Role of public and private actors in delivering and resourcing long-term care services

Dario Barbieri (dario.barbieri@bepconsulenza.it)
Luca Ghibelli (pierluca.ghibelli@cgm.coop)

Transforming Care Conference
Polytechnic of Milan
June 26-28

(7.097 words)

Abstract

The article presents the role of public and private actors in delivering and resourcing long-term care, describing the main types of stakeholders within LTC, formal, informal and mixed. The document presents the possible impact of diverse stakeholders' involvement in LTC and social investment on fostering well-being and active ageing. The relevance of social investment and more generally the importance of social care as a key instrument to overcome the difficulties faced by the public sector, and the problems of LTC privatization trends are also recognized.

This article describes how the growing presence of different actors in the supply and resourcing of long-term care programmes can affect active ageing policies, and impact on the well-being of older people in need of care.

Country specific information have been provided by partners of the European Project SPRINT[1] and the varied situation of LTC in Europe is presented, in order to focus on the role that public and private actors plays in a given institutional setting.

The analysis will take into account different theoretical approaches, mainly from the public management and health care management literature. A network framework is employed, assuming that coordinating the actions of the various actors involved is crucial to guarantee a well performing LTC system. Promoting policies of active ageing cannot be separated from an appropriate organization of the network of different stakeholders, including public, private and not for profit.

The document focuses on the effective role played by LTC actors at the country, regional and local levels, discussing the trends at the European level, their characteristics, problems and potentialities. There is no "ready to apply" solution; however it is important to engage stakeholders in a process across territorial and institutional organizational layers in order to foster active ageing policies.

[1] Role of public and private actors in delivering and resourcing long-term care services.

Key messages

1. LTC service delivery involves a multitude of public, private and not for profit actors, operating at the central, regional and municipal level, with varied degrees of interdependence depending on cultural, organizational and institutional variables. Analysis of the networks in each country should take into account how these variables affect the practices of LTC.
2. The growing long-term care needs in all EU countries have changed the role of traditional actors such as the state, local authorities and families in funding and delivering care services. In some countries this has also increased the relevance of new actors, such as voluntary and user-led organizations, social enterprises, long-term care insurance funds, and private businesses.
3. A variety of stakeholders can be involved in planning and managing LTC policies at the central, regional and municipal level. Training, educative and communication policies could help empower local communities. The public sector needs to design policies to improve capacity and coordination skills of public stakeholders at different levels of government, and determine ways in which local government and other local-level stakeholders are able to increase the efficiency, equity and sustainability of public services and public spending.
4. A successful welfare mix would take into account the different characteristics of the actors delivering the services and the needs of the elderly people, in order to find equitable and affordable solutions in LTC.
5. Active ageing is a possible goal of LTC policies with an aim of social investment: stakeholders' interaction in network-type relations might help develop and promote prevention and rehabilitation measures in order to reduce current and future needs for assistance and promote integration of LTC with other health and social care arrangements, foster quality of care and equity in access and, as a result, promote the well-being of care recipients.
6. There is potential for increased integration of care systems with health care, which might make them more flexible. Developing adaptable services to suit individual needs and individual lifestyles, supporting the establishment of multi-professional teams, and structures facilitating coordination and cooperation with other formal and/or informal care (including mobility and transport), and improving communication flows, planning and care delivery with informal carers could offer further improvements.

Table of contents

List of Figures

Acronyms and abbreviations

EU: European Union
ICT: Information and Communication Technology
LTC: Long-Term Care
MoLGs: Ministry of Local Governments
NGO: Non-Governmental Organization
OECD: Organisation for Economic Cooperation and Development
PAOs: Public Administration Offices
SI: Social Investment
SPRINT: Social Protection Investment in Long-Term Care
wp: Work Package

1 Introduction

In Europe, the older population is growing and the birth rate is falling (OECD, 2010). With a larger older population and a comparatively smaller working age population the economic balance of publicly-funded health and social services including healthcare, social care and pensions will be put under stress (Holmes, 2011). The European Commission underlines that social investment, innovation, efficiency are the keywords of a new approach towards LTC in Europe: "there is growing demand for care due to an ageing population, a shortage of formal and informal carers, a lack of social protection against long-term care dependency" (Fransen, 2014: 3). A variety of initiatives are being promoted with the aim of reducing the need for care in different countries, dependent on the institutional context in each country: active and healthy ageing, improving the capacity for independent living, successful rehabilitation as early as possible, and the use of ICT in a drive for higher productivity.

Long-term strategies for social investment might combine policies of prevention, health promotion and rehabilitation with promoting systematic productivity increases in care delivery and measures that raise the capacity of frail older people to manage self-care and independent living. As the proportion of people of working age falls, recruitment of formal carers may become more difficult, and increasing female labour force participation rates and higher retirement ages will reduce the pool of informal carers (European Commission, 2013). At the same time, the demand for LTC will grow: a way needs to be found to meet increased demand for care while improving the efficiency and efficacy those involved in providing care.

Traditional LTC actors such as the State, municipalities and families are changing their role in funding and delivering services: new actors are coming on the stage, including social enterprises, long-term care insurance funds, not for profit associations but also private for profit providers – varying between different EU countries. Managing this network of actors, with diverse and often conflicting goals, is therefore important. The welfare mix varies considerably among the different EU countries, in terms of the proportions of formal and informal care rate and also the extent of private insurance, the mechanisms of funding, and so on. There is a manifest diversity in the way formal care is organised (e.g. by public, for-profit or NGO providers), financed (e.g. via general taxation, obligatory social security, voluntary private insurance or out-of-pocket payments) and delivered (e.g. as home care or institutional care) (European Commission, 2013). The key debate about LTC in Europe concerns the importance of raising the productivity of care delivery, mitigating frailty and disability, fostering active ageing policies and postponing the need for LTC services.

This articles aims at presenting the private, public and not for profit actors involved in delivering and resourcing long-term care services in Europe and briefly outlining the existing types of long-term care and the actors involved.

The research is the product of a review of academic literature and analysis of policy documents, in particular from the OECD and the European Commission. Country-specific information has been provided by partners of the SPRINT project. The

information contained in the document is in part the result of primary information collection from key informants and in larger part of the review of country analysis documents collected from secondary public sources.

The document is organized as follows: chapter 2 presents the aims and objectives of the analysis; chapter 3 describes the methods of analysis employed; chapter 4 gives an overview of the most important contributions of the literature on networking LTC service delivery; chapter 5 describes the networks of LTC players, their interaction and roles played and provides a summary of the characteristics of the LTC actors in Europe. Finally, some considerations concerning LTC and active ageing are discussed and the conclusions summarize the main findings and policy suggestions which emerged from the analysis. In the annex, data about each country case are presented.

2 Aims and objectives

The aim of this work is to promote understanding and document how the growing presence of different actors in the supply and resourcing of long-term care programmes affects active ageing, economic growth and the wellbeing of older people in need of care.

In the public sector, political, social and organizational dimensions should be carefully taken into account. Stakeholders' relations are key drivers of public welfare performance. Public management literature highlights that the presence of different interests in strategic decision-making is physiological and that balancing goals of different actors in a cooperative way can be a successful strategy. The underlying idea is that each actor's interests can be better satisfied through the achievement of a "common good" that goes beyond their specific interests, but at the same time gains their approval (Borgonovi, 1984; Mintzberg, 1996; Hughes, 1998). Based on these premises, our purpose is to investigate the role played by the actors of LTC in Europe. The aim is to map the framework of LTC delivery in order to (1) identify the roles of different actors that have a stake in the issue and (2) understand their potential contributions toward meeting the beneficiaries' need. The deliverable aims at answering the research question: how can we understand the role of the actors within long-term care in different countries and how will this influence active ageing, economic growth and well-being?

The analysis will first set out the theoretical framework in which the research has been produced: the focus is on the network-type relationships existing among the LTC actors delivering services in European countries. The delivery of LTC services can be done by one actor, but can also be the product of a complex network of public and private, profit and not for profit organizations. Collaborative relations can help to foster virtuous processes with the aim of in an efficient way to satisfy citizens' needs. As it will be discussed below, each of the actors involved plays different roles. Public organizations are usually responsible for setting policy, providing funding and generally defining the regulatory framework, and in many cases also provide services directly. Private ones are usually involved in the delivery of services, and in some cases they can also represent a key variable for the functioning of the system – for example by providing insurance. Not-for-profit organizations can also fill gaps where public provision falls short in terms of quality or quantity or private market-type products are not affordable, and they may sponsor community-type experiments. Social innovation can also be rooted in innovative practices derived from social finance and the experience of social enterprises.

Advocacy is another role often played by users, different organizations and private delivery profit as well as not-for-profit actors. This is not limited to formal care: informal care. Network relationships are included in variegated institutional and cultural settings, and vary across countries. It is, however, not the aim of this research to investigate how these intervening variables may influence the evolution of the role of the different LTC providers. The characteristics of the actors and the rules designed to coordinate their actions are influencing the LTC providers

and thereby the promotion of successful active ageing policies and, more generally, on the well-being of the citizens.

3 Methods

This research uses a qualitative research framework, combined with use of literature and official documents. Following Berg's (2001) approach to "Designing Qualitative Research" this document recalls Berg's precepts that "the research process begins with an idea and only a rough notion of what is to be researched. As you read and collect information from the literature, these rough questions must become clearer and theoretically more refined" (Berg 2001: 25). In particular, we adopt Glesne's approach to the relationship between literature review and fieldwork in qualitative research:

> Some qualitative researchers argue against reviewing the literature until after data collection has begun, for fear that the researcher will be unduly influenced by the conceptual frameworks, research designs, techniques, and theories of others. Although this is a possibility, I think that literature should be read throughout the research process. Reading about the studies of others allows to: verify that you have chosen a justifiable topic; find focus for your topic; inform your research design and interview questions. (Glesne 1999: 20).

First, we undertook an extensive analysis of the existing literature on LTC in Europe, taking into consideration public sources and such secondary sources as national and EU/OECD reports, in order to collect data about the characteristics of the LTC in Europe and to present what are, in a comparative perspective, the relevant actors. We base our analysis mainly on public, long-term and health care management literature in order to lay out a theoretical framework based on a "network" analysis and on the public management debate about the trends in the role of LTC actors.

4 Review of literature

Successful LTC policies are based on well-functioning networks. Policy networks, to be effective, need the participants to share a common background and to be able to manage innovation or to face new problems coming from a turbulent environment, being necessary for an organization to be part of a "community-level" system (Powell et al., 1996). To manage this type of network, the concept of "collaborative advantage" can be introduced into the analysis for studying the interrelations and the interdependence relations between the actors involved in this process – public and private, central and local, etc. Theories of cooperation and partnership, in a network perspective, can be considered. Cooperation and coordination require relationships based on trust (Siverbo, 2004). Networking cooperation has often been a framework to enhance public performance (Robins et al., 2011).

As reported in Berry et al. (2004), networking was first identified and assessed for policy management and governance in rural development and regional councils (Gage, 1984); later, intergovernmental scholars saw networking as a method of management to incorporate the horizontal and vertical relationships necessary to deliver intergovernmental programs effectively (Gage and Mandell, 1990; Agranoff, 1986). By the late 1980s, academics focused on intergovernmental management (Agranoff, 1986), taking into consideration the success of federal policy implementation (Peterson et al., 1986), and defining typologies and characteristics of networks (Gage and Mandell, 1990). By the mid-1990s, network research had become an integrated part of public administration studies and health care management. Following movements "hollowing out" and "reinventing" the state, the focus of scholars, especially in the US, shifted to cover the importance of networks in managing delivery systems for public services (Agranoff and McGuire, 1998; O'Toole, 1997; Provan and Milward, 2001). While this concept does not focus primarily on LTC, it does seem, given the diversity of actors and the common split between financing and delivery, to be a relevant concept. There was a parallel growth in this debate in Europe (Kickert et al., 1997; Mayntz 1993; Marsh and Rhodes, 1992). Provan and Milward (2001) argue that the idea of a service-implementation network is closely tied to the notion of implementation structure, and institutional-level factors, such as professional norms, are positively related to network involvement. Their model of network effectiveness includes elements of network structure and context.

Public administration has been likened to a supermarket delivering a wide variety of public services, disciplined by market competition (Olsen, 1988). In this sense, the contracting of service delivery to non-governmental organizations is a relevant issue, especially for LTC policies. National and local governments are institutions different from the private firms. The main difference (see Boyne, 1998) is in the large use of legitimate political authority (as opposed to market authority) that characterizes governments. For this reason it is very relevant how political and market competition interact in the selection of the form of service delivery. Modes of public service delivery can be various. An increase in service delivery to private (for profit and/or non-profit) actors is reported in many countries, especially in LTC

(see below for details). How much and for which services governments should contract out provision is debated both in academia and in the practitioners' community (Longo and Barbieri, 2013). Some studies suggest that privatization of public services can at least in some cases improve the quality of the services (Cooper, 2003; Savas, 2000).

Public service delivery is disciplined, but also enabled, by citizens' empowerment and social partnerships. Interdependent public and private actors need to cooperate, persuade, bargain, and build trust (Barbieri and Salvatore, 2010). Public administration is organized on the basis of authority but also as competition and cooperation (Olsen, 2005). This needs to be reflected in analysis of complex public policy problems, such as LTC. Decentralization and privatization of public service delivery in itself cannot be considered as an isolated driver of efficiency (Westendorff, 2002). It is argued in the literature that governments might improve efficiency and quality of public service delivery while employing autonomous and specialized public agencies, delegating the delivery to another organization, or pooling with complementary public organizations (Barlow and Röber, 1996; Fernandez, 2007; Ferri and Graddy, 1991; Goldsmith and Eggers, 2004; Hood, 1991; Kettl, 1993; Langfield-Smith and Smith, 2003; Verschuere and Barbieri, 2009).

A large variety of stakeholders can be involved in participatory methods of planning and managing LTC policies at the municipal level. Integration of local communities, training, educative and communication policies encouraged and public service delivery schemes can have mechanisms for customization of the public policies. The key challenge is to find ways to improve capacity and co-ordination among public stakeholders at different levels of government, and for local government and other local-level stakeholders to increase the efficiency, equity and sustainability of public services and public spending (Charbit, 2011).

Overall, this points to a need for concrete empirical analysis of the interaction between stakeholders within LTC, while bearing in mind that national systems are context and historical specific.

5 The role of public and private actors in LTC delivery

Social investment (SI) within the context of long-term care can be defined as the welfare expenditures and policies that generate equitable access to care to meet the needs of ageing populations, improve quality of care and quality of life, increase capacities to participate in society and the economy, and promote sustainable and efficient resource allocation.

Social investment "means policies designed to strengthen people's skills and capacities and support them to participate fully in employment and social life" (http://ec.europa.eu/social/main.jsp?catId=1044, accessed 31 October 2016). SI for long-term care should balance the contributions and benefits expected for society as a whole, for the state and for individuals and families. Indeed, social interventions may impact not only on the recipients of LTC but also on the other stakeholders involved (families, the state, municipalities and others).

It follows that the interaction of the actors operating in this field is crucial to how well the system functions and to how effective each of them are. Public actors are expected to operate in such a way as to provide an efficient and effective use of the social budget, in order to find sustainable solutions and strengthen people's capacities and opportunities to participate in society and in the labour market. Stakeholders' interaction in a network-type relation might aim at fostering prevention and rehabilitation measures in order to reduce current and future needs for assistance and promote integration of health and social care arrangements, foster quality of care and equity and promote the well-being of the care recipients. This approach is linked with the debate about the welfare mix and the role of each stakeholder in setting up an appropriate LTC network, which will depend on the institutional setting of each country.

The welfare mix underlines that LTC provision involves four main categories of stakeholders: public LTC providers (both decision-makers and staff), the market and family-based LTC providers. The interaction of these stakeholders is important in order to develop successful LTC services. On a macro level, the state has in principle the responsibility to design a policy framework to enable all these units to cooperate in meeting care users' needs. On a micro level, appropriate organizational and managerial practices can help all these organizations work efficiently and effectively, to reach the final goal of patients' satisfaction, balancing affordability with quality. Figure 1 illustrates the relationships in the provision of care using the welfare mix approach.

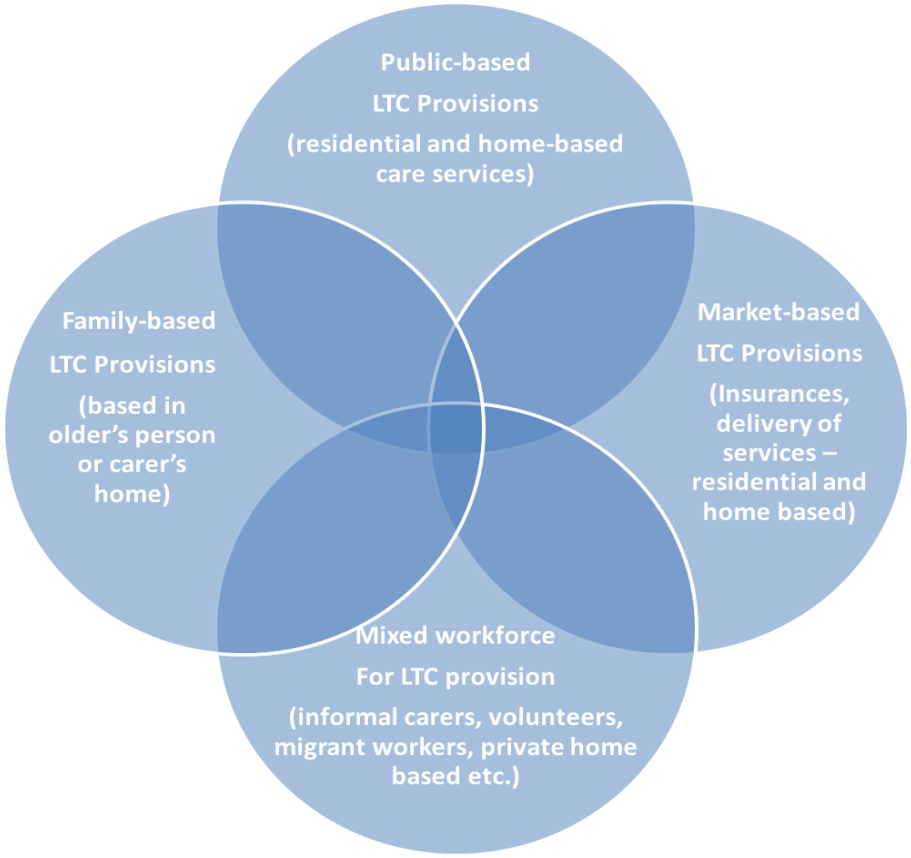

Figure 1: Principal connections between long-term care provision types[2]

Long-term care can be provided formally or informally (see Riedel and Kraus, 2016, who also discuss the variety within the EU of patterns of economically supporting informal care). Formal carers include nurses, doctors or other professional assistants. Services are usually provided by trained, licensed and qualified professionals and often controlled by the state or other types of organization. Formal caregivers have contracts specifying care responsibilities, they are paid and entitled to social rights and working regulations, care tasks are specified according to professional qualifications, and care workers have a time schedule and go 'off duty'. Informal carers are individuals already in contact with elderly care recipients as a result of direct personal ties, as family, friends or neighbours. They are not professionals and not usually trained to provide care (although they may benefit from ad hoc training), they have no contracts regarding care responsibilities, they are not paid (although they may have some reimbursement), they perform a wide range of tasks (also performed by formal carers) including emotional support and assistance. For informal carers, there are no limits to time spent on care, they are rarely 'off duty', and they have no general entitlement to social rights. Halfway between formal and informal care, a mixed offer of LTC services supported by cash-benefits provisions is widespread in some countries. Steering mechanisms are diverse in this area, as Riedel et al. (2016) show.

[2] Derived from document: "A map of social enterprises and their eco-systems in Europe. Results of the mapping study. 17-18 November, Rome. Unlocking the potential of the social economy for EU growth". 2014 Italian Presidency of the Council of European Union.

Stakeholder engagement is a central driver for successful LTC networking. Figure 2 presents possible stakeholder networks in LTC systems. The rationale behind a network framework is that the delivery of LTC services can often involve a multitude of providers (private, public, non-governmental) of services and ancillary organizations, not directly involved in the provision of services but also very important for the performance of the system. The delivery of LTC services is regulated by decisions taken by policymakers, and regulation differs throughout Europe (Riedel et al., 2016; Greve, 2017). This governs delivery and finance, and use of market provision (public, private, but also private provision operating with public funds in quasi-market frameworks). The role of social insurance is also important in some countries, especially Germany. The interrelation of all these stakeholders is based not only on market-based relations but also on collaborative and trust-based cooperation practices. Stakeholders may have a significant influence on policymakers. We discuss below how the roles of the different stakeholders should be evaluated taking into consideration not only what they do for the LTC services' clients but also how they collaborate, or compete, with the other stakeholders. The institutional setting in which this collaboration and/or competition takes place is crucial: where market rules are well developed and a competitive market is preserved (also if the public funding is present) the performance of the LTC actors is usually better. A priority for the public regulator should be to foster collaborative schemes of relationships in which the establishment of active policies to meet the needs of elderly people represents the overall goal of the LTC system. Active ageing policies could also be fostered by collaborative relationships, with potential positive economic effects that should be further investigated.

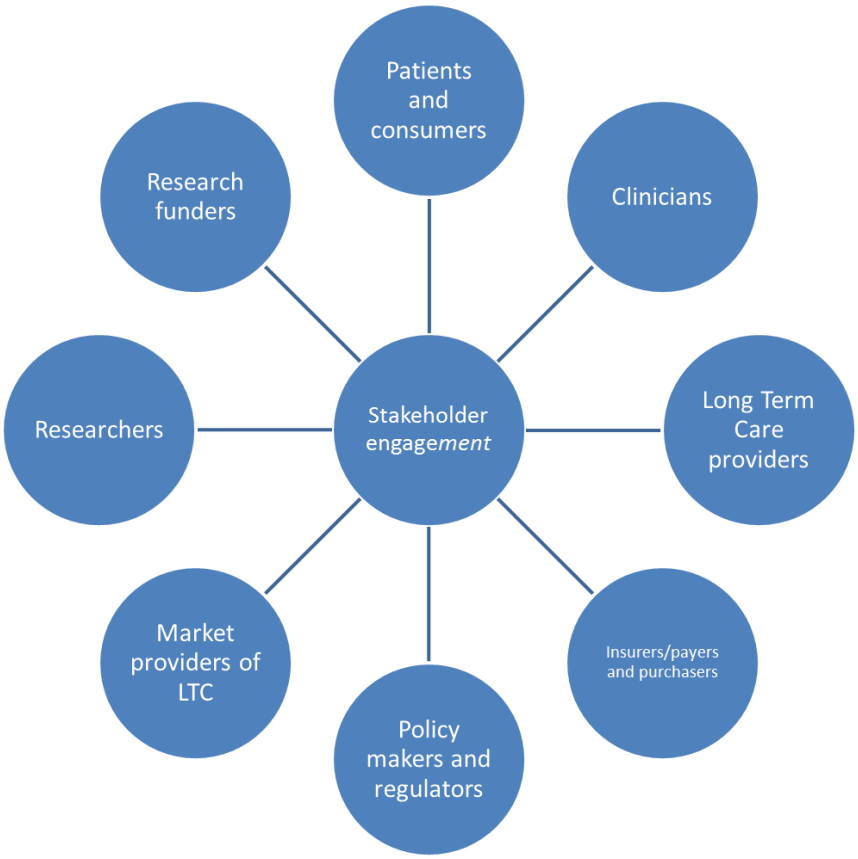

Figure 2: LTC network of actors

On one side, there are public decision makers at many levels (national, regional, local) and public actors involved in the delivery of the services. Long-term care providers may be public and private, formal and informal, and more or less organized. The organization of the care system goes beyond public or family based funding sources: in some cases insurance systems are involved (for instance in Germany). Advocacy groups are important in influencing the decision-making process. Both public and private providers are involved in suppling services (for example nursing homes, special care homes, private home care agencies, cooperative housing organizations, retirement or assisted living homes). Similarly, there are various kinds of support services (not-for-profit organizations, publicly funded organizations and programs, private supplier companies). Ancillary organizations also need to be considered (transport and ICT providers, for example): see Ranci and Pavolini (2012) and Greve (2017).

The balance between residential and home-based provision differs between countries, with wide variation in availability and use of home care services for elderly people. On the one hand, in some northern European countries home care can reach more than one in four elderly people. On the other hand, there are the southern Europe countries where much lower percentages of elderly people receive help at home, although in recent years they have all approved developing programs for this aspect of LTC (Rodrigues et al., 2012). In all the other EU countries, including the United Kingdom (especially since the reforms of the 1990s) numbers in residential care have decreased while the numbers of those requiring intensive assistance at home (which now absorbs a higher amount of resources)

have increased. Institutional care remains the predominant form in only few countries. In the UK, there is approximately an equal number of beneficiaries receiving care at home and in institutions. We can interpret the prevalence of home care in most European countries as a signal of active and healthy ageing of the population, since elderly people who remain at their homes are more likely to be involved in community life. However, this trend has been also promoted by the local authorities with the aim of reducing the burden of the public sector and save money. To make this choice successful prevention policy and integrated schemes of care are important, in order not to shift the burden of care solely on to families and informal carers. The shape, size and financing of long-term residential care are very diversified in Europe (ISTAT, 2010): some countries have very comprehensive care programs and are still financed by public authorities; others have very limited and fragmented services. Prioritizing home care is clearly the most widespread current trend: this goes with an accentuated preference for integrated models of residential care with participation in the community.

The role of informal cares is also relevant if we look at the SHARE data[3]: it is evident that informal assistance is particularly pronounced in those countries where the state traditionally leaves a comparatively larger part of LTC provision to the family: intensity of informal care[4] in the oldest age group care is more than six times higher in Greece, Germany and Poland compared to Denmark. In southern and eastern European countries, the intensity of informal care is even higher, given that that co-residential personal care is more common in these countries and co-residential carers tend to provide more hours of informal care. More generally, in northern countries, the role of the state is most important, while in the south and east there is a predominance of family care, while in central Europe the situation is mixed. Looking at the type of care, in the northern European countries formal care is predominant: the situation is exactly the opposite in the south and east of Europe. The north versus south/east Europe divide is also seen in the care gap, which is higher in the less developed European countries. There is also a gender effect in care mix that exists everywhere except in the north. Indeed, the boundaries between informal and formal care provision (family-based versus public-based), have been reducing, leading gradually to the creation of a mixed workforce made up of informal family carers, migrant care workers, personal assistants and formal professional care staff, operating with varying intensity in providing, delivering and sharing LTC services (Triantafillou et al., 2010).

Social innovation in formal care should improve the well-being of elderly people, and could strengthen economic growth by relieving family of some of their care work and make it possible for them to take on more paid work. In addition, the development of welfare technology could be a growth area. For example, telecare and telehealth offer remote monitoring of individuals' health (Millican et al., 2011). Its use has increased since the early 2000s in many countries as it becomes affordable and cost-effective. Internet tools may help elderly people to be in

[3] www.share-project.org

[4] "Intensity" of care is measured by the number of hours dedicated to care giving/receiving. Some studies have shown that care provided for 20 or more hours a week has an impact on employment, even if others define intense caring as more than once.

contact with family and friends who do not live nearby and provide a vital connection with the world, especially for those with physical disabilities. Smart homes can respond to a variety of needs, especially through assistive technology[5]. Co-housing (clustered housing groups of a variety of formats) is not innovative *per se* (the first experiments started in the 1960s) but it represents a growing phenomenon, linked to the increased role of the non-governmental organizations and social experiments in community care and social participation.

Active ageing goes with this innovative approach. By active ageing we mean "the process of optimizing opportunities for health, participation and security to enhance quality of life" (WHO, 2002: 12). It allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society, providing them with adequate protection, security and care. The word "active" refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. Older people who retire from work, are ill or live with disabilities can remain active contributors with their families, peers, work associates and neighbors. In essence, active ageing initiatives aim at extending healthy life expectancy and quality of life.

Another relevant trend of recent years is the introduction of market competition: it is often seen as one major approach towards ensuring quality in LTC. It is seen as improving the choice of provider and increasing users' self-determination. Choice should help in addressing quality aspects that are difficult to quantify but easy to experience for users, such as the personal interaction between care recipients and caregivers (Lundsgaard, 2005). Many European LTC systems offer free provider choice in both institutional care and home-based care. In Italy, free provider choice is limited mainly to home-based care. Only in Finland are care recipients not free to choose their provider (Riedel and Kraus, 2011). Public-private mix in the provision of long-term care services is managed in different ways through Europe. The German market for long-term care services is dominated by private enterprises in both settings of care, institutional and homebased (Riedel and Kraus, 2011). In Scandinavian welfare systems, public provision is predominant. In all the other countries, 30% or more of the market, at least for formal home-based care, is held by private providers. The larger private presence is usually in home-based care rather than in institutional care. This is true for new EU member states. Surprisingly, in Hungary while most legal entities providing home nursing care are private, most providers of home care are public (Tarki, 2009).

Stakeholders may also impact on the design and layout of national long-term care systems. Social insurance usually plays only a residual role in designing long-term care systems. In Europe only Germany and the Netherlands have comprehensive social insurance for long-term care covering a large portion of the overall population. On the other hand, in many countries social health insurance has full responsibility for providing nursing care. This includes new EU member states like

[5] Assistive technology can be defined as "any device or system that allows an individual to perform a task he would otherwise be unable to do or increases the ease and safety when performing a task" (McCreadie and Tinker, 2005: 92).)

Poland, and some old member states (e.g. Belgium), but not all traditional social (health) insurance countries. Other tasks of long-term care such as home help are usually integrated into the social or welfare system rather than into the health care system (Riedel and Kraus, 2011).

Using a comparative lens the following trends about LTC in Europe can be discerned[6]:

- Decentralization of delivery responsibility (and funding) to local authorities is quite widespread, even if with different levels of decisional and funding autonomy
- The most widespread governance model gives delivery responsibility to municipalities and the decision-making (and partially funding) role to central government. In some cases, for example Italy, there is an intermediate – regional – level with coordination and control powers)
- The involvement of associations/non-governmental organizations is quite widespread, especially in contexts when public provision is not working as well as it could
- Informal care is very widespread. There are few examples of policies designed to include informal carers in a more "formalized" framework.
- In several cases, especially in eastern and southern European countries, the bulk of LTC activities are still provided by households or informal care providers, although governments are increasingly trying to transfer these activities to the formal market
- In some cases, problems of lack of coordination and/or overlapping among the central and the regional/municipal level are reported
- Competition in the social service market is still very low, probably due to anxiety about the profitability of LTC services, the predominance of the public sector, and the unaffordability for most of the population of private services, which tend have higher charges than public ones
- Insurance does not play a large role, with some exceptions (notably Germany). Even where insurance is used, the vast majority of the players on the market are public (and, in the case of Germany, private companies must offer the same benefits as the public system).
- Even in contexts where the role of the public actors is predominant, the marketization of service delivery is limited, mainly taking the form of contractualization (for example in Finland, about competitive tendering used by municipalities to select private service providers)
- The influence of the non-governmental organizations on the decision-making process, and, more generally, their advocacy and lobbying power is

[6] See annex for details.

quite limited, except for the southern European countries (Portugal and, to a lesser extent, Italy and Greece)

- Integration of the health care system and the social services system is often problematic: in cases such as Lithuania have little integration of health care and social care providers; in Poland, no long-term care system as an independent sector exists
- Non-profit providers have traditionally played a key role in Germany and continue to be predominant in this country, as well as in Italy and the Flemish region of Belgium. Public providers remain predominant in the Nordic countries – despite two decades of 'privatization' of care – but also in some eastern European countries
- Migrant work is a key component for the everyday provision of long-term care: the direct (legal) employment of migrant care workers by private households prevails in most Mediterranean countries (except for Portugal), while their presence as staff in formal service providers is stronger in Anglo-Saxon (United Kingdom) and continental care regimes (Germany)

6 LTC and active ageing: discussion

Active ageing, continuity in care, care integration, self-care, smart care are some of the keywords of current approaches to LTC. Often, they are just a new way to refer to old concepts. Social experimentation could be followed by dissemination and scaling up of best practice approaches to form part of long-term care strategy development, as happened in some countries such as Denmark. Ageing in place, independent living and rehabilitation can be promoted through age-friendly environments, assistive technology and appropriate provision of home help and home care. In institutional environments in which formal provision is dominant, focusing on prevention, productivity and independent living would seem a logical extension of present efforts. In contexts in which informal care is predominant and the quality of services provided is lower, a substantial change would be needed.

Social investment, in Hemerijck's words (2015), involves a significant change in the core elements of the policymaking process, moving from a focus on "repairing" the damage caused by events to a focus on preparing individuals and families to address life chances and deal with disruptive events, preventing some of the damage they can cause. This implies focusing on the creation of capacities, shifting policy analysis from an exclusive focus on present costs to a focus on current and future impacts; addressing social risks within life-course dynamics, and in doing so overcoming the divide between carers and recipients; and fostering more efficient work policies. Social investment concept as applied to LTC involves policies that contribute to the most efficient use and allocation of labour resources over the life course in support of elevated levels of participation in the labour market (the "flow"), while enhancing and maintaining capacities and independent living of the human capital (the "stock") and simultaneously working to achieve equity and quality of life. In this sense, it can be understood as welfare state spending and policies generating care arrangements that improve quality of care and equity in access to care while reducing the current and future fiscal and social costs of long-term care. It could increase the capacity of carers and older people to participate in society and the economy.

Long-term care has only relatively recently been acknowledged as a social risk and several practices, procedures and methods, for example concerning quality assurance, have only emerged and developed over the past two decades, partly favored by the introduction of market-oriented governance mechanisms (Leichsenring et al., 2013). The user of long-term care services is generally not in the position to behave as an independent 'consumer', in particular if frail older people are concerned. Indeed, regulatory frameworks and measures for quality assurance were often introduced subsequently to the introduction of competitive markets and market-oriented governance (Armstrong, 2013). All the stakeholders have specific types of vested interests in defining the quality of services and facilities. Often competition and choice have been limited to choose between agencies providing rather similar types of care, given high degrees of standardization of care packages and universally defined quality standards. Over the past few years, issues of integrated care, person-centred and holistic

approaches have gained ground together with a critical stance towards the standardization of care. Public provision, competition and choice are ultimately not the ends of social policy in long-term care. They are the means to provide adequate, affordable and equitable long-term care services that empower users and enhance their independence (Rodrigues et al., 2014).

Active ageing is on the agenda of policymakers dealing with LTC: national health and social care systems are loosely coupled systems facing increasing difficulties due to increasing marketization, lack of managerial knowledge (cooperation, coordination), shortage of care workers and a general trend towards downsizing of social care services (Leichsenring, 2012). This could imply a need for promoting active ageing measures, integrated care systems, flexible and adaptable services to suit individual needs and lifestyles, multi-professional teams, structures facilitating coordination and cooperation with other formal and/or informal care (including mobility and transport), structures that facilitate communication, planning and care delivery with informal carers, etc. It is important to move towards integrated long-term care systems by learning from best practice examples with a focus on prevention and rehabilitation, the development of quality management and support for informal carers. Integrating long-term care to meet the general challenges of ageing societies is a priority (Leichsenring, 2012).

Service delivery fragmentation is seen in the structural and financial barriers dividing providers of primary/secondary care and health/social care; providers having distinct organizational and professional cultures and with differences in terms of governance and accountability (Glasby et al., 2006). Integrated care should simultaneously focus on improving health outcomes, enhancing patient care experience and cost reduction (Berwick et al., 2008). In the literature, for many years now, case managers are seen as important in reducing this fragmentation: they can serve as a link between elderly individuals and the services these individuals need but of which they often are unaware. They can guide potential patients to cost-effective ways of meeting their long-term care needs, and their skills can potentially also help in addressing the issue of cost containment in long-term care (Davidson et al., 1991; Massie, 1993; 1996).

While reliable estimations of economic impacts of integrated care approaches do not exist (Nolte and Pitchforth, 2014), integration is considered the main goal to make LTC impact on economic growth positive. The main forms of integration, according to Delnoij et al. (2002), are functional: integration of key support functions and activities, for example financial management, strategic planning and human resource management; organizational, for example creation of networks and contracting; professional – joint working, group practices, strategic alliances of health-care professionals; and clinical – integration of the different components of clinical processes, with coordination of care services for individual health-care service users. The benefit of integrated LTC approaches is not limited to improved health but includes short and long-term cost savings because reduced healthcare utilization, reduced carer burden, increased labour productivity, and other effects. Despite the lack of evidence on economic gains from integrated care, there is surely potential for transferable lessons to be learned, identifying core elements that will

support better outcomes (Nolte and Pitchforth, 2014). How this can have an impact on measurement of social investment is considered in wp4 and wp5.

The efficiency of care provision can positively impact active ageing, and in so doing on the social and economic well-being of the network of stakeholders dealing with elderly care and on elderly people. This virtuous cycle can be increased through better organisation, financial incentives, quality control and re-engineering, including through the substitution of technology for labour. Securing good integration of the social and health components of LTC and continuity in care is a key goal. Family carers might be supported by introducing better support services, strengthening coordination between the formal and informal care systems. Recruitment efforts can be increased, better job quality ensured and retention of LTC workers increased (EU, 2014). Burgio et al. (2010) point out that integrated assistance practices could be developed to help with the demand for LTC, to foster active ageing and promote well-being. They might be designed by means of multi-dimensional evaluations of elderly needs, defining projects of organized assistance integrating socio-health care services and informal care to guarantee care continuity. The case manager is a key player in this care scheme: assessing the appropriateness of care and the coordination of the care project, coordinating multidisciplinary care operators and fostering collaboration with the network of informal carers.

Promoting active ageing is based on multiple components, among them:

- identifying and targeting resources on the specific causes of dependency
- adopting a “life course” approach
- identifying those within the older age group who are most at risk, designing “personalised action plans” to promote the most effective form of prevention
- implementing innovative organisational approaches and technical solutions targeting frail older people for evidence-based interventions to reach a more efficient use of resources, skills and technology, and improve the health and quality of life of older people and caregivers
- developing and deploying ICT effectively
- exploring innovative ways to promote active and healthy ageing with age friendly environments
- running pilots to analyse integrated approaches to age-friendly urban design, housing, transport health and social services, age-friendly workplaces, ICT and smart environments (EU, 2014).

A central theme is the growing focus on prevention. The efficiency of preventive and early intervention is likely to lead many governments to use models of possible innovative social intervention, destined to an audience of subjects potentially affected by the need, which is broader than the number of actors in need of intervention. Then, the new preventive measures impact directly on the demand of capital in two ways: firstly, considering the natural scale of prevention; secondly,

due to the anticipatory nature of the intervention in comparison to the availability of public resources.

In this analytical framework, we consider stakeholder engagement as an element that might help in the attainment of successful active ageing policies. As discussed above, in almost each country, a plethora of actors, with diverging goals and diverse managerial skills operate in the LTC arena. Stakeholders' interaction in network-type relations might be fostered, promoting collaborative relations, with an emphasis on prevention and rehabilitation measures to reduce current and future needs for assistance. The aim would be to promote integration of health and social care arrangements, foster quality of care and equity and, as a result, promote the well-being of care recipients. Almost everywhere the goal of governments is to reduce the proportion of residential care and to increase the quality of home care and informal care, attracting informal provider to the labour market and providing acceptable living conditions to carers and recipients. Involvement of communities, empowerment of users and promotion of active ageing policies, if integrated with the network of health care structures can result in more flexible and adaptable services to suit individual needs and individual lifestyles. Establishing multi-professional teams, and organizing appropriate structures and practices to facilitate coordination and cooperation among all the territorial and sectoral layers of this network-type set of relationships could improve the formal-informal care collaboration.

7 Conclusions

Stakeholder engagement is a complex process cutting across territorial and institutional organizational layers: managing this complexity should be a priority of public decision makers. Integration of care services, territorialization of service delivery and support for the development of appropriate empowerment programmes for informal carers are needed. The European situation is extremely heterogeneous; even if the coverage and quality of LTC services is increased in many countries, social innovation (and funding) will be a goal for European policymakers soon. Promoting policies for active ageing goes along with improvement in the quality of LTC services and the involvement of all the stakeholders potentially affected by these policy decisions.

This article, presenting a description of the different actors of the LTC system in Europe shows that the high level of heterogeneity across the European countries is rooted in historical, cultural and economic heritages. Privatization of service delivery and the importance of informal care is widespread, partly due to external factors (demographic and/or economic). There are few countries where the "public" nature of LTC is still predominant, even though central government (or a delegated body) commonly sets regulations. Decentralization of service delivery goes with growing provision of autonomy for regional and local public actors, often also concerning decisional rules (including assessment of needs) and funding options. Promoting policies of active ageing might work with an appropriate organization of the public-private-not for profit network of actors: successful welfare mixes might be adapted to the characteristics of the actors delivering the services and the needs of the elderly.

The economic gains from successful active ageing policies and appropriate care paths are potentially high, and promoting innovation and participation can make LTC systems work more effectively and so improve well-being. Further analyses, focused on a comparative case study approach but also on quantitative assessment of the economic effects of effective active ageing policies and collaborative stakeholder engagement practices are recommended.

Annex: LTC actors in Europe

In Belgium, LTC delivery is by a range of services organized at the federal, regional and municipal levels. LTC services are provided mostly as part of the federal public compulsory health insurance system financed by social security contributions and general taxes. Informal care is provided mainly within the family (Willemé, 2010). Day care and short stay centres provide care services for elderly dependent persons who still live at home but (temporarily) lack adequate informal care. Formal and informal care coexists even if the latter is provided mainly by relatives. Recent state reforms designing important transfers of competences in health and long-term care from the federal to the federated level have been decided and are progressively being implemented (EU, Belgium Social Reporting, 2015).

In Denmark[7], the state has the main responsibility for the overall rules concerning the delivery of long-term care services, whereas it is the local municipality which decides the level, based on assessment of needs. Private actors may play a role in the delivery and many private companies deliver cleaning services in private homes, whereas personal care is still mainly delivered by public sector employees. The municipalities offer accommodation in facilities that are suitable for long-term residence for persons who, due to significant and permanent physical or mental impairment, need extensive help for ordinary everyday functions and/or care, and where it is not possible to cover these needs in other ways. Compared to other countries, informal caregivers in Denmark play a relatively smaller role in the caring system. The municipalities now should offer rehabilitation to elderly people in need of home care (EU, Danish Social Reporting, 2015).

In Finland[8], legislation designates the local municipalities as the bodies responsible for the organization of health care and social services, including long-term care. The 342 municipalities are obliged to arrange health and long-term care (LTC) services for their residents. Municipalities can arrange the services by themselves, together with other municipalities, or by purchasing from private providers. Round-the-clock residential long-term care for older people is mainly provided in the inpatient departments of health centres, in nursing homes and in serviced homes, also called sheltered housing units. Most nursing homes and health centres are owned by municipalities, but there are also several private serviced housing units and homes provided by NGOs[9]. The government's elderly policy aims at replacing institutional care with arrangements that allow clients' needs to be met in their own homes and or in a homely environment, such as sheltered housing units with 24-hour assistance. Karsio and Anttonen (2013) have shown that marketization has strongly influenced service provision in the Finnish municipalities and most particularly the services for to older adults.

[7] For further information about the Danish case see also: Greve (2016), Ministry of Social Welfare-Ministry of Health and Prevention (2008) and Schultz (2014).

[8] For further information about the Finnish case see also: Anttonen and Karsio (2016), Ministry of Social Affairs and Health, Finland (2001) and Johansson (2010).

[9] Around 50 per cent of service housing units with 24-hour assistance are private in Finland at the time of writing.

In Germany[10], the role of insurance is very salient: about 90% of the population is insured in the public system, with the remainder having cover through a private insurance company. These private insurance companies should offer the same benefits as the public system. The introduction of long-term care insurance was also associated with an increase in the number of active nurses and professional caregivers for the elderly, especially in the ambulatory sector. Neither the public system nor the private system delivers long-term care themselves. This is done by private providers. Some of these have a link to the churches (e.g. Caritas, Diakonie); others are profit-making private enterprises of varied sizes. Most of them work on at local or regional level only, but there are plans for some enterprises to extend their activities to the national level. Residential care is mostly provided by the same institutions. In addition, some residences are run by municipalities; they follow the same rules as the private institutions. NGOs sometimes support persons in areas that are not covered by insurance (for example visits or reading newspapers). The latest reform of the LTC aims at more integration and better coordination among long-term care, medical and social assistance. Informal carers are supported by benefits from the LTCI funds. Self-help groups and volunteers make an important contribution towards caring for people needing help. Since the insurance system covers only some 50% to 60% of the costs for professional or residential care, care within the family is very frequent.

Greece[11] suffers from poor quality and coverage by the public sector of service provision for the elderly. Private sector services have developed significantly since the 1980s while the role of the voluntary sector remains limited. Care for the elderly in special care units is provided by the public sector, non-profit organizations and private institutions, the majority of which are concentrated in urban areas. Discrepancies between unmet needs and services provided exist as to the range of services provided, and there is wide variation in quality and quantity of services. Several public homes for the aged operate under the supervision of the Ministry of Health and Social Solidarity, providing shelter, food, psychological support, counselling and medical care. There are also private for-profit homes for the aged but the quality of the services they offer is very low (Economou, 2010).

In Hungary, services related to long-term care are provided by both the health care and the social care systems. These two separate systems have their own legislation, financing mechanisms and services (Czibere and Gal, 2010), however both have been administered by the Ministry of Human Capacities since 2010, resulting in slight improvement in the coordination of the two systems. Health care services are primarily financed by the National Health Insurance Fund[12]. The social care system is managed at a local level. The local governments assume primary responsibly for organizing and delivering social care, which includes home care, day care and residential care, under the framework set out by the central government.

[10] For further information about the German case see also: Federal Ministry of Labour and Social Affairs (2015), Schultz (2010) and Fosti and Notarticola (2014).

[11] For further information about the Greek case see also: Ministry of Labour, Social Security and Welfare (2012), OECD (2016) and Vaiou and Siatitsa (2013).

[12] The coordinating and financing agencies of the health care system are under reorganisation based on a new governmental decree No. 386/2016 on health insurance bodies effective from 1 January, 2017.

The main providers of basic social services (home care, day care, etc.) are the local governments while the role of other actors (e.g. churches) is secondary. In the case of special social services (e.g. permanent residential care) the institutions are maintained by a wider range of social actors e.g. central government, local government, churches, the NGOs and corporations but their significance is different (Hungarian Central Statistical Office, 2014 Yearbook of Welfare Statistics, 2014). Social care is mainly financed by a combination of central government, local government and out-of-pocket contributions (OECD, 2011). The maintainer can also supplement the budget of its institutions if the subsidy from the state and the user charge is not sufficient (EU, Hungary Social Report, 2015). The importance of non-governmental providers is secondary, although NGOs providing public services are entitled to the same amount of funding from the central budget (through contracting with local authorities) as the local governments themselves. Care centres maintained by churches receive additional financial support (Czibere and Gal, 2010). Private insurance schemes are poorly developed. The bulk of LTC activities are left to households or the informal market. Recently, new providers, charities, have entered the picture; public administration has become more decentralized; much of the previously informal activity has become formal; and much of the demand that previously remained unmet is now met by supply, even if the LTC system offers poor benefits for recipients to ease access to services. Instead of focusing on cooperation and coordination with alternative providers such as households, the system focuses on funding institutions rather than tasks (Czibere and Gal, 2010).

Long-term care provision in Italy[13] involves multiple public and private (for profit and non-profit) stakeholders, with different and often overlapping roles, which are defined in legislation. The state sets out the main directives on health and assistance, checks the uniformity of treatment, distributes resources from the National Fund for Social Policy and delivers cash benefits in support of elderly and disabled people. Regions mainly carry out coordination and control activities on social interventions regarding health and social care with high health integration (Law 328/2000); define criteria for the authorization and accreditation of agencies that provide services; determine tariffs that municipalities are required to transfer to accredited subjects and deliberate the amount and beneficiaries of the LTC vouchers. This is not a direct operational role; this is exercised by municipalities. Municipalities are responsible for planning, designing and implementing local social services systems and to coordinate the activities of the care givers economic integration in favour of those clients who need hospitalization in stable residential structures. Municipalities are therefore the main actors in the implementation of public assistance to disabled people, in particular as concerns social benefits even when they are related to healthcare. Among private LTC providers, operators come in large part from the non-profit sector or they are home care providers ("carers"). Residential or semi-residential facilities (Residenze Sanitarie Assistenziali – RSA) and community nursing homes (case protette) are the usual institutional settings for caring for elderly and disabled people, including those with mental health conditions. In Italy, rather than one national LTC system there are many regional

[13] For further information about the Italian case see also: Fosti and Notarticola (2014).

systems. The supply of social services is insufficient to meet the population's needs and is extremely diverse across Italian regions (Tediosi and Gabriele, 2010).

LTC for the elderly in Lithuania[14] is provided within the national health care and social services system. Non-governmental organisations together with informal private ones also constitute an important part of LTC provision for elderly people. From 1998 to 2000, a process of decentralization took place among social care institutions and the health care system (Marcinkowska, 2010a). All the institutions that had been subordinated to ministries were transferred to territorial self-governments. The major responsibilities now fall to local government (municipality or county). The Ministry of Health is responsible for health care system policy. The main administrative institutions for social services provided by the social security sector are the Ministry of Social Security and Labour, the Department of Supervision of Social Services under the Ministry of Social Security and Labour, and the municipalities. Municipalities provide general (without permanent assistance by specialists) and special (social attendance and social care) social services for elderly people. There were 48 nursing hospitals (providing nursing care, medical rehabilitation, follow-up treatment, palliative care and sanatorium treatment) in Lithuania (out of 134 hospitals in total) in 2014 (Lithuanian Ministry of Health, 2015: 47). Recently, LTC institutions have been established by private sector and community initiatives, although competition in the social services market remains at a low level. LTC provision by the informal sector (family members, neighbours and friends) supplies the most significant part of the support for elderly and disabled people in Lithuania. It is still very often considered in Lithuanian society that primary responsibility for the care of elderly rests with family. The main critique of the long-term care system in Lithuania is its division between the health care system and social services system, and the weak integration of these two providers of care services.

In Poland[15], there is no long-term care system as an independent sector. After health care system reforms in the late 1990s, the "long-term care" concept has been used within the health care sector, even though a LTC system as such does not really exist. There are care and nursing facilities providing residential long-term care as well as long-term care nurses providing home care. Internal medicine departments of the hospitals often play, to some extent, the role of residential long-term care institution for the elderly. The main actor in terms of care provision is family, then public institutions. Private providers as well as NGOs play residual roles. In the private sector a large part of LTC provision comes from informal but paid carers (often migrants). One of the main problems of long-term care provision is the division of responsibilities and tasks among various bodies (the Ministry of Health, the Ministry of Labour and Social Policy, territorial self-governments and others) and the lack of cooperation between them (Czepulis-Rutkowska, 2014).

[14] For further information about the Lithuanian case see also: European Commission (2015), Government of Lithuania (2014), Marcinkowska (2010b), Ministry of Social Security and Labour (2014), National Audit Office of Lithuania (2015), Poskute (forthcoming), Republic of Lithuania (2006), Štreimikiene and Štreimikis (2013).

[15] For further information about the Polish case see also: Golinowska (2010) and Golinowska et al. (2014).

Care services are usually provided at the local level. The local social assistance centre can delegate the provision of the services to authorized providers or via buying through public tender. Private providers may bid for these contracts. Also care homes can be private actors operating on the market, or private providers funded by public money. Public residential care units are established and managed by local government (usually the "powiats"). Non-public residential care units are established by the Catholic church, religious and other associations, foundations, etc. More than 80% of LTC is provided within the family, a phenomenon due to the culturally strong family ties.

State provision of community care services in Portugal is low but includes long-term care, day centres and social services. Long-term care has not generally been part of the public health agenda and delivery has mainly been provided by family and by Misericórdias (independent charitable organizations). Formal provision of social care, personal care and domestic aid is mostly by private providers, including non-profit and for-profit. Local government involvement has been marginal. The number of for-profit actors in the market is increasing but the main providers so far have been the Private Non-profit Institutions of Social Solidarity, subsidized by the state. Residential care provided in each region by the public sector, funded by the Ministry of Labour and Social Solidarity, is often of poor quality and lacks sufficient resources. To expand services, a new private/public mix centred on public subsidies of non-profit institutions was built up in the late 1980s. The state is facilitating vocational training opportunities in areas such as domiciliary care and informal provision of services as part of a job-creation scheme, although the last two forms of care are still very poorly developed (Joël et al., 2010). One critical issue is the state's ability and will to evaluate and control non-profit organizations (Santana, 2010). One of the main differences between Portugal and other southern and southwest European countries is the high degree of organization and power of the non-profit sector through strong and powerful peak organizations that participate actively in policy-making (Santana et al., 2014). The last decade has seen an improvement of the quality and quantity of services of integrated care delivered, partly due to the launch of the National Network of Long-Term Integrated Care (Governo de Portugal, 2015).

The long-term care system in the United Kingdom[16] is characterized as a "safety-net" type of system where public funds only support those with very severe needs who are unable to meet the costs of their care (Fernández et al., 2009). Formal services are provided by a range of agencies including local authority social services, community health services and independent (for- and non-profit) sector residential care homes, nursing homes, home care and day-care services. Central government is responsible for overall policy on health and social services. Local authorities determine eligibility with large variations: it follows that the service provided can be very different depending on the place in which you live, even though the means-testing rules are nationally set. Some care is provided by the National Health Service, but a large part is provided by the private and voluntary sector. Residential or nursing care is provided in homes specifically for that purpose (Steele and Cylus,

[16] For further information about the UK case see also: National Audit Office (2014), Hancock et al. (2013), Technology Strategy Board (2013), OECD (2013).

2012). As health and social services are a devolved function within the UK the central government role in the three countries other than England is devolved to the Scottish Executive, the National Assembly for Wales and the Northern Ireland Assembly. This means that policies may differ among the four constituent countries of the UK. The long-term care system in England relies heavily on informal or unpaid care provided by family, friends or neighbours. Most home care is provided by home care agencies, most which (75%) are private. The last ten years have seen major changes in home care in England. There has been a substantial decrease in local authority direct provision, accompanied by a major expansion of private sector provision (Comas-Herrera, 2010).

8 References

Agranoff R., 1986. Intergovernmental Management: Human Service Problem Solving in Six Metropolitan Areas, State University of New York Press: Albany.

Agranoff R., and M. McGuire, 1998. Multinetwork Management: Collaboration and the Hollow State in Local Economics, Journal of Public Administration Research and Theory, 8/1: 67–92.

Anttonen A., and O. Karsio, 2016. Eldercare Service Redesign in Finland: Deinstitutionalization of Long-Term Care, Journal of Social Service Research, 42/2: 151-66.

Armstrong P., 2013. Regulating Care: Lessons from Canada, In Meagher G., and M. Szebehely (Eds.), Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences (pp. 217–27), Stockholm: Stockholm University.

Barbieri D., and D. Salvatore, 2010. Incentives Power and Authority Types: Towards a Model of Public Service Delivery, International Review of Administrative Science, 76/2: 347-66.

Barlow J., and M. Röber, 1996. Steering Not Rowing: Co-ordination and Control in the Management of Public Services in Britain and Germany, International Journal of Public Sector Management, 9/5/6: 73-89.

Berry F.S., Brower R.S., Choi S.O., Goa W.X., Jang H.S., Kwon M., and J. Word, 2004. Three Traditions of Network Research: What the Public Management Research Agenda Can Learn from Other Research Communities, Public Administration Review, 64/5: 539–52.

Berg B.L., 2001. Qualitative Research Methods for the Social Sciences, Boston etc.: Allyn and Bacon.

Berwick D., Nolan T., and J. Whittington, 2008. The Triple Aim: Care, Health, and Cost. Health Affairs, 27(3):759–769.

Borgonovi, E., 1984. Introduzione all'Economia delle Amministrazioni Pubbliche, Milano: Giuffrè.

Boyne G.A., 1998. Competitive Tendering in Local Government: A Review of Theory and Evidence, Public Administration, 76/4: 695-712.

Burgio A., Battisti A., Solipaca A., Colosimo S.C., Sicuro L., Damiani G., Baldassarre G., Milan G., Tamburrano T., Crialesi R., and W. Ricciardi, 2010. La Relazione tra Offerta di servizi di Long Term Care ed i Bisogni Assistenziali dell'Anziano, ISTAT,

Charbit C., 2011. Governance of Public Policies in Decentralised Contexts. The Multi-Level Approach, OECD Regional Development Working Papers 2011/04, OECD: Paris.

Comas-Herrera A., 2010. The Long-term Care System for the Elderly in England, ENEPRI Research Report n° 74.

Cooper P.J., 2003. Governing by Contract, CQ Press: Washington, DC.

Czepulis-Rutkowska Z., 2014, Long-term Care in a Post Transition Country: Poland as an Example, The 3rd International Conference on Evidence-based Policy in Long-term Care London.

Czibere K., and R.I. Gal, 2010. Long-Term Care System for the Elderly in Hungary, ENEPRI Research Report N° 79.

Davidson G.B., Penrod J.D., Kane R.A., Moscovice I.S., and E.C. Rich, 1991. Modeling the Costs of Case Management in Long-term Care, Health Care Financing Review, 13/1: 73-81.

Delnoij D., Klazinga N., and I. Glasgow, 2002. Integrated Care in an International Perspective. International Journal of Integrated Care, 2:1–4.

Economou C., 2010. Greece: Health System Review 2010, European Observatory on Health Systems and Policies - Health Systems in Transitions, 12/7.

European Commission, 2015. Country Report Lithuania 2015,. COM(2015) 85 final, Commission Staff Working Document, Brussels, 26.2.2015, SWD(2015) 34 final. http://ec.europa.eu/europe2020/pdf/csr2015/cr2015_lithuania_en.pdf

EU, 2014. Adequate Social Protection for Long-term Care Needs in an Ageing Society. Report jointly prepared by the Social Protection Committee and the European Commission, Luxembourg: Publications Office of the European Union.

EU, 2015. Belgium Social Reporting, European Commission, Employment, Social Affairs & Inclusion, Brussels.

EU, 2015. Danish Social Reporting, European Commission, Employment, Social Affairs & Inclusion, Brussels.

EU, 2015. Hungary Social Reporting, European Commission, Employment, Social Affairs & Inclusion, Brussels.

European Commission, 2013. Long-term Care in Ageing Societies - Challenges and policy options, Luxembourg: Publications Office of the European Union.

European Commission, 2012. Long-Term Care for the Elderly Provisions and Providers in 33 European Countries, Luxembourg: Publications Office of the European Union.

Federal Ministry of Labour and Social Affairs, 2015. 2015 Strategic Social Reporting, Germany.

Fernández J.-L., Forder J., Truckeschitz B., Rokosova M., and D. McDaid, 2009. How Can European States Design Efficient, Equitable and Sustainable Funding Systems for Long-term Care for Older People?, Policy Brief No. 11, World Health Organisation Europe, Copenhagen.

Fernandez S., 2007. What Works Best when Contracting for Services? An Analysis of Contracting Performance at Local Level in the US, Public Administration, 85: 1119-41.

Ferri J., and E. Graddy, 1991. Production Costs, Transaction Costs, and Local Government Contractor Choice, Economic Inquiry, 29/3: 541-554.

Fosti G. and E. Notarticola (Eds.), 2014. Il Welfare e la Long Term Care in Europa, Cergas: Milano.

Fransen L., 2014. The Policy Agenda – EU Approach to Long-term Care. 5th Senior Government Officials Meeting - Connecting the Dots: Formal and Informal Care, 10 June 2014, HICC Hyderabad India.

Gage R.W., 1984. Federal Regional Councils: Networking Organizations for Policy Management in the Intergovernmental System, Public Administration Review, 44/2: 134–45.

Gage R.W., and M.P. Mandell, 1990. Strategies for Managing Intergovernmental Policies and Networks, Prager: New York.

Glasby J., Dickinson H., and E. Peck, 2006. Guest Editorial: Partnership Working in Health and Social Care, Health and Social Care in the Community, 14:373–374.

Glesne, C., 1999. Becoming Qualitative Researchers, New York etc: Longman.
Goldsmith S. and W.D. Eggers, 2004. Governing by Network. The New Shape of the Public Sector, Washington D. C.: Brookings Institution Press.
Governo de Portugal, 2015. Relatório Social Nacional, Lisbon.
Golinowska S., 2010. The Long-Term Care System for the Elderly in Poland, ENEPRI Research Report n° 83.
Golinowska S., Kokot E. and A. Sowa, 2014. Employment in Long-term Care. Report on Poland, CASE Network Studies & Analyses.
Government of Lithuania, 2014. National Strategy for Overcoming Consequences of Aging of Population, approved by the decision N. 737 , June 14th, 2004 (Nacionalinė gyventojų senėjimo įveikimo strategija, patvirtinta Lietuvos Respublikos Vyriausybės 2004-06-14 nutarimu Nr. 737).
Greve B., 2016, Velfærdssamfundet. En grundbog. 4. Udgave, København, Hans Reitzel.
Greve, B. (ed.) (2017), Long-term Care for the Elderly in Europe Development and Prospects, Oxon, Routledge.
Hancock R., Wittenberg R., Hu B., Morciano M. and A. Comas-Herrera, 2013. Long-term Care Funding in England: An Analysis of the Costs and Distributional Effects of Potential Reforms, Personal Social Services Research Unit PSSRU Discussion Paper 2857.
Hemerijck A., 2015. The Quiet Paradigm Revolution of Social Investment, Social Politics, 22/2: 133-46.
Holmes J., 2011. A Note by the Director on the Ditchley Foundation Conference on 'The impact of ageing on developed economies' 12-14 May 2011", May 2011.
Hood C., 1991. A Public Management for all Seasons?, Public Administration, 69/spring: 3–19.
Hughes, O.E., 1998. Public Management & Administration. An Introduction, 2a ed., London: Palgrave MacMillan.
Hungarian Central Statistical Office, 2014. Yearbook of Welfare Statistics 2014, Budapest.
ISTAT, 2010. La Relazione tra Offerta di Servizi di Long Term Care ed i Bisogni Assistenziali dell'Anziano, 4/2010: 34.
Joël M., Dufour-Kippelen S., and Smitca S., 2010. The Long-Term Care System for the Elderly in Portugal, ENEPRI Research Report n° 84.
Johansson E., 2010. The Long-Term Care System for the Elderly in Finland, ENEPRI Research Report n° 74.
Karsio O., and A. Anttonen, 2013. Marketisation of Eldercare in Finland: Legal Frames, Outsourcing Practices and the Rapid Growth of For-profit Services. In G.
Kettl D.F., 1993. Sharing Power: Public Governance and Private Markets, The Brookings Institution: Washington, D.C.
Kickert W.J.M., Klijn E.H., and J. F.M. Koppenjan, 1997. Managing Complex Networks, Sage: London.
Langfield-Smith K. and D. Smith, 2003. Management Control System and Trust in
Outsourcing Relationships, Management Accounting Research, 14: 281-307.
Leichsenring K., 2012. Integrated Care for Older People in Europe—Latest Trends and Perceptions. International Journal of Integrated Care, 12: 1-4.

Leichsenring K., Billings J., and H. Nies, 2013. Long-term Care in Europe - Improving Policy and Practice, Basingstoke: Palgrave Macmillan.

Lithuanian Ministry of Health, 2015. Health Statistics of Lithuania, Health Information Centre of Institute of Hygiene, Vilnius, 2015.

Longo F., and D. Barbieri, 2013. Using Relational and Transactional MCS to Manage the Delivery of Outsourced Public Services: Evidence from Twelve Cases in the USA, Financial Accounting & Management, 29/1: 50-73.

Lundsgaard J., 2005. Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care. How Can it Help Improve Care Outcomes, Employment and Fiscal Sustainability?, OECD Health Working Paper N° 20, OECD, Paris.

Marcinkowska I., 2010a. The Long-term Care System for the Elderly in Lithuania, ENEPRI Research Paper n° 82.

Marcinkowska I, 2010b. The Lithuanian Long-term Care System. CASE Network Studies and Analyses, N. 414/2010, Warsaw, Bishkek, Kyiv, Tbilisi, Chisinau, Minsk. (http://www.case-research.eu/sites/default/files/publications/31396313_CNSA%20414%20final_0.pdf).

Marsh D., and A. Rhodes, 1992. Policy Networks in British Government, Oxford University Press: London.

Massie C., 1996. A Method to Determine Case Manager Caseloads in Long-term Care, Journal of Case Management, 5/1:25-31.

Massie C., 1993. Using Total Quality Management in Long-term Care Case Management, American Journal of Medicine Quality, 8/2:79-86.

Mayntz R., 1993. Modernisation and the Logic of Interorganizational Networks, Knowledge and Policy, 6/1: 3–16.

Millican C., Roberts C., and Mort M., 2011. Telecare and Older People: Who Cares Where?, Social Science & Medicine, 72/3: 347–54.

Ministry of Labour, Social Security and Welfare, 2012. Hellenic National Social Report 2012, Athens.

Ministry of Social Affairs and Health, Finland, 2001. Health 2015 Brochure (accessed from http://www.terveys2015.fi/esite_eng.pdf).

Ministry of Social Security and Labour, 2014. The Action Plan of the Transition from Institutional Care to the Provision of Services in a Family and Community for the Disabled and Children Deprived of Parental Care 2014–2020, N. A1-83, 14th February, Vilnius: Lithuania.

Ministry of Social Welfare-Ministry of Health and Prevention, 2008. National Report on Strategies for Social Protection and Social Inclusion 2008-2010 - Denmark, European Commission, Tallinn.

Mintzberg, H., 1996. Managing Government, Governing Management, Harvard Business Review, No 3.

National Audit Office, 2014. Adult Social Care in England: Overview, London: UK.

National Audit Office of Lithuania, 2015. Do the Social Services Available Satisfy the Increasing Needs of Elder Persons, N. VA-P-10-9-10, 30th June.

Nolte E., and E. Pitchforth, 2014. What is the Evidence on the Economic Impacts of Integrated Care?, WHO Regional Office for Europe, Policy Summary II, Copenhagen.

O'Toole L.J. Jr., 1997. Treating Networks Seriously: Practical and Research-Based Agendas in Public Administration, Public Administration Review, 57/1: 45–52.
OECD, 2016. Health Policy in Greece, OECD Health Policy Overview, January 2016, OECD: Paris.
OECD, 2013. A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care, United Kingdom, OECD: Paris.
OECD, 2011. Hungary. Long Term Care, OECD, Paris, 18 May 2011, http://www.oecd.org/hungary/47877686.pdf.
OECD, 2010. OECD Health Data 2010, OECD, Paris, October 2010 edition.
Olsen J.P., 2005. Maybe It Is Time to Rediscover Bureaucracy, Journal of Public Administration Research and Theory, 16: 1–24.
Olsen J. P., 1988. Administrative Reform and Theories of Organization. In Campbell C. and B.G. Peters (Eds.) Organizing Governance: Governing Organizations: 233-254, Pittsburgh University Press: Pittsburgh.
Peterson P., Rabe B. and K. Wong, 1986. When Federalism Works, Brookings Institution: Washington, DC.
Poskute, V., (forthcoming). Long-term Care for Elderly in Lithuania, in Greve, B. (Ed.). Long-term Care for the Elderly in Europe, e. Developments and Prospects. Routledge.
Powell W., Koput K.W., and L. Smith-Doerr (1996) Interorganizational Collaboration and the Locus of Innovation: Networks of Learning in Biotechnology, Administrative Science Quarterly, 41/1: 116–145.
Provan K.G., and H.B. Milward, 2001. Do Networks Really Work? A Framework for Evaluating Public-Sector Organizational Networks, Public Administration Review, 61/4: 414–23.
Ranci, C. and Pavolini, E. (eds) (2012), Reforms in Long-term Care Policies in Europe, New York: Springer.
Republic of Lithuania, 2006. The Law on Social Services of the Republic of Lithuania, 19-01-2006, N. X-493.
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 n° 95.
Riedel, M. Kraus, M. and Mayer, S., 2016. Organization and Supply of Long-Term Care Services for the Elderly: A Bird's eye View of Old and New EU Member States, Social Policy & Administration, vol. 50, no. 7, pp. 824-855.
Riedel, M. and Kraus, M., 2016. Differences and similarities in monetary benefits for informal care in old and new EU member states. International Journal of Social Welfare, vol. 25, pp. 7-17.
Robins G., Bates, L., and P. Pattison, 2011 Network Governance and Environmental Management: Conflict and Cooperation, Public Administration, 89: 1293-1313.
Rodrigues R., Huber M., and G. Lamura, 2012. Facts and Figures on Healthy Ageing and Long-Term Care, European Centre for Social Welfare Policy and Research.
Rodrigues R., Leichsenring K., and J. Winkelmann, 2014. The 'Make or Buy' Decision in Long-term Care: Lessons for Policy Final Project Report, European Centre for Social Welfare Policy and Research, Vienna,.

Santana S., 2010. Reforming Long-term Care in Portugal: Dealing with the Multidimensional Character of Quality, Social Policy & Administration 2010, 44/4: 512–28.

Santana S., Szczygiel N., and P. Redondo, 2014. Integration of Care Systems in Portugal: Anatomy of Recent Reforms, International Journal of Integrated Care – Volume 14, 24 July: 1-10.

Savas E.S., 2000. Privatization and Public-Private Partnerships, Seven Bridges Press: New York.

Schultz E., 2014. Impact of Ageing on Long-Term Care Workforce in Denmark, WP D12.2, Neujobs Project.

Schultz E., 2010. The Long-Term Care System for the Elderly in Germany, ENEPRI Research Report n° 78.

Siverbo S., 2004. The Purchaser-Provider Split in Principle and Practise: Experiences from Sweden, Financial Accountability and Management, 20/4: 401-20.

Steele D., and J. Cylus, 2012. United Kingdom (Scotland): Health System Review, Health Systems in Transition, 14/9: 1-150.

Štreimikiene D., and J. Štreimikis, 2013. Lithuanian Health Protection System in Comparison with Countries of Baltic Sea Region, Intellectual Economics, 7/2 (16): 161–81.

Tarki (Social Research Institute), 2009. ANCIEN Questionnaire Hungary [internal data collection for the ANCIEN project, not publicly available].

Technology Strategy Board, 2013. Analysis of UK Long Term Care Market, UK: United Kingdom.

Tediosi F., and S. Gabriele, 2010. The Long-term Care System for the Elderly in Italy, ENEPRI Research Report N° 80.

McCreadie C., and A. Tinker, 2005. The Acceptability of Assistive Technology to Older People, Ageing and Society, 25/01: 91 – 110.

Triantafillou J., Naiditch M. and K. Repkovaet, 2010. Informal Care in the Long-term Care System, European Overview Paper, Athens/Vienna.

Vaiou D., and D. Siatitsa, 2013. Current Organisational Framework of Elderly Care Services, COST Action IS1102 WP n. 2.

Verschuere B., and D. Barbieri, 2009. Investigating the 'NPM-ness' of Agencies in Italy and Flanders, Public Management Review, 11/3: 345-73.

Westendorff D., 2002. From Unsustainable to Inclusive Cities, An UNRISD publication in association with the Swiss Agency for Development Cooperation: Geneva.

WHO, 2002. Active Ageing: A Policy Framework., A contribution of the World Health Organization to the Second United Nations World Assembly on Ageing, Madrid, Spain, April 2002.

Willemé P., 2010. The Belgian Long-term Care System, Federal Planning Bureau, WP 7/10, Brussels.

Acknowledgments

We want to thank all the SPRINT partners for their valuable contributions on the country case analysis and for the review of the contents. We also thanks London School of Economics for the language revision and comments. This research has been possible thanks to the funding of the European Union's Horizon 2020 research and innovation programme under Grant Agreement No 649565.