

**Europeanization, Policy Transfer, and Path Dependency
of Elder Care Systems**

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1. Introduction

The development of elder care systems has become a salient issue in many countries around the world, in particular in countries with an aging population such as Germany or Japan. This paper focuses on the Europeanization of elder care systems, in particular on the development of independent funding systems. Europeanization is defined here in a broad sense, encompassing not only the transfer of European ideas to other parts of the world but also the bilateral transfers between EU member states and the development of multilateral networks among them.

Olsen (2002) identifies five definitions of Europeanization: (i) enlargement; (ii) European-level institutionalization; (iii) the export of European institutions to the wider world; (iv) the strengthening of the European 'project' as a political ambition; and (v) the domestic impact of European level institutions. Starting from this broad definition, we will first ask how European ideas have had an impact on the development of elder care systems outside Europe. Moreover, we distinguish between vertical Europeanization, i.e. the direct influence of the EU and its institutions on the Member States, and horizontal Europeanization, i.e.

Europeanization through networking and the exchange of experience among the Member States. In contrast to other policy areas in which the EU can use hard policy tools, such as directives, elder care appears to be a policy area in which the horizontal transfer of ideas and knowledge produce more pertinent results. Elder care systems in EU member states have become more Europeanized due to EU initiatives and bilateral transfer processes between countries. Starting in the 1980s, elder care systems have been subject to far-reaching restructuring processes in most EU Member States. Similar developments can be found in care provision, e.g. the introduction of new funding systems and market-principles.

We discuss how the policy of the European Union affects the social policies of its Member States. Here, we examine various efforts, such as the Open Method of Coordination (OMC) within health and long-term care, undertaken by the EU to support best practice transfer between Member States. Special emphasis is placed on bilateral transfer processes between countries, asking whether and how individual countries learn not only from their own experiences but also from the experiences of their peers. Empirical studies show how policy ideas have been transferred between countries and interact with institutional designs and cultural values of national care systems.

The paper starts from the assumption that policy change at national levels can be explained by a combination of three factors and their interplay: (i) factors originating within nation-states such as specific actor constellations; (ii) factors beyond nation-states such as approaches developed in neighboring countries; and (iii) temporal factors, i.e. we assume that the specific features of a policy change depend on the time when the most relevant decisions are taken.

The paper aims at an analysis of external Europeanization, i.e. the influence of European ideas beyond the borders of the EU (section 2). Furthermore, we ask how vertical Europeanization, including the Open Method of Coordination (OMC), supports best practice transfer between EU Member States and the Europeanization of elder care systems (section 3). In addition, the comparative analysis of care systems helps to get a better understanding of the relations between countries, which shape the forms of horizontal Europeanization between Member States (section 4).

2. External Europeanization

External Europeanization has a long tradition. Transatlantic expert networks, for example, emerged in the area of social policy as far back as the late 19th and early 20th century. At that time, unlike now, European initiatives were readily adopted in the USA (Rodgers, 1998). Thus, for example, there was intensive exchange between the German social reformers and American progressives, most of who had studied in Germany (Schäfer, 2000).

Japan is another example for the transfer of policy ideas. Japanese history shows that Japan has frequently adopted European ideas and innovations, including social security models (Tanaka, 2004). This phenomenon can also be observed in the area of elder care. The introduction of a Long-term Care Insurance (LTCI) in Japan implies a significant departure from the prevalent system of elder care in Japan. As in western countries the traditional Japanese elder care model, which was characterized by a strong emphasis on family care supplemented by local care provision mainly targeting the lower socio-economic classes, was called into question by demographic and social changes as well as the expensive and inappropriate use of institutionalized long-term care in hospitals financed by the health insurance funds (Bureau *et al.*, 2007; Izuhara 2003).

In the late 1980s, two governmental programs were launched to meet the increasing care needs; due to growing problems, however, these programs failed to meet expectations (Ikegami, *et al.* 2003). Eventually, the merging problems combined with extensive lobbying from outside reached a critical juncture. The introduction of an insurance system was supported by a comprehensive analysis of existing German legislation and its consequences. In addition, German experts were invited to Japan to explain the rationale behind the German LTCI reform and present the results and consequences of their research (Matsumoto, 2003).

Within the country, new political actors in favor of the idea of a LTCI system took up the transnational influences. Thus, the introduction of LTCI in Japan is an interesting case of a shift from insider to outsider politics because the conventional social-welfare policy community was destabilized, thereby allowing non-established political players to enter the arena. The ‘Women’s Association for Improving an Ageing Society’, established in 1986, advocated the socialization of care – to be understood as the idea that, instead of the family,

society as a whole should be responsible for the care for the elderly. In the mid-1990s this association was joined by the 'Citizens' Committee', a new action group which also championed LTCI (Eto, 2001). Together they organized a new citizens' action group called the 'Ten Thousand Citizens' Committee' to carry out a campaign for the establishment of a public care system.

A group of municipal leaders established the 'Mayors' Association to Promote Welfare Administration for Residents' (Welfare Mayors) in November 1997. This association supported the LTCI system because the mayors believed that this would provide them with a good opportunity to promote municipal welfare policy and demonstrate leadership. By using the strong influence of the mass media effectively, leading members of the Welfare Mayors in cooperation with the Women's Association and the Citizens' Committee were able to protect the LTCI proposal from the forces that sought to derail it (Eto, 2001).

With the introduction of the LTCI the state-family-market nexus in the area of elder care sector altered significantly in Japan. Comparable to the situation in Germany, the insurance in Japan established a system of universal insurance benefits, transformed the interplay between the central and the local level and opened up care provision to private providers. In contrast to the German model, the idea of freedom of choice between formal care provision and cash payments for beneficiaries was rejected (Cuellar/Wiener, 2000). It was feared that the introduction of cash-benefits would carry the risk of perpetuating traditional gender roles within the family and hamper the establishment of a care infrastructure based on the entitlements provided by the insurance (Karlsson *et al.*, 2004).

It can be concluded, first, that European ideas have influenced the development of social policy around the world from the early stages of social policy in Europe. The Japanese example shows that this trend continues to the present day. Second, Japanese policy-makers referred in particular to the German model of a Long-term Care Insurance and developments in Japan were thus primarily influenced by German ideas and not directly by the European Union. Bilateral contacts between countries and specific policies in individual countries appear to be more important than the European social model. The development in Japan can be regarded rather as an example of (limited) policy transfer between Germany and Japan than as a form of comprehensive Europeanization.

3. Internal vertical Europeanization

Within the European Union we can distinguish between vertical Europeanization, i.e. the direct influence and impact of the EU and its institutions on its Member States, and horizontal Europeanization, i.e. Europeanization through networking and the exchange of experience among Member States. Current debate on Europeanization has been dominated by the debate on vertical Europeanization. This strand of Europeanization research has concentrated on the

relationship between European and domestic politics and the implementation of EU legislation, in particular that relating to the dimensions and mechanisms of domestic change (Coen/Héritier, 2006).

The debate on Europeanization (Olsen, 2002; Featherstone and Radaelli, 2003; Schimmelfennig and Sedelmeier, 2005; Radaelli, 2006; Börzel and Risse, 2007; Graziano and Vink, 2007; Bache, 2008) complements the analysis of the European multi-level system by providing a sense of the means by which multi-level governance is accomplished (Pollack, 2005: 384). Although most Europeanization studies focus on the impact of EU legislation on the Member States, the bottom-up dynamics of the Member States' actions vis-à-vis EU institutions are also important for this approach (Börzel, 2005; Ladrech, 2005: 319; Radaelli, 2006). Since Europeanization processes are more circular and interactive than unidirectional, the traditional hierarchical perspective of vertical Europeanization must be complemented by an alternative perspective, one which takes the co-evolution between the domestic and European level into account (Radaelli, 2006: 59).

Although decisions on social policy are primarily made at national level, EU policies have had many diverse impacts on the development of Member States' social policies. This concerns direct effects on social policy, emanating from social policy campaigns or, more recently, from the Open Method of Coordination (OMC) and – in particular for CEE countries – from programs, funds and reports related to accession. Enlargement can be described rather as a top-down process because it puts candidate countries under extreme pressure (Schimmelfennig and Sedelmeier, 2005). The EU strongly influenced countries such as Poland, Latvia, or Estonia in the pre-accession phase. Financial instruments also played an important role here because these countries were not allowed to join the Union before complying with the *acquis communautaire*, i.e. the whole body of EU legislation.

This means that three forms of vertical Europeanization can trigger national policy changes. First, hierarchical forms of governance such as regulations and directives, which aim at harmonization, have had only limited effects on social policy because harmonization is limited in the area of social policy. EU social policy has been dominated by 'soft' forms of control because the EU abstained from creating a uniform social protection system and rejected the imposition of social policies 'from above'. Second, the EU can use financial stimuli to reach its goals at nation-state levels. Project funding, such as funding through the PHARE program, has been particularly important for the new Member States in Central and Eastern Europe which had to adapt to European provisions before being admitted to the Union. Third, in areas in which neither harmonization nor the provision of financial incentives can be used as a tool the EU is restricted to facilitating the transfer of information and knowledge between Member States. The most important form of this 'enabling mode' of European governance is the Open Method of Coordination (OMC).

The EU's Ageing Policy initially targeted the voluntary adoption of best practice, while the harmonization of national policies was completely rejected (BMFSFJ, 1994; Schulte, 2001). The creation of a European Ageing Policy had already begun at the end of the 1980s as demographic and social changes in EU Member States became evident and the effects of European integration on the elderly, for example in terms of freedom of movement, also became apparent. An initial approach was provided by the European Social Charter of 1989, which called for, *inter alia*, economic security for the elderly and adequate benefits in case of illness for all EU citizens. The first action program for the elderly (1991 to 1993) provided a key impulse for the emergence of a stronger Europe-oriented ageing policy (BMFSFJ, 1994). The main objectives were concretized within this process and became a part of the implementation of the European Social Charter. This development of EU initiatives in the area of elder care shows that harmonization did not play a critical role for the Europeanization of elder care systems. Europeanization through legally binding regulations is clearly not as advanced in social policy as it is in other policy areas. Thus, EU conditionality played a rather limited role for social policy reforms in CEE accession countries (cf. Orenstein, 2008; Sissenich, 2007).

In CEE countries, however, capacity building and policy reforms were supported by twinning projects and subsidized through EU funding programs such as PHARE (Cerami, 2006: 67). Between 1994 and 2004 this EU program, which aimed to support the modernization of social security systems, had far-reaching consequences for the development of social policy.

Different EU programs promote the establishment of social services in CEE countries (Nospickel, 2005). 30 percent of the projects financed by the PHARE and the PHARE-TWINNING programs supported the establishment of adequate administrative structures. In addition, the ACCESS program, which was financed by the PHARE program, supported the development of civil society organizations. A survey among 120 state and non-state actors in the social service sectors in Hungary, Poland, Slovakia, and the Czech Republic revealed that 50 percent of the actors had received financial support within the framework of an EU program.

In addition, reports on 'Progress towards Accession' included a chapter on social policy, which revealed best practice in this policy area. As political actors relied on (positive) reports to avoid negative repercussions on their accession process and secure access to different EU funds, these reports gained importance. This applies, for example, to Estonian health policy, and in particular to the choice of policy priorities. Legislative initiatives were restricted because priority was given to the harmonization of national and EU legislation (Jesse *et al.*, 2004; Trumm, 2006).

Apart from 'hard' regulation through EU legislation and financial incentives the EU can apply 'soft' measures such as benchmarking. The idea of benchmarking has influenced the

development of new forms of European governance. In the EU, “benchmarking seems to be everywhere” (Arrowsmith *et al.*, 2004: 311). Starting with the EMU’s Maastricht membership criteria and the Stability and Growth Pact, the practice of benchmarking has been transferred to other policy areas in which the EU’s competences are rather limited. Since the late 1990s, a new form of regulation, the Open Method of Coordination (OMC), has been applied in the area of employment policy and subsequently extended to other policy areas such as pension reform policy and health care policy.

The introduction of the OMC entails the transfer of certain policy elements and the sporadic adoption of foreign policy innovations to be replaced by an institutionalized form of transnationalization based on the systematic comparison of the performance of all EU Member States. The OMC typically involves a decentralized but systematically coordinated benchmarking process that goes far beyond voluntary actions. As a result, pressure on the individual countries has intensified and tools have been created which ensure functionally equivalent services in all Member states. Various combinations of benchmarking with voluntary or legally binding regulations and a structured coordination process can be found in the EU (Citi/Rhodes, 2006: 469). Although the OMC has created new forums for mutual learning, its strong reliance on peer pressure (Borrás/Jacobsson, 2004: 194) and the absence of sanctions and enforcement mechanisms can be seen as its major weakness (Heidenreich/Bischoff, 2008; Arrowsmith *et al.*, 2004).

The introduction of the OMC in different social policy areas at the European Council summit in Lisbon in 2000 marked the adoption of a more coordinated transfer of ideas and regulations. The OMC on ‘Health and Long-term Care’ launched in 2004 and combined with the OMC Social Inclusion and Pension in 2007 defines three objectives for health and long-term care: (i) the accessibility of care services, (ii) the provision of high-quality care, and (iii) the financial sustainability of the policies. Due to the complexity of the health sector and national differences no system of benchmarking has been applied, but the exchange of information on best practice – with the participation of all relevant actors at regional, central, and EU levels – were defined as suitable measures for the application of the OMC. At EU level the OMC was stressed as a means to improve efficiency in European health care provision. Social policy and financial goals are not regarded as conflicting aims, but as mutually reinforcing elements (Hervey, 2008).

In her analysis of national reports and reviews Hervey (2008) starts from the assumption that the OMC on Health and Long-term Care can be seen as a promoter of neo-liberal ideas, which rest upon keywords such as privatization, liberalization, provider competition and consumer choice. Instead of confirming this assumption, her findings show that a variety of reform approaches in the area of health care are discussed in the reports. Tjadens (2007) criticized that the developments at regional and local levels are neglected, civil society participation is inadequate and family carers are seen primarily as a source for cost savings.

In contrast to research results that show that the EU has only marginal impact on the social policy of its member states, Cerami's (2008) findings suggest that the EU, and particularly the OMC, is significant for the development of social policy in the new Member States. It appears that ideas which prevail within certain policy areas at the European level gradually trickle down and can later be found in policy descriptions at national level, while the obligation to deliver national reports may lead to the development of new actor constellations at national levels.

This means that financial incentives and the OMC influenced the establishment of new care systems in the new Member States in Central and Eastern Europe. Temporal factors are important here because many systems in this group of countries were set up after the introduction of the OMC. Although the Southern Member States were among the EU's founding members (Italy) or joined the European Communities already in the 1980s (Spain, Portugal and Greece), the situation in these countries is similar to the situation in the CEE countries because the OMC was set up at the same time or before the care systems in these countries were established. Thus, it can be assumed that the institutionalization of care systems in Central and Eastern Europe benefited from the OMC because this new form of European governance improved the transparency in this policy area, facilitated the transfer of ideas, and created new opportunities to learn from other members' experiences. Unlike the situation in Southern Europe and in the new Member States, the OMC had less influence in the rest of Europe because care systems were established long before the OMC was institutionalized. While in the UK and the Nordic countries (Sweden and Finland did not join the EU until 1995) care services were provided by existing systems and paid by taxes, separated social security systems were set up in Continental Europe. Although the development of such systems was not directly influenced by EU policies, these processes were affected by horizontal Europeanization.

4. Internal horizontal Europeanization

Europeanization can take place even if EU institutions are not present and directly involved in the process. In Europe we find various forms of horizontal Europeanization caused by best practice transfer between Member States. As Member States face similar challenges across Europe, they have developed strategies for facilitating best practice transfer. They exchange experiences, cooperate in transnational projects, and develop innovative solutions for shared problems that are compatible with different national settings. National policies have become more Europeanized because Member States cooperate, exchange experiences, and have learned to develop innovative solutions based on the experiences of other member states.

Policy diffusion and best-practice transfer is by no means a new phenomenon in the area of social policy. Research in the area of pensions policy, on which social policy research concentrated until recently, reveals, for example, that not only can the German system be

characterized as having a high level of continuity, it also spread to neighboring continental European countries. (Bilateral) policy transfer was already apparent during the initial phase of this innovation. Thus, Luxembourg's system was strongly influenced by the German model while Germany and Austria-Hungary learned lessons from each other (Gloetz, 2003: 51f. 253).

Under the influence of a system developed in New Zealand in 1898 (Ritter, 1991: 89ff.), an old-age pensions system exclusively financed by the state was introduced in the UK in 1908. This was crucial to the development of the Beveridge model as an alternative to the German Bismarck system. Documentation of the debate in the UK at the time shows that, while the German model was known, there was no interest in adopting it. On the contrary, there was an explicit desire to distance the UK system from the German model; the aim was to improve on and outshine the German system (Ritter, 1991: 101). The differences between the Bismarck and Beveridge models, already noticeable in this early phase of social policy, were crucial to the establishment of different welfare regimes and influenced developments in different areas of social policy, including elder care.

Collier and Messick (1975) were the first to draw attention to diffusion processes in the context of international comparative welfare-state research. In terms of the introduction of socio-political programs, the authors explicitly differentiate between internal and external variables and show that worldwide diffusion processes took place as early as the initial phase of social policy in the early 20th century. In general, it may be assumed that the transfer of ideas and policy approaches plays a particularly important role when a radical change in policy takes place due to the creation of a new policy field or the existence of strong pressure for reform. Such a situation may lead to new opportunities for policy entrepreneurs (Kingdon, 1995) and a critical juncture may be reached.

Diffusion processes also became visible in the context of the spread of the multi-pillar model in pensions policy. This process began in 1981 with the privatization of the Chilean pensions system (Orenstein, 2008). Although this radical model has some rather unique features, similar approaches emerged in other countries of South America (e.g. in Argentina, Peru, Columbia) and in Central and Eastern Europe (e.g. in Poland and Hungary) in the first half of the 1990s. The diffusion of policy innovations in concentric circles, i.e. originating from the centers of innovation, can be explained by the fact that the knowledge necessary for the adoption of a policy is far more accessible to geographical neighbors. Neighborhood effects were first confirmed through studies on the diffusion of policy innovations among the states of the U.S. Thus, because neighboring countries tend to imitate and emulate the forerunners, it may be assumed that pioneering countries become centers of regional diffusion clusters. Apart from geographical proximity, cultural proximity (in particular language) can become a crucial factor for the adoption of a policy innovation from abroad.

The general discussion on this phenomenon concentrates on several strongly related concepts such as policy diffusion (Gray, 1973; Kern, 2000; Karch, 2007), policy transfer (Evans, 2004; Bulmer *et al.*, 2007), lesson drawing (Rose, 2005), and policy convergence (Holzinger *et al.*, 2008). While diffusion studies are more concerned with the timing and sequence of adoptions than their actual content (Rose, 2005: 23), the convergence literature focuses primarily on policy effects and both lesson-drawing and policy transfer are more interested in the policy process (Bulmer *et al.*, 2007: 14). Today, most research focuses on policy diffusion and policy transfer among nation-states in different areas of regulation, such as market liberalization, regulatory impact assessment and environmental policy.

Rogers (2003: 5, 11) defines diffusion as “the process by which an innovation is communicated through certain channels over time among the members of a social system”. Based on this classical definition, best-practice transfer depends on the existence of: first, a policy innovation that is acknowledged as best practice; second, a pioneer with the capacities to develop and label best practice; and third, a group of potential adopters with adequate absorptive capacities and the willingness to adopt. However, in reality, best-practice transfer is far from being a smooth flow of ideas and policies from the best-practice source to the recipient. Learning from best practice does not imply that a template can be carbon-copied and universally deployed. Instead, learning from best practice is shaped by debates surrounding contentious issues and requires considerable knowledge about contextual factors (Bulkeley, 2006: 1037-38; Radaelli, 2004: 742). Unfortunately, the promoters of best practice often ignore these aspects. The singling out of a specific program as superior appears to be unnecessarily restrictive because there are alternative ways of learning lessons, ranging from copying and adaptation to hybridization and selective imitation (Rose, 2005: 38, 81).

The development and establishment of care systems across Europe is a good example of many alternative ways of learning lessons. During the 1990s in some Continental European countries new policy approaches and funding systems were introduced to combat the risk of care dependency of older adults, while in Southern European countries and some new EU Member States more comprehensive approaches have been created only recently. Since the end of the 1990s, even in England and Sweden, societal debates have sprung up on the establishment of new funding systems. Taking continental Europe as a starting-point, the following presents an empirical analysis of the introduction of new elder care policies since the 1990s and the processes of policy transfer between European countries. The findings show that despite intense processes of policy transfer, national context considerably determines the institutional designs of care policies.

Development in Continental Europe: Learning from pioneers?

The *Netherlands* can be viewed as a forerunner in continental Europe in that, as early as 1968, the country created a long-term care insurance scheme (AWBZ) as a part of the social

health insurance that, step by step, came to cover residential, semi-residential, and home-based long-term care services (Meyer, 1996; Pijl/Ramakes, 2004). The funding of the AWBZ is based on tax-related insurance contributions as well as subsidies from the state. It is a comprehensive universal-oriented system of public support with a smaller extent of private contributions accounting for about 10% of total expenditure. The general budgetary framework with spending limits, criteria for the allocation of services and quality standards are defined at central level (Österle, 2001). The policy approach in the Netherlands influenced the process of policy development during the 1990s – in particular in Germany (see below).

Austria and Germany, two other forerunner countries, created two different elder care approaches, which have inspired elder care policies in other Continental and Southern European countries, as well as in the new EU Member States. In 1993 a tax-financed national system of attendance allowance “Bundespflegegeldgesetz” was created in Austria by federal law (Meyer, 1996; Pacolet *et al.*, 2000). The societal debate included discussion of the introduction of a long-term care insurance or a tax-based care allowance. Finally, existing tax-based systems of care allowances were harmonized and completed under this law (Pacolet *et al.*, 2000). Until 1993 the public support system in Austria was characterized by a decentralized responsibility and structures of payments and institutional services.

Decentralization resulted in considerable regional disparities with regard to payments and home-based as well as residential service provisions (Österle, 2001). Within the framework of the new scheme the federal level guarantees the financing and the regional authorities adapt their regulations and engage themselves in the further expansion of residential, semi-residential and community care. By defining seven levels of care needs valid in the entire country the care allowance system in Austria aims to guarantee universal access of cash benefits to care users in order to purchase professional services to support care within the family or to cover further needs related to care-dependency (Mager/Manegold, 1999; Pacolet *et al.*, 2000; Egger de Campo/Just, 2003). The establishment of the care allowance in Austria had crucial effects on policy developments in other countries, e.g. in Germany. The developments in Austria had repercussions on the German debate and in addition Austrian experts served as advisors in Germany (see below).

Despite intense policy exchange between Austria and Germany with the creation of the Long-term Care Insurance (LTCI) in 1995/96, Germany adopted a different institutional design. The increasing costs for residential care at municipal levels increased the need for a sounder funding of elder care, which provided the main incentive for the establishment of this new pillar within the German social insurance system (Ostner, 1998; Campell/Morgan, 2005). The introduction of a social insurance to regulate social risks corresponds to the German social insurance tradition. During the process of policy development the introduction of (compulsory) private insurance schemes and, more rarely the introduction of a tax-based system, were contrasted (see Meyer, 1996). In particular, market-liberal politicians voted for

private insurance solutions to promote individual responsibility against the backdrop of welfare state constraints. Advocacies for a social insurance model emphasized the necessity of redistribution between societal groups, something that would not be possible within a private insurance scheme.

Basic regulations mandated by law brought about a significant departure from the German social security tradition with regard to the state-market-family nexus (Landenberger, 1994). As a result of the introduction of LTCI, social rights relating to elder care and the mode of funding were purposely changed. Unlike the existing residual social rights (based on the German Federal Law on Social Assistance), the new insurance introduced a near-universal social right to elder care, which covers 99% of the population. Within the framework of LTCI, however, only basic funding is granted, i.e. the costs are only covered in part by the social insurance and have to be supplemented by private means or informal care delivery. At the beginning of the debate on LTCI most of the political and civil society actors involved argued that the funding level for long-term care should be comparable to the comprehensive funding level for health care, however, the more economically-oriented actors within the political parties gradually prevailed (see Meyer, 1996). In particular, the high expenditures and insurance contributions in the Netherlands were viewed as an indicator for the financial obstacles of a more comprehensive social insurance scheme. Finally, the introduction of a cash-benefit as a symbolic payment, which aimed to maintain the care activities of family members, corresponds to traditional ideas on the role of families while at the same time signifying a departure from the health care tradition.

During the 1990s the policy innovations related to elder care policies inspired policy efforts in further continental European countries. The debates resulted in the introduction of universal social rights and separate funding systems – either tax- or social insurance funded or a combination of both in various other continental European countries such as Luxembourg (1999), France (2002), Flanders (Belgium) (2002).

The long-term care scheme established in **Luxembourg** was directly inspired by the institutional design of the German Long-term Care Insurance and German experts have even been involved in the policy development process. After an in-depth preparatory study in several other countries in 1992/93, in 1994 the Luxembourg government announced the creation of a compulsory insurance, which started from 1 January 1999 (Pacolet *et al.*, 2000).

Comparable to the German LTCI, entitlements are universal, therefore covering people of all ages; the provision includes services in-kind and cash benefits and the scheme is organized within the social security system. In addition, decisive differences can be found, which reflects processes of adaptation of policies to the national context. The entitlements cover care needs comprehensively, e.g. home-based services of up to 40.5 hours per week are made

available. Further, the system is financed on the basis of taxes, i.e. the state budget (45% of the expenditure) and an additional 1% social contribution is levied on all incomes.

In **France** the establishment of elder care schemes is related to a long-lasting debate where financial obstacles in particular impede the implementation (for the following cf. LeBihan/Martin 2008). The development of a policy regarding the frail elderly already arrived on the political agenda in the mid 1980s, but until 1994 there was no specific policy on dependency. During the 1980s and 1990s the political debate centered around issues of eligibility criteria - means-testing versus universalism -, the implementation of a scheme within a social insurance or social assistance framework or, more generally, the designated mode of funding and the administration of the system.

During the development of the long-term care scheme different steps can be distinguished. In 1997, a temporary national assistance scheme was created at the regional level (PSD; Pr  station sp  cifique d  pendance), which granted means-tested benefits according to certain levels of needs to the most needy only. While the cost containment objective was reached, only 15% of frail older people received the benefit and a new reform became necessary. In 2002, with the introduction of the APA (Allocation personnalis  e    l'autonomie) the policy shifted from an assistance logic to universalism and benefits were henceforth allocated to people with medium or high levels of dependency, even in the middle classes. It is a tax-based national scheme in which care packages are defined according to the level of care-dependency on national levels but implemented at local levels. After the heat wave disaster in 2003, the introduction of new policies and additional funding appeared inevitable. In 2005, a fund for the frail elderly was created (CNSA, Caisse nationale de solidarit   pour l'autonomie). As in the German insurance scheme, this new fund was financed by employers' contributions in return for abolition of a one-day bank holiday; additional contributions are based on taxes and transfer of credits for frail elderly and disabled people from the social security fund. This fund has many features in common with an insurance model. French decision-makers have carefully analyzed the German Long-term Care Insurance but the implementation process of the French elder care schemes illustrates that no definitive answer has been given to the debate on an insurance system.

The establishment of the Long-term Care Insurance in **Flanders** (2002) is a quite different case of policy development, where the federal-regional interplay embedded in societal controversies on responsibilities for social policies has become decisive for the development. Before the introduction of the LTCI in Flanders evaluations on the situations show that, by national and international standards, a broad scope of services is available in reasonable quantity and quality (for the following cf. Pacolet *et al.*, 2000). Existing difficulties appear to be concerned with expected demographic developments, a lack of support for informal care, and the low wages of the care workers.

The societal debate on old-age insurance gained momentum in Belgium in the 1990s and has resulted in several government declarations and proposals. While the financial constraints on the federal level did not allow any substantial enlargements, step-by-step improvements have been realized. In the mid 1990s the institutional conflicts between the federal and regional levels with regard to social policies opened up an opportunity to create an own Flemish elder care policy. Since 1993 the Flemish government has claimed responsibility for the policy area and, following an improved budgetary situation, new initiatives were taken. The start of a universal-oriented Flemish LTCI was duly announced in 2002. From 2003 on, the annual insurance contribution was fixed at €25 and maximum benefits were raised to €125 a month (Cuyvers/Pintelon, 2003). Due to the availability of sufficient services subsidized by regional and local taxes, the Long-term Care Insurance has mainly been introduced to create a system to cover future expected cost increases.

Development in Southern Europe and in the new Member States: Latecomers on the Move

Despite considerable levels of underinsurance and a lack of home-based and residential care provision, the family's responsibility for care provision is still emphasized in Southern European countries (Pacolet *et al.*, 2000). Only recently, countries and regions in Southern Europe introduced more comprehensive elder or long-term care schemes. In Italy, for example, the complex central-local interplay combined with a situation of welfare state constraints has impeded the introduction of new, more comprehensive care policies. During the 1990s limited public funds for care provision and significant local and regional differences in relation to the provision of both care services and cash-benefits fostered political initiatives to expand the services and level out differences between the regions (see Ranci, 2007; Lamura, 2007). Center-left governments have favored the introduction of a new national fund to amalgamate the different national, regional and local funds that already exist to finance care support; however, it proved to be very difficult under the premise of cost-neutrality. The center-right governments examined the possibilities of developing private care insurances. Studies revealed that a private insurance market in this area would require a high level of public subsidization to work effectively, and the concept was, therefore, abandoned.

The difficulties to establish adequate social rights and funds for elder care provision at the national level resulted in the introduction of a new policy scheme at the regional level. In 2007, based on the reports of German and Austrian social policy experts, the Italian province South Tyrol, a region that borders Austria, introduced a care allowance system, which resembles the Austrian one.¹ Only the last Center-left Italian government succeeded in the introduction of a new national fund in 2007, which came into effect in 2008. The fund provides financial support to the regions – in 2008 and 2009 about 700m euros – to expand

¹ http://www.provinz.bz.it/index_d.asp; <http://www.provinz.bz.it/sozialwesen/pflegesicherung.htm>. We would like to thank Prof. Costanzo Ranci, Politecnico di Milano, Italy for this valuable information.

the care infrastructure and to support a more integrated care provision for older adults. However, it is not related to the introduction of new social rights. In Spain a tax-funded system was created that grants even new social rights, based on the 'Law on the Promotion of Personal Autonomy and Care for People in a Situation of Care-dependency'. Like the Austrian model it is a tax-funded system, although with regard to the benefits the choice between service provision and a cash payment for family carers makes it closer to the German model (European Commission, 2007a).

During the reform process in the CEE countries, transnational influences played an important role and led to a combination of different policy models. In two CEE countries new funding systems related to social care have recently been or are going to be established. In the Czech Republic a tax-based allowance oriented towards the Austrian system has been introduced (European Commission, 2007b). In Slovenia, plans have been developed to introduce a new compulsory LTCI system (European Commission, 2007a). The transfer of policies from Germany and Austria to Luxembourg, South Tyrol, the Czech Republic and Slovenia reveals that neighborhood effects are important for the diffusion of this policy innovation.

Development in the Nordic countries and the United Kingdom:

The Prevalence of Path Dependency

In the Nordic countries and the United Kingdom the risk of care dependency was already implicitly covered by the existing social security systems. Since the 1990s, in Sweden and England the emerging obstacles to secure an adequate care provision for the elderly resulted in a societal debate on the introduction of a Long-term Care Insurance as a means to solve the problems.² In both countries, however, the concept was not realized.

In *Sweden*, the Social Service Act defines elder care services as an individual citizenship right and stipulates the statutory responsibility of the municipalities to provide universal support for the elderly financed by (local) taxes. Tax funded public service provision was perceived as a guarantee of egalitarianism between social classes and genders and as an instrument for balancing unequal market outcomes (Blomqvist, 2004; Hirdman, 1990).

Due to increasing fiscal constraints and considerable autonomy for local governments with regard to the content of public support, elder care services were restructured and the proportion among older adults receiving services gradually declined during the 1980s and 1990s (Szebehely, 2000; Rauch, 2005). At the end of the 1990s the decline of the proportion among the elderly receiving services and ensuing regional imbalances prompted a societal debate on the introduction of a Long-term Care Insurance modeled on the German or Japanese versions. The introduction of the insurance should provide a sounder funding and

² In the UK long-term care is regulated on a regional level. The debate concerns the development of long-term care in England.

the introduction of more specific entitlements iron out regional imbalances (Söderström et al., 1999). The idea was rejected because it was regarded as a risk for the further privatization of elder care after ongoing efforts to privatize service provision since the beginning of the 1990s (Blomqvist, 2004).

In *England* long-term care policies for the elderly have been the subject of substantial criticism, e.g. the principle of means-testing related to high private responsibilities, in particular for the middle classes, a wide range of confusing benefits based on different eligibility criteria and funding resources and significant local imbalances (Wanless, 2006; Glendinning, 2007). The introduction of a Long-term Care Insurance modeled after the German system was suggested as a solution to the problems, i.e. it is a universal scheme at national level with an effective cost-balance (Glendinning, 2007). In an analysis, Wanless (2006) compared different funding systems on their capacity to overcome some obstacles related to the English elder care schemes, above all to abolish means-testing. Based on defined criteria – such as fairness, economic efficiency, choice, sustainability or acceptability – the social insurance model scored only three. The researchers advocated a partnership model, which leaves more private responsibility to the users. A partnership model is also meant to correspond to the readiness of the people to pay collectively for long-term care. Thus, the examples of Sweden and England demonstrate that path dependency embedded in certain societal values can prevail, even if attractive foreign models are available.

5. Conclusions

Like many other policy areas care policy has become more and more Europeanized. As the example of the establishment of an elder care system in Japan clearly shows, European ideas have even influenced developments outside Europe. Apart from this transfer of European ideas to countries outside the EU, we can distinguish between vertical and horizontal forms of Europeanization within the EU. While vertical Europeanization refers to the direct influence of the EU on its member states, horizontal Europeanization does not need strong EU intervention because it is based on learning among countries.

Direct influence of the EU, however, would seem to be bound by certain limits.

Harmonization—which is dominant in many other policy areas, in particular in the first pillar (e.g. in most areas of environmental policy)—is almost absent in elder care. Moreover, financial incentives and funding programs are also limited and have thus mainly influenced countries in Central and Eastern Europe because of conditionality requirements and the need to adapt to EU provisions before being allowed to join the Union. This leaves the OMC as the most important tool of the EU to directly influence the establishment and development of elder care systems in its Member states.

However, many Member States had already set up own systems to solve existing problems with the under-insurance of care risks when the OMC was finally introduced. This applies not only to the UK and Sweden, where care risks were covered by existing systems and funded by taxes, but also for most members in Continental Europe. Although the OMC improved the exchange of knowledge and learning among Member States, contacts between Member States existed long before. Such intergovernmental and transnational relations were, however, mainly bilateral in nature and focused rather on learning from individual countries than on general overviews and detailed reports on the initiatives in all Member States. Thus, the OMC created more transparency, facilitated learning from other countries, and helped other countries to set up their own systems, particularly those in Southern Europe and the new Member States in Central and Eastern Europe. As these countries had not (yet) established their systems when the OMC was finally introduced, this new form of European governance has provided a better learning environment and set countries such as Spain or Slovenia in a more favorable position than their counterparts in Continental Europe.

The development of care systems, and in particular funding mechanisms, was influenced mainly by three factors: First, national factors which shape actor constellations where the debates and decisions taken at national level appear to be most important. This does not come as a surprise because decisions that affect financial aspects need national acceptance and legitimacy. Second, the development in Continental Europe but also in other parts of Europe (and even in Japan) shows that decisions on national care systems are strongly influenced by foreign ideas. However, a more detailed analysis of the development in selected countries reveals that the direct transfer of institutional arrangements is rather limited because such ideas are modified at the national levels and adapted to national conditions that differ considerably between countries. The transfer of ideas inspires national debates but does not lead to the copying of foreign policies or rarely to radical changes in existing systems. Third, our analysis also shows that the development of care systems and their funding provisions strongly depends on temporal factors. Systems that were introduced early on were less affected by the need to restrain welfare systems and limit the costs of new systems. This may explain why systems that were set up early on, such as the more generous Dutch system, did not develop into general models. The Dutch system played an important role in the German debate, but did not, nonetheless, serve as a model for Germany where it was rejected, mainly for financial reasons.

It can be concluded that the Europeanization of elder care systems is limited, for the main part, to the transfer of ideas, which play an important role for national discussions and shape discourses at national level. Their influence depends on temporal factors and appears to be stronger in phases of system establishment than in phases of system transformation.

Moreover, the OMC can be regarded as an extension of the already existing intergovernmental and transnational links between countries. It transformed these mainly

bilateral relations to more multilateral arrangements. This created a higher degree of transparency and facilitated the transfer of knowledge and learning, in particular in the new Member States and those in Southern Europe that had not already set up own systems when the OMC was finally institutionalized.

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