

Chapter 2

Long-Term Care Systems in Comparative Perspective: Care Needs, Informal and Formal Coverage, and Social Impacts in European Countries

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2.1 Introduction

The aim of this chapter is to provide an overview of long-term care (LTC) policies in Europe and other OECD countries in order to contextualize the findings presented in the other chapters of this book. While the individual country case studies outlined in subsequent chapters offer detailed accounts of LTC policies in various countries throughout Europe, this chapter develops a broad framework based on comparative statistical data, which in turn sets out the general background to transformations that have taken place in recent years with respect to both the demand for and the institutional responses to LTC. This chapter is organized around four themes central to the organization of LTC in Europe: the characteristics and the changing demands of LTC recipients; the organization of informal care; the organization of public (statutory) support; and the impacts of the various “care regimes” on users and their informal carers.

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The picture that emerges identifies, on the one hand, a “universalistic” model, consisting of countries with elevated public spending on LTC, and consequently, highly developed services, and, on the other hand, countries with basic public expenditure, basic coverage, and LTC services, which remain underdeveloped. For the latter, the risk of increases in social and gender inequality is very high (according to relevant data, two-thirds of caregivers are women), particularly in terms of guaranteeing access to care for care recipients and in reconciling caring responsibilities and participation in the labor market for informal caregivers.

2.2 Demand for LTC

2.2.1 *The Ageing Population Over Time: Past, Present and Future*

Eurostat data clearly show that there has been a progressive increase in the older population in all European countries (Eurostat 2011). Indeed, over the last few decades, the proportion of the population aged 65+ has consistently grown, not only in Europe but throughout the OECD. This transformation is likely to have a significant impact on the majority of European countries over the coming decades with serious implications for pensions, health, and social care systems (Christensen et al. 2009; Comas-Herrera et al. 2006; European Commission 2011).

Eurostat (2011) figures estimate that, in 2060, the percentage of people aged 65+ in EU-27 countries will be 29.3 % of the total population. Compared with the 2010 average percentage (16 %), the increase will be in the region of 13 %. Similar trends can be found for the population aged 80+, which in 2010 represented on average 4 % of the population and is expected to exceed 10 % by 2060; in some Mediterranean countries such as Spain and Italy, it may be up to 14 %. The old-age dependency ratio, which measures the relationship between the population aged 65+ and the working-age population (15–64 years), was 23.6 % in Europe in 2010, is expected to almost double in value by 2060, reaching 52.4 %.

The data presented in Table 2.1 help to illustrate the dynamics of population ageing. In particular, it shows that the percentage of the older population (65+ years) increased by more than 70 % between 1970 and 2010 in southern Europe, as well as in Bulgaria, Romania, and Finland. More significant increases occurred in the proportion of the population aged 80+: Finland, Spain, Italy, Portugal, and Poland experienced increases of more than 200 % between 1970 and 2010, while almost all of the other countries registered increases of more than 100 %.

2.2.2 *Disability and Dependency in Europe: Some Estimates*

It is possible to distinguish between three different theoretical approaches to the study of the relationship between demographics, increased life expectancy, and disability; all of which are based on the assumption that disability rates are growing. The first

Table 2.1 Percentage of the population aged 65+ and 80+ in 1970, 1990, and 2010 (ranked by percentage of the population aged 65+ in 2010). (Source: Adapted by the authors from Eurostat 2011)

	Percentage of population aged 65+			Percentage of population aged 80+		
	1970	1990	2010	1970	1990	2010
Germany	13.5	14.9	20.7	1.9	3.7	5.1
Italy	10.8	14.7	20.2	1.6	3.1	5.8
Sweden	13.6	17.8	18.1	2.3	4.2	5.3
Austria	14.4	14.9	17.6	2.1	3.5	4.8
Spain	9.5	13.4	16.8	1.5	2.8	4.9
France	12.8	13.9	16.6	2.3	3.7	5.2
UK	12.9	15.7	16.4	2.2	3.6	4.6
Denmark	12.2	15.6	16.3	2	3.7	4.1
The Netherlands	10.1	12.8	15.3	1.7	2.9	3.9
Czech Republic	11.9	12.5	15.2	1.5	2.4	3.6
Greece	n.a.	13.7	18.9	n.a.	3	4.6
Portugal	9.2	13.2	17.9	1.3	2.5	4.5
Bulgaria	9.4	13	17.5	1.4	2.1	3.8
Latvia	11.9	11.8	17.4	2.1	2.8	3.9
Belgium	13.3	14.8	17.2	2.1	3.5	4.9
Estonia	11.7	11.6	17.1	1.9	2.5	4.1
Finland	9	13.3	17	1.1	2.8	4.6
Hungary	11.5	13.2	16.6	1.5	2.5	3.9
Slovenia	n.a.	10.6	16.5	n.a.	2.2	3.9
Lithuania	10	10.8	16.1	1.6	2.7	3.6
Romania	8.5	10.3	14.9	1.1	1.7	3.1
Malta	n.a.	10.4	14.8	n.a.	1.9	3.3
Luxembourg	12.5	13.4	14	1.7	3.1	3.6
Poland	8.2	10	13.5	1.1	2	3.3
Cyprus	n.a.	10.8	13.1	n.a.	2.3	2.9
Slovakia	9.1	10.3	12.3	1.2	2	2.7
Ireland	11.1	11.4	11.3	1.9	2.1	2.8
<i>Average</i>	11	12.9	16	1.7	2.8	4.1

n.a. not available

approach (the theory of the expansion of disability; Gruenberg 1977) assumes that the increase in longevity has resulted in a prolonged period of disability in the final phase of life due to an increase in the survival rates of those with illnesses and also a growth in the prevalence of age-related diseases. A second approach is that of the “compression” of disability (Fries 1980), for which the increase in longevity is related to a shorter period of disability at the end of life, due to an improvement in the treatment and prevention of disease. The third approach (“dynamic equilibrium”; Manton 1982) is based on the assumption that there has been a slight increase in the rate of mild disability and a corresponding increase in the rate of severe disability, due to an improvement in healthcare.

However, while various surveys conducted in Europe report differing rates of disability among older people (Lagergren and Batljan 2000; Bajekal and Prescott 2003; Cambois et al. 2006; De Hollander et al. 2006; Ekholm et al. 2006), the

general trends do not support the argument that disability rates are rapidly increasing. For example, one study on trends in disability in the older population in 12 OECD countries,¹ conducted by Lafortune and Balestat (2007), suggests that there is clear evidence of a decline in the rate of disability among older people in 5 of the 12 countries examined (Denmark, Finland, Italy, Holland, and the United States). In three countries (Belgium, Japan, and Sweden), there has been an increase in the rate of disability among those aged 65+, while in two countries the rate has remained stable. In France and the United Kingdom, different sources reveal such different trends in the disability rate in the older population that it is impossible to reach any conclusion on the overall direction.

Lafortune and Balestat (2007) show that, although the increase in the older population has not been translated into a corresponding and timely increase in the number of individuals with disabilities (in fact, over the last few years, the disability rate has decreased to a certain extent within some countries), the problem of the increased demand for LTC by older people with disabilities remains significant. However, the ageing of the population and greater longevity of older people will most likely result in an increase in absolute terms in severe disability in the oldest old. Lafortune and Balestat therefore reject the assumption that there will be a general expansion in the disability rate and instead support Gruenberg's (1977) argument that this expansion will be concentrated among those with the most severe disabilities. Regardless of future trends, it can be seen that almost 20 % of Europe's older population is currently in need of assistance with the activities of daily living (ADLs) due to illness or disease, often chronic (see Fig. 2.1; EU-SILC 2008).

2.3 The Organization of Informal Care

2.3.1 *The Role and the Characteristics of Informal Caregivers*

According to OECD (2011) data, more than 10 % of adults in European countries provide unpaid informal care to family members and friends who have strong limitations in their daily living (see Table 2.2). The presence of informal caregivers varies from country to country (Eurofamcare 2006). Some countries in southern Europe have a relatively high percentage of informal carers (16.2 % in Italy and 15.3 % in Spain) while, on the contrary, some Scandinavian countries have a relatively low proportion (9.3 % in Denmark and 8.0 % in Sweden; OECD 2011).

The OECD (2011) analysis also showed that approximately two-thirds of caregivers aged 50+ are women. The "feminization" of caregiving is also reported by Costa and Ranci (2010), who noted the dominance of middle-aged women among caregivers, many of whom could potentially remain active in the labor market. Based

¹ Countries examined in the study: Denmark, Finland, Italy, Holland, United States, Belgium, Japan, Sweden, Australia, Canada, France, and the United Kingdom.

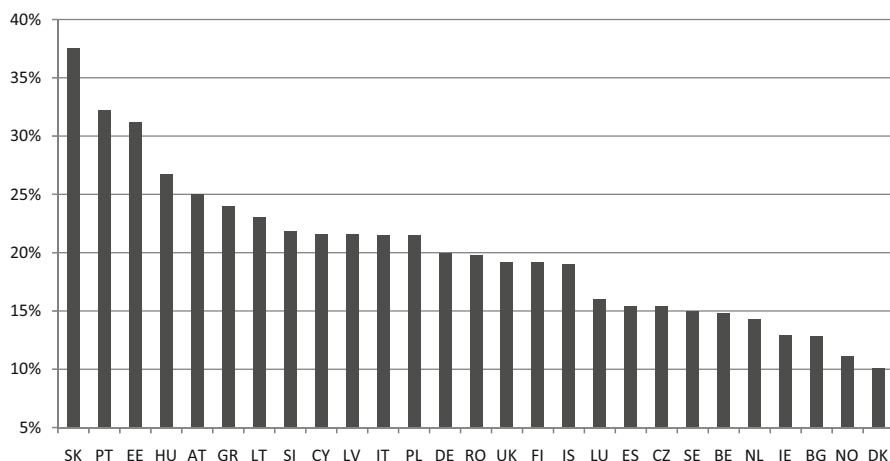


Fig. 2.1 The proportion of the population more than 65 years old with strong limitation in activities due to health problems for at least the last 6 months (2008). (Source: Authors' calculations based on EU-SILC (2008) data)

Table 2.2 Informal caregivers: percentage of the population reporting to be informal carers to people with strong limitations in daily living, different years 2004–2006. (Source: OECD 2011; OECD estimates based on the British Household Panel Survey [BHPS] for the United Kingdom and on the Survey of Health, Ageing, and Retirement in Europe [SHARE] for other European countries)

EU countries	Percentage of informal caregivers
Sweden	8.0
Greece	8.7
Denmark	9.3
Austria	9.8
Poland	10.3
France	10.7
Germany	11.0
The Netherlands	11.4
Czech Republic	12.0
Belgium	12.1
Ireland	14.6
United Kingdom	15.2
Spain	15.3
Italy	16.2

on this study, it can be seen that caregiving is to a greater extent becoming organized in the context of complex family dynamics, in which can be found adults from different generations.

2.3.2 Attitudes Toward Care

In terms of demand, there is some divergence among European countries not only in terms of their social–demographic characteristics, but also from a social–cultural perspective. A Eurobarometer survey from 2007 (Eurobarometer 2007) investigated

both respondents' preferred model of care in the case of the onset of dependency and also the balance between caring responsibilities and paid work among family carers of older people with disabilities. Figure 2.2 illustrates how in Europe there is a significant difference in the attitudes about the role of adult children in caring for dependent parents. At one extreme are the Scandinavian countries, together with France and Belgium, where the idea prevails that care should be provided first and foremost through formal services, either public or private. At the other extreme are central-eastern European countries, together with Greece, where more than 70 % of respondents believe that care provided by children is the best option. In other countries, family care is preferred, but to a lesser extent, particularly in southern European countries (Portugal, Spain, Malta, and Cyprus) and also in Germany and in Austria. In a more complex, intermediate position lie Italy, the United Kingdom, and Ireland, where preferences for informal and formal care are equal.

Opinions regarding the reconciliation of caring responsibilities and work in the labor market, important because it is mostly women who are affected, partially change these results. Country trends outlined in Fig. 2.3 remain unchanged; the majority of central-eastern European countries indicate that work by women should theoretically be sacrificed in order to provide care for older parents if required, while in contrast, those holding such a position in France, Benelux, and Scandinavia are in the minority. In the center, two groups of countries can be found, one in which 40–50 % of the population is in agreement with the idea that the career of the caregiver should be sacrificed (largely various countries of central, eastern, and southern Europe) and those in which the percentage is lower (30–40 %), in the Germanic and Anglo-Saxon countries in Europe.

However, if we consider responses to questions about caring for older relatives and for children at the same time, it is possible to see a strong congruence: there is a strong positive correlation between the two variables, equal to 0.829. Namely, respondents who feel that one should give up work to care for children are also likely to agree that children should give up work to care for their old parents. Nevertheless, almost all countries have on average lower rates of adherence to the idea that sacrificing one's career to provide care is the best option when compared with the idea that childcare is the optimal solution. For example, in Germany, the majority of the population is in agreement with the statement that parents provide the best childcare support (58 %), though only one-third of respondents overall are of the opinion that one's career should be sacrificed to offer care to dependent parents. There are only a few exceptions to this general rule, of which the most interesting cases are Greece and Italy (see Fig. 2.4): In the Greek region (Greece and Cyprus), the preference to leave work to provide care to their children is significantly higher than to provide care to dependent parents, while in Italy, the opinions about the two phenomena are closely intertwined and report virtually the same percentages.

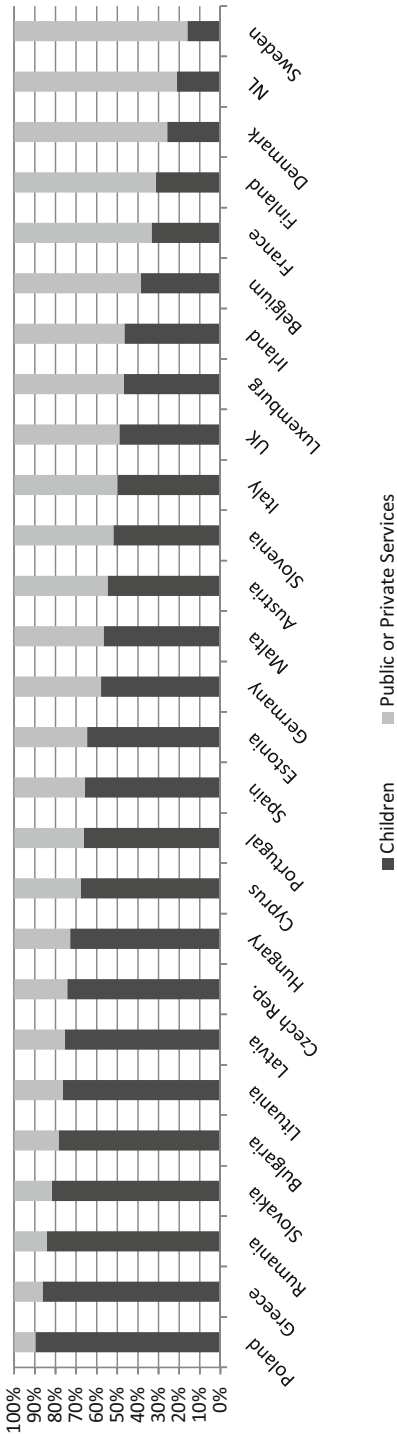


Fig. 2.2 Preferences for type of care desired in the case of parents becoming dependent in old-age—EU-27, 2007. (The data refer only to those who have experience of dependency). Legend: Adult children responding to the Eurobarometer survey were asked to respond to the question “In the case of one of your parents becoming dependent, which would be the best solution? The option “Children” was formed by grouping together the responses “to live with an adult child” or “to be cared for by an adult child living nearby”. The option “formal care services, either public or private” was formed by grouping together the responses “Through the provision of public/private services in his/her own home” and “In a long-stay care setting”. (Author’s calculations based on Eurobarometer (2007) microdata)

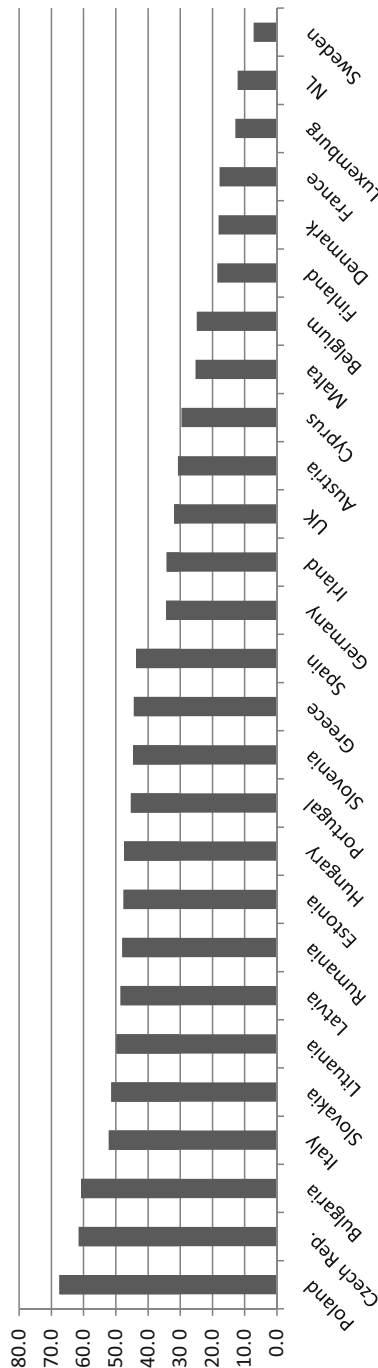


Fig. 2.3 Percentage of individuals who believe that adult children must care for their disabled parents even if this means sacrificing their career—2007. (The data refer only to those who have experience of dependency). (Source: Authors' calculations based on Eurobarometer (2007) microdata)

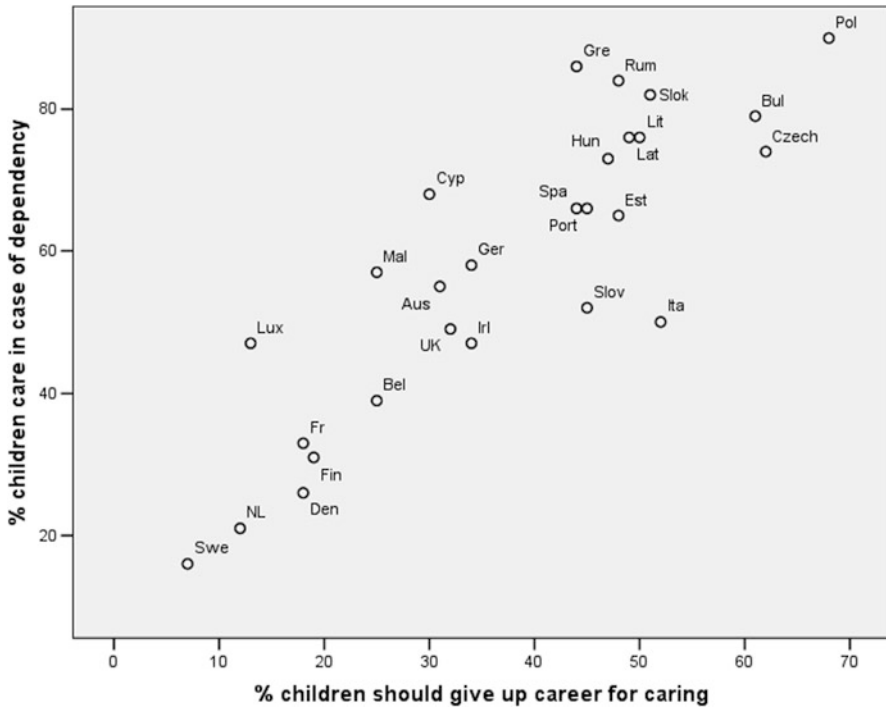


Fig. 2.4 Percentage of individuals who believe that children should provide care to dependent parents even if it means renouncing their career—2007. (The data refer only to those who have experience of dependency; these percentages do not vary significantly when considering the entire sample). (Source: Adapted from Eurobarometer (2007) data)

2.4 The Characteristics of Public Care Services

2.4.1 Coverage and Funding Levels

As LTC is defined in different ways in each European country, national systems of LTC in Europe often have very different characteristics (Kraus et al. 2010). In fact, in each of the various countries, programs of LTC were created at different points in time, with the objective of either complementing or substituting the preceding system of support for disability and dependency. In turn, this has resulted in the development of very different systems of LTC in each country. Furthermore, the delivery of care is often divided between different government departments and state agencies in each of the different countries, making comparison of the overall LTC system somewhat challenging. Finally, in almost all advanced countries, different methods are used for the financing of LTC (OECD 2005, 2011).

These diverse aspects help to explain why the current available statistics about public LTC programs are somewhat patchy (Oliveira Martins 2006; Fernandez 2009).

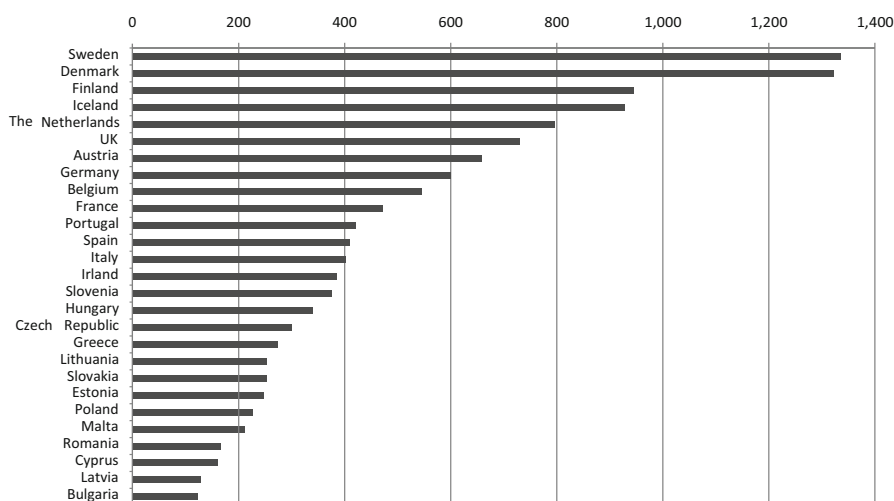


Fig. 2.5 Amount of public spending on LTC in PPS (purchasing power standard) euros per capita 2008. (Source: ESSPROS data, Eurostat [2010](#))

In spite of the quality and richness of the current data available from numerous institutions, which have recently published reports on LTC systems, there is often a notable imprecision within the information provided as well as a number of clear contradictions. For this reason, we limit our analyses to the data, which offer greater reliability and consistency over time.

As a general rule, it should be observed that state intervention in the area of LTC is still relatively underdeveloped, even in advanced countries. Total public spending on LTC in OECD countries is on average 1.2 % of the national GDP (the same average is also true for European countries). If social security for disability is included, spending as a proportion of GDP still only reaches 2 % on average. Eurostat ([2010](#)) estimates also indicate that social protection expenditure on the population of people with disabilities is around 8 % of total social expenditures and has remained relatively stable over the last decade. Nevertheless, LTC can be regarded as one of the policy areas, which have undergone the most significant reform over the last 20 years, even if there has been little evidence of a significant increase in public spending within the sector.

Before we look at expenditure dynamics, we first consider the differences on spending between European countries, looking also at OECD countries, when equivalent data are available (see Fig. [2.5](#)). Based on Eurostat² data up until 2008, we can examine public spending on LTC in euros per capita, adjusted for the purchasing power of the different countries. Out of this analysis emerges a block of countries in which yearly spending on LTC per capita exceeds € 900, which includes the Scandinavian countries, Luxembourg, Switzerland, and Iceland. In these countries, LTC

² European system of integrated social protection statistics (ESSPROS), Eurostat.

Table 2.3 Trends in spending on disability, PPS euros per capita, 1990–2008. (Source: ESSPROS data, Eurostat 2010)

	1990	2000	2008
Denmark	687	1,092	1,604
Sweden		1,175	1,388
The Netherlands	976	763	718
United Kingdom	364	654	619
Austria	518	691	614
Germany		551	559
France		385	456
Italy	405	302	335
Spain	232	247	292

programs constitute one of the pillars of the welfare system, absorbing between 12 and 17 % of total social spending. Spending on LTC represents a share of more than 50 % of all health spending; a clear sign that these policies are now assuming a central role compared with other more traditional sectors of the welfare state.

In a second block of countries, yearly LTC spending represents between 700 and € 900 per capita: a significant amount, which indicates that there is a clear understanding of the need to invest in this area. In this block, the United Kingdom, the Netherlands, Austria, Germany, Belgium, and France can be found. Many of these countries have introduced new LTC programs in the last few years, thus augmenting previous levels of spending in this area, as illustrated in various chapters in this book.

A third block of countries is also evident, in which per capita spending exceeds € 300 but remains below € 700. The Mediterranean countries, together with Ireland and two central-eastern European countries, Slovenia and Hungary, fall into this block. All of the other countries, including most of the eastern European countries and Greece, are characterized by spending on LTC of less than € 300 per capita.

As a general rule, these data illustrate how the volume of spending absorbed by LTC policies depends primarily on the timing of institutional reform. The countries, which spend the most on LTC, are also those which have introduced specific LTC programs much earlier. In addition to the historical perspective has been the more recent institutional reform noted above, which has gradually improved the performance of many of these countries, including Germany and Austria, where the introduction of new reform programs was accompanied by an increase in public spending. In general, Mediterranean countries and central-eastern European countries spend less on LTC programs. The gap for the citizens in these countries, compared with the northern and central-western European countries, is very large; on average, a Swedish or Danish citizen has at least three times more funding available than an Italian or Spanish citizen.

Over the last two decades, a different dynamic developed between the different countries in relation to spending on LTC. ESSPROS data allow us to reconstruct these spending dynamics from the beginning of the early 1990s to 2008 (see Table 2.3). These data show the changing trends in various countries. Positive trends, however, can hide important variations in the spending programs aimed at the older population, as the ESSPROS data also include figures for (younger) adults with disabilities. In general, in spite of a growing demand for LTC services, public spending overall has

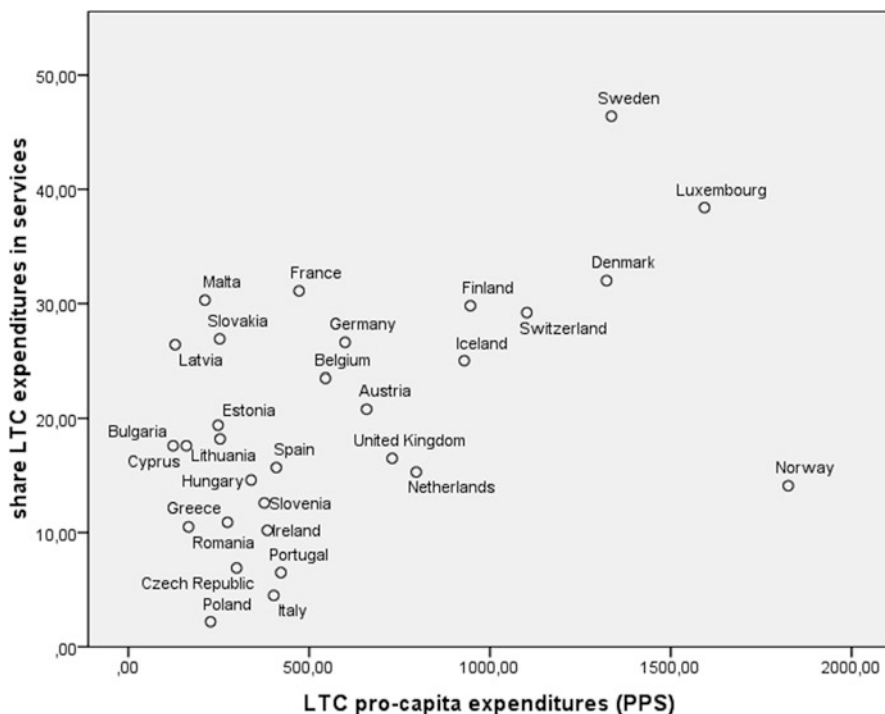


Fig. 2.6 Amount of public spending on LTC allocated to services; as a proportion of total LTC spending (GDP per capita), 2008. (Source: ESSPROS data, Eurostat [2010](#))

experienced a general difficulty to rise with the same pace. Institutional reform in this policy sector therefore developed with the aim of balancing the need to satisfy growing demand for services while simultaneously containing public spending.

The configuration of LTC systems changes considerably depending on whether in-kind services or cash transfers are offered. In-kind services are those in which care services are offered directly to recipients in form of residential or home care, while cash transfers have the effect of passing responsibility to individuals and families for organizing their own care services. The distinction between “care” and “cash” is, however, less clear than may appear to be the case. Over the last 10 years, various cash-for-care programs have been introduced in which monetary transfers are provided to acquire specific care services (Da Roit et al. [2007](#)). However, available statistics do not always include these measures, and confuse them with other cash transfers for which there are few constraints (such as the case, for example, of the “indennità di accompagnamento” in Italy, or of the “attendance allowance” in the United Kingdom).

Taking into account these caveats, Fig. [2.6](#) confronts the share of spending allocated to LTC services with the generosity of their overall performance. The most generous countries are also those which invest to a greater extent in care service

provision (with the significant exception of Norway). This is not an unexpected result, since the cost of maintaining residential and home care services is greater than that related to a cash benefit. It is mostly the northern European countries who fall into this category, together with Luxembourg and Switzerland. Among the countries that have developed a significant complement of services also France and Germany are included (together with Belgium, Slovakia, and other smaller countries), that is the two biggest continental countries, which have also introduced new specific LTC measures in recent years. In the other countries, which have also introduced changes, including Austria, the United Kingdom, and the Netherlands (in which case, however, the Personal Budget is counted as a cash benefit even though it constitutes cash transfers solely for the purchase of professional services), the cash transfers make up almost 80 % of spending overall. Furthermore, these results are not particularly unusual if we consider the structure of LTC systems in these countries. Finally, less generous LTC programs are offered in the Mediterranean and eastern countries, where there is a strong propensity to develop almost exclusively only cash benefits.

If we consider the service coverage guaranteed within each LTC system, a more complete picture of coverage emerges highlighting the differences between the various countries. In this case, we consider only the level of coverage among the cohort of dependent older people, where the greatest need for care is concentrated. Figure 2.7 presents an estimate of how total coverage rates changed between the mid-1990s and the mid-2000s, when most of the institutional reforms took place. Looking at the overall rates of coverage, the Nordic countries, together with the Netherlands (and Israel), offer coverage of more than 20 % of the population aged 65+. High coverage (more than 15 %) can also be seen in Switzerland, Austria, the United Kingdom, and Sweden. The rate in Slovenia, the Czech Republic, and Germany is between 10 and 15 %. All of the other countries offer an overall rate of less than 10 %, with Italy and several central-eastern countries offering a less than 5 %.

Figure 2.7 shows the development of reforms in operation between 1995 and 2005. If the level of coverage measures the ability of LTC programs to satisfy the emerging demand for care, then the dynamics in place are clear. Three different trends can be identified. Some countries, including most of the Nordic countries such as Denmark, Norway, and Finland, and also some continental countries such as Austria and Slovenia, have extended LTC policies, resulting in a high level of coverage. A marked, positive dynamic has also allowed some other continental countries such as France and Spain, to reach a rate of coverage close to that of what Germany had already reached by the mid-1990s (around 10 %).

A second trend has affected the countries that had already reached a relatively high level of coverage in the period preceding that analyzed here. Namely, in the cases of Germany, Canada, and other central-eastern European countries (the Czech Republic and Ireland), there has been a stabilization of the level of coverage over the last decade. Other countries, however, such as Italy and most of the central-eastern European countries have reported an increase in coverage levels too small to have bridged the gap with the more advanced countries, thus further increasing the distance from European standards. Finally, some countries have experienced a retrenchment

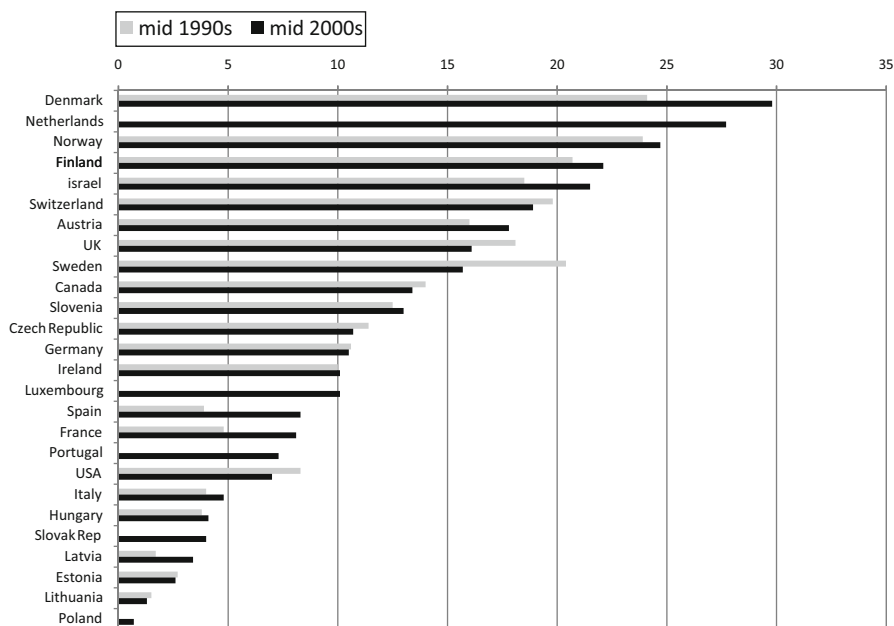


Fig. 2.7 Rates of coverage for LTC services for the population aged 65± mid 1990s—mid 2000s. (Source: ESPROSS data, Eurostat 2010)

of LTC programs, which arose due to the challenges of the significant costs for meeting the increased demand for care. This is an inverse of the trend reported above that affected countries, which had previously extended LTC programs, such as Switzerland, the United Kingdom, and Sweden.

The dynamics of the coverage naturally reflect the structure of LTC services that exists in each country. Available data only allow for an analysis of the difference between the coverage of home and residential care services. Over the course of the last 20 years, the emphasis has continually been placed on the development of home care services, largely not only because of the affordability of this option (especially if the coverage is not particularly intensive and also if service users contribute a fee), but also because it fitted the objective of trying to maintain dependent older people in their own homes (the catchphrase in Europe was in fact “ageing in place”). It is therefore unsurprising that there is a clear, linear correlation (as can be seen in Fig. 2.8) between the overall rate of coverage and the share of home care services (calculated by taking the total rate of coverage for the demand for home care services).³ While the proportion of individuals who use home care assistance reaches 80–90 % in countries with high rates of LTC coverage, the proportion of home care recipients

³ Available data, unfortunately, do not consider the coverage of cash benefits. However, the rate of coverage of home care services also contains the proportion of individuals who receive either “cash-for-care” services or sums of money only available for acquiring home care assistance.

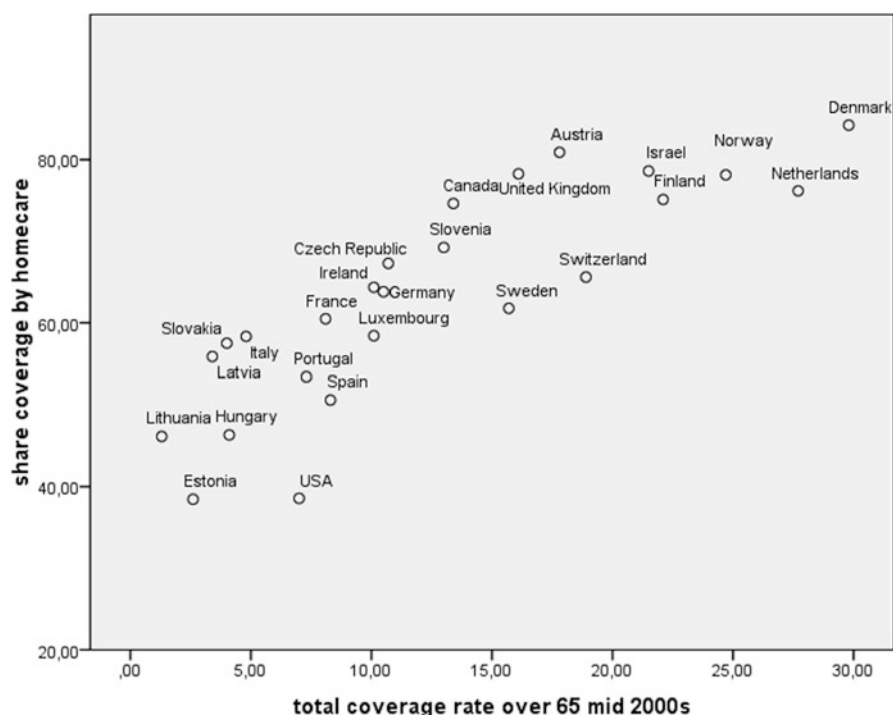


Fig. 2.8 Overall rates of coverage of LTC services for the older population (65+ years) and the rate of coverage provided through home care services—mid-2000s. (Source: ESSPROS data, Eurostat 2010)

is between 40 and 60 % of all users of LTC services in countries with more modest rates of coverage overall. These data indicate that the diffusion of LTC services has been mostly due to an increase in the provision of home care services.

The diverse mix of home and residential care also highlights a number of differences among European countries (see Fig. 2.9). The updated data from the mid-2000s shows the emergence of at least three groups of countries. The first group includes countries with a high rate of coverage for both home and residential care services—this is made up of the Nordic countries. Within this group, Sweden and Switzerland are something of an exception, having experienced a reduction in coverage rates for home care services, following “targeting” policies over the last few years (see also Fig. 2.10 for a comparison with the situation in the mid-1990s). A second group of countries is at the opposite extreme and is characterized by low levels of coverage of both home and residential care: included in this group are all of the central-eastern European countries and Italy. The third group includes France and Spain, which over the last 10 years have witnessed a significant improvement in their rate of coverage (see Figs. 2.9 and 2.10).

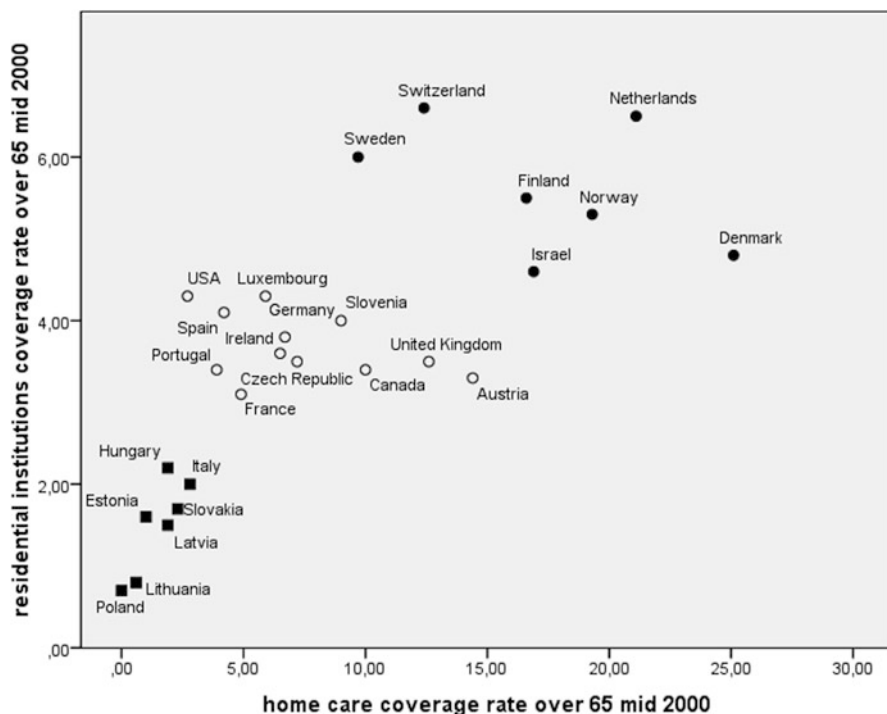


Fig. 2.9 Rates of coverage for home and residential care services—mid-2000s. (Source: Authors' calculations based on ESSPROS data, Eurostat 2010)

The intermediate aggregate group includes countries, which are united by the fact that they have a rate of coverage of residential care services of around 4 %. What distinguishes them, however, is the rate of development of home care services: while some of these countries such as France, Spain, and Germany have a rate of coverage of about 5 % for home care services, other countries such as Austria and the United Kingdom had developed home care services offering coverage for up to 10 % of the older population. Finally, if we compare the situation of various European Union countries with others from the OECD, we can see how the United States can be inserted into the same group as France and Germany, while Israel and Canada have a better developed LTC services system.

Combining together data on expenditure and coverage, a substantial consistency between the different indicators emerges (see Fig. 2.11). Essentially three groups emerge. One group with a very high level of spending (more than € 1,000 per capita, adjusted for PPP) and coverage, which substantially meets demand (coverage rates higher than 15 % of the 65+ population), which includes the Nordic countries and the Netherlands: countries, which provide a universalistic model of LTC with significant levels of service provision. In contrast, a second group includes countries that provide a level of spending almost half that of the first group (not more than € 500 per

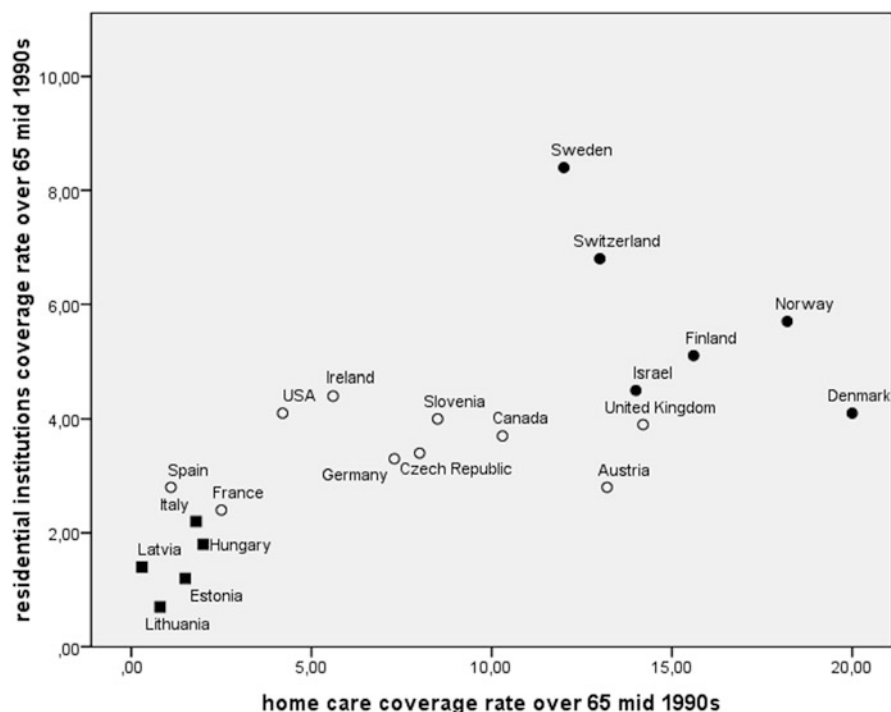


Fig. 2.10 Rates of coverage for home and residential care services—mid-1990s. (Source: Huber et al. 2009)

capita) and with rates of coverage of less than 5 %, in which LTC constitutes a residual and underdeveloped system: this group includes most of the Mediterranean and central-eastern European countries. The third, intermediate, group, includes several European countries that have made significant financial investments into LTC, at different times and following diverse institutional and organizational models, as we have already seen. In these countries, spending reaches an intermediate level of between 500 and € 1,000 (per capita), and, while the rates of coverage are variable, each provides coverage of at least 5 % of the older population. This group includes a set of very diverse countries, which, in one sense or another, have faced significant institutional reforms over the last 20 years. It includes France and Germany as well as countries such as Austria and the United Kingdom. These intermediate countries are those which have incurred the greatest developments over the course of the last 20 years.

2.4.2 Citizen's Level of Satisfaction

Moving from the analysis of spending and coverage to citizen's valuation and satisfaction with the LTC system, we can see some, albeit weak, congruence between the two sets of data. Figure 2.12 shows that the percentage of individuals that declare to

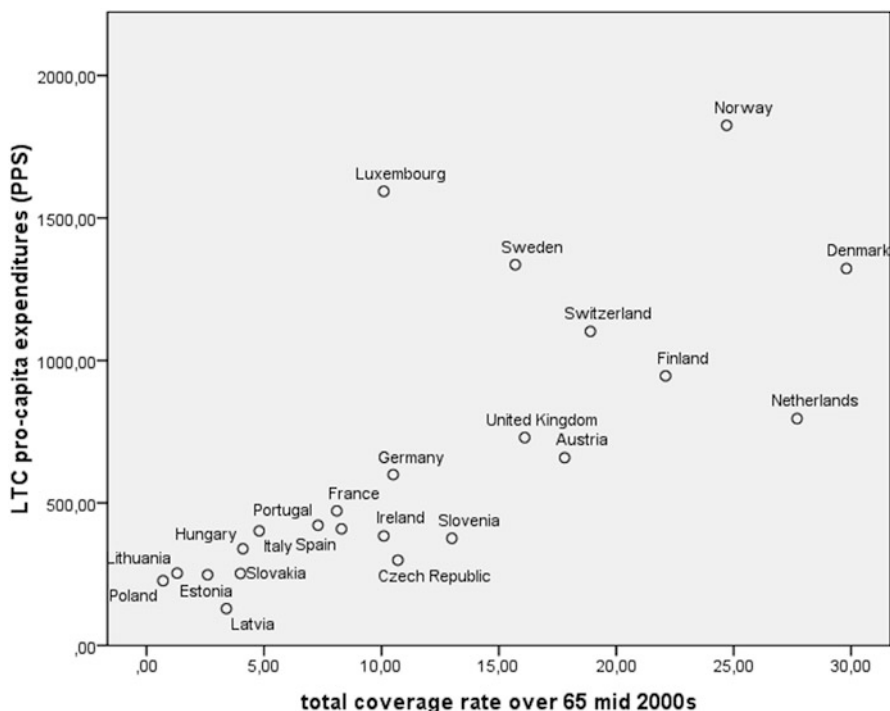


Fig. 2.11 Total rates of coverage for the older population (mid-2000s) and level of spending on LTC (GDP per capita—2008; ESSPROSS data, Eurostat [2010](#))

have paid for or who currently pay for care for their parents is highest in Italy (34.1 %), followed at some distance by Portugal, Austria, Belgium, Cyprus, and Malta, which all have values of between 25 and 28 %. In some of these countries (Italy and Austria, for example), private spending by the family is supported by particular public systems, which favor cash transfers over services. For other countries, including the Scandinavian countries, together with those from the Baltic region and the United Kingdom, the opposite can be found, namely, just 10 % of the population reported paying for care to support their older parents. Between these two extremes lie all of the other countries, including some, which are characterized by a less concentrated form of the phenomenon (for example, the western continental countries with values of around 20 %) and others with a relatively more limited spread (Mediterranean and central-eastern European countries).

If we examine the assessments of those who have had some experience of the public LTC systems both directly (either personally or through family members) and indirectly (through other relatives, neighbors, and friends), strong country variations emerge. Figure [2.13](#) synthesizes the average dissatisfaction ratings for each country, while Table [2.4](#) reports on how this dissatisfaction relates to specific aspects of care (quality, accessibility, and cost). The countries with the worst satisfaction ratings are

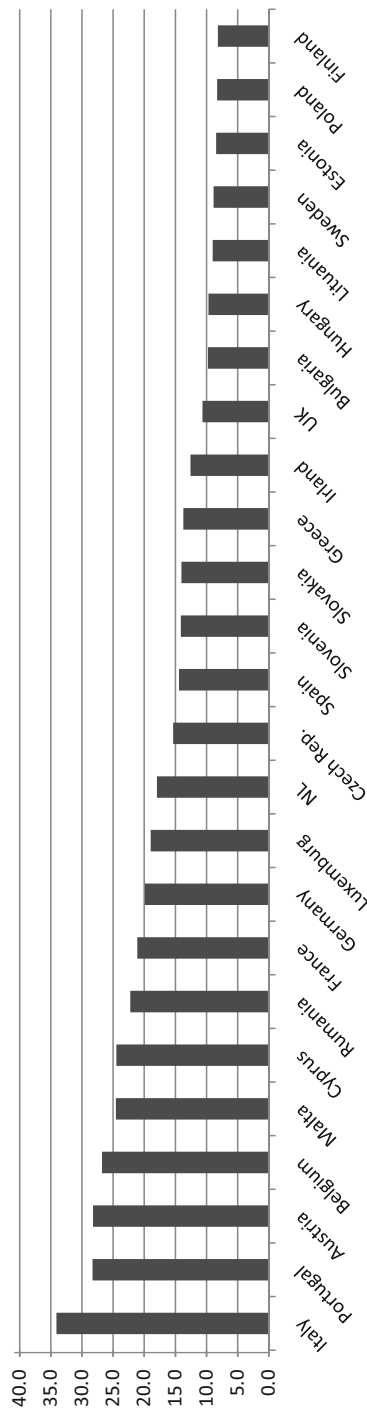


Fig. 2.12 Percentage of citizens who report that they currently pay, or have in the past paid, for care services for their parents (percentage calculated among respondents aged 40+), 2010. (Source: Authors' calculations based on Eurobarometer (2010) microdata)



Fig. 2.13 Percentage of citizens dissatisfied with the performance of their LTC system. (Source: Eurobarometer 2007)

Table 2.4 Satisfaction ratings for various aspects of the public LTC system, 2007 (the data refer only to those with prior experience of the issues of dependency).
(Source: Authors' calculations based on Eurobarometer (2007) microdata)

Country cluster	Country	Percentage of dissatisfaction with aspects of the LTC system					
		Quality of home care services	Quality of residential care services	Ease of access to home care services	Ease of access to residential care services	Costs of access to home care services	Costs of access to residential care services
Complete satisfaction (sometimes with problems relating to the costs of residential care)	Belgium	7.1	12.6	13.1	36.2	22.2	57.7
	Denmark	36.3	37.5	24.7	26.8	4.8	16.3
	France	16.6	12.4	24.5	15.3	33.0	46.4
	Luxembourg	12.2	23.2	8.8	61.9	12.9	52.3
	Netherlands	26.2	31.1	37.5	43.5	23.8	23.8
	Sweden	24.4	23.5	25.3	40.4	24.5	31.8
	Average	20.5	23.4	22.3	37.4	20.2	38.1
	Austria	26.4	34.5	45.9	54.8	63.5	70.8
	Cyprus	33.3	41.5	24.1	21.8	57.5	68.6
	Germany	26.5	40.1	14.9	35.2	54.9	77.1
Complete satisfaction, except with the costs associated with LTC	Malta	11.5	13.6	22.4	34.3	61.4	74.9
	United Kingdom	35.8	35.4	39.3	34.3	39.2	60.3
	Spain	25.9	28.5	39.0	52.6	41.4	68.7
	Average	26.6	32.3	30.9	38.8	53.0	70.1
	Estonia	44.2	47.1	55.7	71.0	59.0	85.8
	Finland	34.6	31.6	52.1	63.7	51.9	65.8
	Ireland	45.0	39.3	49.7	54.8	57.6	73.5
	Italy	58.0	48.2	59.7	47.9	55.1	65.1
	Latvia	48.0	41.1	64.3	70.7	46.7	53.8
	Lithuania	47.9	51.4	63.9	63.9	46.9	47.3
Partial satisfaction, (only with the quality of service provision)	Poland	54.6	62.6	41.3	55.4	45.3	57.7
	Portugal	52.9	35.0	55.2	45.5	70.4	74.3
	Czech Republic	24.7	25.9	60.3	84.6	47.9	57.2
	Slovakia	46.9	46.7	62.3	78.4	60.3	72.4
	Slovenia	24.4	27.6	55.6	68.2	71.7	83.0
	Hungary	47.0	45.5	60.2	74.7	61.3	70.3
	Average	44.0	41.8	56.2	64.9	56.2	67.2
	Bulgaria	71.5	73.3	79.1	80.4	73.4	75.6
	Greece	54.7	74.8	51.6	51.3	76.4	89.4
	Romania	68.7	75.1	66.8	73.7	81.6	80.9
Complete dissatisfaction	Average	65.0	74.4	65.8	68.5	77.1	82.0

Bulgaria and Romania, followed by Greece, where almost two-thirds of respondents declare themselves completely dissatisfied. In a second group of countries, including many central-eastern European countries, together with Italy, Portugal, and Ireland, almost half of all citizens express negative opinions. However, the rates of dissatisfaction fall below 30 % in some Scandinavian countries, in the Benelux, and in France. In the middle can be found Spain, Germany, and the United Kingdom (with values reaching around 40 %).

The data presented in Table 2.4, which outlines citizen's level of satisfaction with the main aspects of residential and home care for dependent older people, helps to confirm these findings: the quality of services, ease of access, and the relative costs. Given the abundance of data reported in Table 2.4, the information on each country is organized into clusters.⁴ Altogether, four sets emerge:

1. In the first group of countries, comprising almost all the Scandinavian countries, together with France and the Benelux, a majority (often large) of citizens report being satisfied with their LTC system in all respects, apart from, in a few national cases, the issue of the costs associated with residential care for older people (in France, Belgium, and Luxembourg).
2. The second group of countries is largely similar to the first group, but the level of dissatisfaction with the costs of both residential and home care is stronger: in this group can be found Austria, Germany, the United Kingdom, and Spain, where there appears to be a relatively strong trade-off between, on the one hand, quality and access, and on the other, associated costs.
3. The majority of central-eastern European countries, together with Italy, Portugal, Finland, and Ireland fall into the third group, in a critical situation, in which citizens are partially satisfied with the level of service provisions, but are very dissatisfied with the level of access and the costs of LTC services.
4. The fourth, and arguably worst-off, group is composed of the Balkan-south-east of the European Union (Romania, Bulgaria, and Greece), where levels of dissatisfaction were the highest for every item.

The picture shows that there is a certain congruence between the level of public expenditure and the citizen's level of satisfaction with the functioning of the various aspects of their LTC system (costs, access, and quality).

2.5 The Impacts of Different Models of Care

Investigating the impact of the different models of LTC using quantitative data is, clearly, a complex issue. It is possible to do so with reference to different variables, which give an overall picture, as we do here. In particular, we aimed to evaluate the impact of these policies, as shown in the following paragraphs, examining in particular inequalities in access to services and the prospects of reconciling work and caring responsibilities.

⁴ The allocation of the country clusters was carried out by using a hierarchical cluster analysis (Ward's method).

2.5.1 Inequalities in the Access to Health Services According to the Level of Disability

Prohibitive costs and limited supply can create barriers to individuals receiving acute healthcare treatment. To investigate whether this barrier also exists in the LTC sector in Europe, we used available data from Eurostat. The EU-SILC survey contains a variable, which identifies situations where it is not possible for individuals to obtain necessary treatment. We were able to investigate ease of access to LTC within Europe using this variable. Furthermore, we used three variables from the EU-SILC data (the subjective evaluation of health, the presence of chronic conditions, and the difficulty of performing tasks of daily living due to health problems), to form a summary variable of individual's health status, which distinguishes between those in good health, those with minor problems, and those with more serious health problems. Using data related only to older people, Table 2.5 summarizes the results of a probit regression analysis, which measured whether older people's health problems impact on their ability to access to health services. The regression analyses are controlled for other independent variables: age, gender, nationality, and level of education (which are not listed in the table).

Four groups of countries emerge from the analysis, which for the most part resemble the classification of countries according to their diverse ways of investing in LTC:

1. The Scandinavian countries, the Benelux countries, France, and Spain do not differ significantly in terms of access to services for older people in terms of their health status. In other words, those in need of LTC are not likely to experience any barriers in receiving treatment.
2. In the Germanic area and Slovenia, those with serious health problems are those most likely to experience some difficulties in accessing care. Germany is at the crux of this group and the first as it produces just marginal significant effects, which are very low compared with the other countries.
3. Both the Anglo-Saxon countries and the Czech Republic are characterized by the fact that health status has a significant negative impact on access to health services. In other words, even those with moderate health problems may experience difficulties in receiving access to care, for a variety of different reasons.
4. All of the rest of the countries, particularly in the south and central-east regions, including Italy, are characterized by the fact that health status (and the presence of disability) of older people has a strong negative influence on access to healthcare and services.

This analysis indicates that, paradoxically, dependency and health problems hinder individual's ability to access health and social care services in some southern and central-eastern Europe countries, rather than promoting access. This often depends on the fact that a lack of access to integrated health and care services is linked to the prohibitive costs, which individuals are often required to pay to obtain treatment (data not reported in Table 2.5). In many LTC systems, therefore, older people with disabilities or health problems are likely to be doubly penalized.

Table 2.5 Probit regression of the role played by the health status of older people on the lack of access to health services: marginal effects (category reference: individual in good health). (Source: Authors' calculations based on EU-SILC (2007) microdata (2008 for Romania and Bulgaria))

	Country	Older people with minor health problems	Older people with serious health problems
Countries in which different health statuses of older people do not reduce the probability of access to health services	Belgium	ns	ns
	Denmark	ns	ns
	Finland	ns	ns
	France	ns	ns
	Luxembourg	ns	ns
	Netherlands	ns	ns
	Spain	ns	ns
	Sweden	ns	ns
Countries in which only the situation of major health problems of older people reduces the probability of access to health services	Austria	ns	.054***
	Germany	ns	.018*
	Slovenia	ns	.045***
Countries in which different health status of older people has a moderate negative effect on the probability of access health services	Czech Republic	.027**	.061***
	United Kingdom	.023***	.068***
	Ireland	.024***	.071***
Countries in which different health statuses of older people has a strong negative influence on the probability of access health services	Hungary	.063***	.102***
	Poland	.076***	.104***
	Portugal	.043***	.110***
	Cyprus	.032***	.111***
	Italy	.071***	.113***
	Estonia	.137***	.167***
	Lithuania	.088***	.191***
	Greece	.098***	.196***
	Bulgaria	.140***	.202***
	Latvia	.102***	.207***
	Slovakia	.128**	.260***
	Romania	.176***	.288***

ns not significant.

*sig. < 0.05; **sig. < 0.01; ***sig. < 0.001

Controlled for: age, gender, level of education, and nationality

2.5.2 *The Reconciliation of Caring Responsibilities and Paid Work*

A second dimension, which requires careful attention when considering the impact of LTC on families and on people with dependency needs, is in relation to the ability to reconcile paid work and caring responsibilities (Glendinning et al. 2009; Lamura et al. 2008). In Sect. 2.3 above, we discussed the attitudes of European citizens with regard to the balancing of caring “duties” with paid work. In this paragraph, we

analyze the frequency of the decision to renounce or reduce paid work in order to engage in informal care work.

In the countries of the European Union (EU-27, Eurostat data), the primary motivations for people of working age (15–64 years) for not participating in the labor force vary by gender. The weight of family responsibilities in a broad sense is a predominant motive for women to withdraw from the labor market. The highest percentages of nonparticipation (between 20 and 40 %) can be seen in the Mediterranean countries (Malta, Cyprus, Spain, Greece, Portugal); however, percentages elsewhere are also significant (Romania, Belgium, Croatia, Austria, Ireland, Germany, Slovenia, Bulgaria, Poland are between 10 and 20 %). However, caring responsibilities affect career choices to a lesser extent in Finland, France, Slovakia, Hungary, Sweden, and the Czech Republic (between 0.5 and 1.9 %).

The countries with the highest rates of inactivity in the labor force due to the need to care for dependent family members/friends are United Kingdom, the Czech Republic, Estonia, Slovakia, Ireland, and Hungary (between 18 and 28 %); followed by Finland, Italy, Austria, Germany, Cyprus, Poland, Holland, and Spain (14–16.5 %). Fewer individuals in Belgium, Croatia, Romania, France, Denmark, and Slovenia report withdrawing from the labor force for this reason (2.5–5 %).

Data analysis of the various reasons is complicated by the fact that the various rationales for inactivity are combined in unpredictable ways, and are related to the conditions of the labor market, the provision of welfare services, cultural models, and family traditions. The fact remains, however, that, among the reasons for inactivity, family responsibilities related to both children or adults with disabilities, is one of the most common, particularly in Ireland, Cyprus, Spain, Luxembourg, Austria, Germany, Greece, and Italy.

A total of 13 % of women who have a relative with a disability reported having to leave paid employment in order to assume caring responsibilities or had to reduce their (paid) working hours (see Fig. 2.14). The Scandinavian countries, Germany, France, the Benelux countries, various countries from central-eastern Europe, Greece, Cyprus, and Malta all fall close to, or less than, the average. However, the proportion of women affected is significantly higher in Austria, the area of the former Czechoslovakia, Hungary, Portugal, Ireland, and Spain. Italy and the United Kingdom have values slightly higher than the overall average, with values of around 15–18 %.

These figures, which relate to current labor market practices, are somewhat different from the information reported in Sect. 2.3 above in relation to cultural attitudes with regard to the acceptability of the decision to continue to work rather than caring for dependent family members (see Fig. 2.15): the correlation between the two variables, although positive and relatively strong (0.441), is not as strong as that reported earlier in relation to other trends. Figure 2.15 shows that, in a large group of Mediterranean (Italy, Spain, and Portugal) and eastern countries (Czech Republic, Romania, Hungary, Slovakia, Lithuania, and Estonia), the prevailing opinion is that caring responsibilities take precedence over work and career expectations, while in the Scandinavian and “Francophone” countries, work and career expectations are prioritized.

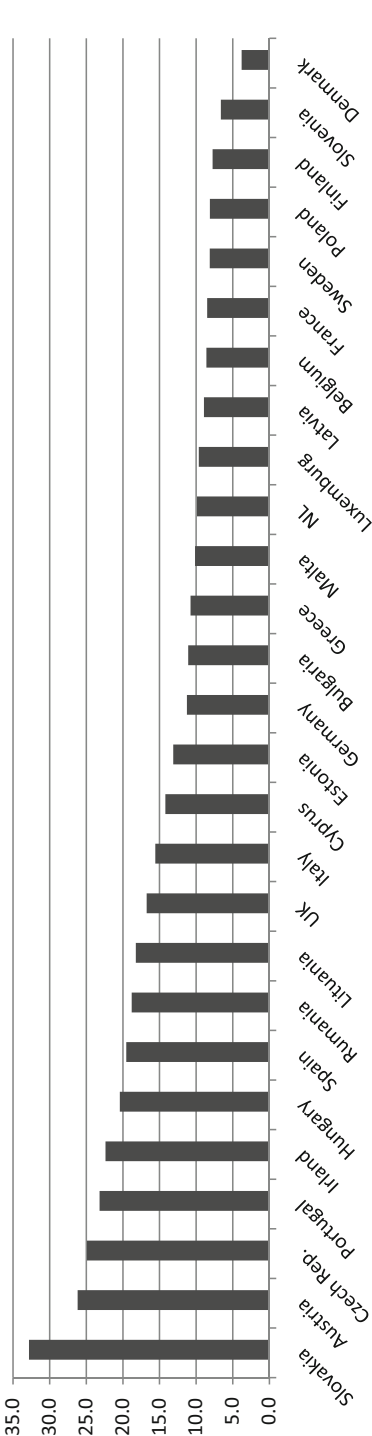


Fig. 2.14 Percentage of women who have withdrawn (partially) from the labor market to take up caring responsibilities (for disability) to close family members including older relatives—2007 (only women aged 40+ with an older or disabled relative). (Source: Authors' calculations based on Eurobarometer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

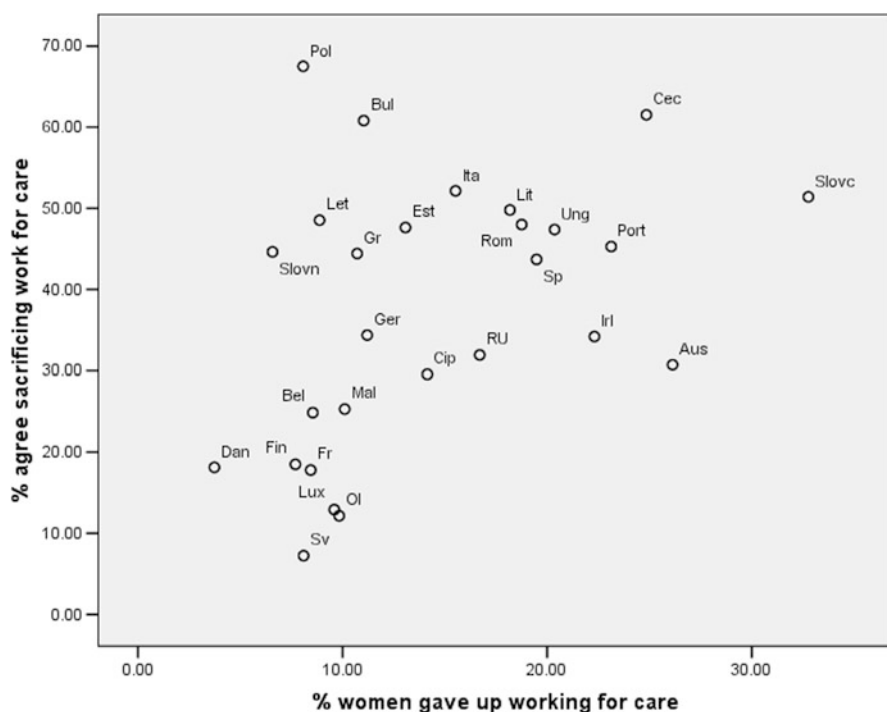


Fig. 2.15 Relationship between the percentage of women that have withdrawn (partially) from the labor market to take up caring responsibilities for a dependent family member (young adult or older person), and the percentage willing to sacrifice their career for caring responsibilities—2007 (sample made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

Other sources help to provide some context for these findings. For example, a recent OECD study (2011) has found that caregivers are less likely to have been in paid employment before taking up caregiving duties and are 50 % more likely to have been homemakers (see Table 2.6). The gap between the occupations of caregivers and noncaregivers is small in northern European countries, but larger between those in the south (Greece, Spain, and also Poland). In Austria and Italy, a high percentage of caregivers are pensioners (48.9 and 36.2 % as compared with an OECD average of 20 %).

According to the analysis carried out by the OECD (2011), the repercussions on career choices are determined by the intensity of the care required by the dependent relative. Indeed, in northern Europe and in Switzerland, care requirements are less intense, with caregivers providing between 0 and 9 hours of care per week. Furthermore, less than 20 % of caregivers provide more than 20 hours a week. Unsurprisingly, in southern and eastern European countries, such as Poland and the Czech Republic, over 30 % of caregivers provide more than 20 hours of care a week.

Table 2.6 Difference between carers and noncarers according to employment status before taking up caregiving duties (percentages in relation to specific population groups). (Source: OECD 2011)

Country	Pensioner		In paid employment		Unemployed		Homemaker	
	Carer (%)	Noncarer (%)	Carer (%)	Noncarer (%)	Carer (%)	Noncarer (%)	Carer (%)	Noncarer (%)
Australia	16.8	16.2	53.1	66.2	1.6	1.8	21.7	6.9
Austria	48.9	44.0	31.8	38.9	3.3	4.0	11.6	9.8
Belgium	22.3	25.6	39.0	42.7	10.5	6.0	16.5	13.0
Czech Republic	34.7	43.4	44.7	48.1	11.2	5.6	0.3	0.0
Denmark	19.1	22.2	59.0	60.6	7.0	5.9	1.3	1.7
France	24.0	25.5	51.6	52.7	4.3	6.1	13.8	9.3
Germany	23.5	20.5	48.2	53.8	9.7	11.2	11.9	8.9
Greece	18.7	23.3	31.4	47.2	2.4	2.8	46.0	25.1
Ireland	11.1	17.0	55.6	51.9	1.7	4.0	24.7	17.8
Italy	36.2	35.5	33.5	35.8	3.2	4.0	24.5	22.3
Korea	7.0	10.6	45.0	48.9	3.8	3.0	36.9	33.2
Holland	6.5	11.0	52.4	5.1	2.9	3.0	27.0	17.6
Poland	37.6	36.2	33.6	60.3	3.4	7.9	9.8	5.3
Spain	10.0	13.8	33.0	45.1	5.9	7.5	43.9	25.7
Sweden	12.9	16.3	75.4	73.9	1.4	3.5	0.8	1.1
Switzerland	7.3	10.2	67.0	69.5	3.5	2.8	15.7	10.0
United Kingdom	10.6	7.3	77.9	80.9	1.4	0.9	5.3	5.0
United States	17.7	15.5	58.5	62.0	2.3	1.8	10.7	9.1
OECD (17)	20.3	21.9	49.5	52.4	4.4	4.5	17.9	12.3

Data refer to people aged between 50 and 65

Thus, the impact of care work on labor market participation becomes more apparent when the caring requirements are intense: every increment of 1 % in the hourly provision of care work increases the likelihood of labor market withdrawal by 10 %. The same figure was also found in a study carried out by Costa and Ranci (2010), who found that caregivers with relatively light responsibilities (less than 14 hours a week) have a higher than average income (per capita), while income reduces by 16 % for caregivers who provide a moderately higher level of care and reduces by 33 % for caregivers with intensive caregiving responsibilities (more than 28 hours a week). In general, intensive caregiving is a strong factor in creating financial risks, while caregiving offered only for a limited amount of time does not appear to have any significant negative economic consequences, especially in the case of families with a medium to high standard of living. Overall, these findings suggest that being a caregiver in northern Europe does not necessarily equate to an automatic reduction in employment opportunities, while in southern Europe, the likelihood of withdrawing, even partially, from the labor market, is more pronounced.

2.6 Conclusions

The findings presented in this chapter paint a picture of a highly differentiated Europe in terms of LTC policies and provision. In particular, in facing increased demand for services because of the ageing of the population, responses from families and the welfare state differ, which in turn have diverse consequences both for individuals with disabilities and their families.

With regard to LTC public provision, findings relating to expenditure and coverage highlighted two main findings. The first is that, even today, the information that is required for international comparison is lacking. This reflects, on the one hand, the complexity of national systems of LTC, the diverse forms of intervention, and institutional responses from the various sectors of the welfare state (for example, the often poorly defined barrier between the social and health sectors). On the other hand, the absence of reliable data can be seen as a reflection of the failure to prioritize the construction of a relevant database at the European level to facilitate independent analysis of comparative statistical data. The progressive increase in financial investment into the LTC sector, as confirmed by the findings presented in this chapter, demonstrates the importance with which national governments are now starting to see this issue, yet also highlights the need for basic statistics in order to determine expenditure requirements and gauge the effectiveness of various interventions. Such data are also imperative for the European Union, which over time is likely to start taking more responsibility, albeit indirect, in this field.

The second major finding is that in Europe, it is possible to identify two diverse LTC systems. The first is characterized by generous financing and a comprehensive set of services, as evidenced through high rates of coverage. In contrast, the second is characterized by low rates of funding and a strong dominance of cash support. These two models correspond, as will become evident in the following chapters, to

diverse forms of definition and extension of social rights in the field of LTC. Between these two extreme positions can be found various national systems, particularly those located in continental Europe, which operate according to a more intermediate model. Over the last 20 years, many of these mid-ranging countries have introduced major policy reforms into their national LTC systems. The available data, although scarce, duly highlight how these reforms have led to a greater convergence between the various European countries over the last 20 years, notwithstanding the significant weakness of specific LTC systems such as that of Italy, in which reform has not occurred in any shape or form. Furthermore, the institutional model adopted in each country is both broadly congruent with the attitudes and valuations of its citizens toward the overall welfare model. However, the operation of LTC policies in some countries diverges from attitudes toward individual's roles in providing direct care to dependent family members (of which countries in central-eastern Europe provide a clear example).

Furthermore, in terms of the growth of population ageing, the operation of LTC systems clearly has an impact on social inequality, particularly in terms of gender. In several European countries, older people's access to healthcare is negatively related to their health status; those with chronic health problems or disabilities experience greater access problems. Likewise, it appears to become more difficult for family members to reconcile their caring responsibilities with paid employment when their older relative has more extensive care needs. This in turn helps to highlight how less well-developed LTC models based around cash transfers, rather than in kind services, result in the relatively widespread penalization of women with caring responsibilities.

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