policies. Welfare state programmes change perceptions of what is seen as welfare and what is expected from the welfare state, and they create incentives in various directions. For example, an increase in retirement age first of all is seen as an approach to reduce problems in financing public pensions. But it also reduces the often underestimated amount of informal care-giving in this age-group. Hence, changes on the demand and on the supply side in long-term care as well as in the causal factors determining demand and supply, tend to expand the expectations on the welfare state to provide and/or to finance long-term care services. At the same time, welfare states are faced with increased pressures in financing such programmes.

Definitions

The OECD defines long-term care as "Any form of care provided consistently over an extended period of time, with no predetermined finishing date, to a person with a long-standing limiting condition or who is at risk of neglect or injury." (Kalisch, Aman and Buchele 1998) Long-term care contains at least four kinds of help or support: skilled medical and nursing care, personal care, domestic support, and social support. Whereas medical and nursing care can

only be provided by specially skilled providers, the other support patterns cover needs of daily living, usually undertaken by the individual or organised within the family and other social networks. Broadly speaking, long-term care covers care needs of frail elderly as well as disabled people.

Concepts defining the target group of long-term care include an assessment of impairments, the inability to or limitations in fulfilling certain activities, and the amount of help needed. The measurement of impairments is concerned with dysfunctions on the physical or mental level, resulting from causes such as diseases or accidents. Contrary to in traditional health care, disabled and frail elderly people often face multi-morbidity. The extent to which this creates the need for support by others depends on a variety of factors, of which impairments are only one.

Impairments have consequences in terms of functional performance in that individuals are restricted in their ability to perform certain activities. Indexes such as the ADL ('Activities of Daily Living', e.g. eating, dressing and undressing, moving outdoors, etc.) and the IADL index ('Instrumental Activities of Daily Living', e.g. shopping, taking medicine, handling money, etc.) are used to measure these restrictions. But there are considerable variations within this approach, as there is no standard list of activities to be covered by such indexes and answer categories in such indexes may differ. A further distinction is necessary as the extent of limitations in performing activities not only depends on the individual. In the World Health Organisation terminology 'disability' represents disturbances at the individual level, whereas 'handicap' is used for the disadvantages experienced by the individual as a result of impairments and disabilities including the 'design' of the individual's surrounding. For example, moving outdoors is not only a question of physical restrictions, it also depends on the design of the home, of public transport, or public buildings.

The more appropriate approach, given the objective of long-term care and the above-mentioned problems with measuring impairments and restrictions in functional performance, may be to look at the amount and/or the frequency of help needed. However, other measurement problems arise here. Whether measurement is based on professional evaluations, which professionals are measuring (e.g. doctors, nurses, social workers, etc.), or how measurement procedures are designed might well produce quite different outcomes.

Actors and policies

Long-term care is about providing and financing care over an extended period of time. Long-term care policies are aimed at those people who need care, assistance or support in their physical, psychological, health or social life and increasingly at those people who bear the bulk of informal care-giving. The household, the forprofit, the voluntary (nonprofit), and the public sector all may act as providers of services and – at least as mediators – financial means as well as financiers of long-term care.

Different options regarding actors and policies in the provision of long-term care are shown in table 1. Even in systems with a relatively high level of social service support, the bulk of care-giving is offered by informal providers, i.e. household and family members and – of minor importance – friends and neighbours, most of whom are women. Men who spend a considerable amount of time care-giving, are retired and care for their partner. (see e.g. Jani-Le Bris 1993; Glendinning and McLaughlin 1993; Badelt, Holzmann-Jenkins, Matul and Österle 1997) Apart from the dominant form of informal care-giving as in kind provision, there also occur private transfers, in particular from family members outside the care-receivers household.

In kind provision and cash payments are to be found in the formal private as well as in the public sector. The two basic forms of in kind provision are care in the community (social services) and care in residential care settings. Apart from nursing homes, hospitals often acted as residential care settings for frail elderly people which is now seen as one of the major inefficiencies in long-term care. Cash benefits as a substitute or a complement to services recently became more prominent on the long-term care agenda shifting purchasing power to receivers of such payments.

Table 1: The provision of long-term care

Providers	*Provision*	
	in cash	*in kind*
Families Other informal networks	private transfers	informal care-giving
Nonprofit organisations Forprofit organisations	insurance payments	social services nursing homes
Public sector Social insurance	payments for care insurance payments regulating provision	social services nursing homes regulating provision

Within the formal private sector, the voluntary sector clearly dominates the forprofit sector in most countries. Even in countries with limited public support, the establishment or the expansion of forprofit initiatives, such as private insurance solutions, is rather limited (Hennessy 1997; Garber 1996). The voluntary sector is a very heterogeneous sector. It ranges from nonprofit organisations working without volunteers, to voluntary organisations combining paid and voluntary employment, to actors organising help by volunteers or neighbours setting up some sort of co-operative initiative. The role of voluntary organisations in the long-term care system ranges from charities depending on a wide range of financial sources to partners in contracting-out models, where finance and provision is divided between the public and the formal private sector.

The role of the public sector in providing long-term care and regulating provision is characterised by shared responsibilities between different levels of public bodies. Apart from giving a general direction in policies, the role of central public bodies often is rather restricted compared to local public bodies. However, there is and there will probably continue to be an increasingly important role in imposing general directions and setting quality standards in order to reduce inequalities in service provision within countries. Central governments also play an important role if social insurance solutions and payment for care programmes are established, which tend to be more standardised within countries than social services. The actual provision of services by public bodies is ususally dominated by those on a local level. Here, the establishment of residential care settings was often seen as the adequate public response, an approach which today is seen as highly inefficient. Trends which increase contracting-out might strengthen the regulatory role of public bodies on both levels.

Financing long-term care is based on contributions in cash as well as in kind, with the latter often being ignored in social policy analyses. Combined with the institutional mix four basic models for the finance of care can be identified (shown in table 2): the two party model (care-receiver and care-giver) and three different third party models. In the two party model care-receivers either make out-of-pocket payments to buy care, or care is offered on an informal basis as in kind contribution without direct compensation. The latter is the dominant form in purely private care relationships, leaving (non)remuneration of these burdens to intra-family or intra-household processes. Only recent policy programmes such as payments for care or the introduction of social insurance coverage for informal care-giving intervene in this domain (Ungerson 1995; Baldock and Ungerson 1991; Leat 1990).

Table 2: The finance of long-term care

	Contributions	
Finance	*in cash*	*in kind*
Two party model (care-receiver + care-giver)	out-of-pocket payments	informal care-giving
Informal third party model (care-receiver + care-giver + informal networks)	cash transfers	in kind transfers
Private third party model (care-receiver + care-giver + private insurance)	private insurance contributions	in kind transfers (co-operative)
Public third party model (care-receiver + care-giver + public sector / social insurance)	taxes social insurance contributions regulating finance	compulsory in kind transfers regulating finance

In the third party models additional actors enter the care arena. In the informal third party model individuals are informal financiers of long-term care. This might be family members apart from the main care-giver or neighbours offering care in order to relieve the main care-giver, or family members transferring money to the person in need of care or to the main care-giver enabling them to buy specific aids or care services.

As a result of the risk-structure, long-term care seems to be a typical case for risk management via private insurance. The formal private third party model therefore should be found in the insurance solution. However, without public

intervention problems in establishing private insurance contracts occur even in countries were the role of the public sector is rather limited (Wiener 1994). In kind transfers in the private third party model represent the idea of co-operatives according to the insurance idea, where services are offered as contributions instead of cash contributions. Apart from grass-root initiatives, this has almost no importance for the design of long-term care systems.

The restrictions in financing long-term care out-of-pocket or out-of-savings – at least in the case of long-lasting care needs – and problems with purely private third party models, have led to the evolution of a wide range of public third party models. Yet, the existing models are far less developed than, for example, those in public health care or public pension systems. The source of financial means in the public third party models are taxes or social insurance contributions, but whereas the finance of long-term care is mostly organised on the central level, the specific use of funds may well be decentralised as has been shown before. A form of in kind contribution – of almost no importance in the real design of long-term care systems – are compulsory in kind transfers. However, through regulations the public sector obliges family members in a number of countries to contribute to the finance of long-term care through in kind or cash contributions. Apart from such regulations touching on the informal sector, public bodies tend to have an increasing role in regulating the formal private sector if private insurance or compulsory private insurance solutions are favoured.

This decade is characterised by an increasingly vivid debate on long-term care policies and has already led to considerable changes and restructuring in policies (see the references given in the introduction). According to Walker, Guillemard and Alber (1993, 62) policy directions in long-term care can be summarised as policies "... to contain the heavy growth of health expenditure, to define policy priorities for the rapidly growing group of elderly persons, to provide adequate coverage for the growing need of long-term care, to reorganise residential care, and to introduce new incentives for the development of community care and informal care." We might find similar policy measures in many countries incorporating many or some of these policy trends; but the extent to which they are introduced, whether they emphasise payments or services, how they recognise the role of informal care-givers and the way in which they are integrated in the whole welfare system results in considerable differences between countries and even within countries. As far as the equity objective is concerned, policy statements in long-term care are rather vague, though objectives such as 'provision of an adequate coverage' or 'redistribution between public and private responsibility' point at the importance of the issue.

A FRAMEWORK FOR ANALYSING EQUITY IN LONG-TERM CARE

Equity is widely accepted as an objective in social policy. Explicitly or implicitly, welfare state definitions and social policy definitions include notions such as equity, justice or equality, they are even at the core of these definitions. And equity is an attractive label in social policy making. However, apart from a basic agreement on equity as an objective of the welfare state, we are far from reaching an agreement on what constitutes equity. Precise specifications of equity are rare, in policy-making as well as in research.

Searching for empirical equity studies in long-term care is an almost fruitless task. Exceptions are Evandrou, Falkingham, Le Grand and Winter (1992) or Bebbington and Davies (1983). Most of the few existing studies address very specific interpretations of equity, other studies are locally restricted, or include only one type of service provision within the complex arena of long-term care. Although the concept of equity or equality is introduced in a number of studies, it is rarely based on an explicit specification of what is meant by equity or an equitable allocation. If there is such a specification, the choice of a specific interpretation often seems to be based on a mixture of what is supposed to be a widely accepted interpretation and what is going to be testable, given the data available.

As stated, it is the objective of this paper to develop a framework for the systematic analysis of equity in long-term care. Equity is an overall approach covering various interpretations, whereas equality is concerned with specific interpretations. Equity defined as 'equal use of services according to need' or as 'equal use of services according to contributions paid' are only two different interpretations of equity, both situations might be seen as equitable, but would certainly result in considerable differences in the actual distribution of long-term care services. The first principle (equality according to need) implies inequality according to contributions paid but might still be seen as equitable, and vice versa.

The basic definition of equity – 'the equal treatment of equals' ('horizontal equity') and 'the unequal treatment of unequals' ('vertical equity') – will find widespread support but does not reflect the wide range of possible interpretations of equity. Therefore, the analysis will start from another general definition of equity – 'a certain amount of x to each y according to z' – reflecting the three main characteristics according to which interpretations of equity may differ. The three questions are: WHAT is to be shared (x), between WHOM (y), and HOW (z), that is according to which principle. In many equity studies there is not much effort on explicitly discussing these questions. Exceptions with an investigation of at least some of these characteristics can be

found in Lee (1995); Sen (1992); Elster (1992); Le Grand (1991 and 1982). The following analysis explores the three characteristics for long-term care following the distinction between the provision and the finance of long-term care. Whereas in the provision the focus will be on care-receivers, analysing equity in the finance of long-term care offers an opportunity to look at informal care-givers in their role as in kind financiers.

The provision of long-term care

WHAT – The resource to be shared

The first issue according to which interpretations of equity may differ is the resource to be shared. This seems to be a rather clear issue. However, an equitable allocation in long-term care is not only about allocating care, it is about support in activities of daily living, compensating for inabilities, self-respect, independent living, etc. Obviously, a more systematic examination of the good or the goods to be shared in long-term care is necessary.

Social policy is aimed at improving social and/or economic conditions of individuals or groups within society. Consequently, it seems appropriate to look at the final outcome of long-term care provision. Specific measures of the final outcome, such as the ability to stay in one's own home, are relatively easy to assess. An assessment of overall measures of the final outcome, such as *well-being*, health or welfare, is confronted with enormous conceptual and practical problems, apart from the ethical question of whether and to what extent it is a public responsibility to equalise the final output.

Long-term care policies therefore might be more concerned with the 'intermediate output' (Davies and Knapp 1981; Knapp 1984). Here, the focus is on *use* of long-term care in quantitative and qualitative terms. Use or treatment has been the focus of a number of studies on equity in social policy (e.g. Evandrou, Falkingham, Le Grand and Winter 1992; Van Doorslaer, Wagstaff and Rutten 1993), partly because this is what policies are aimed at explicitly, partly for reasons of practicality in the assessment of actual use. (Re)allocation of intermediate outputs does not necessarily mean equalisation in the outcome, but may still be seen as equitable. Take the example of A and B both restricted in their ability to walk independently outside their own house. For A walking is a necessary movement to do shopping. For B instead it is more than that; B enjoys walking. If both A and B are supported by social services in shopping, B compared to A is going to have a smaller increase in well-being by the same service.

If the egalitarian objective of equalising resources is reduced in favour of a more liberal approach concerned with the free choice of individuals, a third approach has to be introduced, *access*. Access is the opportunity to use long-term care services. It may be interpreted as the opportunity to get access to a special service, the opportunity to get information on services available, the opportunity to get access to help within a certain amount of time, etc. Policies aimed at equalising access are aimed at equalising potential, not actual use of services. Here, society is not interested whether and to what extent frail elderly or disabled people are really cared for or supported. Widening the concept of access to specific services to a concept of access to a range of potential services addresses *choice*. For example, a system offering places in nursing homes to everyone might fulfill the concept of access to nursing homes, choice however remains rather restricted if social services are limited.

TO WHOM - The focal unit

The second characteristic to investigate different interpretations of equity are the units among which the resources are to be shared. The final units in the provision of care are individuals in need of care. But policies may also address broader units, such as local areas, nations or institutions.

Equity across geographical areas is about the equitable allocation of goods between *local areas*, regions, nations, or even beyond. Quality standards, such as a certain number of home nurses related to the total population, set by the central government for the development of social services on the local level are aimed at territorial justice as is the allocation of national funds for the development of services on the local level according to the availability of services in this area. *Institutions* are another focal unit, which – with the introduction of contracting out-models – tends to become even more important. Here, quality standards may also be used to equalise quality levels across providers. In order to promote service provision by a certain institutional mix resources may be transferred to different institutional forms. Even so, the equity implications within the units should not be ignored. Finally, geographical areas and institutions are intermediate units in order to improve the situation of individuals within these areas and supported by these institutions.

HOW – Principles of allocation

Finally, interpretations of equity are characterised by the principle according to which the allocation takes place. There are a number of approaches to categorise such principles, those who offer mutually exclusive categories (as Walzer 1983) or those who search for an exhaustive list of such principles (as Elster 1992). In light of the practical problems of the first approach and the objective of this

paper to clarify and to systematise the range of interpretations, the following discussion presents various sets of principles that can be used in the allocation of scarce long-term care resources. Apart from need, which is probably the most attractive principle for health and social care issues, these sets of principles include egalitarian, time-related, status, economic, and other principles.

Need, in relation to limiting health conditions and resulting requirements for care, seems to be the most adequate allocation principle with respect to equity considerations in the provision of health and social care. If equity is defined as 'equal access for equal need' need is the respect to which individuals are unequal and to which differentiation among individuals should be made. Other variables such as age, gender, or income should not make any difference in access.

But as discussed above, need is far from being a clear-cut single principle. In benefit schemes as well as in policy analysis or in theoretical considerations on need one can find a variety of very different measures of need, such as morbidity or disability measures, measures based on the ability to benefit, the inability to carry out certain activities of daily living, or the amount of time to help people. In addition, it makes a difference whether we rely on self-reported needs or on the assessment by professionals. Although the definition of need is central to designing and analysing social policies, there is a significant lack of information on how different assessment procedures do influence the actual outcome of policies.

Need has been introduced with a focus on the individual. But society might not only be interested in individual needs. It may as well be interested in the needs of certain socio-economic groups. In this case the principle of need has to be accompanied by other principles, for example age or occupational status. Obviously, principles used for allocating resources are not necessarily used as single principles, but in combination.

The idea of *egalitarian principles* is that resources have to be shared equally. Everyone has to get the same amount of the resource to be shared. This might be used as an ideal objective (or as a reference point) for the 'final output' of well-being. Allocating equal shares of care (taking use as the resource to be shared) without considering different levels of disability does not seem an appropriate principle.

Time-related principles – in particular waiting-lists and queuing – are frequently used in long-term care because of their advantages regarding practicality. Waiting lists are fairly common to allocate places to nursing homes, queuing is a method to allocate services. Waiting lists as well as queuing may

not only be favoured because of practicality reasons, but also as an indicator of the intensity of needs. However, at the same time they may reflect the level of information, which questions this principle as an indicator of need. Another form of time-related principle is used in insurance models, if benefits are (partly) related to the duration of time over which contributions are paid.

The set of *status principles* includes a variety of principles such as age, gender, civil status, family status, residence status or occupational status. In health and social care some of these principles are used as an additional principle to define the target group. For example, people might be excluded from medical treatment by age, or places in nursing homes may be reserved for those who are residents within a geographical area. Apart from being used as allocation principles, status variables as well as income (see below) are important in policy analysis to evaluate the effects of welfare state programmes on socio-economic groups.

The typical example for the use of *economic variables* in allocating resources in long-term care is means-testing. Benefits or free services are provided to those people in need of care whose income is below a certain level. In social assistance schemes people cared for in nursing homes are obliged to use their pensions and savings before public bodies interfere. If different forms of providing care result in the same outcome, efficiency could be an appropriate principle to decide which is to be supported. Although the outcome of caring for frail elderly people in acute hospitals, in residential care settings or in the community will not be exactly the same, there is room for allocating resources among these different institutions according to the efficiency principle. Indeed, this is one of the driving forces for the redesign of long-term care systems in many countries.

Most of the principles described are not used as single principles, but as *mixed principles*. For example, 'payments for care according to need for those 60 years and over' or 'free access to services according to need and income'. Finally, there might be no explicit principle at all, but there is still allocation of resources. Here, *'implicit principles'* will be used discretionary. For example, if people in need of care have to make out-of-pocket payments to get access to social services, this might exclude the poorest because of lack of purchasing power. The guiding principle in the private market becomes an implicit additional principle in long-term care policies. The informational background of users, values of individual decision-makers, lobbying and political power, informal connections, etc. might work as other implicit principles in the allocation of resources.

Apart from defining the target group, principles also determine the amount of resources allocated. Take the example of 'equal use according to need'. If A and B are equal in their needs, then they should get the same amount of treatment. If A and B are unequal, they should get an unequal amount. To what extent they should be treated unequally in order to reach an equitable distribution is part of the allocation principle.

Figure 1: Interpretations of equity in the provision of long-term care

WHAT	outcome	use	access	choice	*by means of*	payments	services	regulation
HOW (principles)	need	egalitarian	time-related	status	economic	mixed	implicit	

Figure 1 summarises the interpretations of equity in the provision of long-term care. The potential resources to be shared in long-term care are final outputs (well-being), intermediate outputs (use), access and choice. The social policy means to achieve an equitable distribution in these resources are regulation, in kind resources or cash payments, which are allocated to individuals, institutions or local areas according to principles such as need, status or economic variables.

The finance of long-term care

Long-term care creates enormous social and economic challenges to those people affected, care-receivers as well as care-givers. Within welfare states there is some agreement that costs of long-term care should not be left entirely to the individuals in need of care and their closest relatives as principal care-givers. However, opinions on the extent to which public action should be taken and how financing responsibilities should be shared differ widely.

WHAT – The burden to be shared

Analysing equity in the finance of welfare programmes usually considers taxes, social security contributions, private insurance contributions and out-of-pocket payments, but ignores informal non-monetary transfers (e.g. Van Doorslaer, Wagstaff and Rutten 1993). An analysis of equity in financing long-term care only based on monetary flows would be highly misleading. The bulk of long-term care-giving is done without remuneration (or at least with very little) in the informal care sector, mostly by women within the family. In order to get a full picture of the allocation of burdens and to recognise the role of informal care-giving, in kind contributions have to be included.

TO WHOM – The focal unit

As with the provision of long-term care, individuals are the focal unit among whom burdens are to be shared. However, other focal units might be addressed in the finance of long-term care as well, for example, if companies become the unit to be taxed. If public bodies oblige close relatives to care for a frail elderly or disabled person, families are addressed as the focal unit, leaving the actual intra-family distribution of burdens to these families.

HOW – Principles of allocation

The most obvious principle in allocating burdens in the public finance of welfare programmes are *economic variables*. Financing welfare programmes through social security systems or tax systems is relating burdens to income. By setting specific relationships between income and the financial burdens systems take account of different income levels. Apart from these differences a broader concept of ability to pay would also have to consider additional variables, such as the number of dependent children in the household, as well as wealth. Although relating burdens to wealth is confronted with some problems of practicality, wealth or private savings are increasingly seen as one of the key sources for financing long-term care in the future, not necessarily as a taxable source, but as a means of private solutions to be supported by fiscal policies (Garber 1996).

As in the provision of care, *status variables* are used as additional principles in the finance of care; for example, when social insurance contributions differ according to occupational status. If a person has to be cared for in a nursing home or by social services, the degree of relationship might be used as an additional principle for allocating burdens by obliging children, partners or other close family members to (partly) finance these services. Here, *mixed principles* are used to allocate burdens. Pure *egalitarian principles* in financing long-term care are of a more hypothetical nature. However, one could argue for mandatory welfare work for every citizen.

As long as the burdens to be shared – as with income – are easily measured in monetary terms and allocation principles clearly defined there is not much room for *'implicit principles'*. But they become increasingly important if the finance of long-term care is organised in the private sector with a regulatory role of public bodies. In a compulsory private insurance scheme, information and informal connections, as well as health status might become implicit principles in allocating burdens. For example, the level of information becomes important if there is a broad diversity of insurance contracts offered in the private sector;

the use of informal connections might help to get access to financially more attractive insurance contracts; or selection according to health status might occur. The extent to which these implicit principles determine the burden of financing long-term care depends on whether and how private insurance companies are regulated. Another implicit principle might come into operation if families are explicitly obliged to care for close relatives, or if the public role is of subsidiary nature. As formal private solutions are usually rather limited, the actual distribution of the burdens within families depends on a number of issues, such as values and attitudes towards informal care-giving, gender roles in society, as well as incentives created by welfare state programmes or the economic environment.

Figure 2: Interpretations of equity in the finance of long-term care

WHAT	burdens	*by means of*	contributions in cash		contributions in kind		regulation
HOW (principles)	income	wealth	ability to pay	egalitarian	status	mixed	implicit

The interpretations of equity in the finance of long-term care are summarised in figure 2. Methods used in social and fiscal policy to achieve an equitable distribution of these burdens are regulation, cash contributions (imposing taxes, social insurance payments; regulating private insurance contributions, out-of-pocket payments) as well as regulating in kind contributions, with economic, status and implicit principles as the guiding rules of allocating these burdens.

CONCLUSIONS

This paper brought together two social policy issues of major importance. Long-term care which is relatively new on the research agenda in social policy, and equity which has been a central theme of the welfare state from the outset. But equity is still described as an 'elusive' issue. The aim of this paper was to contribute to a better understanding of both issues by developing a framework for the systematic comparative analysis of equity considerations in long-term care policies. The focus is not on equity considerations in intra-family arrangements or in purely private solutions but on equity interpretations and policy choices in long-term care programmes and their implications on the target group of care-receivers and informal care-givers. Problems and constraints in analysing long-term care issues in a comparative perspective arise from the complexity of the issue, the variety of concepts and approaches used in research

and in practice, as well as considerable restrictions in data availability and comparability. It is hoped that this paper – by breaking down, clarifying and mapping the equity concept in long-term care policies – offers an effective tool which will serve as a guideline for more systematic analysis of long-term care systems regarding similarities, differences, causal factors and consequences in terms of equity.

REFERENCES

Alber, J. (1995) "A Framework for the Comparative Study of Social Services", *Journal of European Social Policy*, 5, 2, 131-149.

Badelt, Ch., Holzmann-Jenkins, A., Matul, Ch. and Österle, A. (1997) *Analyse der Auswirkungen des Pflegevorsorgesystems*, Wien, BMAGS.

Badelt, Ch., Holzmann, A., Matul, Ch. and Österle, A. (1996) *Kosten der Pflegesicherung. Strukturen und Entwicklungstrends der Altenbetreuung. 2nd Edition*, Wien, Böhlau.

Baldock, J. and Ungerson, C. (1991) "'What d'ya want if you don' want money?'. A Feminist Critique of 'Paid Volunteering'" in Maclean, M. and Groves, D. (eds.) *Women's Issues in Social Policy*, London, Routledge.

Bebbington, A.C. and Davies, B.P. (1983) "Equity and Efficiency in the Allocation of the Personal Social Services", *Journal of Social Policy*, 12, 3, 309-330.

Cambois, E. and Robine, J.-M. (1996) "An International Comparison of Trends in Disability Free Life Expectancy" in Eisen and Sloan (1996).

Davies, B.P. and Knapp, M. (1981) *Old People's Homes and the Production of Welfare*, London, Routledge.

Edvartsen, T.O. (1996) "Possibilities and Problems in a Cross-Country Comparative Analysis of Long-Term Care Systems" in Eisen and Sloan (1996).

Eisen, R. and Sloan, F.A. (eds.) (1996) *Long-Term Care: Economic Issues and Policy Solutions*, Dordrecht, Kluwer.

Elster, J. (1992) *Local Justice. How Institutions Allocate Scarce Goods and Necessary Burdens*, New York, Russel Sage Foundation.

Evandrou, M., Falkingham J., Le Grand, J. and Winter, D. (1992) "Equity in Health and Social Care", *Journal of Social Policy*, 21, 4, 489-523.

Evers, E., Pijl, M. and Ungerson, C. (eds.) (1994) *Payments for Care. A Comparative Overview*, Aldershot, Avebury.

Garber, M. (1996) "To Comfort Always: The Prospects of Expanded Social Responsibility for Long-Term Care" in Fuchs, V.R. (ed.) *Individual and Social Responsibility*, Chicago, The University of Chicago Press.

Glendinning, C. and McLaughlin, E. (1993) *Paying for Care: Lessons from Europe*, London, HMSO.

Hennessy, P. (1997) "Die Zunahme des Pflegerisikos im Alter. Welche Rolle kommt der Familie und der sozialen Sicherheit zu?", *Internationale Revue für soziale Sicherheit*, 50, 1, 25-45.

Hutten, J.B.F. and Kerkstra, A. (eds.) (1996) *Home Care in Europe*, Aldershot, Arena.

Jamieson, A. (ed.) (1991) *Home Care for Older People in Europe. A Comparison of Policies and Practices*, Oxford, Oxford University Press.

Jani Le-Bris, H. (1993) *Family Care of Older People in the European Community*, Dublin, European Foundation for the Improvement of Living and Working Conditions.

Kalisch, D.W., Aman, T. and Buchele, L.A. (1998) "Social and Health Policies in OECD Countries: A Survey of Current Programmes and Recent Developments", OECD, Labour Market and Social Policy Occasional Papers No. 33, Paris.

Knapp, M. (1984) *The Economics of Social Care*, London, Macmillan.

Knijn, T. and Kremer, M. (1997) "Gender and the Caring Dimension of Welfare States: Toward Inclusive Citizenship", *Social Politics*, 4, 3, 328-361.

Leat, D. (1990) *For Love and Money. The Role of Payment in Encouraging the Provision of Care*, London, Joseph Rowntree Foundation.

Lee, T. (1996) *The Search for Equity. The Funding of Additional Educational Needs under LMS*, Aldershot, Avebury.

Le Grand, J. (1991) *Equity and Choice. An Essay in Economics and Applied Philosophy*, London, Harper Collins.

Le Grand, J. (1982) *The Strategy of Equality. Redistribution and the Social Services*, London, George Allen & Unwin.

Manton, K.G., Corder, L.S. and Stallard, E. (1993) "Estimates of Change in Chronic Disability and Institutional Incidence and Prevalence Rates in the U.S. Elderly Population from the 1982, 1984, and 1989 National Long-Term Care Survey", *Journal of Gerontology*, 48, 4, 153-166.

OECD (1996) *Ageing in OECD Countries. A Critical Policy Challenge*, Paris, OECD.

OECD (1994) *Caring for Frail Elderly People. New Directions in Care*, Paris, OECD.

Sen, A. (1992) *Inequality Reexamined*, Oxford, Clarendon Press.

Sundström, G. (1994) "Care by Families: An Overview of Trends" in OECD (1994).

Ungerson, C. (1995) "Gender, Cash and Informal Care: European Perspectives and Dilemmas", *Journal of Social Policy*, 24, 1, 31-52.

Van Doorslaer, E., Wagstaff, A. and Rutten, F. (eds.) (1993) *Equity in the Finance and Delivery of Health Care. An International Perspective*, Oxford, Oxford University Press.

Walker, A., Guillemard, A.-M. and Alber, J. (1993) *Older People in Europe: Social and Economic Policies. The 1993 Report of the European Community Observatory*, Luxembourg, Commission of the European Communities.

Walzer, M. (1983) *Spheres of Justice*, New York, Basic Books.

Weekers, S. and Pijl, M. (1998) *Home Care and Care Allowances in the European Union*, Utrecht, NIZW.

Wiener, J. (1994) "Private Sector Initiatives in Financing Long-Term Care" in OECD (1994).

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