Not all that glitters is gold: Long-term care reforms in the last two decades in Europe

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Introduction

According to Pierson (2001), the majority of changes in welfare policies that take place in an era of permanent austerity typically unfold along a spectrum ranging from 'maintaining the status quo' to 'retrenchment'. The forms taken depend on the 'regime' traditions (Palier, 2010). There are a few welfare policy fields where change has not followed Pierson's prediction. Long-term care (LTC)[1] is one of these fields, together with childcare and activation policies, where since the 1990s many countries have extended needs coverage and social expenditures,

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often investing significant resources to address the emergence of new social risks (Bonoli, 2005; Morel et al., 2012b; Taylor-Gooby, 2004). Transformation in LTC, therefore, is an interesting testing ground to analyse the conditions and institutional mechanisms through which contemporary welfare systems actually manage policy change to accommodate the expansion of social rights.

In this article, we identify the political and institutional dynamics as well as the social and political consequences that have made these changes possible. The time span considered goes from the early 1990s, when the reform process started, to the early 2010s, where most of the European countries started to deal with the financial impact of the economic crisis. In order to do that, we address three main issues. We explain some of the reasons why reforms have taken place in many but not all European countries. We reconstruct the politics of LTC reforms: who have been the main actors and coalitions at work in this policy field, and how change has concretely occurred. We analyse the main outcomes of reform processes in terms of coverage and citizens' social rights, working conditions in the care sector and trajectories of de-/refamilization of care.

In relation to the reasons for change, we consider the impact of potential pressures in LTC policy, particularly cost-containment and financial constraints, and also the increasing need for care. Indeed, it is possible to argue that this 'new social risk' (Bonoli, 2005; Taylor-Gooby, 2004) has emerged as a consequence of demographic (ageing of population), social (higher female labour market participation rate) and cultural (new vision of care) transformations. Policy change has occurred variably in European Union (EU) countries in the attempt to deal with emerging trade-offs between cost-containment pressures and a rising demand for care. We consider the role played by institutional and policy factors to explain changes in LTC policy, vis-à-vis variations in the demographic, social and cultural structure of European countries.

LTC has been a policy field traditionally characterized by a low level of institutionalization in many countries: it has only recently obtained full recognition as a distinct policy area. For many decades, LTC was considered in many welfare systems as part of health policy or a residual public responsibility left to local authorities. Even nowadays, institutional responsibility for this policy is not always clearly and consistently attributed. One of the implications is that the provision of care benefits has not mechanically followed the definition of social entitlements. Dahrendorf (1988) defined entitlements as 'socially defined means of access' or 'entry-tickets' (Dahrendorf, 1988: 11) and provisions as those 'things one is entitled to', 'the whole range of material or immaterial choices that may be opened up by entitlements' (Dahrendorf, 1988: 12). In well-institutionalized welfare policy fields such as pensions or healthcare, social entitlements typically establish specific public responsibility for full service provision that is guaranteed by specific rules and professional standards. In LTC, however, access to social entitlements has not implied that care needs are completely covered by public provision: responsibility for obtaining care still lies, at least partially, on the shoulders of beneficiaries (and their families). LTC has therefore become a 'weak social right' (Daly and Lewis, 1998), which entitles the dependent to public provisions which merely complement their own caring arrangements. As a consequence of this high level of flexibility and ambiguity in the existing arrangements between policy goals (entitlements) and policy means (provisions), open processes of restructuring entitlements and/or provisions are (relatively) likely to take place in most countries.

The answer to the question about how change happened can therefore be found in the process of institutional restructuring taking place in the interplay between entitlement definition and the organization of provisions. Transformations occurred largely through radical reforms in which new LTC programmes were introduced ('third order policy changes' in Hall's 1993 well-known typology), but also by 'first and second order policy changes' through institutional mechanisms (Streeck and Thelen, 2005) – such as the maintenance (or lack of maintenance) of existing programmes, bottom-up innovations, returns to previous arrangements, incremental alterations – which did not explicitly challenge the existing institutional setting. Nevertheless, if weak institutionalization of LTC systems contributed to change, it also exposed innovation and reforms to shortcomings and cutbacks even after they were introduced.

In relation to our third aim, we consider the impact of LTC reforms as the outcome of a very broad set of social and political effects. In the LTC policy field, the issue of the 'dependent variable' (Clasen and Siegel, 2007) is problematic as the generosity of care provision can only be roughly defined in terms of public expenditures or take-up rates. Aspects related to the organization of care, professional quality of social workers, flexibility and capacity of personalized care are relevant in order to assess the adequateness of such services and their ability to meet recipients' needs. The impact of reforms is therefore analysed by considering not only standard measures of size of care provision but also changes related to the working conditions of care providers and to new regulations affecting the overall organization of the care system. Our hypothesis is that the expansion (or maintenance) of social entitlements to provide LTC was obtained in many countries through a general deterioration of the quality of professional care (often perceived as flexibilization or customization of care provision) and new public regulation establishing a partial commodification and (re)familization of care.

The rest of the article is organized as follows. The next section briefly introduces the main reforms that have taken place in LTC in the last two decades. Next, we analyse the reasons why reforms have (or have not) been introduced before moving on to consider the politics of reforms in LTC. Finally, we assess the outcomes of reforms. The article is based on a comparative analysis of eight EU countries, belonging to different welfare state traditions: two Scandinavian countries (Sweden and Denmark), England, the two biggest continental countries (France and Germany), the two main Southern European countries (Spain and Italy) and a Central–Eastern European welfare state (the Czech Republic).

LTC reforms in the last two decades

Each of the eight European LTC systems studied in this article has been affected by changes over the last two decades. The characteristics of these changes have differed according to institutional arrangements in place before the mid-1990s (*universalistic* vs *residual ones*), as well as to choices made during the last two decades (*major reforms* – third order changes vs *minor changes* – first and second level changes). Furthermore, the current crisis and subsequent austerity plans have affected the LTC systems in most of these countries, as we will see.

Table 1. LTC coverage at the beginning of the 1990s (percentage of individuals aged 65+ receiving benefits).

	Home and residential care	Care allowances
Universalistic LTC models		
Denmark	27.1	0.1
Sweden	21.4	0.1
England	14.6	8.6
Residual LTC models		
Germany	7.3	0.6
France	9.7	0.8
Spain	3.9	0.4
Italy	4.0	5.4
Czech Republic	2.8[a]	<1.0

LTC: long-term care.
Source: Organisation for Economic Co-operation and Development (OECD, 1996) for services; Glendinning and McLaughlin (1993), Rostgaard (2002) and Costa (2013) for allowances; Barvíková and Oesterle (2013) for the Czech Republic.
[a]Data on home care not available.

Until the early 1990s, there were fundamentally two models of LTC in Europe (see Table 1): a *universalistic model*, with levels of coverage above 20 percent, and a *residual model*, with quite lower coverage levels (usually below 10%) and higher reliance on family care and improper use of health services. Scandinavian countries belonged to the first model, Continental, Southern and Central–Eastern European ones to the second. England and Italy can be framed as sub-models of the universalistic and residual approaches, respectively, given a specificity they shared: a good part of the coverage was obtained not through services but through cash/care allowances (the 'Attendance Allowance' in England and the 'Companion Allowance' in Italy).

From the mid-1990s, a new genre of reforms started (Table 2). The three countries with a previous universalistic LTC model did not explicitly introduce major changes. Nevertheless, first and second order changes took place; market rules were introduced,

Table 2. Summary of LTC reforms, 1990–2009.

Country	Main reforms since the 1990s	Contents of main reforms/changes (until 2009)
Universalistic models at the beginning of the 1990s		
Sweden	First + second order policy changes	• Criteria of access in home care focused on the most in need • Rationalization in residential care • Shift of LTC responsibilities to municipalities • Introduction of market practices
Denmark	First + second order policy changes	• Re-centralization • Introduction of market practices
England	First + second order policy changes	• Criteria of access in home care focused on the most in need • Rationalization in residential care • Shift of LTC responsibilities to municipalities • Introduction of market practices
Residual models at the beginning of the 1990s		
Germany	Major third order policy changes (1995–1996)	• LTC insurance
France	Major third order policy changes (1997; 2002)	• APA (personal allowance for autonomy)
Italy	First + second order policy changes	• Piecemeal regularization of migrant care work
Spain	Major third order policy changes (2007)	• Dependency Act
Czech Republic	Major third order policy changes (2006)	• Act on Social Services

both in terms of free choice and greater competition among providers. In England and Sweden, the criteria for accessing care service provision for older people were changed (focusing more on those most in need in home care), a rationalization of residential care took place (fostering a decrease in the coverage level) and responsibilities were shifted to a greater extent to local authorities (Glendinning, 2013; Meagher and Szebehely, 2013). In Denmark, changes did not touch either coverage levels or accessibility criteria (Burau and Dahl, 2013).

In contrast, all the countries characterized at the beginning of the 1990s by a residual LTC model, but Italy, have gradually introduced major paradigmatic policy changes, aimed at expanding LTC coverage and generosity and establishing a principle of *universalism*. With the introduction of the Long-Term Care Insurance in 1995/1996, Germany created a universally oriented LTC scheme by expanding the available funds (Theobald and Hampel, 2013). After a period of experimentation, in 2002, France adopted the 'APA' ('personal allowance for autonomy') (Le Bihan and Martin, 2013). In Spain, the 'Dependency Act' came into force on January 2007, aiming at the creation of a universalistic LTC system (Cabrero and Gallego, 2013). The Czech Republic was the first Central–Eastern European country to establish a new LTC system in 2006 with the promulgation of an Act on Social Services (Barvíková and Oesterle, 2013), which introduced a new care allowance. All these countries share a common approach to care support, offered through services and/or allowances, differentiated according to the level of dependence of the beneficiaries and provided through three or four different levels of provision. Among them, only Germany adopted a strictly 'social insurance model'; elsewhere, the financing was more mixed and often based on fiscal revenues. In Italy, no relevant LTC policy changes took place in the last two decades (Costa, 2013). The only main intervention in the sector has been the regularization of migrant care work: the system seems to be shaped more and more around informal and migrant care work as a cheap way to deal with LTC issues, thus limiting public investment (Van Hooren, 2012). Another important element which is shared by England and Italy is that,

Table 3. Problem pressures in different institutional settings.

LTC model	Socio-demographic pressures	Cost-containment pressures	Cultural pressures
Universalistic	+	+++	++
Residual	+++	+	++

LTC: long-term care.
Strength of pressures: +, strong; ++, very strong; +++, very very strong.

apart from what happened in services, an expansion of social transfers to beneficiaries took place: in both countries, the percentage of older people receiving allowances almost doubled over the last 15–20 years (Beasley, 2010; Costa, 2013).

Why reform in the age of permanent austerity? Problem pressures and policy dilemmas

The literature on institutional change has usually considered 'new problem pressures' as one of the main sources for policy innovation (Ferrera, 2005). However, problem pressures are indeed insufficient to stimulate innovation by themselves (Howlett, 2007). They are filtered through specific institutional and political settings giving way to specific diagnoses of problems and related solutions. In this section, we analyse how partially similar problem pressures have had an impact upon both universalistic and residual LTC models and have led to different definitions of a policy crisis.

Three main problem pressures have become increasingly relevant in the field of LTC policy since the 1990s: socio-demographic, financial and socio-cultural ones (Table 3). While the ageing of the population contributed to a significant increase in the amount of dependent people in need of care (Lafortune and Balestat, 2007; Organisation for Economic Co-operation and Development (OECD), 2011), higher participation rates of women in the labour market lowered the supply of family carers, driving up demand for formal care services (Saraceno, 2008; Sarasa and Mestres, 2007). Dependence, mainly concentrated in the older population, as vulnerability related to heavy informal caregiving emerged as a 'new social risk' (Costa and Ranci, 2010; Taylor-Gooby, 2004). All the countries here considered experienced these trends with only slight differences.

A second, frequently overlooked, source of pressure relates to cost containment, as individuals aged 65+ are often also entitled to other welfare services. LTC reforms need to be framed also as part of a broader trade-off between, on one side, retrenchment and restructuring in traditional and more expensive welfare policies (pensions, healthcare, etc.) and, on the other, expansion in 'new' social risk coverage, among which is LTC. Pensions and national healthcare systems experienced strong increased costs in the last two decades as a consequence of the ageing population (Hinrichs and Jessoula, 2012; Pavolini and Guillén, 2013). Meanwhile social assistance systems have been put under stress: large parts of care services for older people were financed by national or local programmes of social assistance (Oesterle, 2001). These social services began to be captured in the 1990s by a huge mass of dependent older people seeking care services.

A third relevant pressure for change is related to cultural attitudes towards care. While the 1970s and the 1980s were dominated by a demand for professional care services, a new orientation towards efficiency and flexibility predominated in the 1990s (Daly and Lewis, 1998). This direction was the result of a twofold movement of ideas: on the one hand, the ideology of New Public Management (NPM) claiming for a formalization and marketization of service provision (Ascoli and Ranci, 2002); on the other, influential groups representing people with disabilities, inspired by ideas of self-determination and empowerment, started to call for freedom of choice, welfare pluralism and cash-for-care measures (Da Roit and Le Bihan, 2010). Paradoxically, these two streams of ideas converged to foster a new culture of care. Yet although these policy pressures were similar, they were framed quite differently in the two LTC models analysed in this article.

In countries with a traditional universalistic LTC model (Sweden, Denmark and England), the need for cost containment, more than rising demand for care (which was already covered by the system), became the dominant issue given the expansion of

an already expensive public care system in previous decades. The necessity for cost containment was mainly understood as an organizational problem and was never explicitly framed as a radical challenge to the mainstream principles of universalism and service completeness (Burau and Dahl, 2013). In Sweden and Denmark, NPM ideas became very popular and contributed to direct attention being paid to the technical aspects of financing and service provision: entitlements to social care were neither disputed nor formally reduced, although cutbacks in expenditure and service provision were actually introduced in Sweden. In England, most of the public discussions about LTC reforms were focused on new forms of regulation or funding of existing services, with much emphasis placed on the shifting of managerial responsibilities from public to private bodies and more recognition for consumer choice. At the same time, there was a diffusion of cash allowances, and intensive home care services started to be provided only to those with the highest levels of need: due to rationing, many people were excluded altogether from publicly funded residential or domiciliary care even if they had only modest levels of assets and/or income.

In comparison, the entitlement structure in the residual LTC countries came under much more pressure as the status of care services was originally lower. In these countries, the need for cost containment did not come from within the LTC field, but from other institutions responsible for welfare provision (pensions, healthcare and local social assistance). The policy crisis therefore came to a crucial breakpoint, paving the way for a general, radical reform. A complete re-orientation of the previous LTC system was called for in these countries, which required the start-up of new programmes and the reduction of previous welfare provision in other policy fields. Italy was the only residual country characterized by inertia (Naldini and Saraceno, 2008). This was due not only to the huge public debt but also to the existence from the 1980s of a national universalistic cash-based programme, the 'Companion Allowance', which was progressively extended to meet the increasing demand for care: therefore, coverage rose, not thanks to a new (universalistic) programme, but instead through diffusion in the use of a former cash allowance programme, which became increasingly universalistic, even if not intended to be so (Costa, 2013).

In conclusion, while all European LTC systems had been facing a similar trade-off since the 1990s between the emergence of a new social risk – dependency – and cost-containment pressures, implying a reduction in the existing public services expenditure, they diverged in the way this policy dilemma was institutionally filtered and framed. The Scandinavian universalistic countries faced more severe financial constraints, given the already developed LTC system and therefore adopted cost-containment measures that were not presented as a paradigmatic challenge. In countries with a residual LTC model, demand-side and financial pressures from other welfare sectors were strong, and so existing services were clearly unable to manage a rising social demand: a paradigmatic change and the introduction of national programmes defining new entitlements and corresponding financial constraints were therefore at stake. In Italy and England, nationwide cash-based measures already in place offered an institutional buffer against the need for more dramatic policy changes, and the limited expansion of services (or even their cutbacks) was partially compensated by the diffusion of cash programmes, even if these programmes offered limited resources to beneficiaries.

The politics of LTC reform: How change has taken place

As Lundquist (1980) wrote many years ago, policy actors, not contextual factors, are those who make policies. Moreover, policy changes in the field of LTC are mainly reflected in the institutions regulating the financing and provision of welfare interventions. Our analysis of the political changes that have occurred in LTC policy is based on two concepts: the relevance of policy coalitions and the kinds of institutional mechanisms adopted in this transformation.

Policy actors do not only individually influence LTC policies according to their preferences and interests, but they also interact with each other, participating in (more or less) stable 'coalitions' (Capano and Howlett, 2009; Sabatier, 1988). Moreover, in order to understand the huge variety of institutional processes

Table 4. Actors and coalitions in each LTC system.

LTC model	Users' and citizens' associations	Public Sector institutions (Local authorities, healthcare and pensions institutions)	National government	Social partners (trade unions, social workers associations, provider organizations, etc.)
Universalistic	+++	+	++	+++
Residual	+	+++	+++	+++

Strength of actors: +, strong; ++, very strong; +++, very very strong.

Table 5. Institutional mechanisms.

LTC model	Country	Institutional mechanism
Universalistic	Denmark	Reproduction by adaptation
	Sweden, England (services)	Gradual transformation: layering and displacement
Residual	Germany, France, Spain, Czech Republic	Breakdown and replacement
	Italy, England (allowances)	Gradual transformation: drift

LTC: long-term care.

leading to transformation in LTC, we adopt the typology proposed by Streeck and Thelen (2005) in their approach to evolutionary transformations, which uses the concepts of 'gradual transformation', 'reproduction by adaptation' and 'breakdown and replacement'.[2]

Different coalitions and institutional mechanisms were at work in the different LTC systems (see Tables 4 and 5). In Scandinavian universalistic LTC models, the traditional coalitions supporting public welfare (primarily made up of social workers and users' associations) were very strong and did not allow an open discussion of the weaknesses of the previous LTC arrangements (Meagher and Szebehely, 2013). However Denmark and Sweden followed partially different paths. In Denmark, service providers, social workers and users' organizations were strongly organized as a welfare advocacy coalition. The high level of integration of the LTC policy community resisted any attempt to attack universalism and social citizenship. Political consensus was also grounded on the diffusion of a solid knowledge of social rights among citizens. In Sweden, instead, political parties, associations for people with disabilities and entrepreneurs' associations built a strong and coherent coalition for change. The role played by Social Democrats was important in facilitating this process: in the 1980s, the party started viewing the public sector as a part of the problem, not the solution, and embraced NPM reforms and marketization as the most suitable ways to restrict the public budget for social care. Associations of people with disabilities also played a major role, reinforcing a 'freedom of choice' anti-professional service orientation which helped to raise doubts about the traditional approach to welfare service provision. In England, the role of organizations representing young adults with disabilities and those advocating for more freedom of choice and flexibility were also relevant: a good part of the discussion in the LTC arena was centred on these issues. However, the strong fragmentation of the policy field hampered any attempt to create agreements among the parties. In a care system characterized by a multiplicity of LTC programmes, captured by different users with specific interests, coalition building proved difficult.

Overall, in Denmark, change was characterized by 'reproduction by adaptation'. Market rules and consumerist approaches were introduced, but rationing did not come into the picture: regulation was concerned with both 'securing' and 'extending' the welfare rights of citizens and, as a consequence, encompassed both measures of control and measures of choice/flexibility. Sweden and England shared common features of a 'gradual transformation' process: by altering the access and generosity of LTC programmes and adding new

care measures, an implicit attack on universalism was achieved, focusing attention on a more targeted use of public care services (Glendinning, 2013). In England, quasi-markets were introduced in 1993; afterwards, rationing became the main leitmotiv, through an increase in the level of needs required to qualify for social care and an absence of investment in services for people with lower level needs for help. In Sweden, two mechanisms were at work: 'layering' and 'displacement'. Layering took place through a policy of rationalizing traditional care programmes (through cuts in social expenditures and shifting responsibility for nursing homes from the health to the social care sector) and the creation of a new layer, which separated provision for specific groups of younger disabled people only (Disability Act of 1993). Displacement was obtained through the marketization of the LTC provision system, an approach that was boosted with the change of government in 2006, when a sort of 'freedom-of-choice revolution' was introduced, encouraging municipalities to introduce customer choice models, via a quasi-voucher system. Although the new private provision based system did not replace the old public one, a primary goal of the act was to promote the type of 'differential growth' that Streeck and Thelen (2005) argue is central to the system-changing dynamics established by institutional layering. However, the English case is more complicated, given the fact that the decrease in services' coverage was compensated, at least from a strictly numerical point of view, by the increase in social transfers (Attendance Allowance): in 2011, around 15 percent of the population aged 65+ received it.

In residual LTC models, the role of users' associations was less relevant and was directed at maintaining the existing system. The most important actors were nationally organized neo-corporatist actors, supporting general interests including those of the traditional stakeholders of the welfare state, who saw LTC reforms as part of a broader restructuring/dismantling of the welfare state (a lowering of pensions coverage and an attempt to contain health expenditure in exchange for higher public intervention in fields such as LTC). The horizontal co-ordination of such actors was complemented by the vertical co-ordination of local, regional and national institutions. LTC innovation was seen by local authorities as a tool to shift social expenditures from local to national responsibilities. The multilevel structure of LTC favoured a mutual adjustment process by which the re-centralization process was easily supported by both local and national actors. In Germany, the reform introduced in 1995 was proposed by a coalition government between the Christian Democratic Party and the Liberal Party, with the agreement of the Social Democratic Party and trade unions. Similar coalitions were active in France, Spain and the Czech Republic. France was more hesitant in changing the system. After a long-lasting period of local and national experimentations, and a broad public discussion involving political parties and social partners, reform was finally introduced in 2001. In Spain, the LTC reform was a central issue of the Social Dialogue Agenda between the government, trade unions and employer organizations. In the Czech Republic, the process towards the reform of 2006–2007 took more than 10 years with only incremental changes made to the previous system. The path that led to the reform was similar to the Spanish case. The reform debate and the direction of the changes were inspired by concepts adopted by other EU countries: in particular, the care allowance scheme implemented with the reform was influenced by Austrian and German programmes. This capacity to build a general political agreement around a specific reform project was not present in Italy, where the strong fragmentation of the policy field and the high division between northern and southern regions hampered any attempt to create agreement between the various stakeholders. In addition, the preference for cash programmes already in place dissuaded many stakeholders, including trade unions and organizations for people with disabilities, from supporting any serious reform proposal.

In terms of institutional mechanisms, the change in most of these countries was characterized by a 'breakdown and replacement' process. Reforms explicitly affected the entitlement structure of the LTC system. However, their implementation and maintenance in the following years were not as clearly disruptive as the reforms first appeared to be. In the long run, if reforms brought about sharp discontinuities in the institutional path of LTC systems, they were followed by incremental decisions restricting part of the benefits or delaying further planned developments. In Germany, the funding method of

the LTC insurance was based on social contributions and the definition of a budget ceiling (Theobald and Hampel, 2013). This submission of social rights to strict budget control paved the way for the incremental adaptation that started right after the insurance fund was introduced. The amount of the social contribution had to be raised in order to keep the system in balance. Over the last 15 years, cost concerns have led the government to delay the adjustment of the benefits to inflation, so lowering the real value of care benefits. In Spain, the implementation of the reform proved difficult as regional governments (which had relevant funding responsibility) had differing propensities to develop a new care system. Consequently, cash-based measures were introduced rather than in-kind services, opposing the original goals of the reform (Cabrero and Gallego, 2013). Even in the Czech Republic, recent budget difficulties actually stopped the implementation of the reform, shifting public provision from care services, as originally planned, to cash-based measures (Barvíková and Oesterle, 2013). Finally, in France, cost-containment concerns drove governments to change the system again and to involve private insurance funds in a new national LTC scheme (Le Bihan and Martin, 2013). In Italy, although no reform has been introduced since the 1980s, a process of institutional change took place nonetheless, whereby the failure to provide adequate welfare provision despite external changes actually resulted in slippage in institutional practice (Hacker, 2004): the missing recalibration of the whole LTC system made the existing national cash-based allowance the type of LTC provision used by an increasing number of severely dependent older people, covering around 11 percent of those aged 65+. From this point of view, Italy shared a similar path of change to that of England. The recent development of a huge private and grey (migrant) care market allowed Italian families to respond to their care needs, without any substantial public specific regulatory or financial intervention (Costa, 2013; Van Hooren, 2012).

The effects of policy changes

The policy changes after the onset of the reforms had manifold effects, three of which are particularly important: access of citizens to LTC provision, the quality of professional working conditions in the care sector and the overall impact of such changes on the level of (de)familization of care.

Changes in coverage levels

Figure 1 summarizes a cross-country analysis of changes in coverage levels during the last two decades. Denmark is a case of a welfare system without significant alterations: levels of coverage and public expenditures have only slightly increased overall, but they were already comparatively high. Germany, Spain, the Czech Republic, France and Italy experienced an expansion of coverage and public funding: the first four as a consequence of the previously described reforms that have taken place since the 1990s (or in more recent years in France, Spain and the Czech Republic); the latter as an unattended effect of institutional inertia linked with a growth in the number of beneficiaries of the principal cash-for-care programme (the percentage of older people receiving the Companion Allowance doubled from the early 1990s to the late 2000s). England shares some features with Italy: in both countries, the overall coverage level hides a situation where services have only slightly increased (Italy) or reduced (England) while at the same time allowances have been expanded. Of course, it is questionable whether a monthly allowance of around £200 (England) or €500 (Italy) is equivalent to the lack of, or cuts to, residential and home services. Sweden is the only case where retrenchment took place, although starting from a quite high level of provision: reduction in public spending, falling coverage and stronger targeting of people with higher levels of need can be seen.

With the onset of the recent economic crisis and the resulting austerity plans, many countries have introduced changes affecting the direction and the scope of their LTC system[3] (Table 6). The two Scandinavian countries were the only cases, together with Germany, where there are no indications that the recent crisis has directly hit the LTC system. No cuts were implemented, but signs of a (slight) lowering of public coverage can be identified: in Sweden, there has been increasing use of waiting lists for residential

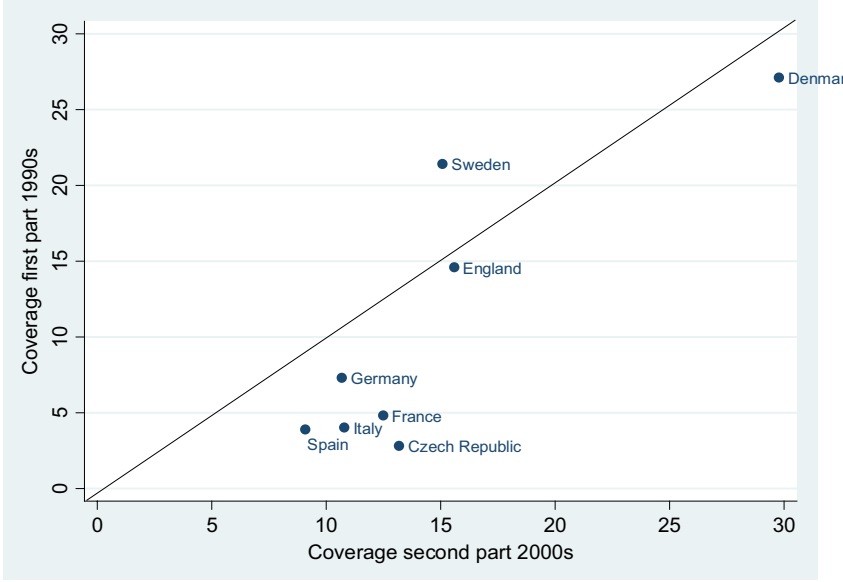

Figure 1. Changes in LTC coverage levels (services and social transfers) over time: the effects of reforms.
Source: Beasley (2010); Organisation for Economic Co-operation and Development (OECD, 1996); Ranci and Pavolini (2013).
Data on home care in the Czech Republic in the 1990s unavailable.

Table 6. LTC reforms in the onset of the economic crisis (2010–2012).

Country	Reform summary
Universalistic model	
Sweden	None, but increasing waiting times in residential care; no financial cuts
Denmark	None, but impact on LTC public employment (decrease); no financial cuts
England	Budgetary cuts to local government
Residual model	
Germany	Slowdown in the preparation of the new LTC reform; no financial cuts
France	Slowdown in the preparation of the new LTC reform (discourse on higher users' participation in costs and on private insurances); budgetary cuts
Italy	Budgetary cuts to local government; increasing waiting times for obtaining care allowance
Spain	Strong slowdown in the implementation of the 2006 LTC reform; budgetary cuts; almost no debate on reforms
Czech Republic	Slowdown in the implementation of the new LTC reform; budgetary cuts

LTC: long-term care.

care (Baroni and Axelsson, 2012), whereas in Denmark there have been cuts to social care personnel – a significant concern in a service-centred LTC system such as the Danish one (Qvist, 2012). In England, the crisis has resulted in financial cuts to local authorities introduced by the national government: out of 2 million older people in England with care-related needs, 800,000 received no formal support from public or private sector agencies before the cuts came into force. With spending cuts under way,

the figure is expected to have passed 1 million between 2012 and 2014 (AgeUK, 2011, cited in Seeleib-Kaiser, 2012).

If we turn to the four countries which innovated the most prior to the crisis, financial cuts have been made in three (Germany being the sole exception). Furthermore, the implementation of reforms has been slowed down or postponed. In Spain, the financial crisis has determined a strong reduction in the universalist orientation of the LTC system (Patxot et al., 2012). In France, new concerns have risen about the financial sustainability of APA, and a public discussion has opened up in order to introduce a second LTC pillar based on private contributions, challenging the original universalist orientation (Morel et al., 2012a). In Italy, LTC coverage has started to decline again: severe financial cuts to local authorities were introduced in social care (including LTC) and waiting times to access the Companion Allowance have increased. Meanwhile, a heated debate is taking place in order to introduce means-testing for the Companion Allowance (Jessoula and Pavolini, 2012). To sum up, while there was a trend towards universalism in many countries in the 2000s, the onset of the crisis has frozen such a trajectory in many welfare states and has even led once more towards retrenchment.

Changes in the care work conditions

Analysis of social policies usually focuses on how reforms and changes affect beneficiaries, their families and public financing. However, as LTC is basically a personal service, it is also important to consider how reforms have affected the sector's labour force. As illustrated by the OECD (2011), there are millions of LTC workers in Europe, and the last decade witnessed an increase in the overall number employed in this field with a higher average annual growth rate of LTC workers than in total employment in most countries. Reforms in the last two decades had a double impact: on the one hand, they contributed to strong employment growth in this field, while on the other, a deterioration of working conditions occurred.

While the rising care needs and the increasing amount of financial resources made available to beneficiaries in many countries played a major role in attracting workers to the field (Williams, 2012), the weakening of the professional quality of LTC services can be mainly attributed to standardization and introduction of freedom of choice principles in care delivery and the consequent reduction in discretionality and autonomy of social workers. On one side, a 'Taylorist-like' approach to LTC service delivery was introduced. In many countries, a tighter definition of the tasks performed by care workers when delivering services was adopted. In Sweden, for instance, under the influence of NPM, there was a related shift from a person-centred organizational model, under which each care worker was responsible for a small number of clients, towards a Taylorized 'assembly-line' model, under which a number of care workers jointly provided specific tasks to a larger number of clients. The Danish and German experiences indicated that a process of standardization of care tasks (and the timing related to provide them) reduced the autonomy of the home care worker. On the other hand, there was a push towards a more consumerist approach, which was strongly supported by organizations for people with disabilities. In most of the countries, an increasing amount of public resources dedicated to LTC has been provided in a way that, in comparison with the past, offers more autonomy to beneficiaries (e.g. cash-for-care programmes integrative or alternative to service provision and more freedom of choice given to users in deciding care arrangements even in a service-provision model) (Brennan et al., 2012; Morel, 2007). Countries like Italy and, to a slightly lower extent, Spain and Germany introduced or strengthened cash-for-care programmes that offered beneficiaries significant discretion in determining its use. Scandinavian countries have strengthened the autonomy of beneficiaries in organizing the services they receive. For instance, the Danish 'freedom of choice' programme allowed users to choose precisely which services they would like to receive. France tried to mix cash programmes and freedom of choice with forms of professional supervision: in the APA, the spending of resources given directly to beneficiaries is subject to approval by social workers.

Finally, in many countries, with a traditional limited level of services' provision (like Italy, Spain and Germany), the rise in care demand attracted a huge number of individual migrant care workers to the care labour market, where they accepted low wages, temporary employment and very difficult working conditions as a consequence of the lack of service organization, low contractual protection and constraining migratory rules (Van Hooren, 2012; Williams, 2012).

Changes in the levels of familization–defamilization

Institutional changes in LTC policies have also had an overall influence over the level of familization–defamilization of care (Esping-Andersen, 1999; Pavolini and Ranci, 2008). According to many authors, defamilization of care implies the growth of in-kind services alleviating families from the burden of directly providing care to the dependent (Esping-Andersen, 1999; Leitner and Lessenich, 2007). In the beginning of the 1990s, an extension of social rights for LTC and a corresponding decrease in family care responsibility were assumed a necessary development in state-funded services. In the course of the following two decades, however, tensions between formal and informal care (Pfau-Effinger and Rostgaard, 2011) have been rising as reforms did not bring about the clear advance towards defamilization of care assumed. The boundaries between formal and informal care have been shifting and blurring, paving the way for intermediate, semi-formal care arrangements (Pfau-Effinger et al., 2009).

In general, most LTC reforms (in Germany and France in particular) have also developed cash-based policies which allow family members to complement the public care system following a path of sustained familization (Saraceno and Keck, 2010). In Germany, more attention has recently been paid to the issue of reconciling care and work, with 2012 legislation allowing employees with a family member in need of care at home to reduce their working hours to a minimum of 15 hours per week for a maximum of 2 years (Schmähl et al., 2012). The most widespread approach in many European countries has been to increase home care in order to reduce the number of people who have to be institutionalized or hospitalized (or to shorten the time of their institutionalization). But home care is an activity requiring the presence of a social network supporting the dependent for many hours. Therefore, a relevant part of care, implicitly, has been left to the responsibility of the informal networks, including relatives, friends and neighbours.

In parallel, renewed attention has been paid to cash-for-care programmes. While the receipt of cash benefits used to be free of any obligations on the beneficiaries, the new tendency has been to increase the volume and extent of these measures by specifying clearer requirements for access and imposing better accountability for the use of these resources. Therefore, the new forms of cash-for-care benefits are not only a low-cost way to pay for care services provided by family members, but they also constitute strong institutional recognition of the care work performed by women in particular, previously considered as an implicit and 'natural' duty. Thus, informal care has been recognized as an integral part of the public provision system. Informal caregivers have been financially sustained and provided with social rights, contributory schemes, respite services and income support (Germany is becoming one of the most interesting cases from this point of view). Part of the responsibility for the actual provision of care has therefore been explicitly delegated from public institutions to private citizens, opening the door to the inclusion of family provision of care within the 'public' care system. The expansion of LTC policies throughout Europe has gone together with the introduction of new forms of regulation aimed at sharing the burden of costs and the responsibility for care provision between the public sector and individual citizens. The process that has been taking place in the last two decades has involved not only the creation of new responsibilities for the welfare state but also the recasting of the relationship between State and the family.

Conclusion

Looking at the process and at the final impact, it seems true to conclude that not all that glittered at the time of reforms has turned into gold.

Institutional change in LTC can be seen as a very complex and long-lasting process. The different reform paths show that the relationship between entitlements and provisions can be recalibrated in different ways depending on the power and level of co-ordination of dominant policy coalitions. In originally universalistic LTC models, the introduction of specific regulations concerning the organization of the care delivery and specific policy instruments allowed cuts in care provision without explicitly discussing the entitlement structure. The social constituency supporting both universalism and generous public expenditure was strong enough to prevent any explicit challenge to the existing paradigm. However, in Sweden and England, cuts and restructuring paved the way towards a hidden road of partial privatization of care. In originally residual models, new social entitlements were introduced by an integrated neo-corporatist policy coalition to radically change the LTC system, but care provision was not always organized accordingly or was often re-adapted to new circumstances. Following the onset of the financial crisis, most of the moves towards universalism were reduced and often reversed towards marketization or refamilization of care provision. Universalism in care provision was introduced as a social right but very often was not actually provided to all people in need. Moreover, broader coverage came partially at the expense of deteriorating working conditions in this labour market.

In order to understand these complex dynamics of change, we adopted a long-term perspective by considering a time span of two decades. Research on institutional change has often focused on explaining why and how discontinuity has happened in inertial, path-dependent, institutional settings. In this task, not only has a wide range of new conceptual tools been invented to account for the various incremental processes of change (Streeck and Thelen, 2005) but a strong emphasis has also been placed on cultural reframing (historical institutionalism) and on strategic actions of reformers (Schmidt, 2008). Reforms are often studied by scholars in institutional change as punctual events that are able to create discontinuity, marking a clear difference between before and after the reform. Consistency and coherence in the transformation process have often been implicitly assumed in order to stress that some sort of discontinuity has actually been in place. In institutional change occurring in the LTC field, however, discrepancy and inconsistency have been dominant: paradigmatic changes as well as incremental changes could be reversed, unexpectedly paving the way for sharp modifications. When the favourable (institutional, fiscal, economic) conditions leading to reforms changed, even the reform process was partially altered, and new institutional mechanisms were introduced to slow down, or even reverse, the reform process. 'Never say the last word' could be considered as the most useful motto for LTC policymakers. If a long-term perspective is adopted, then change appears as a protracted institutional dynamic in which discontinuity and continuity are inextricably linked (Mahoney and Thelen, 2009) and where tensions and contradictions play a crucial role.

The overall impact of such processes is that if the level of universalism has generally increased, or been maintained, *the entitlements* to LTC programmes in all the European countries here considered, this trend has developed alongside limitations *in LTC service provision* due to financial constraints, budget ceiling or sustainability criteria. Furthermore, the practical and organizational conditions of care provision have become much poorer in many European countries, as we showed, through the introduction of a cheap and under-qualified workforce, reduction in provision standards and partial refamilization of care. Finally, universalism was often not explicitly questioned but actually reduced through targeting and stricter need-assessment strategies. A new form of 'restricted universalism' has therefore become dominant, characterized by different institutional forms and with different country configurations. Under the conditions of 'restricted universalism', *all people in need* are explicitly entitled to access the same LTC services, but with a range of restrictions in the provision, quality or access to services. Social citizenship has become not only diversified (Kröger et al., 2003) but even restrained on the basis of substantial economic or organizational criteria.

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Notes

1. We use here the definition of long-term care (LTC) provided by the Organisation for Economic Co-operation and Development (OECD, 2011), as 'a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL)'. Our analysis is restricted only at LTC policies addressing the needs of dependent people aged 65+.
2. Streeck and Thelen (2005) adopt a typology which underlines how, along with more traditional explanations of institutional stability (what they define 'reproduction by adaptation') or abrupt/disruptive institutional change ('breakdown and replacement'), there is a chance of incremental but disruptive institutional change through 'gradual transformation'. Streeck and Thelen propose different types of gradual transformative change: displacement, layering, drift, conversion and exhaustion.
3. Our analysis reaches 2011–2012.

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