European Forum

Equity in the Provision of Long-Term Care: A Comparison of Austria, Italy, the Netherlands and the United Kingdom

AUGUST ÖSTERLE

EUF No. 99/18

EUI WORKING PAPERS

EUROPEAN UNIVERSITY INSTITUTE

EUI Working Paper EUF No. 99/18

Österle: *Equity in the Provision of Long-Term Care: A Comparison of Austria, Italy, the Netherlands and the United Kingdom*

This Working Paper has been written in the context of the 1998-1999 European Forum programme on **Recasting the European Welfare State: Options, Constraints, Actors**, directed by Professors Maurizio Ferrera (Universities of Pavia and Bocconi, Milano) and Martin Rhodes (Robert Schuman Centre).

Adopting a broad, long-term and comparative perspective, the Forum will aim to:
· scrutinize the complex web of social, economic and political challenges to contemporary European welfare states;
· 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.

EUROPEAN UNIVERSITY INSTITUTE, FLORENCE

EUROPEAN FORUM

EUI Working Paper EUF No. 99/18

Equity in the Provision of Long-Term Care: A Comparison of Austria, Italy, the Netherlands and the United Kingdom

AUGUST ÖSTERLE

Vienna University of Economics and Business Administration
and EF Jean Monnet Fellow (1998-99)

BADIA FIESOLANA, SAN DOMENICO (FI)

Printed in Italy in November 1999
European University Institute
Badia Fiesolana
I – 50016 San Domenico (FI)
Italy

INTRODUCTION*

Until recently, long-term care represented a fragmented and often neglected social policy issue in many European countries. Forecasts regarding the demand for long-term care in the coming three decades, changes in traditional support systems and in the attitudes towards informal care-giving and the perception of what is seen as public responsibility in care, as well as incentives from the social, political and economic environment increased awareness for long-term care and made it a major social policy issue. Parallel to the novelty on the top-agenda of social policy, long-term care is one of the less researched areas in social policy, 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; 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 and Illsley 1990), 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 economic questions (contributions in Eisen and Sloan 1996).

The objective of this paper is to analyse how different countries approach the objective of equity in the provision of long-term care. 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. Equity is widely accepted as an objective in social policy. 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. This paper attempts to analyse the equity approaches and the operationalisation of equity in long-term care systems in Austria, Italy, the Netherlands and the United Kingdom. Whereas most equity studies in social policy attempt either to search for *the* interpretation of equity, or to analyse one specific interpretation of equity, the objective of this paper is to search for and to analyse the range of equity interpretations in long-term care policies with regard to the provision of care.

---

* This text is a revised version of a paper presented at the European Forum Conference on "Beyond the Health Care State: Institutional Innovations and New Priorities in Access, Coverage and Provision of Health Services", 26-27 February 1999, at the European University Institute. The conference was organised by Maurizio Ferrera (University of Pavia), Ana Guillen (University of Oviedo) and August Oesterle (Vienna University of Economics and Business Administration) in collaboration with DG V.

First of all, the paper presents a basic definition of long-term care and looks at the institutional and policy mix in long-term care reflecting the options to organise the provision of long-term care. Then, equity as an objective of the welfare state as well as the elements to achieve this objective will be introduced. These conceptualisations will then be used in the empirical analysis of the long-term care systems in Austria, Italy, the Netherlands, and the United Kingdom. The focus of the paper is on the design of the allocation of resources (provision) through public policies and the implications for care-receivers.

BASIC DEFINITIONS AND CONCEPTS

Long-term care

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 focus on the assessment of impairments, the inability to or the limitations in fulfilling certain activities, or the amount of help needed. All these approaches produce considerable variations in the actual target group depending on which activities of daily living are included in the respective indexes, which spaces of help are recognised, how answer categories are designed, how measurement procedures are organised or who is involved in the measurement procedure. (Edvartsen 1996)

The various options regarding actors and policies in long-term care systems are shown in figure 1. The provision of long-term care is characterised by an institutional mix including the informal sector, the voluntary (nonprofit) sector, the market sector, and the public sector. In general the bulk of care-giving is still done in the informal sector. Regarding the formal sector there are considerable differences in terms of the degree of service provision as well as in terms of the division of responsibilities between the public and the private nonprofit sector, which are the main providers in the formal sector. The role of forprofit organisations is generally rather small, even in those countries where

the public role is very limited. Policy approaches include in kind as well as cash provision. Recently, there is a notable shift from residential care settings to care in the community. By introducing cash benefits a number of countries shift decision-making power over the care arrangement to the informal sector.

Table 1: The provision of long-term care

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

Recent 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." (Walker, Guillemard and Alber 1993: 62) As far as the equity objective is concerned, policy statements in long-term care are rather vague although objectives such as 'provision of an adequate coverage' or 'redistribution between public and private responsibility' point at the importance of the issue.

Equity

Searching for 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). However, 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. Taking a broader perspective at equity studies in social policy one can identify two main streams: those studies analysing

social policy issues in the light of theories of social justice and those studies testing specific interpretations of equity. The wide range of interpretations of equity used in practice is mostly ignored. Hence, this paper attempts to analyse how different European countries approach the objective of equity by looking at actual allocation policies and the operationalisation of equity in long-term care systems.

Equity is at the core of welfare state objectives and can be found in all the approaches to categorise these objectives. Following Barr (1993) at least four sets of equity objectives can be identified:

- Minimum standard: reduction / prevention of absolute poverty / disadvantages
- Supporting living standards: prevention of large drops in the living standard
- Reducing inequality: reduction / prevention of relative poverty / disadvantages
- Social integration: reduction / prevention of social exclusion

Equity objectives in the welfare state can be achieved by a wide range of methods. In order to systemise and analyse these methods in long-term care the paper follows the three main characteristics according to which interpretations of equity may differ and according to which choices have to be made: WHAT is to be shared, among WHOM, and HOW, that is according to which principle. (For a more detailed analysis of this approach see Österle 1999) In many equity studies there is not much effort on explicitly discussing any of 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, 1982).

As summarised in table 2, the potential resources to be shared in long-term care are final outcomes (well-being), 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, families, institutions or local areas according to principles such as need, time-related variables, status variables, economic variables or implicit principles.

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	

LONG-TERM CARE IN AUSTRIA, ITALY, THE NETHERLANDS AND THE UNITED KINGDOM: BASIC FACTS

The countries chosen for the empirical analysis of equity interpretations in long-term care policies are Austria, Italy, the Netherlands and the United Kingdom. On the hand these countries share major demographic, social and economic challenges. On the other hand they represent quite distinct welfare state approaches (see e.g. Esping-Andersen 1990, Ferrera 1993, or with respect to the division of care responsibilities Millar and Warman 1996).

A brief overview to the long-term care systems in Austria, Italy, the Netherlands, and the United Kingdom will be given in this section in order to highlight the institutional and the policy mix in the respective countries. The following basic terms will be used: residential care (covering care in nursing homes and residential homes), domiciliary care covering home nursing (related to health aspects) and home help (related to personal and domestic care), payments for care to care receivers and payments for care to informal care givers.

Table 2: Some demographic and long-term care data

	A	I	NL	UK
Population by age group, 65+, total, 1995 (in 1000)	1,211.3	9,401.1	2,033.6	9,205.4
Population by age group, 80+, total, 1995 (in 1000)	312.3	2,292.3	475.8	2,334.7
65-79 as proportion of total population, 1996 (%)	11.4	12.7	10.2	11.7
80+ as proportion of total population, 1996 (%)	3.8	4.1	3.1	4.0
Forecast: Population by age group, 2010				
65-79 as proportion of total population (%)	12.8	14.7	11.2	11.7
80+ as proportion of total population (%)	4.7	5.8	3.8	4.3
Forecast: Population by age group, 2020				
65-79 as proportion of total population (%)	14.6	16.1	14.7	14.2
80+ as proportion of total population (%)	5.2	7.1	4.2	4.7
Residential care 1996 (IT 1992)				
residents as % of those 65+ (Italy 75+)	4	3.5	9	5 *
Domiciliary care 1996				
home help recipients as % of those 65+	-	-	10	6 *

* England

Source: Eurostat (1997); Rostgaard and Fridberg (1998); BMAGS (1998); ISTAT (1997)

Basic demographic and long-term care related information on the four countries is presented in table 2. Missing data in this table regarding residential and domiciliary care is just one small indicator for the constraints in the empirical analysis of long-term care issues. Any comparative analysis in long-term care faces considerable problems and restrictions arising from definitions and concepts varying between and even within countries as well as from data availability and comparability. (Sipilä 1997; Edvartsen 1996)

Long-term care: The case of Austria [1]

Long-term care in Austria has always been strongly based on family networks. Until 1993 the public support system in Austria was characterised by a decentralised structure of payments and institutional services, with provinces and communities being responsible for most of the long-term care matters. This resulted in considerable regional imbalances regarding residential and domiciliary care. In a number of provinces there were almost no social services available. In 1993 a new payment for care programme initiated considerable changes in the system of care. The major policy objectives in Austria are the development of social services in the community, the support of informal care, the assurance of high quality in care and cost containment.

Residential care

A relatively high amount of public money has always been spent for care in residential care settings as well as in hospitals, offering care not only for severely disabled people but also for people who do not have access to alternative care settings due to supply shortage. In 1997 there were 29,400 nursing home beds, and 35,500 beds in residential homes. More than half of these care settings are run by provincial or local public bodies, almost one third by nonprofit organisations and the remaining by private forprofit institutions, which tend to be much smaller regarding the number of beds per unit. A lack of social services in the community as well as waiting lists in residential care settings resulted in a number of frail elderly people who are cared for in acute hospitals without need for acute care. The recent introduction of payments for care (see below) has considerably reduced waiting lists in residential care settings. At the same time, the proportion of more severely disabled people living in these homes has increased. Financing residential care settings is based on fees per day differentiating according to care needs. First of all, clients have to make out-of-pocket payments. Pensions as well as payments for care are directly transferred to these institutions (up to some pocket money). Additional funding is coming from subsidies by provinces or communities. However, according to social assistance regulation in the provinces these payments may be recovered from clients savings and financial means from close family members.

Domiciliary care

Social services in the community still do not exist or are far from covering the demand for such services in many provinces. In this respect the Austrian payment for care programme did not yet fundamentally change the existing system. According to a 'long-term care treaty' between the central government and the nine provinces the latter are obliged to develop a comprehensive community care system covering residential, semi-residential and domiciliary services until 2010. Part of these development plans are quality standards. The provision of home nursing as well as home help services differs considerably between provinces in terms of the level of provision as well as the organisation. Nonprofit organisations are most important as providers of such services. Public bodies as well as forprofit organisations play a minor role in the actual provision. With the introduction of payments for care competition has increased in some provinces, even if in many areas specific organisations still work in an almost monopolistic position. Regarding the coordination between various service providers, there is no nationwide concept, however a number of models evolved all over the country.

Regarding eligibility and access to these services there is no systematic approach. However, most provinces use standardised forms for assessing the needs of the clients. In the case of home nursing by qualified nurses a referral from a physician is necessary in order to be reimbursed by the social health insurance fund. This reimbursement is based on rather strict criteria covering only medical expenses such as for administering injections or dressing wounds. Otherwise home nursing as well as home help are funded by a combination of payments by provinces and municipalities (as a general subsidy or related to the number of clients) as well as clients co-payments. Co-payments became more widespread since payment for care programmes have been introduced. In general, co-payments are means-tested and increasingly related to the amount of the cash benefit.

Payments for care (to care-receivers)

In 1993 a payment for care programme ('Pflegegeld') was introduced for dependent people with at least 50 hours of care needs per month. Care needs are the only eligibility criterion. The payments which are directed to care receivers range from ATS 2,000 (EURO 145) per month in level one, to ATS 21,074 (EURO 1,532) per month in level seven. Level 1 is equivalent to care needs between 50 and 75 hours per month, level 7 is equivalent to care needs of more than 180 hours per month in combination with complete immobility. The evaluation of care needs is based on a medical certificate based on a standardised assessment procedure covering medical as well as household and personal needs. In dependency level 1 to 3 only the quantitative amount of care is taken into account, whereas evaluating dependency levels 4 to 7 also includes

qualitative aspects. In general, the assessment is undertaken by medical staff of the authorities administering the payment for care programme. With the latest reform of the payment for care programme, care documentation has to be taken into account and informal care-givers have to be consulted in the assessment procedure.

Payments for care are not means-tested and paid directly to care receivers. Beneficiaries are free how to use the money. Only in case of 'improper use' benefits in kind can be offered as a substitute. In case of residential care the allowance is directly transferred – down to some pocket money – to the body in charge of the residential home. In 1997, attendance allowances were paid to about 310.000 disabled and frail elderly people, representing 3.9% of the Austrian population. About half of them are over the age of 80, 85% over the age of 60.

Payments for care (to informal care-givers)
There are no direct payments of care to care-givers. However, to some extent payments made to care-receivers are transferred to informal care-givers. In general these payments cannot be seen as any form of income or compensation as they have to be used to cover extra expenses for care and in general do not even completely cover these extra expenses. Since 1998 there is a possibility for coverage in the social pension insurance system at a lower rate for informal care-givers who have been in employment at any time before. In addition, a one week leave for care is offered to anyone caring for a close relative. In the case of caring for children under the age of 12 there is another week of leave for care.

Informal care
90% of those receiving payments for care are cared for at home. Regarding the status quo of home nursing and home help services, this makes close family members to main care-givers. In about 5% to 10% of all care arrangements social services have to be seen as the main care-giver. 80% of the main informal care-givers are women, in particular daughters, daughters in law and partners. More than one third of the care-givers are over the age of 60. 37% of those under the age of 60 are doing their care work alongside another formal job. In Austria there is a legal care obligation – with variations between the nine provinces – for close family member (spouses, children, parents), which becomes particularly important in the case of financing care in residential care settings.

Long-term care: The case of Italy [2]

Long-term care is strongly based on family and other informal care arrangements. The long-term care system is characterised by decentralised responsibilities and comparatively low numbers of people cared for by formal services. However, because of enormous differences between regions and communities this does not reflect the situation of the whole country. There are innovative forms of provision and in a number of cities formal service levels are quite high. A programme from 1992 ('Tutela della Salute degli Anziani') issues norms and guidelines for the development of long-term care. Although these are not legally binding for provinces and local administration, it can be seen as a national approach for a more systematic development of long-term care services. One of the important principles to be found in this document is the integration of health and social services.

Residential care

The number of people in residential care settings is considerably lower than in most other European countries. The distinction between the different types of residential care settings are becoming less important. The above mentioned document proposed to bring them in line with the so-called 'Residenza Sanitaria Assistenziale'. In 1991 186,000 people were cared for in these homes, among whom slightly less then 50% are categorised as 'not self-sufficient', and the others as 'self-sufficient'. The term 'self sufficiency' is used if primary functions of daily living such as eating or walking are still available, but autonomous living is limited by other physical or mental restrictions or the unavailability of informal support. Regarding the institutional mix there is a rather strong private sector. About 43% of beds are offered in the public sector, 24% in institutions closely related to the public sector, and 33% of beds in the private sector. Regarding funding of these homes there is a division between the health and the assistance aspect. Whereas health related care is financed by the regions, the assistance part has to be paid by the clients. If the client does not have sufficient financial means and close relatives (children and other first-line relatives) are not capable to financially contribute, the local administration will finance the rest from social assistance funds.

Domiciliary care

The responsibility for social services is on the regional and local level. The central government is only involved in funding projects in their experimental phase. There is no clear cut division of responsibilities between the health sector organising domiciliary care within the local health authorities ('Unita Sanitaria Locale') and the social service sector organising domiciliary care within the local authorities. Enormous differences occur not only regarding the extent and the content of the services, but also the organisation of services.

In the 1992 programme the concept of integrated home care ('Assistenza Domiciliare Integrata') was put forward, emphasising the integration of health related care and social services within the local health authorities. It requires collaboration between medical and nursing home care teams from the health sector and home help teams form the local authorities. This of course conflicted with already existing approaches organising home nursing and home help in the social service sector in the north of the country. A second approach which became important for the elderly, and in particular for terminally ill people, is the so-called home hospitalisation aimed at supporting people after hospitalisation and reducing length of stay in hospitals.

The assessment procedure does not require a formal referral and is usually undertaken by a geriatric evaluation committee (integrated home care), by a team from the hospital (hospitalisation at home) or social workers for home help services. As projects in their experimental phase, integrated home care as well as home hospitalisation were partly funded by national subsidies. Apart from this, domiciliary care is financed from global budgets of the communities (for social services) or from regions and local health authorities (for health related care). Budgets for health related expenditure are based on insurance contributions, general taxation as well as co-payments. Co-payment arrangements in the home help sector differ widely. Overall, it is estimated that 50% is paid by the clients themselves.

Payments for care (to care-receivers)

There are two payment for care programmes: the 'Indennità di Accompagnamento' (companion payment) and the 'Assegno di Accompagnamento' (companion cheque). The companion payment is a financial support for adult people with care needs, whereas the companion cheque is for disabled people under the age of 18. Potential beneficiaries have to apply to the local or provincial health units. Although the basic idea of the Indennita di Accompagnamento was to support disabled people in the working age, it turned out to become a major form of support for frail elderly people. There are national definitions of the degree of disability and care needs. The payments are directed at the disabled or frail elderly person, who is free to use the money either to purchase formal services or to transfer money to informal care-givers.

The maximum level of payments is ITL 192,000 (EURO 99) per week. The level of the payment is set by the central government, but the regions and provinces are allowed to pay more. There is no means-testing. In 1990 the companion payment was paid to 1.1 million people.

Payments for care (to informal care-givers)
There are no direct payments to care-givers. But care-receivers are expected to use the cash benefit just described to either buy formal services or to pass it to informal care-givers. Similar to Austria the payment for care programme seems to be a national response to the pressing challenge of an increasing number of people in need of care without sufficient support from informal networks on the one hand and a lack of social services on the other hand.

Informal care
Due to the fact that the level of residential care as well as formal domiciliary care is rather low in Italy, because care for adult family members is legally defined as family obligation and the traditional model of extended family relations being still important in the south of the country, informal care plays the central role in long-term care in Italy. Because of a lack of services in many parts of the country there is no other choice than informal care-giving.

Long-term care: The case of The Netherlands [3]

Besides a two-tier health insurance system (combining social insurance and private insurance) there is one social health insurance scheme for the entire population, the General Act on Exceptional Medical Expenses (AWBZ), which in particular covers long-term care needs. This system was introduced in 1968. Whereas nursing homes were integrated from the beginning, homes for the elderly were integrated in the AWBZ system only in 1997 (with a transition period until 2001). Compared to the other compartment of the health insurance system, the influence of central public bodies on AWBZ is rather strong. In 1996 payments for care (personal budgets) as an option to in kind services were introduced, however on a rather small scale. Cost-containment became an issue in the long-term care system earlier than in most other European countries. In addition, individual responsibility and choice, an increased integration and flexibility of the system as well as the promotion of forprofit initiatives are major policy concerns.

Residential care
The provision of residential care in the Netherlands is characterised by a decreasing number of people living in homes for the elderly and an increasing number of residents in nursing homes. Related to the number of those aged 65 and over, the proportion decreased for homes for the elderly and remained constant for nursing homes. The reason for this is a strict cost containment policy, including for example a 7% rule (limiting the number of beds to 7% of the elderly population in the region), or the introduction of user fees in nursing homes. In general, differences between the two types of residences diminish, while alternative forms of residential or semi-residential care occur. Most of the

residential care settings are run by nonprofit organisations, to a very small extent by public bodies and an almost negligible extent by forprofit organisations. Financing residential care is mainly based on AWBZ funds. This is particularly true for nursing homes, although user fees related to income were introduced. Homes for the elderly are in a transition period. Up to now the residents have to pay fees out of their income combining a fixed and a means-tested fee. In addition, private savings have to be used, but there is no family obligation to do so. The difference is paid by local authorities out of social assistance funds. For the future financing regulations in residential care are being harmonised under AWBZ.

Domiciliary care

Social services caring for the clients in their own home (home nursing and home help services) are organised within regional organisations, which became more integrated home care organisations recently. Most of the services are run by nonprofit organisations in an almost monopolistic position on a regional level. The importance of private forprofit home care organisations is small, although recently they were explicitly supported by reserving part of the budget for such organisations. Competition therefore might become more important, also because there are waiting lists in the home help sector and people increasingly have care allowances at their disposal (see below).

Access to the services is universal with no formal referral required. The assessment of care needs is done by special assessment teams covering home nursing, home help as well as care in residential settings. Although there is universal access there is no individual right to receive home help services (which exists for home nursing). Therefore, strict budget control by the government led to waiting lists in the home help section. In 1996, 10% of those 65 of age or older received some sort of home help. Home nursing as well as home help services are mainly paid out of the AWBZ budgets transferring money to the Home Care Organisations who in turn pay the providers. To a smaller extent means-tested co-payments and membership fees have to be made.

Payments for care (to care-receivers)

After an experimental phase personal budgets were introduced in 1995 as an alternative to in-kind services for those people to be expected in need of care for an extended period of more than 3 months. There is no formal referral required and the assessment is the same as with in kind benefits. However, whether a personal budget will be at disposal depends on the regional home care budget reserved for personal budgets. This amount is rather low compared to the whole budget for home care (about 3-5%).

Personal budgets are funded by AWBZ transferred to the local Home Care Organisations. The maximum amount a client can get is based on the assessment of hours of care needs and the tariffs for the different kinds of services. From this amount a means-tested co-payment is deducted. In 1995, the personal budget was NLG 1,500 (EURO 681) per month on average. Recipients are allowed to use freely only a small part of this amount. Personal budgets are first of all used to buy services from forprofit and nonprofit providers and the so-called alpha-helpers employed by care receivers, to a small extent for informal providers.

Payments for care (to informal care-givers)
There are no payments of care to care-givers and the amount of money from personal budgets that is used in the informal sector is rather small. Regarding the opportunity of leave for care there is no statutory scheme. But arrangements regarding leave for care for a sick relative or the so-called emergency leave can be found in a number of agreements between social partners. Another opportunity is offered by the so-called career leave (2 – 6 months), which might be used for care as well. However, the level of benefits – which are paid out of the unemployment fund – is below the assistance level.

Informal care
Informal care still plays an important role in domestic care and to some extent in personal care, although the extent to which care is offered in the formal sector is considerably higher than in the other three countries. In the Netherlands there is no legal obligation to care for a close relative. With the introduction of co-payments, limitations in the access to residential care and the existence of waiting lists in home help services, private forprofit solutions as well as informal solutions might play an increasing role in the future.

Long-term care: The case of the United Kingdom [4]

Long-term care in the United Kingdom is strictly divided from health care with strong local responsibilities. According to the NHS and Community Care Act 1990 the main responsibility for long-term care is with the local authorities. The long-term care system is characterised by a mix of residential and domiciliary care, with independent providers becoming more and more important, and a wide range of different payment for care programmes. The major policy concerns are the finance of care, the support of care in the community, a shift from public to private (nonprofit and forprofit) provision, an integration of services, and the recognition of the role of informal carers.

Residential care

Residential care in the United Kingdom is run by public as well as private organisations. Since the 1980s the role of public providers declined, whereas the role of forprofit providers increased and nonprofit providers held their position. This contracting-out of residential care was supported by economic incentives and the requirement to spend a certain amount of budgets in the independent sector. Until the beginning of the 1990s there was a considerable increase in the number of people living in residential care settings. Since then numbers slightly fell. The assessment for access to residential care is combined with the general assessement of care needs by multi-disciplinary assessment teams, which has also contributed to the decrease in the number of residents in institutionalised care.

The regulation of fees has been changed in 1993. Those under the new system receive Income Support if their savings are under a certain level plus a specific residential allowance for housing costs. Fees not covered by income and savings as well as Income Support or other social security benefits will then be covered by local authorities. In this case clients are not free to choose the home, except relatives are topping up the fee for a more expensive home. There is no legal obligation for relatives to pay. On average, one third of costs is covered by clients payments.

Domiciliary care

Home nursing is part of the National Health Service and accordingly organised. Home help services are organised by local authorities (acting as purchasers and providers), voluntary organisations as well as private forprofit organisations. Following the objective of splitting the role of purchasing and provision the role of private forprofit as well as nonprofit organisations became more important, but local authorities are still the main providers of domiciliary care services.

The assessment is increasingly based on standardised assessment forms and undertaken by a social worker of the local authorities, a home care team, or a care manager. In the decision over the care arrangement the possibility to stay in the own home as well as the wishes of clients and carers have to be considered. The availability of sufficient financial means can be taken into account, denying public services for the more wealthy clients. In 1996, almost 6% of those 65 years of age and 17% of those 85 years of age and older received home help. Whereas there was a considerable decrease in the number of people receiving home help in the 1990s, the number of hours per client increased. This development shows a concentration on personal care (and less on domestic care) and on those with higher care needs.

Nursing care is fully covered by central government money. Home help is financed out of local funds (based on grants from the central government and local taxes). Whether services are paid out of these funds depends on needs assessment and means-testing, which varies considerably between local areas. Regarding co-payment regulations there is a shift towards such regulations and towards means-tested fees instead of flat rate payments.

Payments for care (to care-receivers)

The payment for care system in the United Kingdom is characterised by a variety of such programmes, differing in objectives and target groups. The Attendance Allowance is a tax-free and not means-tested social security benefit for people who are 65 and over in need of personal care. The intention of the allowance is to cover extra expenses related to these needs. Claimants must have been in need of help for at least six months. For the terminally ill there are special regulations. The Attendance Allowance is either UK£ 33,10 (EURO 47) per week or UK£ 49.50 (EURO 71) per week for people needing help by day and by night. In 1997 14,5% of those over the age of 65 years received this benefit. The Disability Living Allowance was introduced in 1992 for people under the age of 65 (replacing the former attendance allowance for this age group). Claimants must have needed personal care for three months and must be expected to need such care for at least six more months. The Disability Living Allowance, which is not means-tested, consists of two components: The care component which is between UK£ 13.15 and UK£ 49.50 (EURO 19 – 71) per week and the mobility component which is between UK£ 13.50 and UK£ 34.60 (EURO 19 – 49) per week. In 1997 there were 1.768,000 recipients.

Benefits from the Independent Living Fund 1993 are restricted to people in the age between 16 and 65 living alone or with another person unable to provide care. Allowances are based on an assessment of care needs, but very much restricted in a number of additional respects. For example, claimants may only have a very small amount of private savings and an income that is too small to cover care needs not covered by other benefits. The benefit has to be used to employ one or more people (not close relatives living in the same household) for support in personal or domestic care. The number of beneficiaries is rather small, but they tend to have very high care needs. On average beneficiaries receive UK£ 185 (EURO 264) per week. As part of the Income Support, Residential Allowance can be claimed, which however is only available to those living in private homes. The Severe Disability Allowance is made to working age people who have not been able to work for at least 28 weeks because of an illness or disability, but do not have access to sickness or invalidity benefits. The assessment is made by a general practitioner. The benefit is UK£ 36.95 (EURO 53) per week plus an extra benefit between UK£ 4.05 and UK£ 12.90 (EURO 6 – 18) per week depending on age and an extra benefit for dependent people

living in the same household. The Severe Disability Premium is a means-tested benefit for people with a high level of care needs living alone or with a person that does not receive the Invalid Care Allowance (see below).

Direct Payments were introduced in 1997 offering local authorities the opportunity to make direct payments to people in need of care instead of in kind services. The programme is directed at those between 18 and 65, and at those over 65 if they entered the programme under this age. Whether such a programme is established and to what extent such payments are made is regulated on the local level.

Payments for care (to informal care-givers)

The Invalid Care Allowance is paid to informal care-givers in the working age (16 – 65 years), but not to those in full-time education. The person cared for must receive an Attendance Allowance or a Disability Living Allowance at a middle or higher rate. Caring has to exceed 35 hours per week. The idea of the programme is to replace lost earnings. The Invalid Care Allowance is not means-tested. Apart from a basic rate of UK£ 37.35 (EURO 53) per week in 1997, there are extra payments if there are other dependent persons in the same household. The Carer Premium is a means-tested allowance for informal carers in receipt of Income Support. In 1997 this was UK£ 13.35 (EURO 19) per week. With the Home Responsibilities Protection the right to Basic Retirement Pension is protected if carers are engaged in caring for at least 35 hours a week for a person receiving benefits because of sickness or disability.

Informal care

The fiscal value of informal care was recently estimated to be at least as 5 times as high as total public spending. There is no family obligation in the UK to care for an older relative. However, recent developments in residential and domiciliary care regulations allow local authorities to consider the availability of informal care in the assessment of care needs and the decision over the care arrangement. This tends to increase family responsibilities either for informal care-giving or for the arrangement of formal private solutions. On the other hand, the role of informal carers is recognised more than in other countries through the 1996 Carers Act and the Carers National Association, which is engaged in advising and supporting informal carers as well as in lobbying.

'EQUITIES' IN THE PROVISION OF LONG-TERM CARE

All the countries covered by this study are characterised by a division of responsibilities between public bodies on the various levels. Compared with other social policy fields the role of regional and local levels in the provision and regulation of provision is rather strong. Whereas central public bodies are in charge of cash benefits, regulations regarding financing long-term care and basic regulations regarding the provision of care, regional and local public bodies are in charge of the provision and/or regulation of residential care settings and social services. The role of informal care-giving has for long been almost ignored in all the countries but is nevertheless the main source of care-giving. Only in recent years there is increasing recognition of informal long-term care which is – to some extent – also reflected in policy initiatives, such as the recognition of informal care-giving in social insurance and social benefit schemes, the introduction of payment for care programmes or the establishment of carers associations. The following discussion attempts to analyse the equity approaches in long-term care policies focusing on the provision of care and the implications on care-receivers.

What is to be shared?

The main resources public policies might be aimed at are the *final outcome*, the *use* of specific services in the formal or informal sector, *access* to care, as well as *choice* between various care arrangements.

Regarding the use of specific services quite clear distinctions can be figured out in the four countries. Whereas in Italy and Austria there is a legal obligation for family members for care between adults, this does not exist in the UK and in the Netherlands. (Millar and Warman 1996) In Austria this obligation covers children, in Italy other first-line relatives too. In both countries not the actual provision of care is mentioned, but the 'obligation of maintenance'. Financial sources from relatives may be used to recover public expenditure for publicly provided services. However, there is considerable room for discretionary decision in both countries. Although in the UK there is no explicit legal obligation of family members in long-term care, there is an increasing recognition of the informal care potential in the assessment of care needs and in the decision over the care arrangement. With regard to the use of residential versus domiciliary care settings there is a strong trend towards domiciliary care in all the countries. Historically, home nursing and home help became more widespread in the Netherlands and in the UK before this was the case in Austria and in Italy. In Austria – apart from some of the provinces – residential care has been seen as the major public response to the long-term care issue until recently. Italy is characterised by low supply levels in the residential as well as in the

domiciliary care sector, although there are considerable differences within the country.

Payment for care programmes are a trend to be observed in long-term care policies in a number of European countries. The impact on the care arrangement depends on the actual design of such programmes as well as the overall long-term care system. Whereas payment for care programmes without restrictions in the use of the money (as in Austria, in Italy, and partly in the UK) emphasise 'choice', other payment for care programmes restrict 'choice' to buy services in the formal sector or just a segment of the formal sector (as it is the case in the Netherlands). Herewith, payment for care programmes reflect different public objectives, either directed at the use of specific services (freedom of choice is restricted to providers within this service sector), or directed at offering choice between different kinds of services (including the formal and the informal sphere). However, whether such choice really exists in practice also depends on the development of services in the formal sector as well as the extent of such care money. In all the countries, payments for care can only be seen as a financial contribution to cover long-term care expenditure. This is even true when benefits are relatively high, as in Austria where these benefits are explicitly defined as a contribution to cover extra expenses of care. In the Netherlands cash benefits for care play a minor role. Here, choice is based on a broader set of in kind services. Among the countries studied here, take-up rates in the residential and the domiciliary care sector are highest in the Netherlands.

Access describes the opportunity to use, but not the actual use of services. Although the levels of provision in Italy and in Austria are considerably lower than in the Netherlands and in the UK, there are no significant differences in waiting lists in these countries. However, this cannot be interpreted as equality in the opportunity to use such services. A number of studies have shown that demand in long-term care is greatly determined by the supply level in specific sectors. (e.g. Kemper 1992) In fact, access to domiciliary care still does not even exist in parts of Italy as well as parts of Austria. Payments for care can be seen as an intermediate means to enable access to the actual provision of care. Increased purchasing power in the hands of the clients (or informal carers) will tend to create more demand for services from outside the narrow informal care network. However, as payments are usually only a contribution to the costs of care, they first of all tend to increase demand for services either in the wider informal sector, in a low paid formal sector or in a subsidised formal sector.

Outcome, the final objective in long-term care, is rather difficult to approach. Care is about nursing, as well as assistance and support in personal and domestic activities. The contribution of long-term care to the final outcome is to be found in the quantity and quality of care. This includes a wide range of

variables, such as the response of care arrangements to individual preferences, the qualification of care-givers or the opportunity of independent living under the constraints of limiting conditions in health. Long-term care policies tend to approach the broader issue of the final outcome in at least two ways: quality standards and a range of service alternatives. Standardised needs assessment and standards for the actual service provision in the formal sector (such as professional qualifications, guidelines and care plans, the number of beds in residential care settings or the number of qualified home nurses related to the elderly population) are seen as major approaches to support the final outcome. The fact that this policy concern evolves at the same time as cost containment concerns suggests that such measures are aimed at securing certain standards of quality under more rigid economic constraints. At the same time they might have an equalising effect over institutions and local areas, at least for some basic standards. Although on very different levels, in all the countries a broadening of service alternatives (e.g. semi-residential settings) can be observed at the same time as increasing restrictions regarding access to specific forms of provision.

Among whom?

Following the overall objective of guaranteeing a specific quantity and quality of care by specific providers, public policies in the provision of care may be directed at *individuals* as the final target group as well as *individuals*, *local areas* or *institutions* as intermediate target groups. Local areas become the focal unit if, for example, central government money is transferred to local authorities. This might not just be the case, because local public bodies are in charge of social services, but also to reduce inequalities in the service supply within a country. Specific institutions or specific segments in the institutional mix might be preferably subsidised in order to shift expenditure levels between the residential and the domiciliary care sector or between the public and the private formal sector. Examples are the 7% rule in the Netherlands (subsidising beds in residential care settings in the regions is limited to 7 beds per 100 elderly people aged 65 and over) or the reservation of public funds for the independent sector in the UK. In Austria and Italy this objective is less explicit in long-term care, but the same trends can be observed.

The role of family members as carers in the four countries has been briefly described above. Apart from rather clear differences in the 'obligation' to care, an increasing recognition of the role of informal carers can be observed in all the countries. Individuals are increasingly approached in their role as informal carers. In general, these approaches have to be seen as a cost-containment approach and as a means to strengthen the role of informal care-giving in potential care arrangements. The socio-economic situation of informal carers is recognised to a much smaller extent in these efforts, if at all. In all the

countries except the Netherlands payment for care programmes are seen as direct or indirect financial support (or incentive) for informal care-giving, at least as one option how to use the money. Care leave programmes are an additional approach to promote informal care-giving, although the importance of such short-term leaves is limited in the case of long-term care.

How?

To what extent shares of specific resources are allocated is defined by a wide range of principles of allocation. These principles not only determine whether someone receives a share of the resource or not, but also the amount of resources allocated. The basic principles according to which resources in long-term care may be shared are need, time-related, status, economic, mixed and implicit principles.

Need seems to be the most adequate allocation principle with respect to equity considerations in the provision of health and social care. And in fact, need is probably the most widespread principle of allocating resources in long-term care. On the other hand, need is far from being a clear-cut single principle. Need principles are based on morbidity or disability measures, the inability to carry out certain activities of daily living, the amount of time needed to support people or the ability to benefit from the support. In addition, needs measurement differs according to those who are involved in the assessment procedure.

Principles of need can be found for all forms of provision in all the countries looked at in this study. In the Netherlands needs assessment for all different forms of provision – residential care, domiciliary care, and payments for care – is now undertaken by the same assessment team, which also decides over the care arrangement. To some extent this is also true for Italy and the in kind sector in the UK. In Austria those responsible for the assessment are general practitioners (in case of payments for care as well as home nursing to be financed by social insurance funds), in the case of residential or domiciliary care this is a nurse or an assessement team from the respective institution. If someone is applying for a place in a residential care setting, some of these institutions are increasingly assessing whether domiciliary care would be adequate and possible, but there is no such general approach in Austria.

In Italy and to less extent in Austria coverage with residential and domiciliary care only exists in part of the country or is rather limited. Apart from these restrictions, assessment procedures and herewith the decision whether a person receives home care or a place in a residential care setting, depends on policies on the regional and local level as well as on the approach by the respective providers. Payment for care programmes in both countries are

based on national definitions of disability or care needs. Although there have recently been adaptations and clarifications in the definition of needs in Austria, evidence supports the conclusion that a high take-up rate and a high level of equal payments according to need is achieved in this country. In Italy considerable variations between different areas occur, which cannot be related to differences in morbidity and disability.

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. Standardised needs assessment combined with care plans might reduce room for discretion on the micro-level, in particular if this approach is accompanied by an improvement of data on long-term care issues. Overall, needs assessment plays an important role in the allocation of long-term care resources but we are far from having need as the only allocation principle in all the countries.

A second approach to allocate resources are *time-related principles*, in particular waiting-lists. Time related principles are used in long-term care either for practicality reasons, as an explicit or implicit concept of rationing or as an additional indicator of need. Waiting lists have been and still are an important allocating principle in the residential care sector in most of the countries. However, trends to support domiciliary care, economic restrictions for the further expansion of the residential care sector, and targeting of this sector towards the severely disabled have reduced these waiting lists.

Regarding waiting lists in the domiciliary care sector there is evidence for waiting lists in the home help sector in the Netherlands, which is one of the driving forces for the development of independent providers outside the publicly financed scheme. Whereas there are no guarantees for home help in none of the countries, there is such a guarantee for specific home nursing activities from the health system. But even here, procedures might be designed in a way that leads to considerable waiting time. In general, the existence of waiting lists is only a mediocre indicator for comparing unmet need across countries or even across local areas, as the demand for such services is very much determined by the existing supply structure.

Another form of time-related principles can be found in the Attendance Allowance scheme in the United Kingdom which requires that those applying must have been in need of care for at least six months.

The set of *status principles* includes a variety of principles such as age, 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. Age can be found in many payment for care programmes as an additional principle of allocating resources. Whereas the Austrian payment for care programme is open for disabled people of all age-groups, the Italian and partly the UK payment for care programmes differentiate according to age, but offer cash benefits for all age groups. In Italy there is a division between adults and those under the age of 18 but the actual allocation principle does not differ between these two age-groups. In the UK 65 years of age is the dividing line for receiving either Attendance Allowance or Disability Living Allowance, offering a different amount of benefits. Direct Payments in the UK are reserved to those between 18 and 65 years of age as well as elderly who entered the programme before they have reached the age of 65. But differentiation according to age can not only be found as an explicit principle. There also seem to exist hidden assumptions regarding different objectives in long-term care according to age, as for example in the objective of independent living.

It has already been mentioned that in Italy and in Austria, and increasingly in the UK, informal care-giving resources are taken into account in the decision over the care arrangement. Herewith, family status as well as the question whether a person is living on its own or together with other people, is used as a principle for allocating long-term care resources.

One of the principles to be found in all the countries is a rather high level of decentralisation, allowing considerable local variations in the provision of long-term care. Among the four countries the Netherlands are the exception in this respect as there are important national standards alongside the organisation on the local level. Whereas decentralisation is not questioned in principle and even strengthened in some respects, at the same time a number of measures have been introduced in recent years to increase national regulation and to develop nationwide approaches. Steps in this direction are payment for care programmes, the reservation of central public money for specific use, quality standards, or guidelines which are not legally binding but do have some influence on the development on the local level.

Economic variables in allocating resources in long-term care occur on the micro as well as on the macro level. On the micro-level means-testing is either used to allocate benefits in kind or in cash just to those whose ability to pay is below a certain level or to design co-payments according to the ability to pay. In general, the ability to pay is based on the income of the client, but might be broadened covering also savings as well as income and savings from close relatives. Financing residential care in Austria and Italy as well as in the UK is first of all based on financial means of the clients including benefits such as payments for care or Income Support in the UK. Total costs not covered herewith will then be covered by local authorities. These costs might be

recovered from close relatives in Austria and Italy, although there is much room for discretion in this respect. In the Netherlands residential care is financed out of public funds (residential homes are in a transition period) with co-payments form residents which are related to income.

As a general rule, domiciliary services are covered by a combination of public funds and increasingly means-tested co-payments. Although these co-payments differ considerably within countries they are lower in Austria and in the Netherlands compared to Italy and the United Kingdom. Payments for care are not means-tested in Austria and in Italy. This is also true for some benefits in the UK (such as for the Attendance Allowance and the Disability Living Allowance scheme), but there are means-tested programmes as well (such as the Carer Premium). In the personal budget programme in the Netherlands income related co-payments are deducted. Overall, payment for care programmes are a more or less important contribution to cover long-term care expenses. Covering an extended amount of care by external providers remains a privilege for those with private financial means to cover additional costs.

Another form of economic principles apply, if different forms of providing care result (or are supposed to result) in the same outcome. Here, efficiency could be used as an appropriate principle to decide which form of provision to promote. 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. And indeed, this is one of the driving forces for the redesign of long-term care systems in many countries. One example for an explicit approach in this direction can be found in the 7% rule in the Netherlands restricting the number of beds in the residential care sector. Similar explicit incentives are used to shift the actual provision from public providers to providers in the independent sector in the UK. Although there is always the restriction in the availability of funds, budgets are increasingly used as an instrument of guiding allocation. Apart from the examples already mentioned (reserving parts of the budget for certain activities), overall budgets given to local authorities have a similar effect in that it puts pressure on these authorities to search for cost-effective ways for providing long-term care.

Obviously, most of the principles described are not used as single principles, but as *mixed principles*. The concept of need is combined with time-related principles, a variety of status principles, economic principles as well as *implicit principles*. In this case allocation of resources is (partly) determined by principles that are not explicitly stated in any regulation or guideline.

If people in need of care have to make out-of-pocket payments to get access to social services, this might to some extent exclude the poorest because of lack of purchasing power. This is even true if there is means-testing, as means-testing might involve consequences (e.g. stigmatisation) creating an incentive not to claim for a benefit. Attitudes towards care giving (such as viewing external care as pushing off a moral obligation) may create incentives to offer informal care, even if there are formal services available. Such incentives seem to highly correlate with the legal obligations to be found in the different countries and the amount of services offered in the formal sector.

The informational background of users is another implicit principle, which tends to favour those with better access to information. For example, take-up ratios for cash benefits are often higher among those supported by social services as these also have an important role as providers of information. Other implicit principles in the allocation of resources might occur because of orientations of individual decision-makers, lobbying or political power. Considerable local variations in take-up ratios in the Italian payment for care programme seem to result to some extent from such implicit principles. The creation and support of lobbying associations, as the Carers Association in the UK, are important to increase awareness of the issue and to reduce some of the inequalities based on such implicit principles.

Although the legal obligation to care for frail elderly family members still very much shapes long-term care in Italy and in Austria, room for discretion is also used in these countries to reduce financial burdens in case of residential care. On the other hand, in the UK there is no such legal obligation. But, because of strict budget control, hidden assumptions about family obligation seem to become more important in the assessment of care needs increasing expectations regarding the role of the family.

CONCLUSIONS

The results may be summarised as follows: Regarding the division between family and public responsibilities and the level of services provided there is a clear hierarchy ranging from the Netherlands with a high level of public responsibility and a high level of services regarding the number of people covered as well as the range of services, to Italy with a low level of public responsibility and a low level of service supply from the welfare state. Austria and the United Kingdom are situated between the other two countries, with Austria closer to Italy. Whereas the Netherlands emphasise in kind provision, payment for care programmes are an additional approach in the other countries, which is rather important in Austria. Choice is increased regarding the

alternatives between residential care, semi-residential care and domiciliary care but restricted on the other hand by stricter standardised needs assessment and co-payments becoming more widespread.

Need is in the centre of the allocation principles, but all the countries are far from allocating resources just according to an interpretation of need that is related to the health condition and resulting requirements for care. In all the countries there is a tendency towards stricter needs assessment. The public response to long-term care needs is restricting residential care more and more to those with severe disabilities, and domiciliary care to home nursing and personal care. As responsibilities in long-term care within the public sector are very much with regional and local public bodies, the allocation of resources is characterised by considerable local variations. The exception are the Netherlands where national regulation is strongest. Overall, means-testing and income-related co-payments are becoming more important in the in kind service sector in all the countries. These measures are aimed at cost-containment, providing more cost-effective care, and sharing financial responsibilities. In the residential care sector, means-testing in Austria and in Italy includes not just the client but close family members too. On the other hand, in these two countries the existing payment for care programmes are not means-tested.

It remains the question, to what extent these approaches to allocate services and benefits through long-term care policies fit with basic equity objectives of the welfare state. The minimum standard objective is strongest in Austria and in Italy. Although payments for care offer some relief in these countries, in the case of long-lasting and severe disabilities they do not prevent people to spend all their income and savings – to some extent including income and savings from close relatives – for long-term care, if they have to be cared for in residential care settings. However, this just reflects the long-term care issue. Taking the overall economic situation in old age into account, might result in a different picture regarding the situation of frail elderly people in Austria, Italy and the UK.

The objective of supporting living standards, that is the prevention of drops in the living standard, is achieved in all the countries to the extent to which the public sector provides payments or services free of charge through direct provision, purchasing provision, or insurance systems. However, compared to health care, being in need of long-term care means a considerably higher risk of dropping in the standard of living. Support in this respect is highest in the Netherlands. Residential care giving results in a considerable drop in the living-standard in the other three countries, including close family members in Italy and Austria. Such considerable drops are less likely in the case of domiciliary care (if such services exist), but might still be considerable in the

case of severe and long-lasting care needs. Informal care-giving is a major form of providing care in all the countries, in particular in Italy and in Austria as well as in the United Kingdom. Here, the risk of dropping in living standard is shifted within family relationships. In practice, mostly women are acting as main informal care-givers and herewith being in a most precarious position regarding labour market opportunities and social security.

The redistributive objective cannot be assessed without taking the finance of long-term care into account. This has not been the objective of this paper. As with regard to provision, redistributive implications are limited, although means-testing and income-related co-payments do have such an effect. Overall, the redistributive implications from the provision side are restricted to the implications of what is guaranteed as a minimum level of support or as support of a specific level of living standard, herewith reducing horizontal inequalities.

The effects of the respective long-term care systems on the issue of social integration can not be judged without taking the social and cultural background in these countries into account. Apart from the resource situation (covered by the three objectives just mentioned) choice sets are an important determinant. Here, some similarities in qualitative trends (not in the extent) can be observed: All the countries looked at spend some efforts on a diversification of long-term care systems offering opportunities between the traditional approach of residential and domiciliary care as well as measures to integrate the various services. Whereas this tends to increase choice, access to specific services is reduced by stricter assessment of needs and of the availability of informal care.
An increase in public awareness of the issue, and similar social and economic challenges in all the countries are responsible for similarities in recent approaches to redesign the allocation of resources in long-term care. However, because basic principles of public vs. private responsibilities have not been changed fundamentally in explicit terms, differences will remain quite remarkable for at least some time to come.

NOTES

[1] Based on Badelt, Holzmann-Jenkins, Matul and Österle (1997); Badelt and Österle (1998); Kalisch, Aman and Buchele (1998); Millar and Warman (1996); Weekers, Pijl (1998).
EURO conversion rate: 1 EURO = 13.7603 ATS

[2] Based on Facchini and Scortegagna (1993); Glendinning and McLaughlin (1993); Hutten (1996a); ISTAT (1997); Kalisch, Aman and Buchele (1998); Millar and Warman (1996); Weekers and Pijl (1998).
EURO conversion rate: 1 EURO = 1,936.27 ITL

[3] Based on Kalisch, Aman and Buchele (1998); Kerkstra (1996); Okma (1998); Millar and Warman (1996); Pijl (1993); Rostgaard and Fridberg (1998); Weekers and Pijl (1998).
EURO conversion rate: 1 EURO = 2.20371 NLG

[4] Based on Baldock (1993); Glendinning and McLaughlin (1993); Hutten (1996b); Kalisch, Aman and Buchele (1998); Millar and Warman (1996); Rostgaard and Fridberg (1998); Weekers and Pijl (1998).
Exchange rate: 1 EURO = 0.7 UK£

REFERENCES

Alber, J. (1997) "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. and Österle, A. (1998) *Grundzüge der Sozialpolitik. Spezieller Teil: Sozialpolitik in Österreich*, Wien, Manz.

Baldock, J. (1993) "Home and Community-Based Services for the Elderly in the United Kingdom" in Lesemann and Martin (1993).

Barr, N. (1993) *The Economics of the Welfare State. 2nd Edition*, Oxford, Oxford University Press.

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

BMAGS (ed.) (1998) *Altenheime und Pflegeheime in Österreich*, Wien, BMAGS.

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.

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*, Cambridge, Polity Press.

Eurostat (Ed.) (1997) *Demographic Statistics*, Luxembourg, European Communities.

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

Facchini, C. and Scortegagna, R. (1993) "Home Care Services for the Elderly in Italy" in Lesemann and Martin (1993).

Ferrera, M. (1993) *Modelli di Solidarietà. Politica e riforme soiali nelle democrazie*, Bologna, Il Mulino.

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

Hutten, J.B.F. (1996a) "Home Care in Italy" in Hutten and Kerkstra (1996).

Hutten, J.B.F. (1996b) "Home Care in the United Kingdom" in Hutten and Kerkstra (1996).

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

ISTAT (1997) *Anziani in Italia*, Bologna, Il Mulino.

Jamieson, A. and Illsley, R. (eds.) (1990) *Contrasting European Policies for the Care of Older People*, Aldershot, Avebury.

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.

Kemper, P. (1992) "The Use of Formal and Informal Home Care by the Disabled Elderly", *Health Services Research*, 27, 4, 421-451.

Kerkstra, A. (1996) "Home Care in The Netherlands" in Hutten, Kerkstra (1996).

Kerkstra, A. and Hutten J.B.F. (1996) "A Cross-National Comparison of Home Care in Europe. Summary of the Findings" in Hutten and Kerkstra (1996).

Knijn, T. and Kremer, M. (1998) "Gender and the Caring Dimension of Welfare States: Toward Inclusive Citizenship", *Social Politics*, 4, 3, 328-361.

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

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

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

Lesemann, F. and Martin, C. (eds.) (1993) *Home-Based Care, the Elderly, the Family, and the Welfare State: An International Comparison*, Ottawa, University of Ottawa Press.

Millar, J. and Warman, A. (1996) *Defining Family Obligations in Europe*, London, Family Policy Studies Centre.

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

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

Okma, K.G.H. (1998) "Die Pflegeversicherung in den Niederlanden" in Sieveking, K. (ed.) *Soziale Sicherung bei Pflegebedürftigkeit in der Europäischen Union*, Baden-Baden, Nomos.

Österle, A. (1999) "Equity and Long-Term Care Policies. A Framework for the Comparative Analysis", unpublished manuscript.

Pijl, M. (1993) "Care for the Elderly in the Netherlands: New Policies and Practices" in Lesemann and Martin (1993).

Rostgaard, T. and Fridberg, T. (1998) *Caring for Children and Older People – A Comparison of European Policies and Practices*, Copenhagen, The Danish National Institute of Social Research.

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

Sipilä, J. (1997) "Comparative Research on Social Care Service Systems: How to Proceed?" in Kautto, M. (ed.) *European Social Services – Policies and Priorities to the Year 2000*, Helsinki, Stakes.

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

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

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

EUI WORKING PAPERS

EUI Working Papers are published and distributed by the
European University Institute, Florence

Copies can be obtained free of charge
– depending on the availability of stocks – from:

The Publications Officer
European University Institute
Badia Fiesolana
I-50016 San Domenico di Fiesole (FI)
Italy

Please use order form overleaf

Publications of the European University Institute

To

The Publications Officer
European University Institute
Badia Fiesolana
I-50016 San Domenico di Fiesole (FI) – Italy
Telefax No: +39/055/4685 636
e-mail: publish@datacomm.iue.it
http://www.iue.it

From

Name .....
Address.....
.....
.....
.....
.....

- ❑ Please send me a list of EUI Working Papers
- ❑ Please send me a list of EUI book publications
- ❑ Please send me the EUI brochure Academic Year 2000/01

Please send me the following EUI Working Paper(s):

No, Author .....
Title: .....
No, Author .....
Title: .....
No, Author .....
Title: .....
No, Author .....
Title: .....

Date .....

Signature .....

Working Papers of the European Forum

EUF No. 95/1
Diemut BUBECK
A Feminist Approach to Citizenship

EUF No. 95/2
Renaud DEHOUSSE/Thomas CHRISTIANSEN (eds)
What Model for the Committee of the Regions? Past Experiences and Future Perspectives

EUF No. 95/3
Jens BONKE
The Concepts of Work and Care - An Economic Perspective Applied to Britain and Denmark

EUF No. 95/4
Jens BONKE
Education, Work and Gender - An International Comparison

EUF No. 95/5
Henriëtte MAASSEN VAN DEN BRINK/Wim GROOT
Household Production and Time Allocation, the End of the Male Chauvinist Model

EUF No. 95/6
Andrés BARRERA-GONZÁLEZ
Language, Collective Identities and Nationalism in Catalonia, and Spain in General

EUF No. 95/7
Diemut BUBECK
Gender, Work and Citizenship: Between Social Realities and Utopian Visions

EUF No. 95/8
Miriam A. GLUCKSMANN
Gendered Economies of Time: Women Workers in North-West England

* * *

EUF No. 96/1
David PURDY
Jobs, Work and Citizens' Income: Four Strategies and a New Regime

EUF No. 96/2
Barry EICHENGREEN/Andrew ROSE/Charles WYPLOSZ
Contagious Currency Crises

EUF No. 96/3
Yasemin SOYSAL
Boundaries and Identity: Immigrants in Europe

EUF No. 96/4
Yasemin SOYSAL
Changing Parameters of Citizenship and Claims-Making: Organized Islam in European Public Spheres

EUF No. 96/5
Giovanna PROCACCI
Poor Citizens. Social Citizenship and the Crisis of Welfare States

* * *

EUF No. 98/1
Yuri KAZEPOV
Citizenship and Poverty. The Role of Institutions in the Structuring of Social Exclusion

EUF No. 98/2
Massimo LA TORRE
Citizenship and Social Rights. A European Perspective

EUF No. 98/3
Ewa MORAWSKA
Structuring Migration in a Historical Perspective: The Case of Traveling East Europeans

EUF No. 98/4
Virginie GUIRAUDON
International Human Rights Norms and their Incorporation: The Protection of Aliens in Europe

*out of print

EUF No. 98/5
Patrick WEIL
The Transformation of Immigration Policies. Immigration Control and Nationality Laws in Europe: A Comparative Approach

EUF No. 98/6
Public Services and Citizenship in European Law
Mark FREEDLAND
Law, Public Services, and Citizenship - New Domains, New Regimes?
Silvana SCIARRA
Labour Law - A Bridge Between Public Services and Citizenship Rights

* * *

EUF No. 99/1
Virginie GUIRAUDON
The Marshallian Triptych Re-Ordered: The Role of Courts and Bureaucracies in Furthering Migrant Social Rights

EUF No. 99/2
Ewa MORAWSKA
The New-Old Transmigrants, their Transnational Lives, and Ethnicization: A Comparison of 19th/20th and 20th/21st C. Situations

EUF No. 99/3
Ann Shola ORLOFF
Ending the Entitlement of Poor Mothers, Expanding the Claims of Poor Employed Parents: Gender, Race, Class in Contemporary US Social Policy

EUF No. 99/4
Fiona ROSS
"Beyond Left and Right": The New *Partisan* Politics of Welfare

EUF No. 99/5
Elisabetta ADDIS
Gender in the Italian Welfare State Reforms

EUF No. 99/6
Ana M. GUILLÉN
Pension Reform in Spain (1975-1997): The Role of Organized Labour

EUF No. 99/7
Pål EITRHEIM/Stein KUHNLE
The Scandinavian Model: Trends and Perspectives

EUF No. 99/8
Luis MORENO/Ana ARRIBA
Welfare and Decentralization in Spain

EUF 99/9
Jens ALBER
The German Welfare State in the Era Kohl

EUF 99/10
Rosa MULÉ
The Politics of Income Redistribution. Factional Strife and Vote Mobilization under Thatcher

EUF 99/11
Bruno PALIER
Du salaire différé aux charges sociales, les avatars du mode de financement du système français de Sécurité sociale

EUF 99/12
Antonia MAIONI
Market Incentives and Health Reform in Canada

EUF 99/13
Maurizio FERRERA/Elisabetta GUALMINI
Rescue from Without? Italian Social Policies 1970-1999 and the Challenges of Internazionalization

EUF 99/14
August ÖSTERLE
Equity and Long-Term Care Policies: A Framework for the Comparative Analysis

EUF 99/15
Michael MORAN
Death of Transfiguration? The Changing Government of The Health Care State

EUF 99/16
Ana M. GUILLÉN
Improving Efficiency and Containing Costs: Health Care Reform in Southern Europe

EUF 99/17
Monika STEFFEN
Institutionalising New Policies in the Health Sector. The Challenge of the AIDS Epidemic

*out of print

EUF 99/18
August ÖSTERLE
Equity in the Provision of Long-Term Care: A Comparison of Austria, Italy, the Netherlands and the United Kingdom

*out of print