Organisation and supply of long-term care services for the elderly: A bird’s eye view on old and new EU member states*

*Early view of full paper available in Social Policy & Administration (DOI: 10.1111/spol.12170)

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Objectives

The aim of the paper is to portray and compare the organisation of formal LTC systems for the elderly population in 21 EU member states. We address the following research question: How do organisation and supply of LTC services differ between new and old EU member states? In this context, we explore three hypotheses.

Data

The data are mainly drawn from a set of country reports on national LTC systems published in the context of a project funded under the 7th Framework Programme (FP7 Health-2007-3.2.2, Grant no. 223483). It comprises the following countries: Austria, Belgium, Bulgaria, the Czech Republic, Denmark, England, Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Lithuania, the Netherlands, Poland, Romania, Slovakia, Slovenia, Spain and Sweden.

Hypothesis 1 – in new EU member states regulation of LTC is more centralised than in old EU member states

Results

- **Basic structure of governance:** the findings support our hypothesis, as in five of the ten new EU member states the main responsibility for regulating LTC lies on the national level (CZE, HUN, LTU, POL, ROU), whereas only in three of the eleven old EU member states this responsibility lies on the national level (ESP, ITA, SWE).

- **Capacity planning:** the findings do not clearly support our hypothesis, as differences between new and old EU member states are less pronounced; in the majority of the countries authorities on both levels, national and regional, are of some importance.

Hypothesis 2 – new EU member states restrict access to LTC services more tightly

Results

- **Means-testing and entitlement:** the findings do not support our hypothesis, as LTC governance in new and old EU member states aims at keeping organisational barriers to access at a rather low threshold.

- **Easy accessibility along both lines, no means testing and a legal entitlement**, can be found in six new EU member states (BGR, CZE, EST, HUN, ROM, SVN) and seven old EU member states (BEL, DNK, FIN, FRA, GER, NLD, SWE).

Four new EU member states (LTU, LVA, POL, ROM) and three new EU member states (ESP, GBR, ITA) have a **means-tested access** to LTC services.

Only two EU member states (AUT, ROM) have implemented legal entitlements neither for institutional nor for home-based LTC services.

Hypothesis 3 – in new EU member states, capacities to provide formal LTC services are lower and less often located in the private sector, compared to old EU member states

Results

- **Institutional capacities:** the findings clearly support our hypothesis that institutional capacities are lower in new EU member states than in old EU member states; furthermore, a convergence in terms of institutional capacities between both new and old EU member states cannot be noticed, there is only some degree of convergence within the group of old EU member states.

- **Public-private mix of care provision:** the findings partly support our hypothesis.

Institutional care: private care provision is still of far less importance in new EU member states than compared to (non-Scandinavian) old member states.

Home-based care: private care provision ranges from about 10% to about 90% in new EU member states.

Conclusions

- **Basic structure of governance:** our findings confirm a more pronounced centralisation of LTC governance in new EU member states which we interpret in the context of history and also lower population size in these countries.

- **Access to LTC services:** our findings show easy accessibility to LTC services across new and old EU member states; this, however, needs to be seen with some scrutiny, as the absence of these organisational barriers alone does not necessarily translate into easy and timely access in practice.

- **Public-private mix of care provision:** our findings indicate increasing importance of the private not-for-profit sector across new and old EU member states, especially in home-based care.