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Abstract

The coverage for public long-term care (LTC) programs supporting dependent elderly in Europe is well underdeveloped compared to the risks associated with poor health, longevity and unemployment. To understand explanations for the limited coverage of LTC systems we examine trajectories of LTC insurance reform in Europe. We argue that financial sustainability remains an important constraint to coverage expansion. Coverage expansion takes place as an 'implicit insurance partnership' where public coverage expands by increasing family cost sharing alongside subsidising family caregiving. We document insurance coverage trajectories in seven European countries and survey data capturing attitudes, which we use to explore political drivers. We find evidence suggesting that the expansion of both the 'effective cost sharing' (proportion paid of care paid by families) and subsidisation to family (informal) care is concomitant with LTC coverage expansions.

Keywords: cost sharing, welfare development, long-term cares, family care, Europe.

Contents

1. Introduction

Long-term care (LTC), also known as long term care services and supports (LTCSS), refers to care services for people requiring support in essential facets of daily living.[1] Today they form a corner stone of advanced social protection schemes, alongside policies such as pensions, health care and unemployment support. However, both public and private LTC insurance coverage is far less developed compared to other policy areas, which puts long term care at the forefront of the social protection debates in Europe (OECD, 2011). The provision of LTC have traditionally been understood as a family responsibility (Leitner, 2003) enforced by the fact that the delivery and financing of care for elderly dependents lies at the intersection of universally covered health care services and irregularly supported social care in most European countries.

Even though the differential involvement of the informal care providers is a key denoting feature useful for classifying LTC systems[2] the role of family caregiving and family caregiving preferences offer only a part of the story. Primarily, given the uncertainty on the future costs of LTC, the expansion of public coverage faces resistance due to both short-term cost-containment and longer-term financial sustainability grounds. This, taken together with differences in social and demographic change, helps explain Europe's diversity of LTC systems. Given that governments play an active role in reforming long-term care services; financial sustainability restrictions (e.g., cost containment in welfare services) are an essential barrier to reform, as the evidence on the CLASS Act revealed in the US context (Miller, 2012), However, such restrictions need to be balanced out against socio-political factors such as demands for further public coverage (Costa-Font, 2010b).[3] The results of such trade-offs, if political demands meet economic restrictions, can arguably provide opportunities to expand LTC coverage by reforming means-tested system, and, more generally, by developing 'implicit partnerships' where both government (central, regional and local) and families share part of the costs. However, existing research has not given much attention to the demand and supply drivers of LTC reforms that lead to coverage expansion and, more specifically, to the different potential agendas those reforms could serve.

The reliance on family caregiving can be explained by the continuing role of family care as a main source of LTC provision being reproduced, as well as a preference for family caregivers (Kemper 1992). However, a preference for family provision might crowd out support for

systems with substantial in-kind public sector involvement and when informal carers are not subsidised (Costa-Font, 2010a) . This might in turn have slowed down the expansion of public LTC coverage, compared to other social services during the 'golden age' of welfare development.[4] In later years, family care is often incentivised through various cash-for-care or cash benefit systems which we argue are a key feature for understanding LTC coverage change. These are typically a conditional subsidy to those who meet the needs (and means) test to purchase care, and is found in many Western European countries.

In this paper we aim to explain the determinants of the expansion of coverage, and more specifically the breath of total (though mostly public) insurance coverage[5] in Europe. We argue that coverage expansion generally takes place as an 'implicit partnership', that is, insurance coverage tends to be partial, so that individuals are expected to contribute part of the costs. The latter includes informal care subsidisation, which is generally subject to a higher effective cost sharing. Our evidence consists of LTC reform trajectories in seven West-European countries. We base our exploration on a set of possible motivations for public insurance coverage drawing upon the literature on welfare reform (Pierson 2001; Korpi and Palme 2003; Hacker 2005). The choice of countries has been such that it provides some identifiable heterogeneity in policy trajectories of insurance coverage. More specifically, in explaining coverage expansion we focus on policy in three types of countries: those where coverage expansion reforms have taken place (Germany, France and Spain), those where reforms have narrowed the focus of long-term care coverage (Netherlands and Sweden) and finally those where in the period examined exhibit no major reform (England and Italy).

Evidence is suggestive of an implicit partnership between family and the state. Indeed, our find findings are that of a correlation between entrenched family structures and the LTC insurance coverage. The latter is explained by the fact that the family provision of LTC services represents the status quo in many European countries where welfare development has been slow, and was the more general mode of provision in the pre-welfare state system era. The development of formal care giving systems hence competes with such a status quo in several ways (Steverink 2001; Taylor and Donnelly 2006; Dubois et al. 2008). Our second finding suggests that the expansion of cost sharing was concomitant to insurance expansion, especially in countries where coverage became universal. In contrast, we find that in countries where access to LTC remains means-tested, reform proposals to further coverage

extension are nurtured by the socio-political claims overshadowing financial sustainability constraints.

The paper is structured as follows: the next section contains the reform background. Section three draws upon secondary sources for institutional evidence and reform trajectories in order to explore the motivations for reform in the set of European countries. Section four quantitatively examines the empirical evidence of a motivation for reform, namely public preferences for family care, and the final section provides a concluding discussion.

2. Reform and Long Term Care Coverage

There is an extensive literature (see Korpi and Palme, 2003) on the drivers of welfare reform which also acknowledges the fact that governments face a range of constraints; financial and social. Accordingly, the main constraint to insurance expansion is financial sustainability (Lave, 1985). Financial sustainability is likely to be a major driver given the underdeveloped state of LTC insurance coverage in many countries, together with a pressing demand underpinned by demographic and labour market demands alongside the loosing of family ties (Costa-Font, 2010). However, the mechanisms explaining the extent to which financial sustainability acts as a binding constraint are far from clear-cut. On the one hand, it can be a constraint to reform by limiting the extent of public involvement. It may not necessarily impede reform if coverage expansion encompasses cost sharing and the expansion of funding for family care provision of LTC. The latter implies a new rebalancing the funding sources to meet financial sustainability. Given the higher cost of institutional care, one would expect that cost-containment is an important factor when there is limited support for formal residential care (nursing care) and a favouring of means-testing and local authority involvement in financing. The most obvious way of opposing the expansion of costs is by maintaining the status quo, which in pre-reform countries would typically be limited provision and high family involvement and level of informal care provision.

Cost sharing when a universal LTC funding entitlement is in place has the purpose either to complement or supplement public financing of services, mostly in an attempt to co-opt non-profit providers. It is however not immune to political influence. However, the extent to which political influence is a factor, as we argue below, depends on the initial setting. Reforms that expand coverage tend to create their own political supporters, not only the

middle class who benefit more from universal entitlements, but also private providers gaining market shares. Both explain the electoral appeal of this type of policies to political parties across the spectrum.[6] Long-term care is currently mainly or partly privately financed most countries. This is predominantly through out-of-pocket payments for users failing means tested public provision, where such are in place. However, a small market for private insurance exists and various moves are being made to encourage this form of LTC financing. The great uncertainty of future LTC needs, coupled with the active state of reform has so far resulted in insurance companies being reluctant to offer LTC packages. This reproduces a situation in which the state maintains responsibility for LTC with the individual or the family and in essence forms a constraint for further LTC coverage expansion.

3. Institutional evidence

This section describes the evidence on the main drivers, and particularly points out the role of family caregiving, which we examine more in detail in section four. More specifically, this section traces the reform trajectories of the seven countries using a combination of international (OECD), national reports (ANCIEN studies) and scientific publications. The set of countries were selected to reflect the commonly used welfare clusters; the Scandinavian model (Sweden, Netherlands), Continental Europe (France, Germany), Mediterranean (Spain, Italy) and Anglo-Saxon (England). There is no specific clustering applied to LTC systems, however Wendt and colleagues (2009) has adjusted the classical Esping-Andersen clustering for health care systems which reflects the clustering we are using in this paper.

The models of LTC range from highly integrated systems reliant on public provision with limited private alternatives to highly privatised systems where family is the key provider and the role of the public system is merely residual (Anttonen and Sipilä, 1996). Universal LTC systems were until recently rare, the Scandinavian countries (initiated in the 1940s) and the Netherlands (1960s) being the exceptions. Several countries such as Germany followed in the 1990s, but LTC is as a general rule still provided through means-tested or partial payment systems with considerable responsibility for both financing and provision remaining with the individual and the family. For example, the compulsory LTC insurance in Germany (introduced in 1994) has been criticised for relying on insufficient benefits levels (Rothgang, 2010).

Table 1 outlines the institutional structure of the seven LTC systems analysed. Sweden represents an "old" LTC system, established in the early 20th century, with tax funded universal coverage and a reliance of the state as the provider of care (Karlsson et al., 2010). Similarly, the Netherlands has a universal LTC system established in the 1960s. Care is however funded through social insurance, mainly channelled towards formal residential care or institutional care. Users have a large degree of autonomy and choice over organisation of care (Lundsgaard, 2005, p. 12).[7] In contrast, Italy and Spain represent the other extreme in terms of expenditure and public involvement denoted by low expenditure and care largely provided informally by family, complemented by predominantly publicly funded institutional care (Costa-Font, 2010).

Table 1. Overview of institutional setting of the LTC systems

		Expenditure (% of GDP)	Financing	% private provision	Private insurance
France	Means-tested	1.8	Diversity of actors and sources	>90%	The largest private insurance market in Europe
Germany	Universal	1.3	Mandatory social health insurance scheme	36% private for profit (2)	Private or public insurance providers – no competition
Italy	Universal	0.6 *	Tax funded, fragmented (central, regional, local)	22,0% for profit	No reliable estimates
The Netherlands	Universal	3.8	Mandatory social health insurance scheme	Private but not for profit (90%)	Insignificant role
Spain	Universal	0.65	Mandatory central government	70% private not for profit	Less than 10%
Sweden	Universal	3.7	Decentralised	23% in 2012	Insignificant role
UK	Means-tested	1.1 *	Decentralised	Minor role (9% home help)	Insignificant role
Year		2007			

Sources: OECD Health Data 2010 (October 2010), ANCIEN study country reports.

Germany and the United Kingdom represent countries that have considerably more public resources spent on LTC compared to Spain and Italy; with a significant share supporting

informal care. The devolved nature of the United Kingdom political system has resulted in diverging LTC systems; the Scottish system provides free home care and subsidies for nursing home care whereas in England strict means testing is applied for all services (Comas-Herrera 2010). We here report financial data for the UK as a whole while the following survey data analysis explores the difference between England and Scotland. The German system is unlike the English universal, yet in reality requiring private additional funding, through compulsory LTC insurance was introduced in 1994 (Rothgang 2010). The French LTC system is denoted by a mix private and public care, dubbed "the French compromise". France is also denoted by the largest European market for private insurance (Le Bihan and Martin, 2010).

Formal institutional (nursing home) LTC provision in Scandinavian countries forms a larger part of the total expenditure compared to European counterparts; Sweden and the Netherlands respectively provide 84 and 70 beds per 1 000 population (65 years and older), in nursing and residential care facilities. Italy and Spain, relying heavily on family provision; provide around 20 beds, whereas France, Germany and the UK, form a mid-range category, with 45-55 beds per 1,000 population (OECD, 2010). Total LTC spending is the highest in Sweden and the Netherlands (3.5 per cent), whilst Mediterranean and continental countries rank the lowest (see table 1).

Our argument on the role of family care as a facilitator of LTC reform rest on policies which support this type of care. A prominent rather recent trend is the prevalence of user choice in the shape of cash-for-care schemes, which varies significantly between the countries. The extent and trajectory of cash-for-care type schemes illustrates the extent to which family care is seen as a valuable LTC provision. Table 2 outlines the cash-for-care schemes of the countries of our sample. Particularly noticeable is the differences in coverage and the national "view" of who should be the key provider of care – the state, the family or the market. In section 4 we examine support for family care to understand the drivers of such a trend.

UK and Germany both promote "cash-for-care" schemes, albeit more standardised in Germany which universally offers a choice between formal care or cash payments as part of the national LTCI. The English LTC system cash payments are known as direct payments and are often used to employ informal carers, however with some restrictions on employing relatives (Glendinning 2008). Carers can also receive direct payments, generally as a one-off

payment, for example for training. Cash-for-care was institutionalised in France in 2002 through the scheme Allocation personnalisée à l'autonomie (APA), seeking to introduced increased autonomy over care services receipt (Le Bihan and Martin, 2010). In Sweden cash payments play a smaller role and are generally concentrated to young disabled rather than elderly with care needs.

Table 2. Overview of cash-for-care schemes and their role as part of LTC financing.

	Cash-for-care scheme	Initial policy setting	Cash/ in kind (service)	Percentage covered	Size of benefits	Family versus state care
Germany	General LTCI	Foundation of LTC policy	Cash or in kind services	11	level 1: €215 level 2: €420 level 3: €675	Family
France	Allocation personnalis´ee d'autonomie (APA)	Foundation of LTC policy	Cash	7.8 (on population 60+)	Average amount: €494/month	Mixed/State
Italy	Indennit`a di accompagnamento	Core position within implicit LTC policy	Cash	10	Flat-rate payment, 2009: €472	Family
Spain	Sistema para al autonomía y la atención a la dependencia (SAAD)	Foundation of LTC policy	Cash or in kind services	3.3	200-500 euro per month	Family /Mixed
Netherlands	Attendance allowance	Flexibility of established LTC policy	Cash or in kind services	1.4	Average budget, 2006: €11,500/year	State/ professionals
Sweden	Decentralised attendance allowance	Flexibility of established LTC policy	Cash	0.1	487/month	State/ professionals
UK	Individual budgets	Flexibility of established LTC policy	Cash	0.5	Depending on need	Mixed/State

Sources: ANCIEN study country reports and OECD Health data and documentation.

The review of the seven systems highlights the various challenges. Firstly, in terms of the countries experiences and response to cost-containment pressures wen note that Sweden and the Netherlands, with their well-established LTC systems face less of a financial sustainability pressure than countries, such as Spain where the system is new, and the novel perception of dependency as a social risk will induce rising demand (Costa-Font and Patxot 2005). However, also well-established LTC systems tend to revert from more expensive institutional care to home care provision, provided mainly by professional carers but also to an increasing degree informal carers (Sundström et al. 2002). Italy, in providing only limited

cash-based support and relying on the family as the caring agent, exhibits clear cost-containment considerations. Political debates over LTC reform arise from time to time, but has to date not lead to reform change, which highlights the relevance of these pressures (Tediosi and Gabriele 2010). France is a particular case, where the focus has traditionally been on formally provided care, in institutions or at home. The large private insurance market (the largest in Europe) provides payments mostly used as supplementary benefits to 'top-up' payments from other sources and is argued to have arisen as a response to the limited benefits provided through the APA rather than driven by a desire for private insurance per se (Bihan and Martin 2010). Finally, in all countries the size of the cash benefits (see table 1) is uniformly too low to be considered as real income replacement for a full-time informal carer. In Germany social assistance is often used to complement the insufficient payments (Rothgang, 2010).

Incentives for private providers are discernible in some countries, particularly in France, Germany and Italy, where, compared to Netherlands and Spain, private provision tend to be for profit rather non-profit (Riedel and Kraus 2011). In contrast, Sweden and UK have somewhat smaller markets for private provision (consistent with how they fund health care), however still dominated by large for-profit enterprises, clearly in a position to form a strong lobby (Trydegård and Thorslund 2010). As discussed above, a large role of co-payments induces the need for supplementary insurance, and also the possibility of opting out enhances the role of for profit providers. This is evident in the French private LTC insurance market which began to develop in the mid-1980s, and offers a variety of products, both individual and collective, which guarantee a monthly cash benefit in the event of dependency (Bihan and Martin, 2010). France is however a unique case; LTC insurance markets are in other countries generally poorly developed. In contrast, Germany and Spain stand out as countries with particularly high proportion of co-payments (see table 1); in Spain co-payments account for 25 per cent of community care and 75 per cent of residential care (Costa-Font and Patxot, 2005) and in Germany, due to capping of insurance benefits private co-payments and means-tested social assistance play an important role in financing, particularly nursing home care (around 30 per cent of all residents receive social assistance) (Rothgang, 2010).

To some degree, pleasing the electorate through gaining political legitimacy is however a distinct feature in the introduction of LTC systems which have come about after years of debate in countries such as Germany, the Netherlands, Spain and France, which have all also

importantly included more or less extensive coverage increases (Roit and Bihan 2010; Colombo 2011). Although, these systems are universal in the sense that they only apply needs tests, they all have been designed to embrace significant cost sharing schemes. The French system exemplifies the complementarity between public and private financing which is argued to benefit the middle class in allowing a choice between a large variety of financial options to fund long term care services and a interlinked variety of provision options (Bihan and Martin 2010). Conversely, it is argued that middle-income households are those that suffer the most from the financial calibration of the LTC support in France, but in the current system also in the UK (England) (Commission on funding of care and Support 2011). In fact, means-testing in the absence of an individual spending cap hits middle-income earners the hardest, and this was the status quo in the countries with more recent LTC systems (all but Sweden and the Netherlands). In Spain the reform was the golden welfare proposal of a socialist government with limited majority in parliament to win the support of middle classes for a re-election (Costa-Font and Patxot 2005).

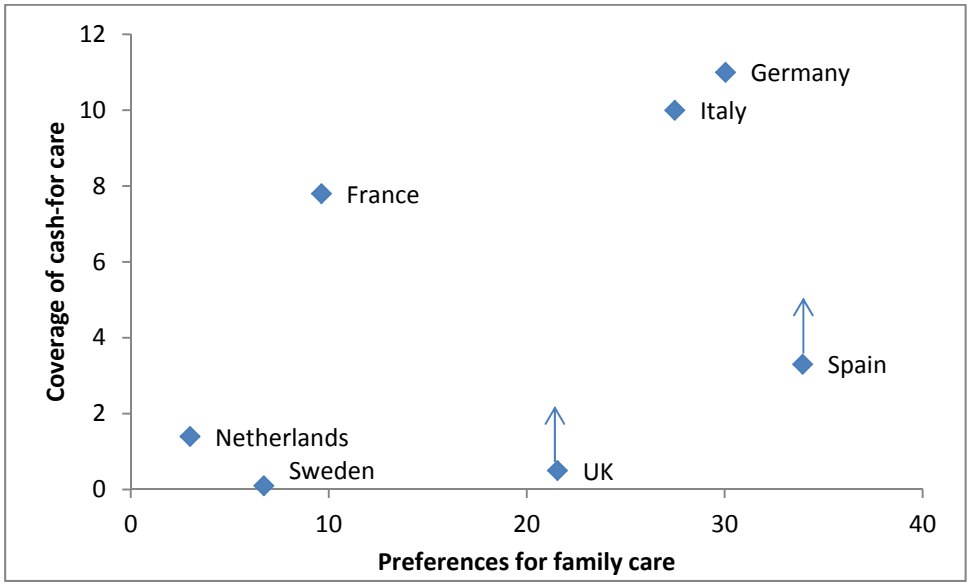
4. Survey data evidence on preferences for family care

With the data at hand we have no opportunity to complement coverage dynamics over time with data on care preferences. However, analysing cross-sectional evidence in light of institutional evidence on the prevalence of family care provides an alternative approach with the aim of mapping the possible coverage reform. We here use Eurobarometer survey nr 67.3 from 2007, which provides a representative sample of respondents' attitudes towards long term care financing and provision across European countries. The Eurobarometer data was collected after the main choice reforms in most of the countries, except for Spain. However, the motivation of this analysis is not to claim causality but to empirically substantiate some of our claims through the observation of the relative preferences for family care. As discussed above, coverage expansion reforms almost uniformly rely on the family as a key provider, and when family care preferences intersect with strong political coalitions we interpret this as a driver of the reform agenda in LTC.

Figure 1 illustrates the correspondence between the extent of family care preferences among the surveyed population in each country and the coverage of cash for care systems (as a percentage of population). As the figure shows cash-for-care systems are consistent with incentivised family care, which as we argue in this paper - is driving reform. Spain appears to

be an outlier here insofar as it does not align with Italy in expanding insurance coverage, and France does not align with Germany countrywide social insurance approach. In addition, regional heterogeneity in those countries is wide and hence country averages mask important regional differences. However, regional clustering is here primarily used to illustrate change.

Figure 1. Familism and LTC coverage schemes (Percentage by country)



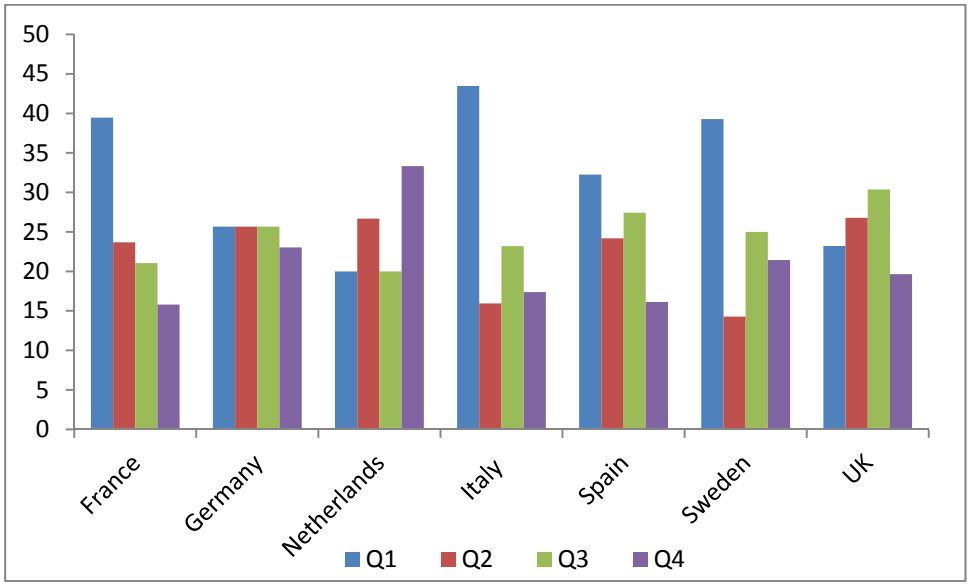
Note: Cash-for-care coverage from table 2. Familism measure based on survey responses from Eurobarometer 67.3 (2007) question QA7a.
Arrows indicate current reform trajectory: UK experimenting with individual budgets while Spain is expanding LTC coverage at a regional level.

We then move to consider family care preferences among socio-economic groups which can tell us something about the role of potential socio-political demands for coverage. We use income quartiles as an indicator of socio-economic belonging. In Figure 2, the bars indicate the percentage of respondents who prefer family caring for elderly parents rather than nursing home or formal carers at home, by income brackets.

The Netherlands and the UK exhibit similar preference structures with regards family care preferences, which only increase slightly with income. In contrast, in Sweden the lowest quartile has the highest preference, followed by quartile 3 and 4. In Germany family preferences are evenly distributed across the income distribution, which well corresponds to the universal social insurance system with highly institutionalised choice. The preference structure is the opposite in Italy, where it is low income earners who prefer family care. Also

the character of its uniformity can explain the Italian distribution; the Italian cash-benefit system resembles an income supplement. The same distribution is found in France, but with less typical differences. Spain on the other hand shows a much higher family care preference among the middle-income earners, which can afford market contracted care. Hence, in all countries with limited coverage expansion we find that family care is a high priority among middle-income groups (except for Italy), which nurtures some claims that socio-political demands might stand behind reform of opportunities, which need to be balanced out with financial constraints. Cost sharing under that scenario appears as the institutional mechanism in place to accommodate reform and financial constraints.

Figure 2. Preferences for family care by income category



Source: Eurobarometer 67.3 (2007), Question QA7a.

5. Conclusion

This paper has sought to examine the main determinants of long term care coverage reform in Europe, and specifically examined the role of subsidising family care and the widening of the effective cost sharing which opens up both financial (cost-containment) and political opportunities for coverage expansion. Drawing on both institutional and quantitative analysis of European survey data, we have documented evidence from reform experiences indicating that countries which have reformed to expand coverage, have done so by introducing cost sharing schemes and subsidising informal caregiving where a prime example is Germany.

The former suggesting that cost sharing and incentivising family caregiving might serve as an implicit partnership, which helps the adoption of coverage expansion reforms.

Nonetheless, the expansion of the breath of insurance coverage for long-term care is not without problems. Some pressing issues include dealing with potential moral hazard problems associated with the public coverage of long-term care. Well- designed cost sharing structures can to an extent provide a solution. Indeed, one of the downsides of subsidising family care is the so-called 'woodwork effect', whereby individuals that already provide care for free, request a subsidy once an insurance scheme is put in place (Elken et al, 2013). Finally, it might be argued that, in many countries, LTC coverage expansion is also made a necessity by demographic shifts and changing family structures, rather than a desire to extend coverage per se. Cost sharing and subsidies act to share costs and responsibilities that the state is unwilling (has not political support) or indeed unable (has no budget) to meet in full. Hence, based on this evidence, partnership schemes are likely to be developed further. That such an approach also neatly corresponds with fiscal sustainability constraints, and is in accordance with a balance between individual and social responsibility in the funding of long term care.

Notes

[1] Need for LTC is commonly discussed in terms of ADLs "Activities of Daily Living" and IADLs "Instrumental Activities of Daily Living".

[2] The existing heterogeneity in long term care structures, along with the pressures of ageing populations justify the European Union's 'soft involvement' under the Open Method of Coordination and, accordingly, the setting of objectives for national care systems with focus on access, quality and sustainability (Huber et al. 2008:16).

[3] For example in the England the current means-tested system implies a possible loss of up to 80% of total wealth for individuals within certain wealth segments corresponding to middle class status. (Fairer Care Funding: The Report of the Commission on Funding of Care and Support July 2011)

[4] LTC did not figure in International Labour Organisation Convention 102 of 1952. Early development of social security is related to meeting the demands for protection of organized labour and supporting the male breadwinner model.

[5] The breath of coverage expansion refers to the 'universality in the access' to care rather than 'universality in the financing' which is mainly a question of the depth of insurance cover.

[6] Le Grand argues that the demands of the middle class carry a heavy weight for welfare reform (Le Grand 2007:156).

[7] The Algemene Wet Bijzondere Ziektekosten (AWBZ) established in 1968 to cover previously uninsurable health care costs.

References

Anttonen, A. and J. Sipilä (1996). "European Social Care Services: Is It Possible To Identify Models?" *Journal of European Social Policy* **6**(87).

Arksey, H. and C. Glendinning (2007). "Choice in the context of informal care-giving." *Health & Social Care in the Community* **15**(2): 165-175.

Bihan, B. L. and C. Martin (2010). "Reforming Long-term Care Policy in France: Private–Public Complementarities." *Social Policy & Administration* **44**(4): 392–410.

Blomqvist, P. (2004). "The Choice Revolution: Privatization of Swedish Welfare Services in the 1990s." *Social Policy & Administration* **38**(2): 139–155.

Colombo, F. (2011). Help Wanted?, OECD Publishing.

Comas-Herrera, A., L. Pickard, et al. (2010). The Long-Term Care System for the Elderly in England. ENEPRI RESEARCH REPORT. 74.

Costa-Font, J. (2010a). "Family ties and the crowding out of long-term care insurance." *Oxford review of economic policy* 26 (4): 691-712.

Costa-Font, Joan (2010b) Devolution, diversity and welfare reform: long-term care in the 'Latin Rim' *Social Policy and Administration*, 44 (4). 481-494.

Costa-Font, J. and C. Patxot (2005). "The Design of the Long-Term Care System in Spain: Policy and Financial Constraints." *Social Policy and Society* **4**(01): 11-20.

Downs, A. (1957). An Economic Theory of Democracy. New York, Harper and Row.

Dubois, M. F., N. Dubuc, et al. (2008). "Correlates of the Perceived Need for Institutionalisation among Older Adults without Cognitive Impairment." *Gerontology* **54**(4): 244-251.

Eiken S , B Burwell & K Sredl (2013). An Examination of the Woodwork Effect Using National Medicaid Long-Term Services and Supports Data. *Journal of Ageing & Social Policy*, 25 : 134-145.

Glendinning, C., Challis, D., Fernández, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. () (2008). Evaluation of the Individual Budgets Pilot Programme: Final Report,. York, Social Policy Research Unit, University of York.

Goodin, R. E. and J. Le Grand (1987). *Not Only the Poor: The Middle Classes and the Welfare State*. London, Allen & Unwin.

Hacker, J. S. (2005). Policy Drift: The Hidden Politics of US Welfare State Retrenchment. Beyond continuity : institutional change in advanced political economies W. Streeck and K. A. Thelen. Oxford ; New York Oxford University Press**:** 40-82.

Huber, M., M. Maucher, et al. (2008). Study on Social and Health Services of General Interest in the European Union. Brussels., DG Employment, Social Affairs and Equal Opportunities.

Karlsson, M., T. Iversen, et al. (2010). Scandinavian long-term care financing. Health Economics Research Programme Working Papers, University of Oslo.

Kemper, P. (1992) "The use of formal and informal home care by the disabled elderly" *Health Services Research* **27**(4): 421-451.

Korpi, W. and J. Palme (2003). "New Politics and Class Politics in the Context of Austerity and Globalization: Welfare State Regress in 18 Countries, 1975–95." *American Political Science Review* **97**(03): 425-446.

Lave, J. (1985). "Cost-containment policies in long-term care." Inquiry **22**(1): 7-23.

Le Grand, J. and W. Bartlett (1993). *Quasi-markets and social policy* Basingstoke, Macmillan Press.

Leitner, S (2003) "Varieties of familialism: The caring function of the family in comparative perspective" *European Societies* **5**(4): 353-375.

Lundsgaard, J. (2005). Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care. OECD Health Working Papers. Paris, OECD. 20.

Mellor, J. M. (2001). "Long-term care and nursing home coverage: are adult children substitutes for insurance policies?" *Journal of Health Economics* 20(4): 527-547.

Miller, E (2012). The Affordable Care Act and Long-Term Care: Comprehensive Reform or Just Tinkering Around the Edges? *Journal of Aging & Social Policy* 24 (2): 101-17
OECD (2011). Help Wanted? Providing and Paying for Long-Term Care, Organisation for Economic Co-operation and Development.

Pickard, L., A. Comas-Herrera, et al. (2007). "Modelling an entitlement to long-term care services for older people in Europe: projections for long-term care expenditure to 2050." *Journal of European Social Policy* **17**(1): 33-48.

Pierson, P. (2001). *The new politics of the welfare state* Oxford, Oxford University Press.

Riedel, M. and M. Kraus (2011). The Organisation of Formal Long-Term Care for the Elderly: Results from the 21 European Country Studies in the ANCIEN Project. ENEPRI RESEARCH REPORT, European Network of Economic Policy Research Institutes (ENEPRI). **95**.

Roit, B. D. and B. L. Bihan (2010). "Similar and Yet So Different: Cash-for-Care in Six European Countries' Long-Term Care Policies." *The Milbank Quarterly* **88**(3): 286–309.

Rothgang, H. (2010). "Social Insurance for Long-term Care: An Evaluation of the German Model." *Social Policy & Administration* **44**(4): 436–460.

Steverink, N. (2001). "When and why frail elderly people give up independent living: The Netherlands as an example." *Ageing & Society* **21**(01): 45-69.

Sundström, G., L. Johansson, et al. (2002). "The Shifting Balance of Long-Term Care in Sweden." *Gerontological Society of America* **42**(3): 350–355.

Taylor, B. J. and M. Donnelly (2006). "Professional Perspectives on Decision Making about the Long-term Care of Older People." *British Journal of Social Work* **36**(5): 807-826.

Tediosi, F. and S. Gabriele (2010). The Long-term Care System for the elderly in Italy. ENEPRI RESEARCH REPORT, European Network of Economic Policy Research Institutes (ENEPRI). **80**.

Trydegård, G.-B. and M. Thorslund (2010). "One Uniform Welfare State or a Multitude of Welfare Municipalities? The Evolution of Local Variation in Swedish Elder Care." *Social Policy & Administration* **44**(4): 495–511.

Wendt, Frisina and Rothgang (2009), " Healthcare System Types: A Conceptual Framework for Comparison" *Social Policy & Administration* **43**(1): 70-90.

Zigante, V. (2011). "Subjective Well-being as a Measure of Welfare and Equity: The Case of Choice Policies in Health Care." *CESifo Economic Studies*.

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