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Social Protection Innovative Investment in Long-Term Care

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EUROPEAN LONG-TERM CARE MODELS AND COMPATIBILITY WITH SOCIAL INVESTMENT APPROACHES

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Executive Summary

The concept of social investment (SI) has been defined in various ways but a common theme is that SI should promote a broader set of outcomes than traditional policy approaches to public services. While there have been attempts to understand the overall readiness of European Union countries to adopt SI approaches across public services, there is a gap in our understanding around the specific compatibility of national long-term care (LTC) systems with SI goals.

The following report uses the examples of four European countries (England, Finland, Germany and Italy) to analyse how the characteristics of different types of LTC system could support or impede the adoption of SI principles. In light of the lack of specific studies on how LTC systems could be designed to incorporate SI, the report uses existing literature and information on each national system to devise a framework for assessing SI readiness. We conducted a rapid review of the academic literature and supplemented this with reports from previous EC-commissioned projects, as well as literature identified through the use of 'snowballing'.

We analysed the compatibility of the four LTC systems with SI approaches using a framework with two dimensions: the opportunity for *flexibility* in different functions of each system, and the extent to which the systems supported the achievement of *outcomes*, both at an individual level and more broadly. We explored three aspects of LTC systems which might influence their receptiveness to SI approaches, namely funding and eligibility; service commissioning; and quality oversight.

Findings

Assessing the compatibility of each country's LTC system with SI approaches is hampered by a lack of research in this area. However, our analysis suggests that the lack of flexibility in the German social insurance model means that it is the system least compatible with SI approaches. The use of a rigid algorithm-based entitlements model, supported by clinical assessments based on Activities of Daily Living, means that there is little scope to focus on outcomes at either an individual or societal level. Quality standards are nationally defined and have been focused on input and process indicators, rather than on outcomes, whether for the individual or for other stakeholders. In contrast, for the large number of users have taken cash benefits, having control over services and support affords them the opportunity to focus on their own preferred outcomes. However, the government has neither input into ensuring those users receive a level of care quality which is likely to achieve those outcomes, nor influence over whether individual choices contribute to broader societal outcomes.

The strength of the Italian system is that LTC system functions are largely devolved to the local level, affording the maximum degree of flexibility of the four systems. The emergence of new types of third sector organisations in Italy suggests that the system has a certain degree of flexibility and responsiveness which would support SI goals. However, the challenge for the system in Italy is the reliance of users on the *Indennità di accompagnamento* (IdA) attendance allowance. As with cash

benefits in Germany, the IdA effectively excludes the government from determining SI-friendly outcomes and goals. This lack of control over quality is particularly relevant due to the large grey market of migrant carers.

The strength of the LTC systems in England and Finland in the context of SI is their adoption of an outcomes-based approach and goals which embrace the wellbeing of both the individual and of their family carers. Both countries also prioritise prevention goals. Many responsibilities, including the responsibility for needs assessments, are devolved to the local level and this enables a focus on the individual outcomes for users. However, the systems are less amenable to broader societal outcomes, demonstrated by the difficulties in integrating health and LTC functions.

The following are specific observations about the compatibility of LTC systems and SI approaches:

- Systems which are devolved to the local level, as in England, Finland and Italy, have more flexibility to respond to emerging needs. The bottom-up growth of organisations like social cooperatives in Italy is a demonstration of this responsiveness. On the surface, this responsiveness suggests that the systems are more compatible with SI approaches as they are more focused on delivering outcomes for individuals. The potential downside is that localism results in variability, which potentially undermines equity in the system.
- Entitlement models, such as the social insurance-based system in Germany, are generally too rigid and focused on defined services to be compatible with SI approaches. The use of algorithm-based, clinically-led assessment processes exacerbates this misalignment. The strength of these models, however, is their transparency and positive impact on equity, when compared to the variability across areas in England, Finland and Italy.
- Cash benefits afford a large degree of flexibility within LTC systems for both users and policymakers, and allow individuals to plan around their own priorities and outcomes. However, the use of cash benefits generally excludes governments from being able to influence the quality of care required to achieve these outcomes. The use of cash benefits also potentially sabotages other social policy goals, for example, supporting carers to stay in formal employment. This issue is particularly pertinent for priorities for female labour participation, given the ratio of female to male family carers.
- More broadly, the emergence of consumer choice and market-based mechanisms in LTC, particularly in England and Finland, can be said to have prioritised the requirements of the individual 'consumer' over the responsibilities of the 'citizen'. This transition from citizen to consumer is an important factor in determining whether market-based systems can support long-term societal goals.
- The design of quality oversight will influence the possibilities for SI-friendly, outcomes-based approaches. Prescriptive quality indicators (like those in Germany) which focus on structural and process measures are unlikely to support outcomes-based measures and could potentially sabotage them. The oversight of quality should emphasis priorities which promote outcomes for individuals and their families and carers. Where possible, these outcomes should relate to broader system priorities such as health and wellbeing and employment goals.

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Acronyms and Abbreviations

CQC	Care Quality Commission (England)
IdA	*Indennità di accompagnamento* attendance allowance (Italy)
LTC	Long-term care
LTCI	Long-term care insurance
SI	Social Investment

1 Introduction

This report sets out to investigate the way in which national frameworks of legislation and regulation for European long-term care (LTC) systems interact with the potential implementation of social investment (SI) approaches.

The report builds on SPRINT's definition of SI as

> welfare expenditure 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 (Lopes *et al*. 2016, p4).

SI strategies therefore focus on a broader set of outcomes than 'traditional' investment approaches, emphasising non-financial outcomes for the individual, their families and society more broadly (Maier *et al*. 2017). For older people, SI approaches might consider the delivery of decent levels of income, access to health care, the opportunity to participate fully in society and to remain active and productive for longer (Kangas and Kalliomaa-Puha 2015). These approaches are likely to involve the design of health and LTC services, but equally they may involve supporting older people in other ways to age healthily and live independently as long as possible. Positioning LTC as a type of SI might improve the opportunities and chances of attracting increased funding, by valuing explicitly the impact of LTC support on the quality of life and opportunities to contribute to society of individuals with care needs, their families and carers, as well as having an impact on wider societal goals. Employers might, for instance, see the case to invest in services for carers so that they can retain trained and experienced individuals rather than lose them to their caring responsibilities.

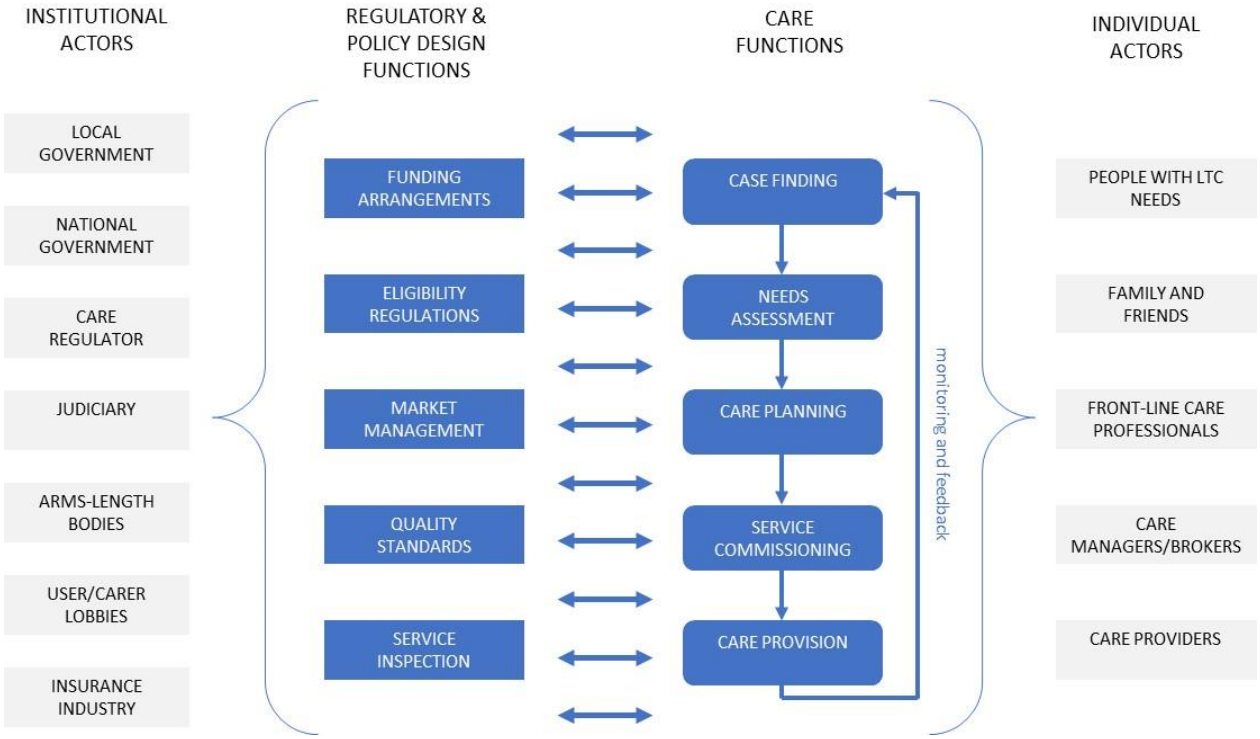
The level and type of investment in LTC systems is unlikely to be driven purely by cost-effectiveness considerations. Instead, systems design will often be guided by broader normative and cultural considerations related, for example, to local expectations regarding the roles of the welfare state and the family in the care system (Daatland and Herlofson 2003, Haberkern and Szydlik 2009). These factors will influence the structural and regulatory design of LTC systems, and in turn the distribution of LTC support. LTC systems are defined by the characteristics of key regulatory and policy functions such as those determining how funding and eligibility work, and functions directly related to the allocation and delivery of care such as needs assessments and service commissioning.

There have been previous attempts to assess the readiness of countries to adopt SI approaches. However, there has not been a strong focus on the compatibility of SI with specific areas of policy, for example, LTC (Bouget *et al*. 2015, Hemerijck 2015). There is therefore a gap concerning specifically how certain features of the regulatory systems governing LTC might support or constrain the adoption of SI principles. This report sets out to investigate the way in which national frameworks of legislation and regulation for European LTC systems interact with the potential implementation of SI approaches. The research question that frames this report is:

Can social investment criteria applied in resourcing decisions about LTC be used to improve rights or entitlement to LTC services at national and at EU levels?

To arrive at an answer to this question, the report looks specifically at the regulatory and policy functions of LTC systems as outlined in Figure 1. The analysis examines how the impact of the LTC regulatory framework on the way the different care-related functions are implemented affects the potential adoption of SI approaches in LTC. The benefits of (and opportunities for) SI will be mediated by the way in which opportunities for investment are promoted or limited by these existing LTC regulatory frameworks.

Figure 1: Key actors and functions in the LTC system



The report explores the compatibility of SI with national LTC systems using the cases of four European countries with different approaches to the organisation and provision of LTC: England, Finland, Germany and Italy. We selected these countries as representative of broad typologies of LTC and social welfare systems: the highly localist Scandinavian care system, the German social insurance model, the 'familistic' Southern European model, and the English, market-oriented, means-tested system. The aim is to assess whether and how, by shaping the allocation of different LTC services to people with LTC care needs, different systems present significantly different opportunities for cost-effective SI in LTC. The report explores three areas of LTC system design which could influence the potential for SI approaches: funding and eligibility, service commissioning, and quality oversight.

Based on our analysis of the national systems, we identified two key dimensions of LTC systems which might influence compatibility with SI approaches. The first dimension is the degree of *flexibility* available in each system. Flexibility refers to the degree of local and professional autonomy to determine policy and implementation and also to the degree to which systems rely on national regulations and rules around care eligibility and service provision. The degree of flexibility also refers to characteristics such as the flexibility for government and non-government actors to be involved in care funding and provision, and the degree of flexibility around how services and support can be commissioned to meet care needs. The second dimension concerns the extent to which LTC systems can support goals which are based on *outcomes*, both at an individual level and to achieve broader societal goals.

2 Methods

This report builds on previous research from the SPRINT project (see for instance the legal analysis of LTC systems in Reinhard 2018) and draws on analyses of the legal frameworks in the four countries in the study, as well as from existing literature about SI approaches for LTC in Europe. The literature referred to in the study was first identified using a 'rapid review' approach. Rapid reviews borrow from the principles of systematic reviews but simplify and streamline the review in order to produce results in a timely manner (Ganann *et al*. 2010, Tricco *et al*. 2015). A rapid review typically takes between one to six months (Watt *et al*. 2008, Ganann *et al*. 2010).

An important feature of a rapid review is transparency – the review must be described with explicit and documented search strategies and assessment protocols. The first stage of the rapid review was to search for literature regarding SI and LTC, using the SCOPUS and ISI Web of Science databases. An initial list of 1,047 unique items was reviewed using a set of exclusion criteria which included the year of publication and articles which were not of direct relevance to the discussion of SI in the context of LTC. A flowchart showing the review process and a table listing the search terms and inclusion and exclusion criteria are included in Annex 1. At the end of the process only three articles were found to be of direct relevance to this report in that they dealt with the issue of both SI and LTC (León and Pavolini 2014, Fraser *et al*. 2018, Kazepov and Ranci 2017). Tellingly, this compares with 20 articles on SI and aspects of early childhood education and care, perhaps reflecting the focus in SI literature on investing in the life course and specifically, on child care and development.

This is not an unusual outcome – while it is often assumed that a structured and rigorous approach to literature searches will elicit the best and most important literature, it is often the case in reality that the best results come from browsing, using existing knowledge, 'asking around' and using 'snowballing' methods to track both references of articles and literature which has subsequently cited the most important articles (Greenhalgh and Peacock 2005). The second stage of the rapid review therefore consisted of three further purposeful searches for literature about LTC and SI. The

first was to make use of previous European Commission-funded projects on LTC in Europe, namely the ANCIEN, CEQUA and Interlinks projects (see Annex 1 for details). The second search used 'snowballing' based on literature which has previously analysed and compared aspects of European LTC systems (Da Roit and Le Bihan 2010, Gori *et al*. 2015, Burau *et al*. 2016). The final search used Google Scholar to find additional information on specific aspects of the LTC systems of the four countries, for example, the growth of social cooperatives in Italy and the use of vouchers in Finland.

3 Findings

This report explores the extent to which each the regulatory system in each country might be ready to exploit SI opportunities. Our analysis identified two dimensions of systems design which are particularly relevant to this analysis: the degree of flexibility and the potential for systems to focus on outcomes.

Flexibility is a key requirement for an LTC system to be compatible with SI principles because of the heterogeneity of the characteristics, needs and preferences of recipients of LTC services. This heterogeneity means that it is difficult to maximise effectiveness and efficiency across LTC recipients through the use of highly standardised, inflexible care packages and services (Knapp 1984). Flexibility in LTC systems requires that different actors in the system (e.g. policy makers, service managers, social workers) are enabled to take advantage of opportunities for cost-effective investment by having the appropriate decision-making authority to distribute resources between individuals and between different forms of support. Different regulatory set-ups can therefore either set barriers or act as an enabler for SI depending on whether it enables the 'right' provision to take place. The report therefore analyses flexibility in the following areas of LTC systems:

- Rules for the targeting of resources to cases
- Processes for deciding the content of care packages (e.g. the choice of care services)
- Regulation of care service markets, including of service standards and quality.

The second dimension, outcomes, is inextricably linked with how flexible systems are to respond to different needs and preferences, but merits specific attention. An important part of this is whether the LTC system prioritises outcomes that are focused on broad societal goals, or whether the system is more concerned with input and process quality, such as indicators of expenditure or numbers of recipients.

3.1 Local Autonomy versus National Consistency

An important consideration regarding the degree of flexibility in decision making is the level of government responsible for the design and delivery of LTC policy. With regards to the SI approach, local autonomy in the organisation and funding of LTC should theoretically enable the tailoring of investment around the most cost-effective local opportunities for investment.

Localism, whereby key decision-making functions regarding the funding, commissioning and provision of care are situated at local administrative levels is increasingly prevalent in many areas of social policy. Localism tends to be supported with three arguments; first, that local systems are more effective because they can be tailored to local contexts and needs; second, they are more likely to mobilise and empower citizens and nongovernment actors and incorporate civil society into services and welfare; and third, they are more sustainable because they can raise additional resources – both financial and labour – from the local economy and from local social groups and networks (Andreotti *et al*. 2012). In principle at least, these arguments suggest that localist LTC systems might be more compatible with SI principles.

In terms of these levels of decision-making, the four countries in the study lie on a spectrum, from Germany, where all the rules around funding and provision are prescribed at the national level; to England and Finland, where there is strong national influence but funding and provision are devolved to the local level; through to Italy, where virtually all responsibilities are devolved to the regional and local levels, with significant geographical variation across the country and between regions (Pavolini 2016, Arlotti and Aguilar-Hendrickson 2017). In England, Finland and Italy, LTC services are mainly funded through a combination of grants from central government, local taxation and user charges. Grants from central government are not earmarked, meaning that the local authorities and municipalities have a high degree of discretion in how and what they fund in terms of health and LTC services. These countries are characterised by wide local variations in most key aspects of LTC provision, and significantly wider geographical variations than those observed in the German system, which is operated under a nationwide compulsory social insurance model with standard criteria for determining eligibility of needs and levels of support[1].

In England, managing the funding and provision of LTC is the responsibility of 152 local authorities, which differ in size, demographics, financial strength and strategic competence, and this is reflected in many different strategies for commissioning LTC services (Laing and Buisson 2015). Each local authority is responsible for assessing needs based on national minimum eligibility criteria, as well as for arranging LTC. Levels of local variability in service provision have been severely criticised by commentators and public alike, however analyses have shown that to a significant extent these

[1] The German insurance system does not cover all of the financial costs for LTC. Means-tested co-payments are required from the beneficiary or his or her family. The German system also includes a means-tested LTC support system for people with low income, which is run at the Lander level but governed by national legislation.

reflect differences in the underlying patterns of LTC need across areas, as well as to differences in characteristics of care supply such as wage levels and the costs of capital (Fernández *et al*. 2007, Fernández and Forder 2015). These studies suggest that local patterns of support in England respond to geographical variations in the relative cost-effectiveness of services. As a result, for instance, rural and coastal areas in England utilise more intensively institutional care services than urban areas, reflecting the differences in house prices between the areas.

In Finland, the responsibility for organising both health and LTC sits with 311 municipalities, which are responsible for assessing needs for services to support the health and wellbeing of the person, as well as the opportunity for them to live independently (Linnosmaa and Sääksvuori 2017). The system is supposed to provide a consistent approach to care across the whole country, however a study by Pulkki *et al*. (2016) found significant levels of local variability in the take-up of LTC services across Finland. In contrast with the English case, however, this variability has not been found to reflect variations in need and/or wealth. Population morbidity and old age dependency were not found to predict local service levels, and it was factors such as the size and location of the municipality that showed the strongest relationship with differences in LTC use. The significant effect of delivery system characteristics on the use of LTC services and the observed levels of geographic heterogeneity suggest issues with equity in access to LTC.

Italy presents even stronger geographic disparities than England and Finland. In Italy, the fragmentation of responsibilities and the autonomy of the regions and municipalities mean that there are effectively 21 different LTC systems, each with their own strategies and approaches for integration and coordination (Barbabella *et al*. 2017). The variety of approaches has been explained by the lack of clear regulation from central government, limited national funding and 'complicated' arrangements at the local and regional level for defining services and managing funding (Arlotti and Aguilar-Hendrickson 2017).

The level of ownership of policy and delivery raises crucial questions for SI strategies in LTC. Governance and policy design at the national level can limit geographical differences in access to services, and thus improve spatial equality of access to care (Andreotti *et al*. 2012, Fernández *et al*. 2009). Furthermore, it might be more effective in ensuring homogenous approaches to care delivery and service quality. However, if the intent is to maximise flexibility in LTC services – a key feature of SI-based approaches (Maier *et al*. 2017) – then control of policy and spending at a local level may bring a stronger ability to adapt to local and context-specific needs. A key question for policy makers and regulators is therefore the extent to which observed local variability in care can be justified on the grounds of accountability and responsiveness to local preferences and opportunities for cost-effective investment, or whether it bears witness to significant variations in performance, territorial inequity and possibly inefficiencies associated with the loss of opportunities for returns to scale in the administration of the care system (Boyne *et al*. 2001, Powell and Boyne 2001).

3.2 Matching Resources to Needs at the Individual-Level

Given the heterogeneity in the characteristics of people with LTC needs, the matching of LTC resources to needs is often a complex process which must consider a wide variety of circumstances, e.g. physical and mental needs, informal support, and housing environment. The approach to assessment is therefore an important factor when considering the system's capacity to take up opportunities for cost-effective investment of the type advocated by SI approaches. The approach to needs assessments is also related to how well the system supports the achievement of outcomes, covered later in Section 4.4.

Entitlements to care vs budget constrained funding systems

There are important differences across the four countries in their approach to whether individuals are entitled to receive state support. Differences in eligibility for care are most notable between Germany and the other three countries, largely related to the differences between tax-based and social insurance-based LTC models. The systems in England, Finland and Italy are examples of tax-based, means-tested models. In contrast, social insurance countries such as Germany are financed by mandatory insurance premiums which translate into explicit *entitlements* for services.

Tax-based LTC models, the usual process is that the person in need of care applies to a local agency which determines what services are needed, and the individual does not have any specific entitlements to receive services. Tax-based models have typically developed incrementally through the expansion of services and by altering means-testing to determine eligibility, rather than using a rigid entitlements-based approach (Ikegami and Campbell 2002).

In Germany, the national LTC insurance (LTCI) scheme was introduced in 1995. Participation in LTCI is mandatory for all people living legally in the county and neither participation nor entitlements depend on individual characteristics (for example, age or income) (Doetter and Rothgang 2017). Rules and regulations are set at the national level, with provision organised by social and private insurance funds. Access to services is regulated by the central government in Germany and applied by the insurance companies. While eligibility criteria for tax-based systems can be regarded as flexible, entitlements in social insurance-based systems are decided on 'objective' criteria based on needs, normally without consideration of factors such as income or the availability of family care (Ikegami and Campbell 2002).

Defining eligibility criteria for LTC services

An aspect related to whether the systems is based on entitlements is the nature of the rules and processes for determining who can receive care and support. Rigid national rules around eligibility, for example as used in social insurance models, undermine the flexibility required for SI opportunities, and potentially deter or prevent the emergence of new sources of funding (e.g. from the private sector) and the development of new models of care.

An example of the constraints of rigid rules is how they make it difficult to recognise and reflect the nature of relationships between family carers and the dependent person when determining care packages. Algorithm-based systems can struggle to internalise whether a 'bad' or 'good' relationship exists, or what support is needed for carers. For algorithm-based systems, 'blanket' policies are required to assure the provision of homogeneous levels of care, and which generally use definitions of need-related characteristics based on a small number of quantifiable factors. In contrast, flexible approaches to assessing eligibility and designing care packages are potentially better aligned with SI principles because they allow the means of LTC (what and how much support is provided) to be tailored to specific outcomes for the individual.

In England, eligibility regulations are set at the national level and are intended to be consistent across the country. However, as noted above, the significant level of local control and autonomy in the organisation and implementation of the LTC system has led to significant geographical variations in coverage and care mix (Fernández *et al*. 2015, Marczak *et al*. 2017). Local authorities are responsible for assessing individuals and to provide services for those eligible for public support, and can decide to exceed national minimum eligibility standards. Individuals are eligible for care if they are unable to achieve two or more of a list of outcomes, as long as these shortfalls are considered to have a significant impact on their wellbeing. The outcomes range from managing and maintaining nutrition and personal hygiene to being able to develop and maintain personal relationships, to accessing and engaging in work, training, education or volunteering (HM Government 2015). The care package is designed, subject to the local availability of support, jointly by care managers and the person in need of care, and should aim to maximise the person's quality of life. As noted above, the fact that care managers can use their professional judgement to shape the care package arguably helps to match services to needs in a cost-effective way. There is however a lack of quantitative evidence to test the extent to which this system leads to better targeting of resources.

An important element driving eligibility for state support in England is the existence of means-testing, whereby people with capital and savings over £23,250 are excluded from receiving state support. The means-testing of LTC support undermines the capacity for the state system to invest across the whole population, for instance, in terms of the provision of small levels of support across the population to prevent the emergence and deterioration of needs. Furthermore, the system's understanding about the LTC needs of the population is significantly focussed on individuals entitled to state support, and very little is known about the needs of 'self-payers' and the support they enjoy (NatCen Social Research and Ipsos MORI 2017). In this sense, mean-testing arrangements in England are undermining the capacity for local LTC systems to use SI principles for investing in LTC.

In Finland, there is no national definition of a 'need for care' and the municipalities are responsible for deciding how needs are assessed and is eligible for care. As in England, there are national guidelines on what constitutes good practice in needs assessment; however, these guidelines are voluntary, and the municipalities have a high degree of autonomy in determining what services the older person will receive, leading to a great deal of variation (Johansson 2010).

Out of the four countries, the regions in Italy have the highest degree of autonomy over who is eligible for care. Assessment for services is based mainly on the needs of the older person in terms of Activities of Daily Living (Casanova 2012). However, the approach is still not rigidly defined at a national level. In 2002 the government in Italy developed the basic level of services for some types of LTC (*livelli essenziali di assistenza sociale* or *LIVEAS*), although the definition of entitlement is 'vague' (Arlotti and Aguilar-Hendrickson 2017, p4). The assessment of needs is conducted by regional Multidimensional Assessment Units (Casanova 2012), in principle with a standardised approach but, in reality, with a high degree of variation across the country (Da Roit and Le Bihan 2010).

In Germany, the social insurance model dictates a much more rigid approach to assessing eligibility. The approach to assessment is highly prescriptive and based on a 'medical grid' (Da Roit and Le Bihan 2010), with assessments mainly carried out by clinicians (Schulz 2012). The grid consists of five levels which consider the remaining capabilities of the applicant (capability-orientated approach). Assessments are based on Activities of Daily Living and correspond to an amount of care hours per month (Da Roit and Le Bihan 2010).

Implementing eligibility to care: algorithms versus professional judgement

As mentioned above, a common characteristic of many tax-based LTC systems is the lack of rigid algorithms for allocating services. In such systems, eligibility rules are often implemented by front line workers (so-called 'care-managers') with a degree of discretion in tailoring levels of formal support to individuals' circumstances. Such 'care-managed' systems allow front-line professionals to use their judgement, and in conjunction with service users and carers to develop a care solution which reflects a wide range of factors, including some not easily amenable to measurement, such as the need for supervision of the person and the management of risk. This type of system also allows front-line workers to contain overall costs more easily, by continuously updating eligibility rules in line with available budgets. Care-managed systems, however, have been criticised for lacking transparency in the allocation process (which relies heavily of the skills of the care-manager) and for not providing individuals with clear expectations of their entitlement to care.

Of the four countries selected for the study, the English system has espoused the use of care management for the assessment of eligibility and care package design to the greatest extent. In contrast, the German social insurance model operates with highly explicit rules of entitlement built at the back of algorithms for assessing needs, as described above. Whereas the German system provides greater transparency in the allocation process (in the sense that the relationship between needs and entitlement to care are explicitly stated), a question remains as to the extent to which the algorithms take into account all the subtle and often important characteristics of individuals in need. Hence, factors such as the nature and level of informal support, general frailty, and the need for supervision are generally difficult to incorporate into formal algorithms of entitlement to support.

When choosing a LTC entitlement model, policy makers are faced therefore with the following general dilemma: to achieve greater transparency, defining eligibility criteria on the basis of 'rules', or to allow some discretion at the front-line level in the hope that it may lead to a better fit between individual care packages and individual needs. From an SI perspective, the two types of models offer a different balance between the objective of maximising cost-effectiveness and ensuring equity and transparency in the care system.

3.3 Service Commissioning and Care Market Regulation

The cost-effectiveness of a care package will vary depending on two factors: the characteristics of service users (e.g. their physical and mental health, dependency, personal preferences); and local supply factors, such as the relative costs of different services (e.g. the relative cost of community and institutional forms of support). Encouraging diversity in the supply of services should help develop a range of services which cater for the different circumstances, wishes and preferences of services users.

Opportunities for SI should therefore be enhanced by flexibility in the supply of care services, so that care commissioners are able to invest their resources on those services that maximise outcomes for the population they serve. This section explores strategies for commissioning care services in the four countries that might support an SI approach.

Markets in LTC

The rationale for promoting markets in LTC is usually based on the dual assumption that as a result new and better types of services may develop in response to the wishes and preferences of service users (and care commissioners more generally) and that market forces and competition might drive prices down (Leichsenring *et al*. 2015). Arguably, the application of EU antitrust rules helps ensure these benefits by preventing abuses and restrictions over competition.

A significant literature has, however, examined some of the pros and cons of markets in health and LTC, and indicated some limitations in these hypotheses (e.g. Wistow *et al*. 1992, Knapp *et al*. 2001). The extent to which markets improve quality of services or reduce prices at the expense of quality remains an important question. One of the biggest challenges facing market mechanisms are the significant information asymmetries which exist in LTC, which means that service users have considerable difficulties in understanding differences in the quality of care (Eika 2009). Another, broader, question for this discussion is whether the introduction of consumer choice into public services effectively prioritises the needs of individuals over broader welfare goals, effectively changing the 'citizen' into a 'consumer' (Baldock 2003, Clarke *et al.* 2007, Scourfield 2007).

In both England and Finland, since the 1990s, the provision of publicly-funded LTC services has increasingly been carried out by private sector organisations, following several decades of direct provision by local authorities and municipalities (Karsio and Anttonen 2013, Lewis and West 2014).

At least in theory, the contracting out model provides significant flexibility to design services which are compatible with SI approaches. At the same time, the two countries have different commissioning and contracting processes, which also have the potential to affect the compatibility between choice of suppliers and SI approaches.

In England, the combination of information asymmetries with market pressures and a reduction in the resources available to local authorities for purchasing care has led to lower prices but also to lower service quality in the residential and nursing care sector (Forder and Allan 2014). Furthermore, policy makers should balance the potential benefits of more 'competitive' markets against the cost implications of the monitoring and regulatory framework required to insure quality in the supply of services (Fernández *et al*. 2009).

In Finland, policymakers have sought to introduce market forces into the LTC system using care vouchers issued by municipalities (Burau *et al*. 2016). The rationale for the provision of vouchers is to increase freedom of choice, and to promote entrepreneurship and diversity in the supply of services. Vouchers are seen as an effective way of overcoming two problems with cash benefits: firstly, they can only be used to purchase services, rather than cash being absorbed into household budgets and not used to support the care of the older person, and secondly, they provide less of an incentive to 'cheat' to achieve eligibility criteria (Ikegami and Campbell 2002, p726). Approximately half of the municipalities have implemented vouchers, with municipalities setting the value of the voucher based on the service user's need for care and their income. At the same time, municipalities are obliged to provide services for older people who do not want to receive vouchers, either through their own provision or through contracted providers (Moberg 2017).

From a SI perspective, the use of vouchers might be an effective mechanism for ensuring that resources are used for particularly desirable investments (for instance, on services perceived to be particularly cost-effective), whilst allowing some degree of competition between those providers accredited within the voucher system. It is worth noting, however, that vouchers in Finland can be used only with preferred providers and therefore limit the flexibility for different types of suppliers to be involved in care provision (Moberg 2017).

Achieving flexibility in support – the example of social cooperatives in Italy

Arguably the strongest type of flexibility in terms of provision is where services have evolved organically in response to local needs and preferences. An example of this is the increased role of the third sector in Italy, through the growth of social cooperatives. Despite the reliance on the *Indennità di accompagnamento* (IdA) attendance allowance, the increasing involvement of employers and third sector organisations provides some scope for flexible arrangements and opportunities to support labour market participation, opening up the opportunity to implement policies with an increased SI focus.

Recent years have seen an increase in policies to support families and carers within specific industry sectors or companies, often developed in discussion with private companies, trade unions and local authorities and include initiatives such as professional help and 'extra-statutory' leave for caring

responsibilities (León and Pavolini 2014). In Italy, major growth in the role of third sector in care provision began in the 1990s due to a lack of government provision LTC and welfare. While first supported by volunteers and philanthropic contributions, regional governments now contract with third sector organisations for the provision of LTC services and these organisations receive the bulk of government funding (Borzaga and Fazzi 2014). The form of third sector organisation in Italy which has undergone the biggest change is that of the 'social cooperative', a form of organisation recognised in law. These social cooperatives have emerged 'bottom-up' in response to needs neglected by both government policy and private care provision, and due to the direct engagement of citizens (Borzaga and Galera 2016).

The role of social cooperatives is increasing and represents approximatively 14 per cent of home care providers and six per cent of care workers (Farris and Marchetti 2017). There are two types of social cooperatives: those that supply social, health and educational services (which account for more than half of existing cooperatives), and those that focus on integrating the employment of vulnerable people (Borzaga and Galera 2016). Since the financial crisis of 2008 and cuts to government spending, the role of third sector organisations and social cooperatives has broadened further, with the arrival of new cooperatives and the reorganisation of existing ones in order to deliver health care services, for example, nursing at home and rehabilitation (Borzaga and Fazzi 2014). Even though these organisations are increasingly professionalised, many social cooperatives maintain close ties with the community and volunteers (Borzaga and Galera 2016).

Incorporating flexibility around service provision was highlighted earlier as one of the essential considerations for whether SI approaches might 'stick'. In Italy, social cooperatives represent one highly entrepreneurial, bottom-up form of support. The benefit of these organisations from an SI perspective is that they have grown directly in response to user needs and are therefore perceived to be more responsive and flexible to both the direct and indirect users of services (Borzaga *et al*. 2016). However, there is also some evidence that this entrepreneurialism has been at the expense of equity, with some cooperatives focused on high quality services for specific target groups rather than a concern for socially disadvantaged groups (Borzaga and Fazzi 2014) – an important lesson when considering how different types of organisations might contribute to an SI-focused system.

Delegating flexibility to users – the role of personal budgets and cash benefits

The most extreme form of market-driven reform is arguably policy which seeks to empower individuals themselves to make decisions regarding their care. These decisions might include the nature of the support package they receive or which providers deliver their care. Across Europe, LTC systems have increasingly sought to achieve user empowerment through the increased use of direct/cash payments, often under the banner of the 'personalisation' of care (Colombo *et al*. 2011).

Personalisation policies seek to promote both flexibility in the matching of services to needs, and also to promote responsiveness from providers to the needs of users, who are newly able to 'vote with their feet' if they are dissatisfied with services. In theory, this responsiveness should in turn lead to providers devising 'out of the box' creative solutions for supporting care needs. This

'consumer choice' rationale is often used to justify the implementation of cash-for-care systems (Da Roit and Le Bihan 2010).

These personalisation policies place care recipients at the centre of the decision-making process, with empowerment typically seen as an explicit policy objective. Local authorities in England have a high degree of flexibility around which services are provided to meet the needs of individuals, and increasingly this choice is being passed to the user in the form of personal budgets and direct payments. For the bulk of LTC services, local authorities' legal duty is focused on making sure that there is an adequate supply of high-quality services in their local area, without specification of what form these services should take (Department of Health 2017).

However, in spite of the significant policy emphasis on personalisation and choice, only a minority of service users in England opt for a direct payment, and research has shown that direct payments do not always translate into improved outcomes (Glendinning *et al*. 2008). Evaluation of direct payments found that their successful implementation for older people required the provision of significant support to deal with the administrative arrangements involved, particularly to help individuals to recruit and formally employ their own 'personal assistants' (Fernández et al. 2007, Glendinning *et al*. 2008).

In Germany, service users can choose between cash benefits or care services, or a combination of the two. Cash benefits have proved to be the most popular option even though they are set at around half the value of in-kind benefits. Families tend to opt for cash so that they can put together their preferred package of care. Recipients are free to spend their benefits as they wish, although there are periodic reviews of the service user's circumstances to make sure there are care arrangements in place (Da Roit and Le Bihan 2010).

From an SI perspective, these self-directed care models present an interesting dilemma. On the one hand, these models are used to promote more creative forms of support, by maximising the flexibility with which resources can be used, and thus to improve cost-effectiveness in the care system. Furthermore, by empowering service users to take control of the decisions regarding their care package, direct/cash payments empower individuals to design care packages which meet their wishes and preferences.

From a societal point of view, however, it is possible that the outcomes sought by service users are not perfectly aligned with societal outcomes compatible with SI approaches. For instance, service users might not place the same emphasis on supporting carers and enabling their labour market participation as the state might. Furthermore, cash payments might be used as income supplements rather than for supporting care needs directly. This issue has been especially difficult in Italy where the take-up of the IdA has resulted in a reliance on a large 'grey market' of migrant carers from Eastern Europe (Barbabella *et al*. 2017). The reliance on this grey market does not allow the government to define the scope and quality of LTC services and outcomes, limiting the scope for care to be designed to deliver SI goals. Efforts to support families to formalise these employment arrangements have been regarded as innovative but poorly-funded, with very limited reach (Costa 2013).

3.4 Quality Oversight

Even where LTC is publicly funded, the trend in Europe has been for the delivery of care to be contracted out to the private sector, whether to for-profit or not-for-profit organisations (Rostgaard 2002). Accompanying this contracting out has been an increase in government activity to monitor the quality of care provision (Vogel 1996). European countries generally have some form of LTC quality monitoring in place along two main dimensions: the design of quality standards; and quality and service inspection. Countries can have multiple approaches to quality, for example by differentiating their approach between residential and community-based care, or between providers which receive government funding and providers which do not (Mor *et al.* 2014).

Quality standards

The nature of the national care quality monitoring processes is an important factor determining the compatibility of national regulatory systems with the SI approach. Particularly important is how quality is understood and measured and specifically whether monitoring efforts focus on care processes or on final outcomes, in terms of the impact of services on the quality of life of service users, their carers, and other relevant outcomes from a societal point of view (e.g. impact of LTC services on other sectors of the economy). At the same time, an important point from an SI perspective is that the imposition of standards might act as a barrier to entry for new and innovative services which may better meet the needs of individuals.

Assessing the value and success of SI approaches requires looking at quality in terms of final outcomes rather than simply at the quality of the care process itself. When assessing national quality assessment systems, it is useful to refer to Donabedian's service quality framework, which distinguishes between three types of indicators of quality (Donabedian 1988):

- Structural or input indicators, such as the number of staff or building specifications;
- Process indicators, relating to processes and outputs such as adherence to medications management processes or whether care was delivered at the right time;
- Outcomes, which focus on the effects of care and services, and particularly on aspects of quality of life. In turn, the concept quality of life varies according to the preferences of individuals and covers multiple domains including social participation, control over daily life, or more basic requirements such as feeling safe or having a clean and comfortable home (Netten 2011).

Developing a framework for measuring quality is vital for an understanding of whether the LTC system achieves its desired objectives. From an SI approach, the ideal definition of quality should focus on outcomes for multiple stakeholders and incorporate wider societal benefits. These benefits might be for stakeholders close to the individual, such as outcomes for carers regarding mental and physical wellbeing, or the opportunity to take up, resume or increase their formal employment. Alternatively, the benefits might be viewed from a societal level, for example, reducing the load on the health service, or the fiscal benefits which accrue from higher labour market participation.

Identifying and measuring these outcomes is however difficult, particularly where ongoing measurement is needed to assess the longer-term impact of services.

The compatibility of the quality standards used in the care system with an SI focus varies across the four countries under investigation. These systems range from having a lack of national quality standards (Italy), through prescriptive standards which are focused mainly on clinical care processes (Germany), and the use of outcomes indicators in England and Finland. In England and Finland, the fact that the quality system is intended to include wellbeing and quality of life issues suggests that the quality systems of the two countries are better placed to support SI approaches than in Germany.

In England, all formal care organisations must meet the 'Fundamental Standards' set out by the UK Care Quality Commission (CQC), an arms-length body reporting to the Secretary of State for Health and Social Care. The standards are positive from an SI perspective, as they focus on the quality of life outcomes for the individual. In Finland, the government has set outcomes targets at the system level, rather than simply for individual providers, something which fits well with the concept of SI as a long-term systemic project. For example, the government has set a goal that by 2017 91-92 per cent of older people aged over 75 should live in their own homes, with only 2-3 per cent in residential care (Linnosmaa and Sääksvuori 2017).

The quality standards in place in Germany are arguably less compatible with SI approaches. In Germany, this incompatibility is due to the dominance of prescriptive regulations based on structural and process standards. The German system has been criticised for its focus on structural and process indicators, and for neglecting outcomes and effectiveness (Garms-Homolová and Busse 2014, Doetter and Rothgang 2017). Providers are also expected to follow formal guidelines which focus on aspects of clinical and nursing care such as pain management and falls prevention strategies, but that do not take into account the individual's preferences to determine the nature of the support provided (Garms-Homolová and Busse 2014). For residential care in Germany, the Homes Act specifies a number of prescriptive regulations, such as room size and number of bathrooms, as well as management qualifications and staffing ratios and skills. The strict division of labour leads to care which is highly task-oriented rather than geared towards achieving quality of life outcomes for individuals (Daly *et al*. 2016).

Other studies have shown that conforming to prescriptive input standards may not result in a better outcome for the user, and in fact, may impede quality improvement efforts (Miller *et al*. 2010).

Inspection and oversight

Quality standards are one dimension of quality monitoring which varies across countries, as shown above, but there are other questions associated with the design of regulatory systems. For SI, the benefit of having a centralised body for inspections and oversight might be to set the 'correct' approach to quality management which in turn might guide the 'right' type of investments in the care system.

All four countries have different types of governance around quality oversight. In England, the CQC sets the national quality standards and conducts inspections of all home and residential care providers. In Finland, Valvira, part of the Ministry of Social Affairs and Health, is responsible for licensing, inspection and performance auditing. Valvira works in collaboration with six Regional State Administrative Agencies (AVI) and the AVIs are responsible for monitoring the quality of care in both residential and community-based services (Finne-Soveri *et al*. 2014).

In Germany, responsibility for regulation is spread among different levels of government. The Federal government is responsible for setting the overarching legal framework for how funding and provision is organised, as well as the roles and responsibilities for quality at a high level. The oversight of quality is then devolved to the states and municipalities, with the municipalities responsible for quality monitoring of providers (Garms-Homolová and Busse 2014). The detailed requirements for quality are specified in the contracts with the LTC insurance funds, and the state level medical advisory service (Medizinische Dienste der Krankenversicherung (MDK)) is then responsible for conducting quality assessments and publishing results (Schulz 2012, Daly *et al*. 2016)

The system in Italy might in theory be better suited to SI approaches, at least at a programme level, in the degree of flexibility in the adoption of quality monitoring systems. The central Ministry of Health and Social Policy produces recommendations on quality standards, interventions and monitoring, but it is the regions which then regulate the quality of different local services (Casanova 2012). The regions define their own rules and standards for their local needs and preferences, determine which agencies take control of quality assurance and design the tools and methodologies to be used for monitoring, assessment and accreditation (Casanova 2012, Di Santo and Ceruzzil 2009). The regions are also responsible for recommendations on whether providers should adopt specified external quality accreditation systems (Casanova 2012).

In principle, the potential for taking-up SI approaches in Italy appears positive because the regions have the autonomy and flexibility to alter their quality approaches to meet local needs and supply factors. However, this potential is undermined by the fact that quality systems and indicators which do exist are predominantly input and process-based, for example, the number of professionals involved in providing service and waiting times (Di Santo and Ceruzzil 2009, Casanova 2012). The minimum quality requirements for the authorisation of residential care providers are all input-based and include how rooms are organised, the availability of space for therapies and social activities, the amount of space per person, and minimum and maximum temperatures (Casanova 2012). Further undermining potential SI approaches, there is a lack of development of ways of measuring whether services meet the user's needs and preferences (Di Santo and Ceruzzil 2009).

4 Policy Implications

This report set out to answer the following question:

> *Can social investment criteria applied in resourcing decisions about LTC be used to improve rights or entitlement to LTC services at national and at EU levels?*

Through our analysis of four LTC systems we have identified that the rights and entitlements to LTC services are inextricably linked to the opportunity to promote SI approaches. However, the relationship is more complex. To a certain extent, the formulation of rights and entitlements needs to be established in a way which supports SI approaches, rather than the other way around.

In theory, SI approaches could be adopted in all care systems. However, their effectiveness in supporting an SI approach will be affected by the extent to which rules and regulations enable or discourage resources from being targeted on those services yielding the greatest SI returns. This report has analysed the LTC regulatory and legislative context in four countries to discuss how their different configurations might affect the potential implementation of SI approaches.

The question is complex, not least due to the various definitions which exist of SI. For some, the concept of SI represents a new paradigm in the delivery of welfare, incorporating the whole life course, prioritising labour market issues and maintaining a safety net for those who need it. For others, the SI approach represents a new way of organising the funding and financing of services through investment instruments such as 'social impact bonds' (Maier *et al*. 2017). Both approaches have some common ground, which is that they both recognise that an SI approach could deliver better outcomes for multiple stakeholders and in line with broader societal goals.

The analysis of the interrelationship between regulatory frameworks and opportunities for SI is further complicated by the lack of evidence on the take-up of SI schemes in different countries and by the need to simplify for analytical purposes (and given space constraints) what are highly complex and interdependent regulatory systems. Our analysis has therefore taken a theoretical view of the likely interplay between care model configurations and the potential for implementing an SI approach.

The analysis has focussed on regulatory models from countries with well-established (if by no means perfect) LTC systems. The benefit of limiting the choice to four countries was that the report could include more detail about the respective LTC systems; however, this meant excluding countries without well-developed LTC systems such as some of the Eastern European models. We decided that concentrating on more longstanding models would be of most use, particularly for policy makers from emerging LTC systems who might use the evidence to shape their future policy choices.

Bearing these issues in mind, the analysis above highlights two, interdependent characteristics of LTC systems likely to influence the development and success of SI schemes:

1. Whether regulations allow for *flexibility* in the choice and allocation of support services.
2. The extent to which the regulatory system encourages *outcomes-led* allocation of resources

4.1 Flexibility

An important mediating factor for SI approaches to LTC is the extent to which the regulatory system allows enough flexibility so that resources can be tailored to individual care needs and supply conditions. We considered flexibility in terms of the impact of regulations on local variability, and on how well local care system configurations reflect local preferences and supply conditions. We have noted, however, that increased local autonomy usually leads to increased territorial inequality.

The trade-off for these LTC systems is between the implementation of flexible and highly localised approaches to supporting LTC on one hand, and equity throughout the system on the other. The strength of the relatively inflexible German system is that it is designed to be highly equitable across users and geographical areas. In theory, this equity also exists in England and Finland, although geographical variations have been noted due to differences in local resources and priorities. In Italy, however, both the level of decision-making and the degree of flexibility reinforces inequities both within and between regions.

At the individual level, the impact of regulations on flexibility in the allocation of support is clearest where need eligibility rules are based on strict algorithms linking needs to service levels (typical of social insurance systems), or alternatively whether they allow a degree of professional discretion in the allocation of support. All four countries in the study have some form of national eligibility framework, but Finland and England rely more heavily on professional judgement to determine levels of support for individuals. The trade-off here is between potential improvements in the effectiveness of care packages for individuals through a more flexible assessment process and the increased transparency and clarity of entitlements present in algorithm-based assessment systems.

The need for flexibility in the system, however, needs to be balanced with the ability to design LTC systems where there is some control over outcomes at both an individual level and at a broader societal level. Arguably the most flexible arrangements within LTC systems are where benefits are paid in cash, but as Section 4.3 sets out, it is possible that the outcomes prioritised by the individual may not be aligned with societal, SI-oriented goals. This is particularly problematic where cash benefits are used to effectively pass responsibility for the supply of care to family, usually female, carers. For example, the reliance of the systems in Germany and Italy on care provided by female family members has had negative effects on the rate of female labour market participation (Marchetti and Scrinzi 2014, Ranci and Pavolini 2015, Doetter and Rothgang 2017).

On the other hand, actively supporting informal carers could yield significant fiscal returns as well as reducing the need for formal support, and is therefore an important strategy for SI. These returns can be particularly significant in situations in which LTC policies are effective in enabling carers to join the labour market and to stay in formal employment (Kangas and Kalliomaa-Puha 2015). For example, the government in England has implemented carer support policies which arguably have a stronger 'SI' bent. Local authorities in England have a responsibility for identifying opportunities for prevention for carers, and there is an emphasis on policies which support formal carers to continue in paid employment, for example, through legislation on flexible working arrangements

(Marczak *et al*. 2017). Germany has also introduced policies to support informal carers to stay in work, including legislation around care leave for informal carers (Doetter and Rothgang 2017). Similarly, in Italy the government has increased the obligations and opportunities of employers to support employees in their caring responsibilities, for example, providing tax incentives for companies to provide performance-related bonuses in the form of LTC services or by providing services as part of their welfare schemes (Barbabella *et al*. 2017).

4.2 Outcomes

In terms of the aim of developing outcomes-led care systems, our analysis has underlined the impact of different quality assurance systems on the potential for SI approaches. Of particular importance is the extent to which quality systems focus on the impact of services on the wellbeing of users and carers or instead concentrate on monitoring (more easily measured but arguably less relevant) indicators of process quality, such as staffing ratios and staff qualifications. We argue that focusing excessively on process-related factors might undermine the development of innovative forms of support and so provide a barrier for SI approaches.

Equally important for achieving outcomes-led systems is the need for LTC investment decisions to consider the full breadth of their consequences across society, including the effects on other public services (e.g. reductions in the demand for hospital care) and on the economy more broadly (e.g. fiscal impact of differences in carers' labour force participation). Taking an SI approach therefore implies a need for some level of integration between different areas of social policy. Typically, the most closely linked area to the LTC system is health care, and across all four countries there are stated policy goals around improving 'integration' between these two sectors (Barbabella *et al*. 2017, Doetter and Rothgang 2017, Linnosmaa and Sääksvuori 2017, Marczak *et al*. 2017).

However, efforts to deliver integration between the two sectors in all four countries are hampered by how the funding of health and LTC is organised (Barker 2014, Leichsenring *et al*. 2015, Linnosmaa and Sääksvuori 2017, Barbabella *et al*. 2017). In the tax-funded systems in England, Finland and Italy, the differences in funding can have two detrimental effects. First, they create a 'cliff-edge' effect, where individuals with very similar needs are charged different amounts for their care depending on whether they are classified as 'belonging' to the LTC or health care system. Second, the differences in funding can result in service retrenchment and cost shunting, usually at the expense of LTC as the weaker partner in the relationship (Lewis 2002). In Germany, the links between health and LTC also remain poor because the financing of the two systems is organised separately (Leichsenring *et al*. 2015). The country which is best placed to overcome these issues is Finland which is in the process of large-scale reforms to restructure and consolidate the health and LTC systems. These are expected to be in place by 2019 and involve moving the responsibilities for care from municipalities to 18 autonomous regions (Linnosmaa and Sääksvuori 2017).

To support SI approaches, it is therefore important that LTC systems incorporate a full overview of the consequences across society of different policy decisions, and that existing rules and regulations

do not generate cliff edges and perverse incentives between public services. Our analysis noted that although highly flexible and empowering for service users and carers, totally unregulated direct/cash payment models might not ensure that LTC resources are used in line with societal preferences.

Preventing the need for LTC, and particularly residential care, is another important priority for an SI approach to LTC (Rostgaard 2016). These policies are rarely labelled as 'SI' policies, even though decision-makers may be focused on the investment of care resources to obtain social outcomes and improve cost-effectiveness across the care systems (Lopes *et al*. 2016). Three of the countries in the study (England, Finland and Germany) have adopted prevention and healthy ageing as policy priorities, and all three countries have passed related legislation within recent years (Doetter and Rothgang 2017, Linnosmaa and Sääksvuori 2017, Marczak *et al*. 2017). The system in Italy gives less priority to prevention and is still focused on interventions for dealing with the onset of health problems. This lack of focus on prevention is attributed to several issues, including the lack of coordination between health and LTC, the reliance on care provided by informal family and migrant carers, and the associated emphasis on cash transfers in the form of the IdA carers allowance and also the fiscal challenges it has faced since the financial crisis of 2008 (Barbabella *et al*. 2017).

In terms of the four countries studied, previous analyses have positioned Germany and Finland as systems which are broadly ready for SI approaches, England as somewhat ready and Italy as least ready (Bouget *et al*., 2015). Using the criteria of outcomes-focus and degree of flexibility this study presents a slightly different assessment of LTC system 'readiness' with SI approaches. In Germany exhibits the least flexibility of the four LTC systems to adopt SI approaches. Funding is earmarked for LTC services through the LTCI system and rigid, needs-based eligibility criteria are used to match users with services provided by the LTC insurance funds. Centralised decision-making allows the government to set national policies around SI-related policies such as prevention and integration, but these have had limited success.

The LTC systems in England and Finland appear to be similar in their readiness for SI approaches. have the most similarities. Both governments have delegated responsibilities for the management of LTC to the lowest level of government, which in theory allows each system to adapt services for the needs of the local population and users. The system in Finland limits this flexibility however, by using vouchers to direct users to government-approved providers and services, in contrast to the broader choice available through the system in England.

Italy has been described as an 'adverse case' when it comes to SI (Kazepov and Ranci 2017). The LTC system has several characteristics which are not compatible with SI, for example, a low level of service provision, variation across regions, and the limitations of policies to reach those in need (Jessoula *et al*. 2015). This is exacerbated by the fact that care is considered to be a 'family matter' (Da Roit and Sabatinelli 2013). The system is highly constrained from the perspective of a system-level approach to SI. From a programme-level, however, the involvement of multiple actors in the system at a local level, such as social cooperatives and private sector employers makes the sector more open to innovative solutions around funding and provision which might not be available in the

other countries. In Italy, therefore, SI approaches, at least at a programme-level, may provide the route to establishing a more robust care system than currently exists.

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Annex 1: Details of Rapid Review

Flowchart of initial literature review process

Initial literature search

Databases	SCOPUS, Web of Science
Search Terms	'Social investment' and 'care' and 'Europe' 'Social investment' and 'care' and 'UK' 'Social investment' and 'care' and 'England' 'Social investment' and 'care' and 'Finland' 'Social investment' and 'care' and 'Germany' 'Social investment' and 'care' and 'Italy' 'Social impact bonds' and 'Europe'
Inclusion Criteria	
Year	Published during or after 2003
Language	Published in English
Nature of evidence	Peer-reviewed international literature
Topic	Social investment and long-term care; SI and preventative care; social impact bonds
Exclusion Criteria	
Year	Published before 2002
Language	Not published in English
Nature of evidence	Databases
Topics	Early childhood education and care; labour market; investment models; socially responsible investing for institutions (e.g. ethical investments); general health care Topics not related to social policy

European Commission projects identified for information on LTC systems

Project name	Website
Assessing Needs of Care In European Nations (ANCIEN)	https://cordis.europa.eu/project/rcn/90930_en.html
European network on long-term care quality and cost-effectiveness and dependency prevention (CEQUA)	http://www.cequa.org/
INTERLINKS	http://interlinks.euro.centre.org/project

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