

# Care homes for older Europeans: Public, for-profit and non-profit providers





# Care homes for older Europeans: Public, for-profit and non-profit providers



**When citing this report, please use the following wording:**

Eurofound (2017), *Care homes for older Europeans: Public, for-profit and non-profit providers*, Publications Office of the European Union, Luxembourg.

---

**Authors:** Daniel Molinuevo and Robert Anderson

**Research manager:** Daniel Molinuevo

**Eurofound project:** Delivering public services – continuation

**Acknowledgements:** The report draws on data and studies gathered by Eurofound's Network of European Correspondents (and Florian Kruse for the Netherlands). Eurofound is also grateful to participants at meetings held in Dublin on 30 March and 6 April 2017 in Brussels and to the Age Europe Platform secretariat (especially Anne Sophie Parent and Borja Arrue) and their members for their input and feedback to the report.

---

**Luxembourg:** Publications Office of the European Union

**Print:** ISBN: 978-92-897-1606-2      doi:10.2806/719312      TJ-01-17-950-EN-C

**PDF:** ISBN: 978-92-897-1607-9      doi:10.2806/737365      TJ-01-17-950-EN-N

© European Foundation for the Improvement of Living and Working Conditions, 2017

For rights of translation or reproduction, applications should be made to the Director, European Foundation for the Improvement of Living and Working Conditions, Wyattville Road, Loughlinstown, D18 KP65, Ireland.

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency, whose role is to provide knowledge in the area of social, employment and work-related policies. Eurofound was established in 1975 by Council Regulation (EEC) No. 1365/75 to contribute to the planning and design of better living and working conditions in Europe.

**European Foundation for the Improvement of Living and Working Conditions**

**Telephone:** (+353 1) 204 31 00

**Email:** [information@eurofound.europa.eu](mailto:information@eurofound.europa.eu)

**Web:** [www.eurofound.europa.eu](http://www.eurofound.europa.eu)

---

**Europe Direct is a service to help you find answers to your questions about the European Union.**

**Freephone number\*:** 00 800 6 7 8 9 10 11

\*Certain mobile telephone operators do not allow access to 00 800 numbers or these calls may be billed.

**Printed in Luxembourg**

**Cover image:** © Eurofound, Juha Roininen/EUP Images 2017

# Contents

	<b>Executive summary</b>	<b>1</b>
	<b>Introduction and methodology</b>	<b>3</b>
<b>1</b>	<b>Trends in care provision over time</b>	<b>9</b>
	Service delivery data from previous studies	9
	Service delivery data from the Network of European Correspondents	11
<b>2</b>	<b>Private care provision and service delivery: Accessibility, quality and efficiency</b>	<b>25</b>
	Accessibility	25
	Quality	32
	Efficiency	39
<b>3</b>	<b>Conclusions</b>	<b>41</b>
	Trends in service provision	41
	<b>Bibliography</b>	<b>45</b>
	<b>Annex</b>	<b>51</b>
	Table A1: Number of care homes by ownership type	51
	Table A2: Number of places in care homes by ownership type	53
	Table A3: Number of service users by ownership type (most recent year)	54

## Country codes: EU Member States

AT	Austria	FI	Finland	NL	Netherlands
BE	Belgium	FR	France	PL	Poland
BG	Bulgaria	HR	Croatia	PT	Portugal
CY	Cyprus	HU	Hungary	RO	Romania
CZ	Czech Republic	IE	Ireland	SE	Sweden
DE	Germany	IT	Italy	SI	Slovenia
DK	Denmark	LU	Luxembourg	SK	Slovakia
EE	Estonia	LT	Lithuania	UK	United Kingdom
EL	Greece	LV	Latvia		
ES	Spain	MT	Malta		

## Country codes: Non-EU countries

IS	Iceland	NO	Norway
----	---------	----	--------

## Abbreviations used in the report

CSR	Country Specific Recommendation
EQLS	European Quality of Life Survey
EPC	Economic Policy Committee
LTC	Long term care
NEC	Network of European Correspondents
OMC	Open Method of Coordination
SPC	Social Protection Committee

# Executive summary

## Introduction

This report provides an overview of how public and private (both for-profit and non-profit) provision of care homes for older people has changed over the last decade. Even though there has been considerable change in the size and ownership of care homes, there are no EU-wide harmonised data disaggregated by type of ownership and/or the economic purpose of service providers. The report draws together the available data and also provides information from studies, evaluations and surveys about the differences between the accessibility, quality and efficiency of services provided in public and private care homes for older people. The information was gathered mainly through a literature review and by Eurofound's Network of European Correspondents, which provided data from national statistical offices and studies.

## Policy context

Most of the debate and policy initiatives at the EU level on long-term care do not make specific reference to public or private provision. In the 2017 Annual Growth Survey, which kick-starts the European Semester process, the European Commission called for further investment in long-term care in order to decrease the burden on informal carers. It also highlighted the need to increase the efficiency and accessibility of long-term care, given the expected rise in expenditure due to the ageing of the population and technological advancements. The Social Protection Committee has argued that long-term care systems must also boost preventive healthcare, rehabilitation and independent living. Country Specific Recommendations tend to focus on improving the cost effectiveness and cost efficiency of expenditure on long-term care, while ensuring the accessibility of services and improving service quality and provision. The European Social Pillar includes the right to affordable long-term care services of good quality, in particular home care and community-based services.

## Key findings

### Trends in provision

Over the last 10 years, there has been an increase in the number of care homes in nearly all the countries for which there are data available. In Romania, Slovakia and Slovenia, the number of private care homes has doubled (albeit from a very low starting point). At the same time, the number of public care homes is either

decreasing (Croatia, the Czech Republic, France, Germany, Norway, Slovenia and the UK (Scotland)), or growing at a slower pace than private care homes (Cyprus, Lithuania, Romania and Slovakia). Malta and Spain are an exception to this trend, with the number of public care homes increasing faster than private ones in both countries.

Over the last decade the number and share of places have increased in private care homes to a greater extent than in public care homes in all countries for which there are data, with the exception of Spain. Places in non-profit care homes increased more than in homes run by for-profit providers in Belgium and Norway, whereas the opposite was the case in the UK (Scotland). The latest data show that private provision constitutes more than two-thirds of the total number of places in Greece, the Netherlands (where it is almost entirely non-profit), the UK (Scotland), Ireland, Spain, and Belgium. The public and private share of places is more or less the same in France, Austria, Malta, Lithuania and Romania. Public provision constitutes approximately 70% of the total number of places in the Czech Republic, Lithuania, Poland, Slovakia and Slovenia, and nearly 90% in Norway. In some countries there are marked differences between the size of public and private care homes. In Slovenia and Malta public care homes have twice the average number of places as private ones. Over the last decade the average size of private care homes in the Czech Republic, Malta, Lithuania and Spain has increased considerably, whereas the size of public care homes has decreased or remained stable.

### Implications for service delivery

Financial pressures on care home providers are a major issue (e.g. in the UK), one that is increasing with the rising number of people needing care, the costs of providing services and recruiting staff, and the promotion of quality for users. In some countries, private care homes provide fewer specialist medical services than public care homes. As private provision increases, costs to users are likely to become a more significant issue unless there is an increase in public benefits to subsidise funding. There are also differences in the location of different types of care homes, with private care homes more likely to be found in affluent urban areas. The types of residents prevalent in each type of care home are influenced by the profitability of the services they require – residents who require less profitable care services are more likely to be in public care homes. In most countries where information about staff-to-resident ratios was available, there were more staff per resident in public care homes.

There is a lack of agreed quality indicators, particularly on quality of life for service users in long-term care. The range and quality of services in public and private care homes differ from country to country, with studies tending to focus on the aspects of quality that are easier to measure. Differences have been reported in terms of having a single room, level of hygiene, the residents' choice of food and activities, attitude of staff, nutrition, continuity of care, preventive healthcare and care practice.

Comparison of cost efficiency of public and private care homes seem to be greatly influenced by staff costs and differences in the types of resident, with public care homes often having a higher share of residents with health complications or who are less profitable.

## Policy pointers

**Importance of analysing possible trade-offs between efficiency, quality and accessibility of services:** Several studies highlight how private providers are facing a dilemma between cutting costs by decreasing the quality of service or increasing prices and thus losing competitiveness. Studies that document differences between different types of providers need to document whether improvements in one area come at the expense of others.

**Clear common definitions essential:** In order to better monitor the extent of public and private provision, it is essential to have clear common definitions that allow gathering data about the different types of long-term care services and providers. Definitions and data about public, for-profit and non-profit provision should take into account the legal status, ownership and economic activity of providers.

**Need to aggregate and review studies systematically at national and European level:** The studies gathered in this report provide an indication of the differences in the accessibility, quality and efficiency of services. With results differing between studies and between countries, to gain more definitive conclusions about differences in service delivery it is important to aggregate and review studies systematically, at national and European level. Findings and data can be used at European level (in particular, in the European Semester) to better understand the extent of different types of service provision.



# Introduction and methodology

This report presents the findings of Eurofound's research on the provision of services in care homes for older people; it is part of the Agency's ongoing research into the private provision of social services. The research started with exploratory case studies looking at the private provision of health and social services, and continued with research into the private provision of hospital services (Eurofound, 2015; Eurofound, 2017).

The main objective of this research is to determine to what extent and in which areas private providers are expanding and/or replacing the public sector in the delivery of services. This report shows that over the last 10 years, public provision of care homes has decreased (or increased to a lesser extent) than the private for-profit sector. Furthermore, the report aims to discover the implications of increased private provision in relation to service delivery, looking at the differences in accessibility, quality and efficiency of public and private (for-profit and non-profit) provision of services. The report starts with a description of the policy context and then sets out the data emerging from studies on public and private provision, concluding with a summary and key messages for policymakers about how reform can best meet service user needs.

## Scope and definitions

The area of study in this research is care homes for older people, with a focus on the differences between public services and private services (both for-profit and non-profit). This report uses the definition of care homes by Huber et al (2009):

*institutions and living arrangements where care and accommodation are provided jointly to a group of people residing in the same premises, or sharing common living areas, even if they have separate rooms. This does not include, however, temporary or short-term stays, such as respite care*

(Huber et al, 2009, p. 21)

This definition covers nursing and residential care homes for older people and corresponds approximately with NACE codes 87.1 and 87.3.<sup>1</sup> The definitions of residential care and nursing homes used in this research are adapted from those established by WHO and the OECD. Residential care is defined as 'accommodation and support for people who cannot or who do not wish to live in their own home'. The services in residential

care may include social care, group activities, personal care, help with performing daily tasks (such as general mobility, dressing, personal hygiene and eating) and medical care (various levels of nursing care and therapy services) (WHO, 2004).

Nursing homes are defined by WHO as 'high dependency care facilities primarily engaged in providing inpatient nursing and rehabilitative services to individuals requiring nursing care'. Staff can also provide acute healthcare, assistance with day-to-day living tasks and assistance towards independent living (WHO, 2004). The types of nursing homes included in this research correspond, to a great extent, to those included in the definition of long-term nursing care facilities in the OECD, Eurostat and WHO System of Health Accounts, which encompasses homes for older people with nursing care, care homes, nursing homes and rest homes with nursing care (OECD, Eurostat and WHO, 2011).

This study does not include sheltered housing, independent and assisted living facilities, hospices or other establishments focusing on palliative care, the terminally ill and convalescence. Furthermore, the study does not include semi-residential care services such as respite or day care, or temporary stays in care centres for social services, or establishments referred to as hospitals or health centre wards primarily engaged in providing inpatient long-term nursing and rehabilitative services to persons requiring convalescence. Service provision for children and working-age adults with physical and mental disabilities is also outside the scope of this study as these services are of a different nature and it would be difficult to compare the findings of studies linking ownership with service delivery.

The division and definition of public and private services can be made according to criteria such as legal status, ownership and economic activity. With regard to private service providers, it is important to highlight whether their services have been contracted out by the public sector or are part of public policy in some other way, as the conditions in which services are provided is similar to public provision. However, data on the number of subsidised places in private care homes are very limited. Therefore, the data and studies compiled in this report focus on public and private provision defined and differentiated by type of ownership, legal status, and/or economic activity. The definitions of public and private

1 Statistical Classification of Economic Activities in the European Community ('NACE' in French).

used in this research are those used by the European Commission's study on social services of general interest (SSGI) (European Commission, 2011) and the report *Facts and figures on healthy ageing and long-term care* (Rodrigues, Huber and Lamura, 2012). 'Public providers' means 'organisations in which public authorities (e.g. Ministry, municipalities) directly manage or have power to appoint management' (Rodrigues, Huber and Lamura, 2012, p. 95).

Private service providers are defined as 'providers which are not public authorities or other bodies governed by public law' (European Commission, 2011, p. 311).<sup>2</sup> They can be either for-profit or non-profit and include services commissioned by a public authority to private providers. Non-profit providers are defined in the Commission's SSGI study as

*institutions or organisations created for the purpose of producing goods and services whose status does not permit them to be a source of income, profit or other financial gains for the units that establish, control or finance them.*

(European Commission, 2011, p. 312)

This can include organisations whose board of directors is composed of volunteers, as well as organisations managed or owned by religious or civil society bodies (e.g. unions, political parties, cooperatives) (Rodrigues, Huber and Lamura, 2012, p. 95). Private for-profit providers include organisations controlled by shareholders or that are privately owned (Rodrigues, Huber and Lamura 2012, p. 95). Whenever the studies and the data available make it possible, a distinction is made between for-profit and non-profit provision. However, many countries do not provide data making this disaggregation, which is fraught with methodological difficulties.

As in previous research carried out by Eurofound in the fields of health and long-term care services, the definitions of accessibility, quality and efficiency used here are very broad in order to identify as many differences between public and private provision as possible. In the case of accessibility, this would comprise aspects covered in the third European Quality of Life Survey: availability (such as waiting lists and lack of services); access (for example, due to distance or opening-hours) and affordability. No information was found about other differences in other aspects of accessibility explored in previous Eurofound research, such as population coverage, waiting times and lists, and information (Eurofound, 2013a; Eurofound, 2014b).

Quality is analysed in this report in terms of structure, process and outcomes. Some of the aspects analysed in this report and in the fourth European Quality of Life Survey are: quality of the facilities (buildings, rooms and equipment); expertise and professionalism of staff; personal attention given to residents; and being informed about care. It also includes elements of quality that are part of the European Quality Framework for long-term care services, such as respect for human rights and dignity.<sup>3</sup> With regard to efficiency, the studies included in this report analyse both technical and cost efficiency.

## Methodology

Research started in 2016 with a literature review focusing on care homes in Europe and the extent and impact of private provision. This helped to identify issues and knowledge gaps to be explored further by Eurofound's Network of European Correspondents. This network is based in all EU Member States and Norway and provides information about the situation in the respective country on such matters as the labour market, employment policies and company restructuring, as well as related social policy topics.

In April 2016, correspondents received a questionnaire; they provided their input largely over the summer. The questionnaire asked for information on the following topics:

- the definitions of residential care, nursing homes and public and private services used at the national level
- data about the volume of public and private (for-profit and non-profit) care home provision in the last 25 years (from 1990 to 2016), including explanations for the changes in the proportion of services provided by the private sector
- a description of the responsibilities for regulation, organisation, financing and delivery of services
- a description of relevant political and legal initiatives directly affecting care homes
- a description of the differences between public and private care homes in relation to their staff and the services provided (including their quality, accessibility and efficiency)
- an assessment of the future of public and private provision of care homes.

<sup>2</sup> Bodies governed by public law are defined as being established for the specific purpose of meeting needs in the general interest (such as not having an industrial or commercial character); having legal personality and financed, for the most part, by the State, regional or local authorities or subject to management supervision by those bodies; or having an administrative, managerial or supervisory board, more than half of whose members are appointed by the State, regional or local authorities, or by other bodies governed by public law (European Commission, 2011, p. 311).

<sup>3</sup> The European Quality Framework for long-term care was developed in 2012 as part of a European research project. It includes principles and guidelines for the wellbeing and dignity of older people in need of care and assistance (WeDO, 2012).

In addition, a questionnaire was distributed in December 2016 to all member organisations of AGE Platform Europe, the European network of non-profit organisations of and for citizens over the age of 50. This was to obtain feedback from the point of view of services users about the perceived differences between public and private provision (with regard to accessibility, availability and quality of services). This information was complemented by a webinar in April 2017 with AGE Platform Europe members from Belgium, the Czech Republic, Denmark, Finland, Germany, Greece, Ireland, Italy, Malta, the Netherlands and Spain.

## Review and synthesis of findings

The information gathered through in-house research, from the Network of European Correspondents and in consultation with members of AGE Platform Europe included different types of evidence, such as inspection reports, academic studies, policy statements and the opinions of experts. This report synthesises the information by clustering thematically the documented differences between public and private care homes. The findings of this research and the policy pointers that could be derived from them were discussed at meetings in March and April 2017 between social partners, academic experts and associations of service users and providers.

## EU policy context

### Long-term care policy monitoring and governance

Since 2006, long-term care has been a key element of the Open Method of Coordination on Social Protection and Social Inclusion (known as the Social OMC). The reform of the Social OMC in 2005 included the incorporation of health and long-term care to this process. In addition to the main principles of the Social OMC, an objective was set for long-term care ('ensuring accessible, high-quality and sustainable long-term care'). The Communication from the European Commission setting out this new Social OMC makes reference to the need for coordination between public and private institutions by ensuring a rational use of resources in order to achieve this objective (European Commission, 2005).

Since 2010, the coordination of national economic policies aiming to reach the objectives of the Europe 2020 strategy takes place in the framework of the annual European Semester. The objectives of this process include: ensuring sound public finances; avoiding excessive government public debt, and fostering structural reforms that create jobs and growth. The scope and direction of the national programmes drafted by Member States as part of this process are directed by a set of integrated guidelines for economic

and employment policies. The 2015 employment guidelines for Member States and the Union make reference to the promotion of work-life balance through access to affordable, good quality early childhood education, care services and long-term care (Council of the European Union, 2015).

The European Semester process starts with the European Commission's Annual Growth Survey, which provides guidance by setting general economic goals and recommendations for the euro zone. The Annual Growth Survey in 2017 calls for further investment to develop long-term care in order to decrease care obligations, highlighting the negative impact that they have on the labour market participation of women. The survey also makes reference to the need to increase the accessibility and efficiency of long-term care in order to address increases in public expenditure driven by ageing and technological developments (European Commission, 2016c).

In addition, a 'reinvigorated' Social OMC process continues. From 2011 onwards, Member States prepare National Social Reports that are used as the basis for the Social Protection Committee (SPC) annual report, which includes an assessment of progress made towards meeting the Europe 2020 target on reducing poverty and social exclusion. This is then fed into the European Semester process (Social Protection Committee, 2011; Social Protection Committee, 2012). The work of the SPC also includes a thematic report about the challenges faced in long-term care provision and the policy responses they require (Social Protection Committee and European Commission, 2014). The report makes reference to the public-private divide in funding, but not in relation to service provision.

Each year, the European Commission analyses each national government's actions as stated in their National Reform Programmes and, together with the Council of the European Union, issues Country Specific Recommendations (CSRs) to each Member State. In 2014, six countries received recommendations in the field of long-term care. Curbing expenditure by making actions more cost effective was the most frequent recommendation made that year, with some countries being asked to ensure the accessibility and quality of services (the Netherlands) and the development of home care (Slovenia) (European Commission, 2014). In 2015, Austria was urged to improve long-term care provision in order to improve the labour market participation of women and older workers, and Finland and Slovenia were encouraged to adopt and implement reforms in their healthcare and long-term care systems. In 2016, the European Commission and the Council of the European Union gave Estonia, Slovenia and Spain CSRs, making explicit reference to the accessibility and cost efficiency of long-term care. In 2017 Slovenia was recommended to adopt the planned reform of long-term care, increasing the cost effectiveness, accessibility and quality of care.

In parallel to this governance process, the European Commission monitors developments in long-term care using a horizontal assessment framework (HAF) similar to the one used for pensions and healthcare. These thematic assessment frameworks, carried out by DG ECFIN for the Economic Policy Committee (EPC),<sup>4</sup> aim to identify medium- and long-term risks for fiscal sustainability that require structural and fiscal reforms. Generally speaking, those countries where there is a CSR on long-term care have also been identified as experiencing structural fiscal challenges (European Commission, 2014). In 2016, the assessment concluded that the Czech Republic, Estonia, Latvia, the Netherlands and Poland can increase efficiency in spending by transferring care from institutions to home care. The ratio of unit costs per dependant in institutional care was deemed to be ‘very high’ in Malta, the Netherlands, Poland and Sweden (European Commission, 2016a).

In December 2016, the European Commission presented a proposal to review EU legislation on social security coordination. The proposal includes coordination rules that are (for the first time) specific to long-term care. The new rules will provide a common definition of long-term care benefits, criteria to identify them and a list of benefits in each Member State (European Commission, 2016b). Long-term care benefits will continue to be coordinated as sickness benefits, where the Member State in which citizens are insured will provide long-term care benefits in cash and reimburse the cost of benefits in kind provided by the Member State of residence.

In order to strengthen the social dimension of the Economic and Monetary Union (EMU), in March 2016 the European Commission published a first outline of a European Pillar of Social Rights. This outline, which was made available for public consultation, makes reference to long-term care as one of the policy domains under the category ‘Adequate and sustainable social protection’. It includes the need to ensure ‘access to adequate long-term care services, while guaranteeing the financial sustainability of long-term care systems’, which requires ‘increased efforts in improving the provision and financing of long-term care’ (European Commission, 2016e). The European Commission recommendation establishing the Pillar sets out a number of key principles and rights, which include the right to affordable long-term care services of good quality – in particular, home care and community-based services (European Commission, 2017).

## EU policy initiatives regarding long-term care

In 2010, a voluntary European Quality Framework for Social Services was developed, which includes ‘supporting coordination among service providers so as to achieve a comprehensive and integrated delivery of social services’ as a quality criterion (Social Protection Committee, 2010). At the end of 2012, which was the European Year for Active Ageing and Solidarity between Generations, the Council of the European Union adopted the Guiding Principles for Active Ageing and Solidarity between Generations. These principles aimed to provide orientation to national governments as to how to continue to promote active ageing. One of these principles is maximising autonomy in long-term care by ensuring the autonomy and participation of people in need of help and care (Council of the European Union, 2012).

Also in 2012, the European Commission launched the Employment Package, which consisted of a set of policy documents that identified areas with a potential to create jobs, as well as identifying ways Member States could create them. Health and social care were identified as sectors with potential for job creation, but accompanied by many challenges such as the ageing and shrinking workforce, poor pay, demanding working conditions, the need for new skills associated with technological change and a growing proportion of the population with chronic conditions (European Commission, 2012a).

The Social Investment Package published by the European Commission in 2013 to address the social consequences of the economic crisis included the staff working document *Long-term care in ageing societies – Challenges and policy options* (European Commission, 2013). This document describes briefly the public–private mix in the funding and delivery of long-term care in Europe, and the advantages and drawbacks of public and private provision. It also highlights the challenges that future demand for the provision of long-term care will pose for public budgets. The document also proposes using the SPC as a focal point for long-term care-related activities across European Commission services.

In addition to the SPC, the EPC also provides information about long-term care and other age-related expenditure. The economic and budgetary projections up until 2060 are done on the basis of different scenarios, which include variations in public spending on formal home care in homes and in institutions, and variations in cash benefits. In these projections, private

<sup>4</sup> The EPC advises and contributes to the work of the European Commission and the Economic and Financial Affairs Council and in the areas of economic policy and public finances.

expenditure on long-term care is put together with informal care provision. Therefore, the scenarios foresee increases in public provision influenced by a shift from informal care, without taking into consideration changes in privately funded services. Some scenarios include not only the provision of publicly funded institutional and home care, but also public benefits in cash, which can be used to fund private care homes (European Commission, 2015).

The European Commission and the EPC have also published a joint report on healthcare and long-term care systems and fiscal sustainability. The report gives an overview of the challenges for long-term care systems and gives a list of policy options that countries could follow in order to resolve them. The options to ensure the fiscal sustainability of healthcare spending include the improvement of reimbursement mechanisms and enhancing service provider

competition (European Commission, 2016f). Both options are perceived as important tools for ensuring the fiscal sustainability of long-term care spending, used by a majority of the countries surveyed as part of the report.

The European Commission's Directorate General for Communications Networks, Content and Technology (DG CONNECT) also carries out activities that are linked to residential care in the framework of the European Innovation Partnership on Active and Healthy Ageing, which was initiated in 2011. These partnerships aim to be transversal initiatives that bring together all relevant stakeholders in order to speed up innovations to tackle societal challenges. One of the three objectives of this partnership is to support the long-term sustainability and efficiency of health and social care systems, with one of the action groups that form the partnership focusing on integrated care.



# 1 Trends in care provision over time

This chapter presents the data available from different sources about public, non-profit and for-profit care home service provision, and how it has changed over the last 10 years. Care home provision takes place in a context of longstanding diversification of long-term care services. Long stays in hospitals have been replaced in all countries with care home and home care services (Wittenberg, Sandhu and Knapp, 2002). In particular, since the mid-1990s, there has been a shift towards more investment in home care (OECD, 2005). This reflects the preference of most European service users to receive care in their own home. In a Eurobarometer survey, around 80% of those surveyed expected and/or preferred to receive care in their home, whereas less than 10% preferred and/or expected care in a nursing home (Eurobarometer, 2007).

In this context, policymakers need to decide how to best provide long-term care services. The new public management (NPM) discourse has advocated for increased private provision on the grounds that competition between service providers will increase the quality and efficiency of services at a reduced cost to the public sector (Hermann and Verhoest, 2012). The reforms in the public sector inspired by NPM put the emphasis on performance, contractualisation and the adoption of management practices from the private sector. Market mechanisms and quasi-markets have been introduced so that different types of providers compete with one another. These reforms and market mechanisms include tendering, commissioning, user choice, user fees, and vouchers (Rodrigues, Leichsenring and Winkelmann, 2014). In its 2010 report on long-term care in Europe, the World Bank stated that

*The main public policy question vis-à-vis provision is whether to 'make or buy', that is how much formal long-term care services should be provided by the public sector and how much should be contracted out to private facilities.*

(World Bank, 2010, p. 12)

The report made a recommendation 'to think proactively' about how to leverage reforms in the long-term delivery of care services and encourage

private sector provision: 'This depends a great deal on long-term care financing policies and the overall regulatory environment' (World Bank, 2010, p. 9).

## Service delivery data from previous studies

The data available about care home provision disaggregated by ownership come from estimates from experts, national studies and national statistics. For example, the European Commission study on social services of general interest (SSGI) (European Commission, 2011) provides estimates of the relative volume of private provision of long-term care services. The study also underlines difficulties in collecting data disaggregated by ownership, such as the mixed economy in the funding and provision of services, the fragmentation of services, the lack of data in many countries about service providers outside of the public sector and the fact that long-term care includes both health and social care. This affects the reporting of the services available since data about health and social care are gathered separately. The authors of the study also call for standardised definitions of for-profit and non-profit provision.

The data in Table 1 show the share of private expenditure (both for-profit and non-profit) as reflected in the SSGI study. Care homes are almost exclusively privately provided in the Netherlands, Germany and the UK (England and Scotland). In the Netherlands, care home services are by law provided entirely by the non-profit sector. In Germany, non-profit provision is also predominant, although there are significant regional variations. On the other hand, in the UK (England and Scotland) private provision is mainly for-profit. Private provision constitutes 20% or less of the total in the Nordic countries, some eastern European countries (Estonia, the Czech Republic, Romania and Slovenia) and Greece, where formal provision of long-term care is very limited. The SSGI also highlights the lack of cross-sectional data and that the data available show a shift towards private provision, driven by the increase in vouchers and cash benefits.

**Table 1: Share of care homes provision in Europe**

Country	Private for-profit	Private non-profit	Year	Unit
Austria	22%	29%	(no information)	Residential care beds
Belgium (Wallonia)	32%	29%	(no information)	Residential nursing home beds
Belgium (Flanders)	12%	49%	2007	Residential care beds
Czech Republic		16%	(no information)	Residential care places
Estonia	80%		(no information)	Residential care places
France	17%	28%	2008	Residential care beds
Germany	34%	59%	2007	Residential care home places
Greece		Approximately 1%	(no information)	
Hungary		37%	2006	Residential care beds
Ireland	65%	9%	(no information)	Residential care places
Italy	22%	43%	2005	Residential care beds
Netherlands		100%	(no information)	
Norway	4%	6%	2008	Long-term care institutions
Romania		17%	(no information)	Residential care places
Spain	27%	27%	(no information)	Residential care services
Slovenia		14%	2007	Residential care beds
Sweden		17%	2009	Individuals living in all types of residential and sheltered housing
UK (England)	76%	16%	2009	Residential care homes
UK (Scotland)	75%	11%	2007	Residential care home places

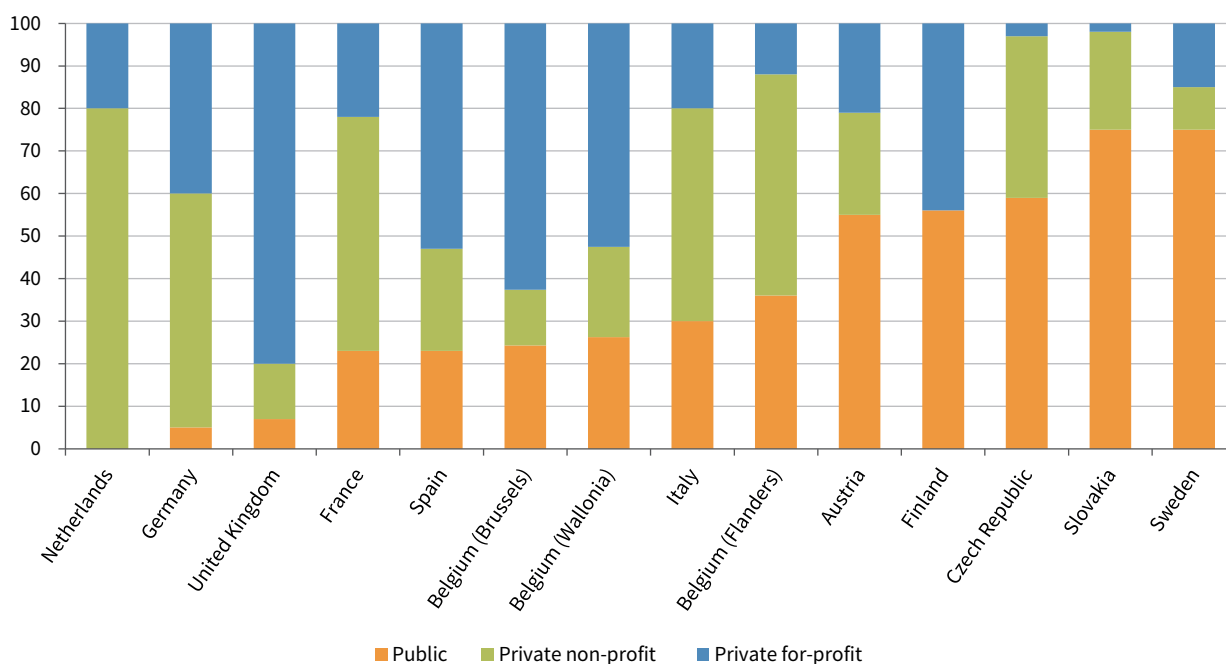
Source: European Commission, 2011.

Another source of data is the study *Facts and figures on healthy ageing and long-term care: Europe and North America* (Rodrigues, Huber and Lamura, 2012). Part of the information available in the study comes from data collated in the FP7 research project INTERLINKS (Allen et al, 2011). The data in this study (shown in Figure 1) illustrate again that private provision is particularly high in the Netherlands (where it is almost entirely

non-profit), Germany and the UK (where it is mainly for-profit). The data also confirm that most services in the Nordic countries and in eastern Europe are provided by the public sector. The authors point out that the public-private mix seems to be determined, to a great extent, by path dependency – for example, who the main provider was when services started to be developed.



Figure 1: Distribution of providers of care homes according to ownership (%)



**Note:** In Spain, Italy, the Netherlands and Slovakia, only data combining residential and home care are available. In Spain, no clear distinction can be made between for-profit and non-profit providers. Non-profit providers include all those with a formal contract with autonomous communities; private for-profit providers include those with an authorisation only.

**Source:** Rodrigues, Huber and Lamura (2012).

## Service delivery data from Network of European Correspondents

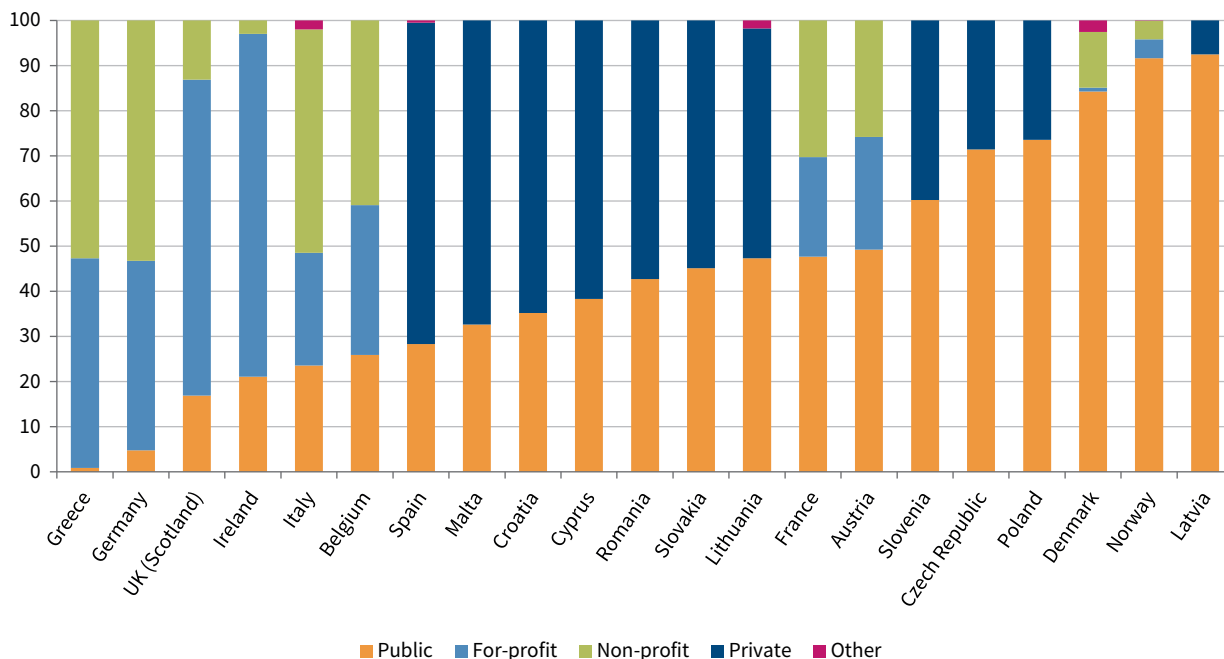
The data gathered at the national level presented in this section are based on different definitions and classifications of care homes, as in some countries there is not a clear division between residential care and other long-term care services.<sup>5</sup> Whenever possible, the data correspond to residential care. For example, in Finland, sheltered housing (also called service housing) includes group homes as well as sheltered accommodation where residents have their own apartments. In regular sheltered housing (*tavallinen palveluasuminen*), staff are not present at night (but residents often have alarms to call for assistance in an emergency). In 24-hour sheltered housing (*tehostettu palveluasuminen*), staff are present in the facility around the clock. In this report, only data about 24-hour sheltered housing are included, together with residential homes (*vanhainkodit*). On the other hand, the data gathered in Sweden on special/sheltered housing (*särskilt boende*) do not include a breakdown of the different services it provides (such as care institutions, service homes or group homes for people with dementia). A description of the types of care

homes, places and service users included in each country is provided in the annex. Whenever possible, the data presented in this study focus specifically on care homes for older people. In Latvia for example, only those centres that are in NACE code 87.1 in the company register, and that provide health and social care services for older people, are included in this study. Only five undertakings (four local government institutions and one private limited liability institution) from NACE code 87.1 in the national register were care homes for older people. Other establishments in this NACE code, such as sports rehabilitation centres, family support activities, institutions for people with mental impairments, former hospitals that now provide inpatient long-term nursing and rehabilitative services, and institutions providing other healthcare services, are not included.

The data reflect only those institutions that are officially registered, which can include organisations that own several care homes (as in the case of Hungary); this omits care homes that operate in the grey economy. In the Czech Republic, for example, the Ombudsman's Office estimates that at least 70 illegal residential social services facilities are in operation, while the Minister of Labour and Social Affairs estimates their number at around 80. These facilities represent a 7% share of the market (based on a total number of 987 providers recorded in the Ministry Register).

<sup>5</sup> The number of countries in the figures in this report varies, as data corresponding to more than one year were only available in a limited number of countries.

Figure 2: Share of care homes by ownership type (%)



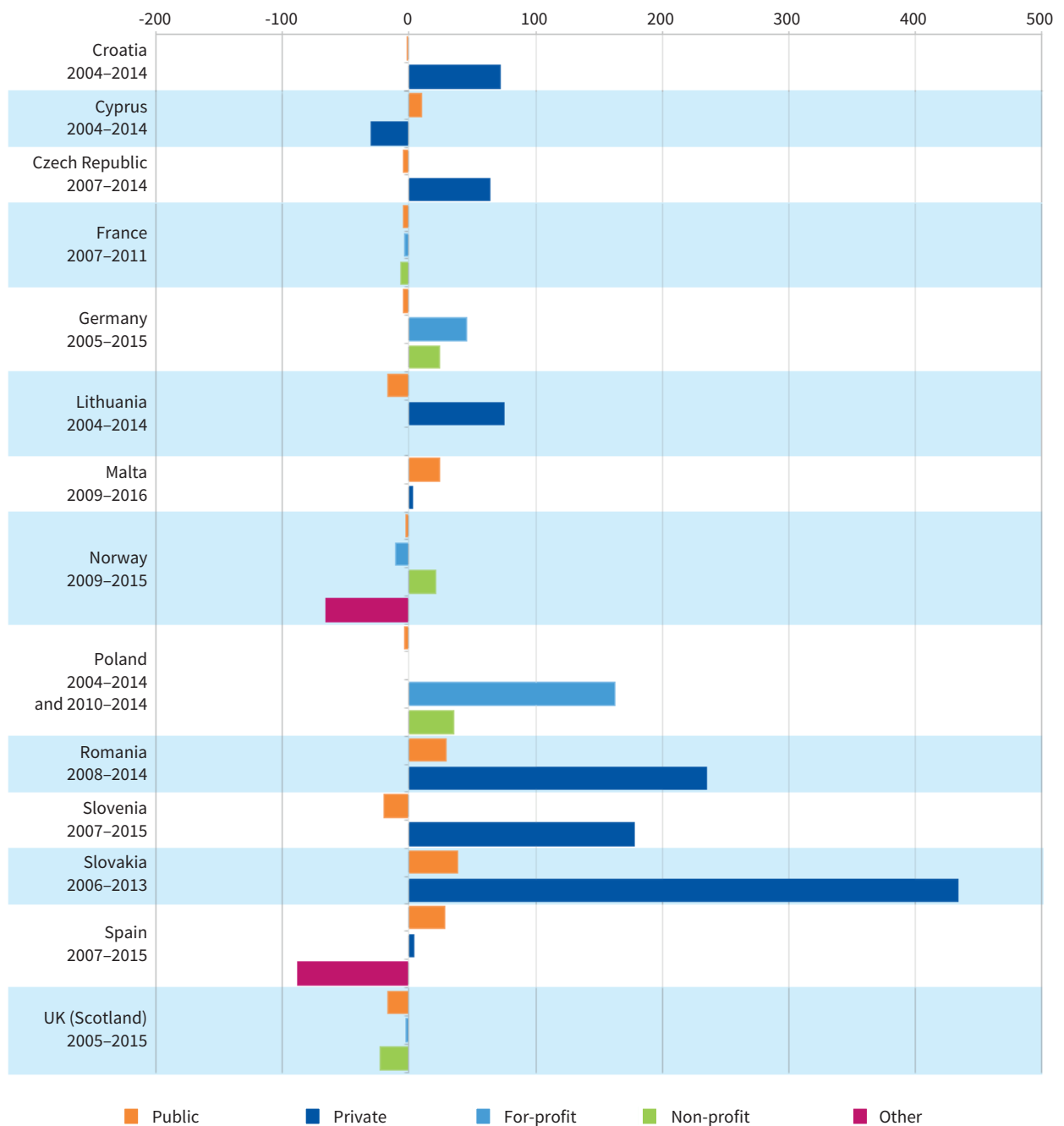
Note: All data are from latest year available for each country. Private encompasses both for-profit and non-profit.  
 Source: Eurofound’s Network of European Correspondents.

### Number of care homes

The data in Figure 2 show that less than one-quarter of the total number of care homes in Greece, Germany, the UK (Scotland), Ireland and Italy were public. In the case of Greece, there are only two public care homes for older people. Public provision constitutes more than half of the total in the Nordic countries and in central and eastern Europe (with the exception of Croatia, Lithuania and Romania).

Taking into consideration the changes in the total number and share of care homes over the last decade (displayed in Figures 3 and 4), the number of public care homes has increased considerably in Slovakia (by 39% between 2004 and 2017) and in Romania (by 30% between 2008 and 2014). In both countries, this is coupled with a much higher growth in the number of homes in the private sector. In Romania, the number of private care homes increased from 42 in 2008, to 141 in 2014. In Slovakia, there were 116 private care homes in 2004 and 267 in 2017. Consequently, the share of private provision has increased: private care homes in Romania constituted around one-third of the total in 2008, whereas in 2014 they represented more than half of all care homes.

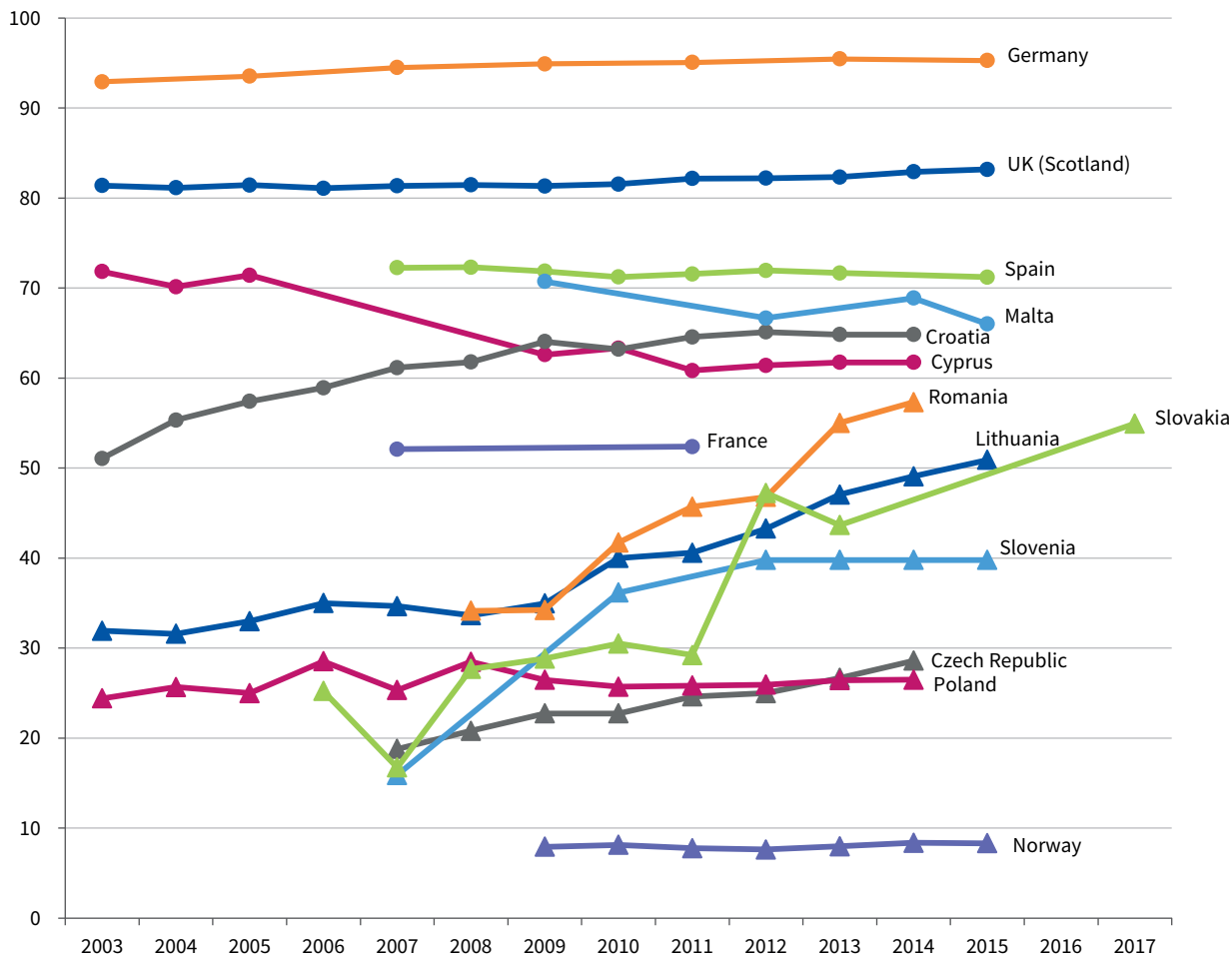
Figure 3: Changes in the number of care homes in the last 10 years (%)



**Note:** Private encompasses both for-profit and non-profit. Data on for-profit provision (economic activity) and non-profit provision (statutory activity) in Poland correspond to establishments ensuring 24-hour care (placówki zapewniające całodobową opiekę).

**Source:** Network of European Correspondents.

Figure 4: Changes in private care homes as a share of the total (%)



Source: Network of European Correspondents.

The increase in Romania represented a growth of 236%; this can be partly explained by the reform of its health system in 2009, when health insurance was discontinued for 66 public hospitals due to high operating costs and the low numbers of patients (Eurofound, 2014b). These hospitals were closed down in April 2011, although some later reopened as nursing and residential care homes for older people. Of these, 19 were operational in 2015, with a total of 966 beds and 896 enrolled beneficiaries. European structural and investment funds also played a role in the development of private care home services. From 2007 onward, several funding opportunities were available to NGOs to ‘rehabilitate, modernise, develop and equip social service infrastructure’; the eligibility of such NGO private projects was restricted to the north-east and Bucharest-Ilfov regions (Ministry of Regional Development and Public Administration, 2011).

The increase in the number and share of private care homes in Slovakia took place in a context where private providers were eligible for public grants only in cases where services could not be publicly provided. This rule was declared as infringing the right to freedom of trade

and hence unconstitutional by the Constitutional Court in 2010 (Allen et al, 2011).

The number of public and private care homes also grew (albeit to a lesser extent) in Lithuania, Malta and Spain. In Lithuania, at the beginning of the 1990s, the management of public care homes was transferred from the state to local authorities. By 1994, care institutions owned by the state already accounted for less than 20% of the total number of public care homes, with the rest being managed by local authorities. On the other hand, in Malta, while the number of non-profit care homes owned by the church has decreased slightly since 2009, the number of private and government homes for older people is on the increase. In 2016 there was an equal number (15) of church, private and government homes. The rate of growth in Spain was very similar to that of Malta, with public care homes increasing by around 25%, with a smaller increase in private care homes. The proportion of public care homes in Spain has progressively increased since 2007. Before 2011, the residential care centre sector had increases of around 6% per annum. However, public budget cuts and decreasing purchasing power resulting from the

economic crisis limited increases to just 0.2% between 2010 and 2011, with subsequent decreases. The crisis particularly hit those private centres with ‘arranged’ places (that is, with private places subsidised by the public system). Public administrations reduced the number of arranged places and public contracts’ prices. Some media sources were critical of the reductions, saying that public administrations were paying for ‘arranged’ places at a lower price than their market value (Aquoras, 2014).

Cyprus is the only country (for which data are available) where there has been an increase in public care homes and a decrease in private ones. While public provision has increased by around 10% over the last decade, around one-third of private care homes closed, partly due to a reduction in state funding to non-profit providers.

Another group of countries is that in which there was a decrease in public care homes at the same time as the number of private care homes grew: the Czech Republic, Croatia, Germany and Slovenia. The Social Services Act came into force in 2007 in the Czech Republic. Service users can avail of a care allowance to pay for part of the costs of residential care provision. The conditions that all types of providers need to meet to be registered and obtain public funding were unified. In January 2014 the act was amended to transfer competencies from the state to the regions in terms of the allocation of subsidies and the registration of providers.

In Croatia, the number of public social welfare homes (mostly established by local and regional authorities) for older and infirm persons decreased from 46 in 2003 to 45 in 2014. All new care homes established between 2003 and 2013 were private (mainly for-profit), with the market share of private homes increasing significantly from 15% in 2003 to 27% in 2013. The main driver behind this increase is the lack of capacity in state and other public homes to meet the increased demand for accommodation.

In Germany, the introduction of long-term care insurance in 1994 was followed by reforms inspired by new public management, such as opening the market to private providers to increase competition, introducing contract management between the state and the providers, and the allocation of public funding by care insurers who also negotiate contracts with providers. This has led to an increase in for-profit providers within the care infrastructure and the restructuring of organisational forms of care provision – especially in the case of non-profit providers (Theobald, 2012). The number of public care homes in Germany decreased by 14%, from 649 in 2003 to 555 in 2013. During this period, the number of non-profit providers increased by 29%

and for-profit providers by 49%. As a result, the share of care homes that are private (both for-profit and non-profit) grew to 95% of the total.

In Slovenia, private sector providers started to provide residential care in 1999 in order to meet the demand that could not be met by the public sector and to offer a wider range of services. Between 2007 and 2015, the number of public care homes decreased from 74 to 59, while the number of private care homes increased from 14 to 39.

The last group of countries where both public and private provision declined include France, the UK (Scotland) and Norway (except in the case of non-profit care homes, which grew from 33 to 40 between 2009 and 2015).<sup>6</sup> In the UK (Scotland), the biggest decreases were in the non-profit sector and public care homes, with nearly one-quarter and one-fifth respectively of care homes closing between 2004 and 2015. In Norway, non-profit nursing homes (which are mostly linked to religious institutions) have generally been part of the municipal healthcare system and the services provided differed little from those in municipally run homes. Up until 2006, private non-profit providers struggled when competing with private for-profit providers: because they must ensure the same level of benefit pensions as public providers, they face higher costs. To address the difficulties faced by non-profit providers, the then prime minister of Norway, Kjell Magne Bondevik, passed a procurement provision included in the new procurement regulation from 2006, stating that the full procedure of the EU Procurement Directive does not apply in the awarding of contracts for health and social care services provided by non-profit organisations. Thus, municipalities were free to make agreements with non-profit care providers without publishing their requirements in the national public procurement database or having to use competitive procurement procedures.

In France, over the past 15 years, financial incentives have been given to for-profit nursing homes and home care agencies to enable them to enter the long-term care market (Allen et al, 2011). Between 2007 and 2011, the share of public and private care homes remained stable and even (48% and 52% respectively).

In some countries it was not possible to obtain precise or formal data showing the evolution of care home provision over the last decade, but it was possible to obtain estimates. These are detailed here.

**Estonia:** Although there are no statistics by ownership type, by the end of 2016 there were 152 facilities providing general care services for adults. Around 75%

<sup>6</sup> Poland could also be included in this group as between 2004 and 2014 there was a slight decrease in public provision of social assistance houses, whereas the number of private houses remained the same. The number of private establishments providing 24-hour care for disabled persons, chronic patients, and older persons grew between 2010 and 2014.

of them were managed and owned by local governments, by private companies or other associations established by local governments.

**Latvia:** It would seem that private sector provision has shrunk, with several companies having ceased economic activity or having closed.

**Hungary:** There has been no major change in the share of private provision. Even though there was an attempt to strengthen the role of civil society organisations (such as associations and foundations), lack of funding and regulation of outsourcing did not make this possible. Since 2011, only organisations that have non-profit status are allowed to take over tasks such as residential care from central or local government.

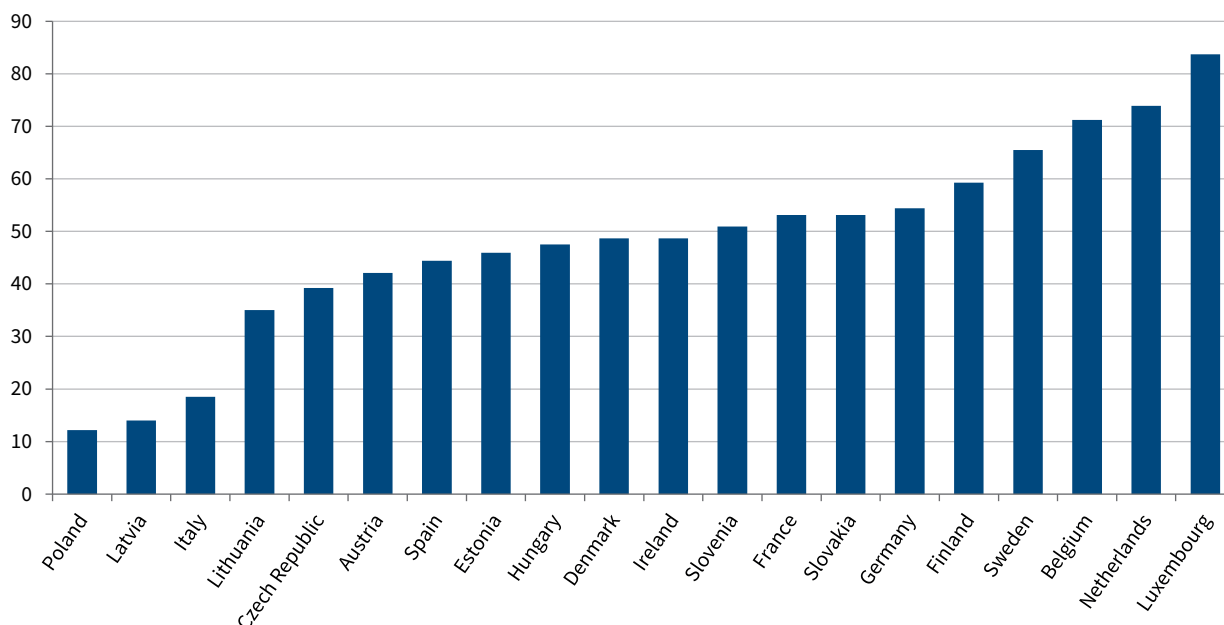
**Sweden:** The past two decades have seen a steady increase in the share of private care homes (National Board of Health and Welfare, 2012). The share of private homes increased from around 14% in 2007 to around 21% in 2014. In 2015, the number decreased to around 19%. It is mainly large international corporations or companies owned by them that provide private services. Around half of the privately run residential care homes were owned by just two companies – Attendo and Vardaga (Szebehely, 2014).

**Netherlands:** Care has historically been provided by religious groups. Currently providers of care home services are not permitted to make a profit. The agency WTZi licences the non-profit private providers that are financed by the regional care offices (*zorgkantoren*). There are also privately funded nursing and residential care homes (*particuliere verpleeghuizen*) that are financed completely privately and therefore do not need approval from the WTZi. Because privately financed nursing homes operate outside of the formal long-term care system, it is more difficult to get the official statistics of these providers. The Health Inspectorate (IGZ) identified 72 privately financed nursing homes in 2013 in its Care Registry (*Zorgregister*) out of a total of 141 care homes (data from the Care Registry as of December 2016).

### Number of places

The only information available at European level is the number of beds in residential long-term care facilities (OECD, 2017a).<sup>7</sup> The source of this information is the joint survey carried out by Eurostat, OECD and WHO on non-monetary healthcare. Unlike the information available about the number of hospitals and hospital beds, this information is not collected by the type of ownership. The number of long-term care beds in residential long-term care facilities is shown in Figure 5.

**Figure 5: Beds in residential long-term care facilities for service users 65 years+**

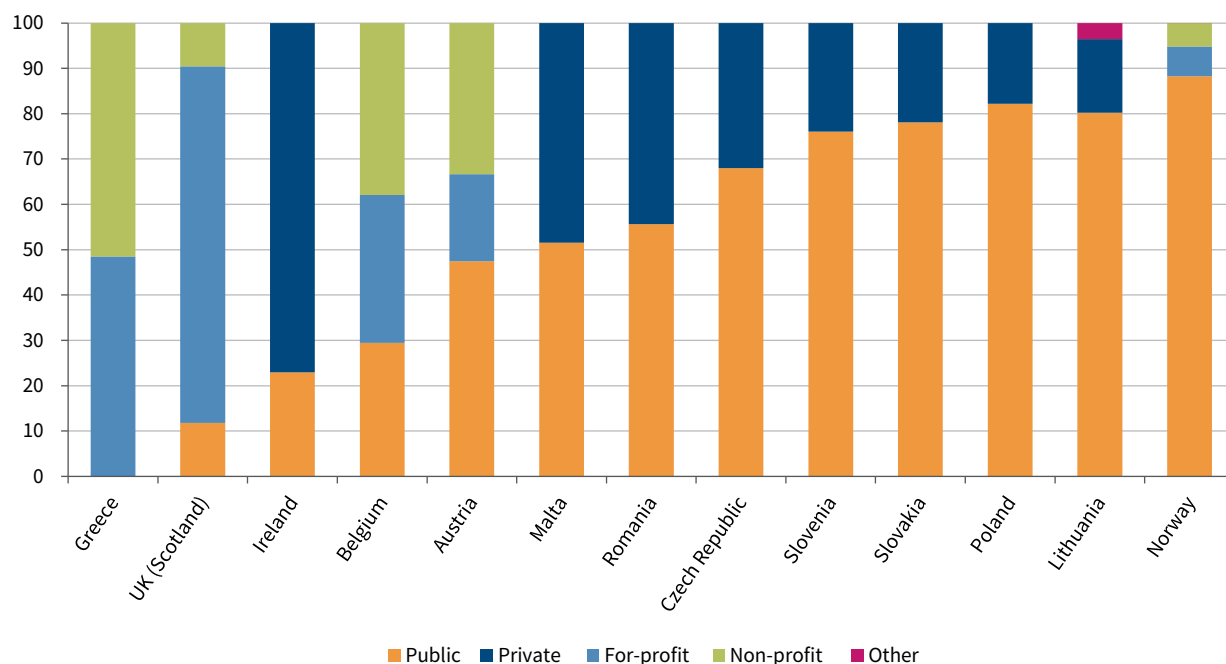


**Note:** Data are per 1,000 people aged 65+ in 2015 with the following exceptions: data for Denmark correspond to 2011; data for Belgium corresponds to 2012; data for Luxembourg and Ireland correspond to 2016.

**Source:** OECD.

<sup>7</sup> The terminology used differs from country to country, with the data in some countries referring to the number of beds; in others, to the number of places.

Figure 6: Share of places in care homes by ownership type (%)



**Note:** All data are from latest year available for each country. Private encompasses both for-profit and non-profit.  
**Source:** Network of European Correspondents.

The share of places in care homes by type of ownership is shown in Figure 6. Data on the number of places are disaggregated by ownership in fewer countries than the number of care homes. The share of places is similar to the share of care homes in most countries, with the exception of Malta, Romania, Slovakia and Slovenia, where the share of places in public care homes is considerably higher than the share of care homes (by more than 10 percentage points). This indicates that they are bigger in size than their private counterparts (see following section on size). These are all countries in which public and private provision of places has increased over the last decade, with the greater increase being in the number of beds in private care homes.

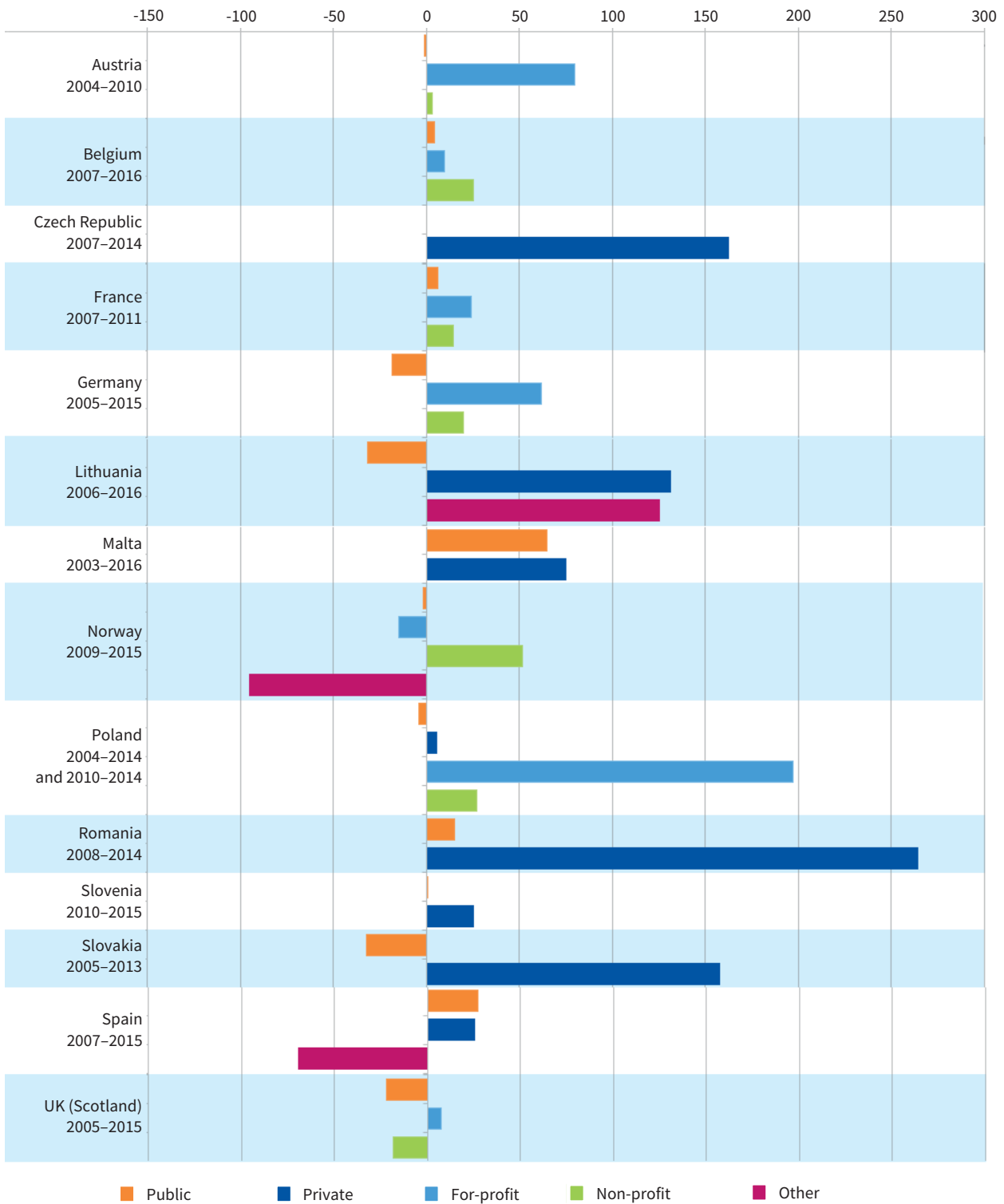
The change in the number of places over the last 10 years is shown in Figure 7 and Figure 8. In most of the countries for which data are available, there has been an increase in the number of both public and private places. This is the case in Belgium, Spain, Malta, Romania, and Slovenia. As with care homes, the biggest relative increase in the number of places in private care homes took place in Romania (from 1,538 in 2008 to 5,601 in 2014, an increase of 264%). This high increase meant that the share of places in private care homes increased from 20% to 44%. The number of places in public care homes has increased faster in Malta

(65% between 2009 and 2016). Despite a decrease in the number of homes owned by the church, since 1992 the overall number of beds available in Malta has increased in all categories of care home ownership.

Between 1996 and 2016, the total number of beds in Belgium in the residential nursing homes sector expanded by 35%. The biggest increase was found in Flanders, where private beds grew by over 20% between 2003 and 2013. In contrast, the total number of beds in the Brussels region has decreased since 2001 due to an overcapacity of beds (particularly in private care homes). The only type of beds that has increased slightly (by 2%) between 2003 and 2013 are those in non-profit care homes. In the Wallonia region, the number of non-profit beds has also increased (by 17%), with the rest remaining more or less stable.

In Spain, the reports from the National Institute for Older Persons and Social Services (IMSERSO) distinguish between public places, private beds with a public subsidy (*concertadas*) and private places. Data for 2010 show that – among the total number of beds available (368,805) – 25% were offered in public centres, 27% were publicly subsidised places in private centres and 48% were purely private places. The percentage of subsidised places in private centres compared with the total available has increased from 15% in 2002 to 27% in 2010.

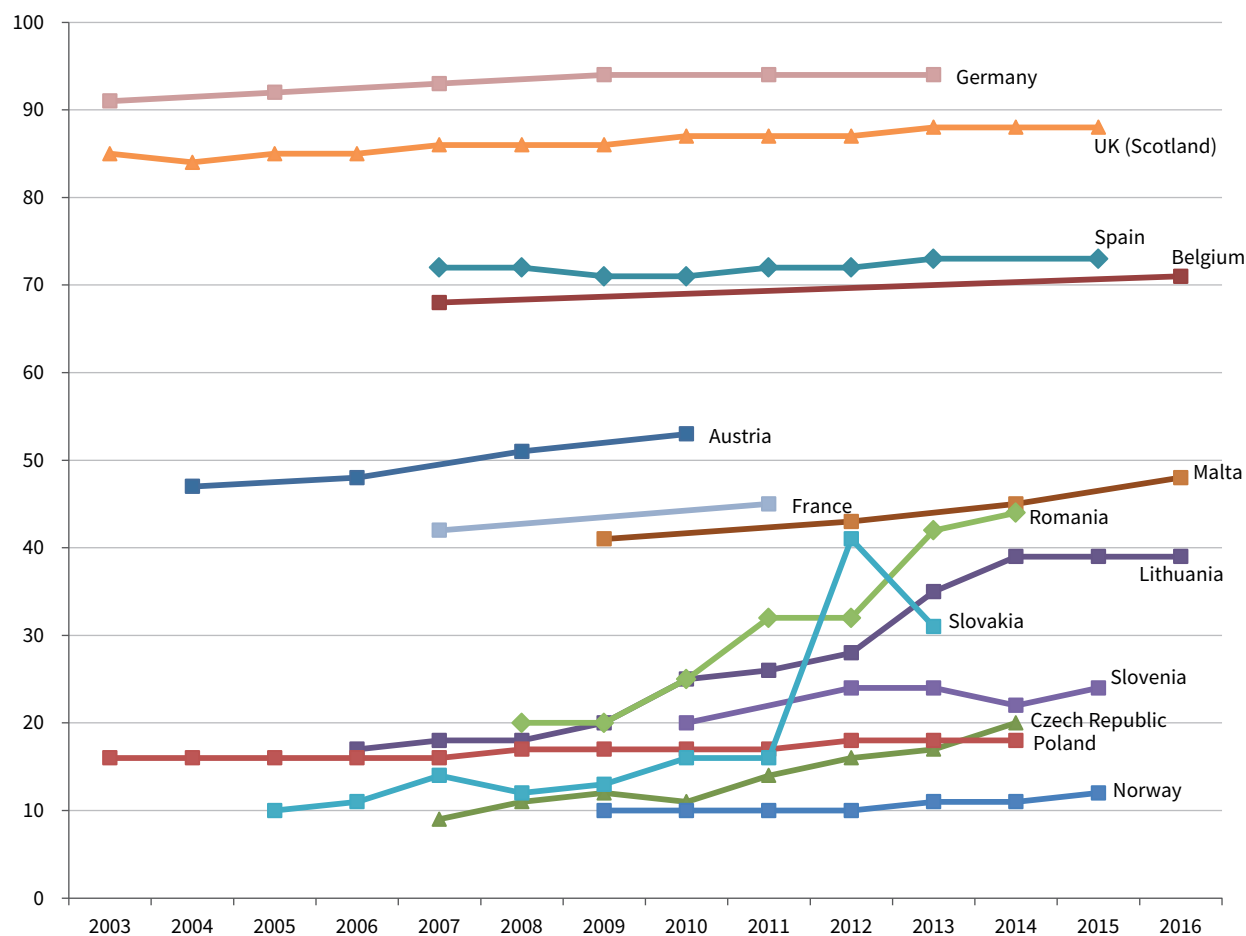
Figure 7: Changes in the number of places 2004–2016 (%)



**Note:** Private encompasses both for-profit and non-profit. Data on for-profit provision (economic activity) and non-profit provision (statutory activity) in Poland correspond to establishments ensuring 24-hour care (placówki zapewniające całodobową opiekę).  
**Source:** Network of European Correspondents.



Figure 8: Changes in the share of private beds 2002–2016 (%)



Source: Network of European Correspondents.

Another group of countries are those in which the provision of private beds has increased and provision of public beds has decreased; this is the case in Austria, France, Ireland, Lithuania, Slovakia and to some extent Norway, where there has been a decrease in the number of for-profit beds. In Austria, with the introduction of a long-term care allowance (*Pflegegeld*) in 1993, the overall number of beds increased considerably, while the number of beds in public and non-profit institutions has stagnated since 1998 and the share of private for-profit beds and residential homes has continued to increase – so much so that in 2010 they accounted for about one-fifth of all beds.

Between 2003 and 2014, the use of private providers for nursing home care of older people increased significantly in Ireland, with a 49% increase in private beds and a decrease in public beds from around 9,000 to 6,656. This was aided by tax concessions for building private nursing homes, which were in place from 1997 to 2009. The aim had been to increase overall nursing home bed supply in order to relieve pressure on public hospital beds, which were being used for care of older people in areas with relatively few nursing home beds. While there was no explicit policy of replacing public

beds with private beds, the existence of tax breaks for the latter and the lack of investment in the former have effectively led to this trend. The increase in the total number of beds is mainly due to the expansion of the private sector. In 1988 there were nearly 15,000 long-stay beds, with nearly half of them provided by the public sector (health board geriatric hospitals and homes) (BDO, 2014). By 2015, the total number of places was almost 30,000 but with only 23% in public care homes.

In Norway, the number of privately operated beds in residential care and nursing homes has remained relatively stable during the last decade, although it rose slightly between 2012 and 2015 as a consequence of an increased number of beds provided by for-profit providers. However, this stability masks a significant shift from non-profit providers to commercial providers. The number of beds in non-profit care homes has changed little since the 1980s but has declined in recent years. According to employer organisation Virke, 30 nursing homes run by non-profit providers were closed between 2000 and 2011 (Gautun, Bogen and Grødem, 2013, p. 45). Municipalities also have the opportunity to enter into long-term contracts with

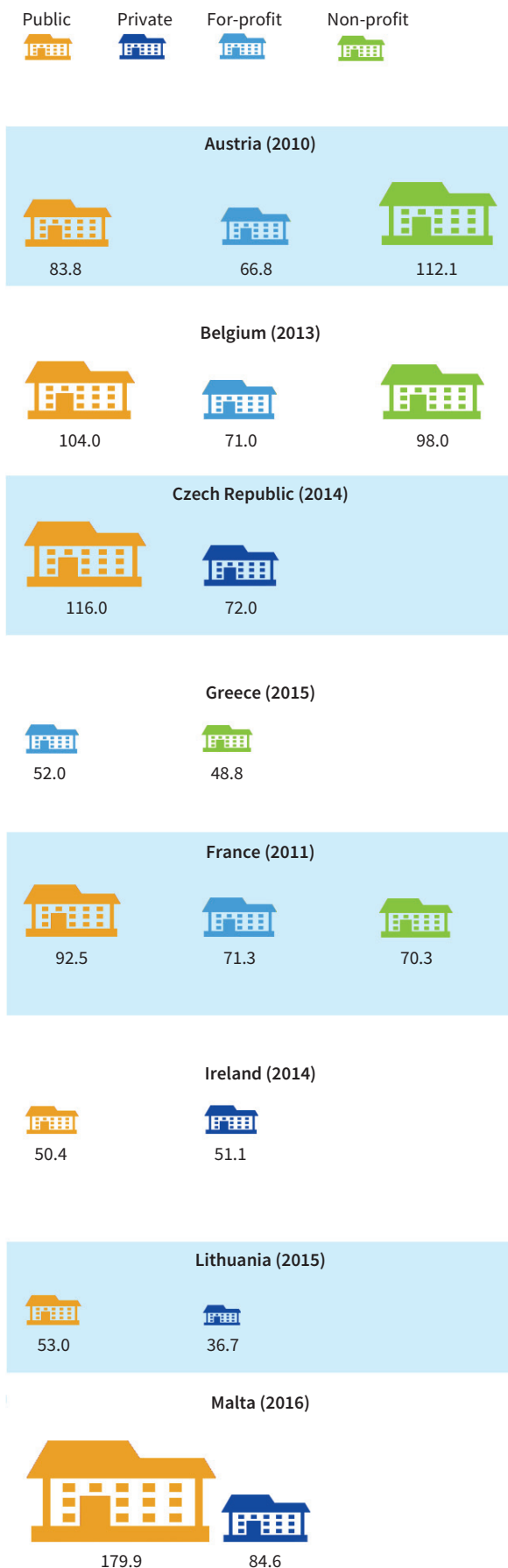
non-profit providers without needing to implement competitive tendering procedures. Since a cooperative agreement was reached between the government, NGOs and employers’ organisations in 2012, the number of beds provided by non-profit organisations seems to have stabilised. The growth in commercially run nursing homes and residential care has been a lot slower than anticipated; this is largely due to the fact that the use of public tenders in this field is limited to a small number of municipalities (Hermansen, 2011).

From the early 1990s onwards, more and more beds in UK residential care have been provided by the private sector, with the private for-profit sector now providing the bulk of places. The increase in independent (for-profit) sector provision was driven by a government policy that called for a ‘mixed provision of care’ and the adoption of the ‘best value’ principle, that effectively led to more outsourcing of local authority purchased care to the private sector as this offered greater cost-savings compared with local authority in-house provision. As a result of these reforms, in 2014 in the UK as a whole there were 187,800 places (86% of all places) in for-profit care homes, 17,600 in non-profit care homes and 12,300 long-stay National Health Service (NHS) beds. Overall, the 25 largest organisations provide 30% of the care home beds (with a total of 15% being provided by the four largest organisations alone: Four Seasons, Bupa Care Homes, HC-One Ltd and Barchester Healthcare) with the remaining organisations each supplying 0.4% or less of total capacity (LaingBuisson, 2013, cited in Jarrett, 2016). In Scotland during the last decade, there has been a decrease of around 20% of public and non-profit beds, while the for-profit sector has increased by slightly under 10%. Given these changes and the fact that the private for-profit sector may operate larger homes, the share of for-profit beds in 2015 accounted for 79% of the total, whereas in 2004 it was 73%.

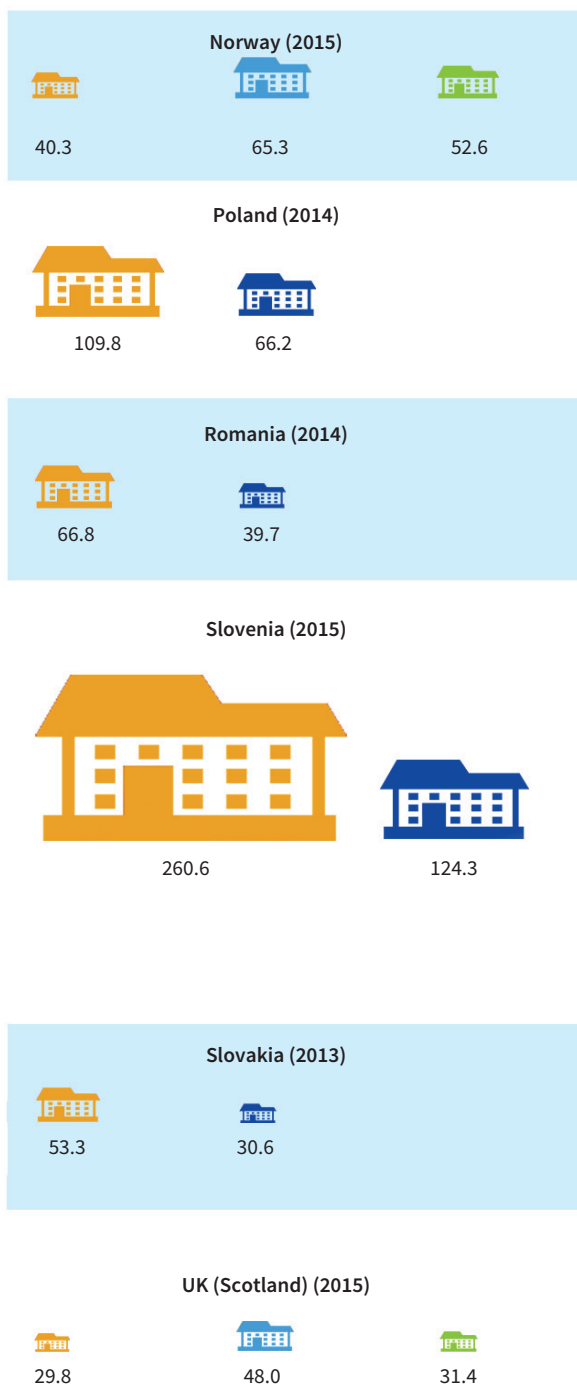
### Size (average number of beds)

The data regarding the number of care homes and beds gives an idea of the differences in size between public and private care homes. Figure 9 shows the average number of beds in each type of care home. In Slovenia and Malta, public care homes have more than double the average number of places as private ones. In Norway, private care homes are approximately 50% bigger than public ones; and in Sweden, private care homes also have a bigger capacity (National Board for Health and Welfare, 2012). On average, all types of care homes were smaller in the UK (Scotland) and in the Czech Republic. The average number of registered places in the UK (Scotland) per care home stood at 42 in March 2014. Care homes were also small in England: in 2010, local authorities ran on average larger residential

Figure 9: Average number of beds by ownership type



Note: All data are from latest year available for each country; average size in Belgium was calculated in Pacolet and De Coninck (2015). Private encompasses both for-profit and non-profit.



care homes (24 beds) and nursing care homes (54 beds) than the private for-profit sector (19 beds and 48 beds respectively) or the voluntary sector (15 beds and 36 beds respectively) (CQC, 2010, cited in Lievesley, Crosby and Bowman, 2011). In Germany, most care homes run by public or non-profit providers have between 60 and 150 places, whereas 50% of private for-profit homes have between 10 and 50 places (Destatis, 2013).

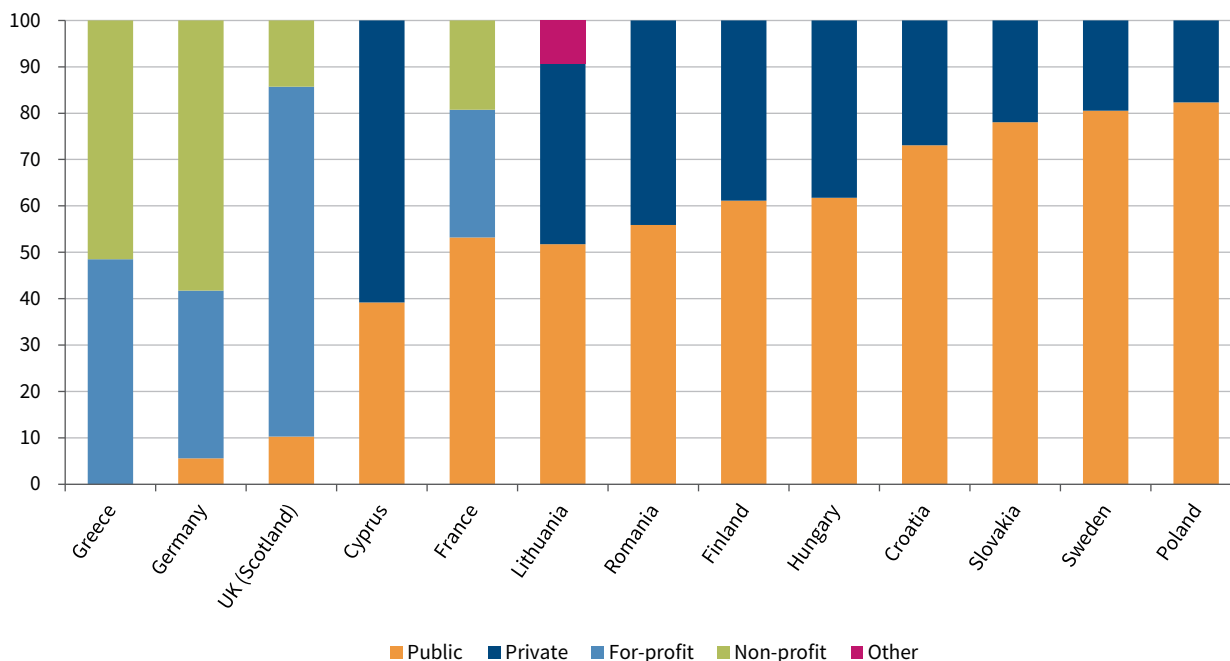
With regard to changes over time in the average size of care homes, in most countries for which data are available (Lithuania, Spain, Malta and Romania) there has been a decrease in the average number of places in public care homes and an increase in the size of private ones. This has also been the case in the UK (Scotland), where there has been an increase in the average number of places per care home (38 in 2004) as older homes may have given way to larger purpose-built facilities (ISD/NHS, 2015). Similarly in Ireland, the number of private nursing home beds increased significantly over the period between 2003 and 2014, from 14,946 beds to 22,343 (an increase of 49%), although the number of homes only increased slightly, from 408 to 437 (by 7%). This shows that most beds are added through putting additional capacity in place in existing homes. Around 42% of participants in the 2014 Nursing Homes Ireland survey intended to increase capacity the following year by an average of 19 beds. In France, care homes have increased their capacity by 5% since 2007. At the end of 2011, the average capacity was 68 (or 719,810 places for 10,481 facilities). In Denmark, there is also a trend towards building bigger homes with more residents (AGE Platform Europe consultation). However, the opposite trend can be seen in Lithuania where there has been a decrease from 202 beds in 1990, to 48 beds in 2015.

### Number of staff

The size and number of care homes also explains, to a great extent, the differences in the number of staff employed. In the UK (Scotland), where most beds and care homes are private, 87% of care home staff were employed there in 2014 (67% for-profit and 17% non-profit), compared to 13% working in care homes run by local authorities or the NHS (ISD/NHS, 2015; Scottish Social Services Council, 2015).

This percentage is even smaller in England. Overall, there were around 555,000 jobs in adult care homes in 2015, representing 42% of adult social care jobs, or 38% when focusing on care homes only (Skills for Care, 2015). Only 4% of jobs in residential care (26,500) were in local authorities, and their number had fallen by around 30% between 2011 and 2015. This is mainly due to organisational restructuring, outsourcing and closure of facilities (Health and Social Care Information Centre, 2015; Health and Social Care Information Centre, 2016).

Figure 10: Share of service users by ownership type (%)



Note: Private encompasses both for-profit and non-profit.  
 Source: Network of European Correspondents.

Personal care worker in residential care activities is one of the jobs for which demand increased the most in Europe between 2011 and 2015 – by 16.2% (Eurofound, 2016). Changes over time in employment figures reflect the changes in the number of care homes and beds.

**Germany:** The number of staff in public care homes declined by 11%, whereas the number of staff increased by 26% in non-profit homes and by 67% in for-profit homes between 2003 and 2013.<sup>8</sup>

**Finland:** The number of staff in privately run sheltered housing facilities increased from 8,353 in 2012 to 11,054 in 2013. This presumably was partly related to the introduction of the Elder Services Act in 2012, together with a recommendation of a minimum staff-to-resident ratio of 0.5:1. There was also a notable rise in the number of staff in privately run residential homes from 2009 to 2010 and an even more significant drop from 2012 to 2013, the explanation for which is unclear.

**Croatia:** The average number of employees in public social welfare homes for older and infirm persons was 64 in 2003 and 79 in 2014, while the average number of employees in private homes was 17 in 2003 and 22 in 2014.

**Slovakia:** Between 2005 and 2013, the number of employees in care homes increased by 39%, while there was an increase in the share of employees in non-public providers from 10% to 18% of the labour force employed in nursing homes.

**Latvia:** Care homes employed 217 workers in 2014. Of these, 29 (or 13%) were employed in private institutions.

**Romania:** The number of staff in private care homes increased from 99 in 2008 to 406 in 2013. The impact of the economic crisis led to a moratorium on recruitment in public institutions. Even though the average size of public care homes is greater than private homes, it is only in large cities (such as Arad, Brasov, Bacău and Iași) that public care homes have more than 50 employees.

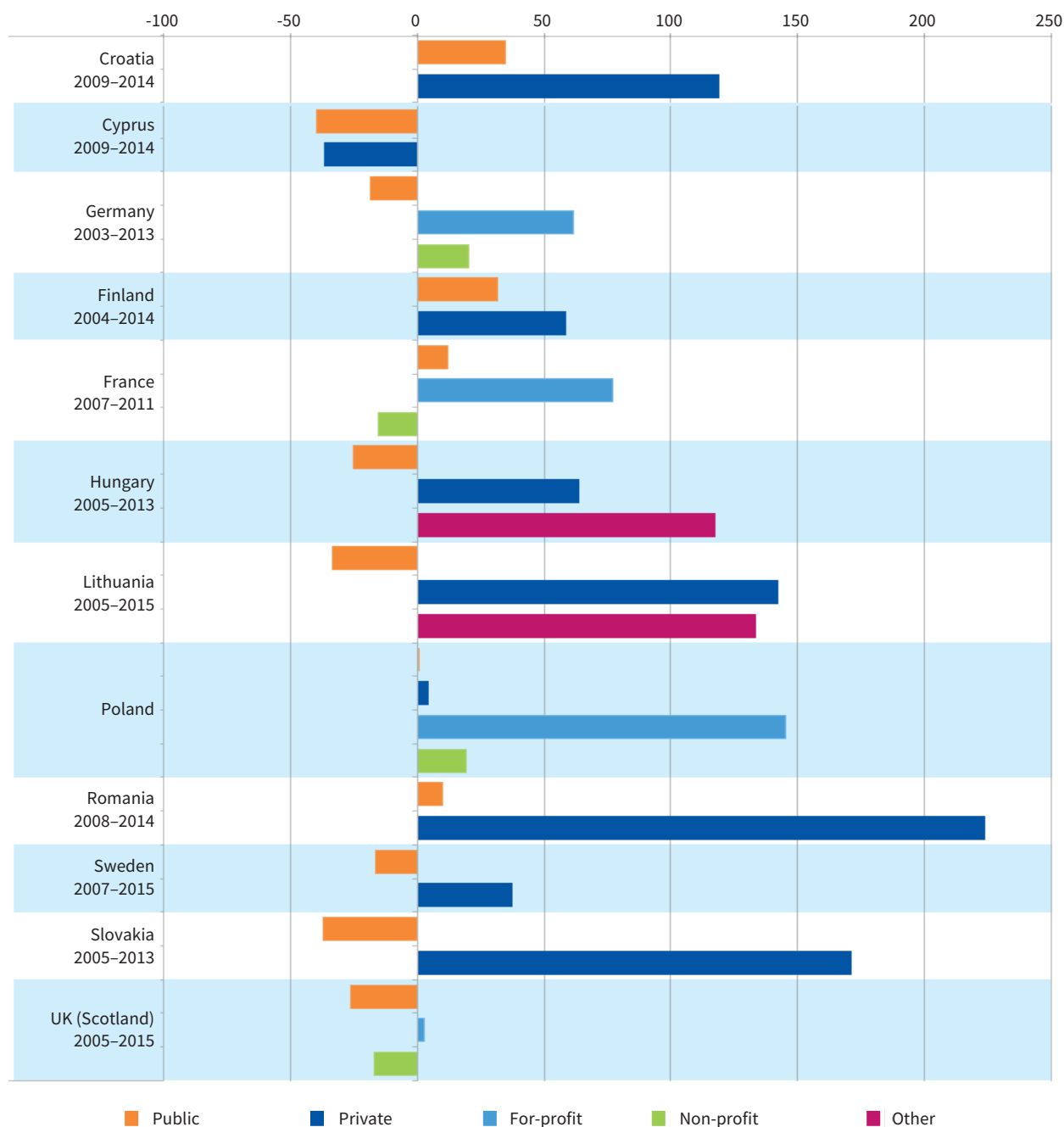
### Number of service users

The differences in size and market share influence the share of residents in each type of care home, as shown in Figure 10. (Changes over time in the number and share of service users are shown in Figure 11 and Figure 12.)

Figures 11 and 12 show that the highest increases in the number and share of residents in private care homes were seen in Romania, reflecting the increase in private provision. In Romania, the share of residents in private care homes increased from 21% of the total in 2008, to 44% in 2014. The number of users increased both in public and private care homes also in Finland, Croatia

<sup>8</sup> Data refer to all workers in residential care including palliative care, and care of those with mental health problems.

Figure 11: Relative change in the number of service users over time (%)



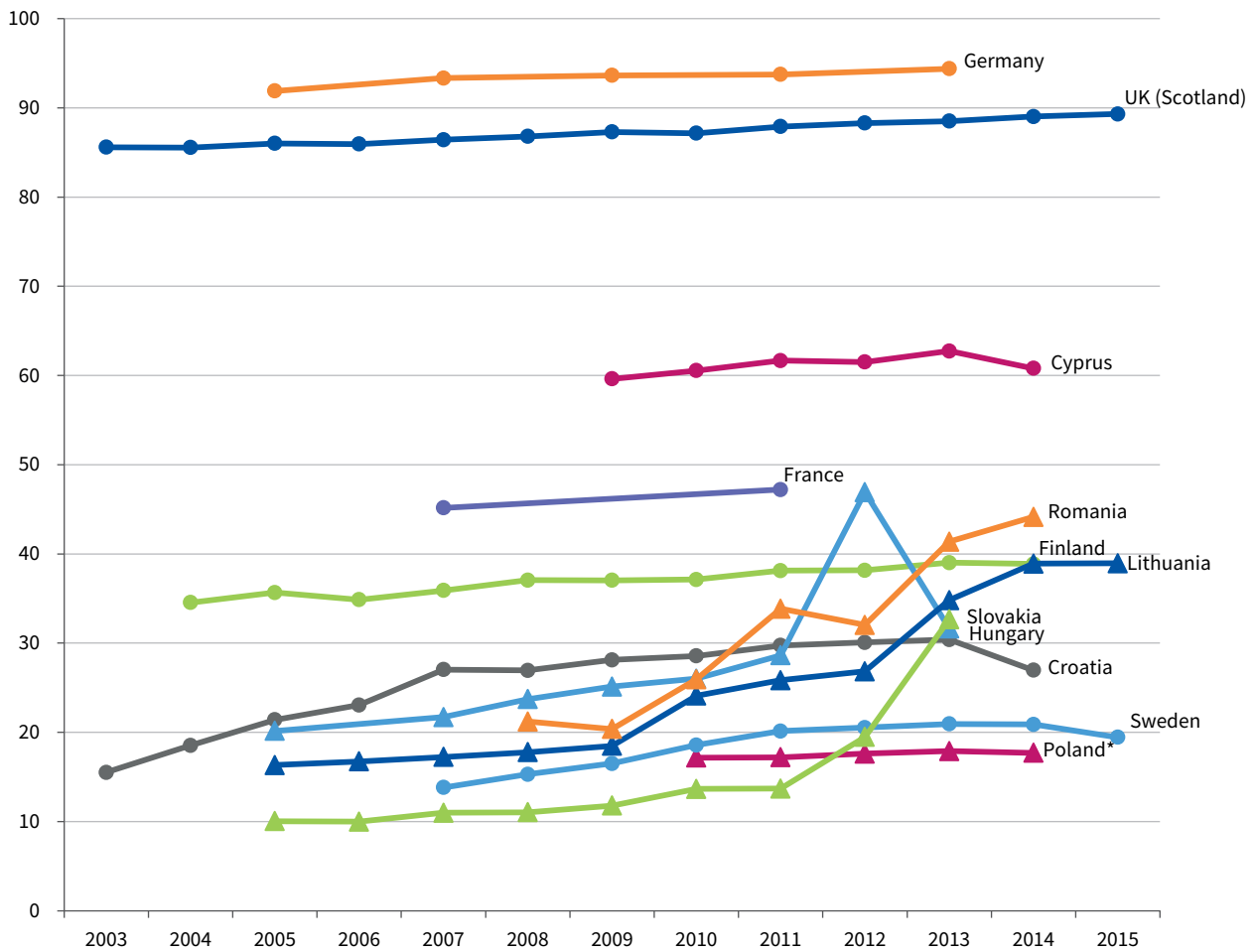
**Note:** Private encompasses both for-profit and non-profit. Data on for-profit provision (economic activity) and non-profit provision (statutory activity) in Poland correspond to establishments ensuring 24-hour care (placówki zapewniające całodobową opiekę).

**Source:** Network of European Correspondents.

and Poland. In all these countries the increase in service users was higher in the case of private care homes than in public ones. Between 2004 and 2014, Croatia registered the highest increase of residents in public care homes of all the countries for which data were available (35%), as well as a considerable growth in the number of private residents (119%). In Germany, Hungary, Lithuania, Sweden and Slovakia, the number of residents in public care homes decreased whilst there was an increase in the number of residents in private care homes (Figure 11). Regarding the number of

residents in care homes in Lithuania, this number more than doubled between 1990 and 2015. At the end of 2015 there were around 5% of bed vacancies in all types of care homes for older people in Lithuania. The decrease in the number of residents in Swedish care homes can be explained by an increase in the number of people receiving care at home. However, home care has only partly compensated for the down-scaling of care homes (Meagher and Szebehely, 2013). Declining coverage can partially be explained by improved health among older people, but, overall, it has become

Figure 12: Change in the share of users of private services over time (%)



Source: Network of European Correspondents.

increasingly difficult for older people in need of assistance to get a place in residential care (something often brought up in policy debate). The increase in the number of residents in private care homes could be due to the 2009 Law on System of Choice in the Public Sector (the LOV Act), which allows long-term care users to choose a service provider. As of June 2016, some 158 of 290 Swedish municipalities had introduced a LOV system in some form; 15 of these had introduced it in the area of special housing for older people.

The number of service users decreased in Cyprus, Greece and the UK. While no data are available for Greece prior to 2014, the President of the Greek Care Homes Association noted that a wave of departures from homes for older people has been recorded since the beginning of the economic crisis, particularly among service users who are not dependent. Before the crisis, these care homes were at full capacity with waiting lists. If unemployment increases in Greece, the trend for nursing homes to empty is expected to intensify.

Previous research carried out by Eurofound showed that older people in Latvia, Hungary and Portugal moved out of nursing homes as a consequence of the crisis and moved into their offspring's home in order to support the household financially with their pensions (Eurofound, 2014b). The number of care home residents funded by local authorities in the UK (England) fell to approximately 213,000 in 2014, representing a 22% decrease between 2004 and 2014. The percentage of local-authority funded places provided by the for-profit sector steadily increased from 88% in 2004 to 96% in 2014. Overall, 50% of residents in care homes receive funding from local authorities (LaingBuisson, 2013, cited in Grant Thornton, 2014). In Scotland the number of long-stay residents in public and non-profit care homes decreased between 2005 and 2015, with the number of long-stay residents in for-profit care homes increasing slightly (3%) during that period.

## 2 Private care provision and service delivery: Accessibility, quality and efficiency

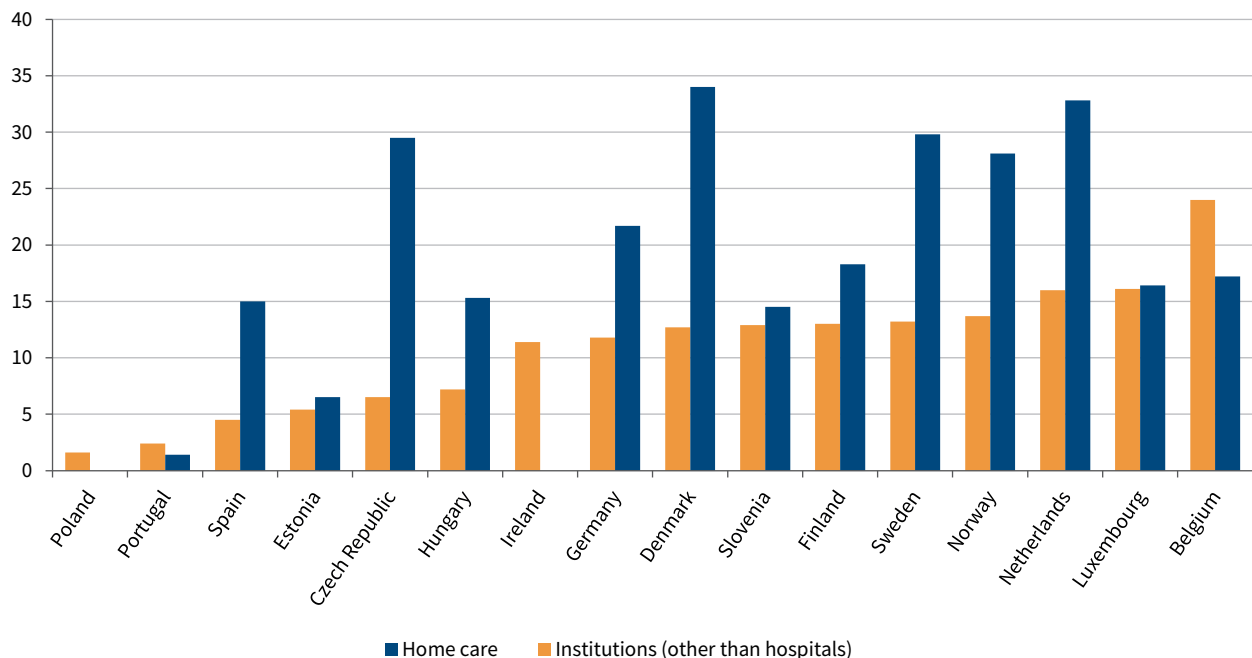
This chapter describes the differences between the services delivered in public and private care homes according to the evidence gathered through desk research and from Eurofound’s Network of European Correspondents. It also uses data gathered through a consultation among members of AGE Platform Europe regarding the views of service users and their families about the differences between public and private services. The focus is on the three aspects of service delivery (accessibility, quality and efficiency) that have been already analysed by Eurofound in relation to hospitals (Eurofound, 2017).

### Accessibility

#### Availability of services

Figure 13 shows the percentage of Europeans over the age of 80 availing of home and residential care. Belgium, the Netherlands and Luxembourg have the highest share of residents in care homes, while Poland, Portugal and Spain have the lowest share, with rates below 5%. Overall, the percentage of older people residing in care homes is lower (below 10%) in central and eastern Europe. With the exception of Belgium and Portugal, there is a higher percentage of people availing of home care than residential care homes, with some countries, such as the Czech Republic, having a ratio of more than 4:1, and Spain, with a ratio of more than 3:1.

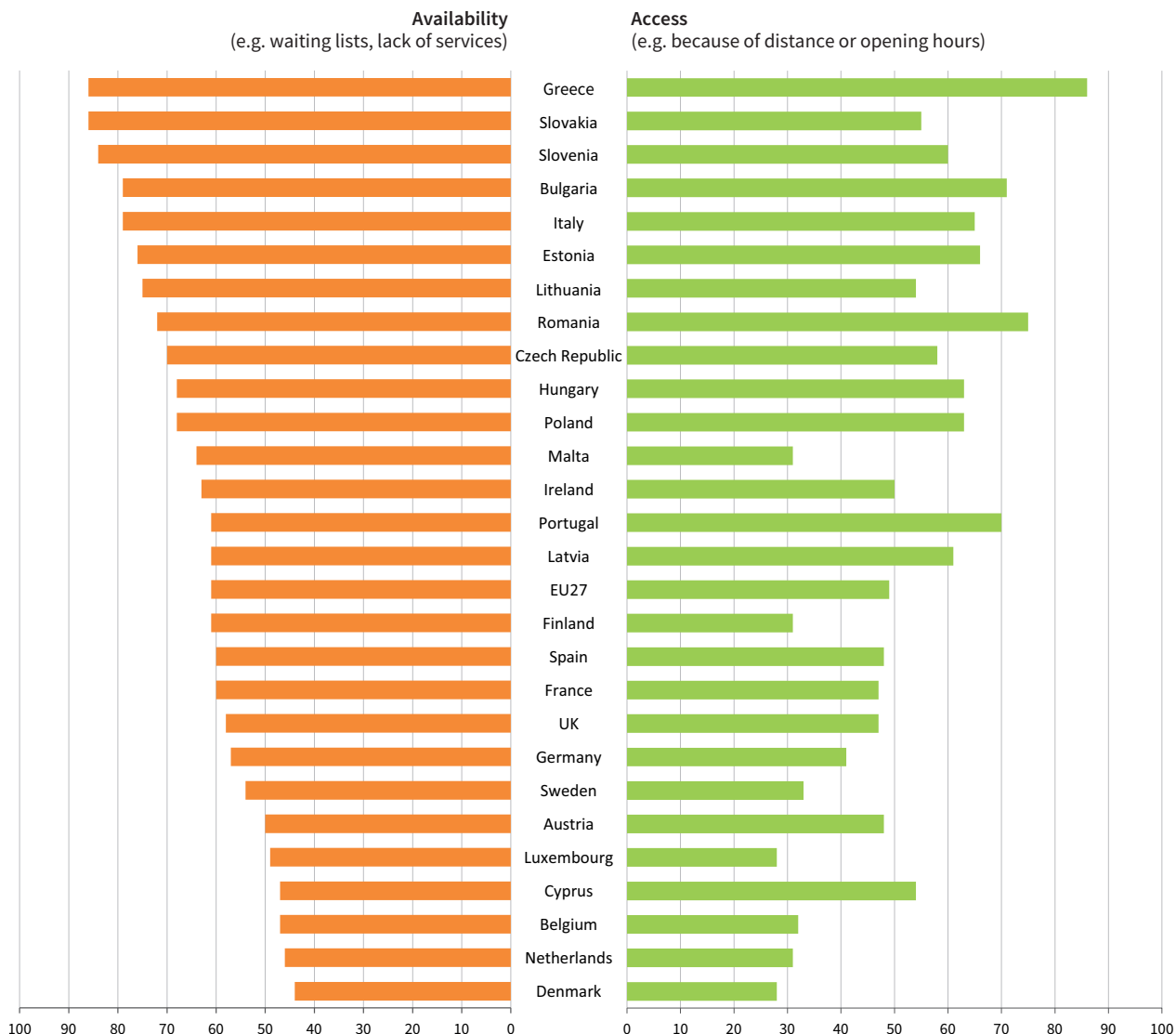
Figure 13: Long-term care recipients at home and in healthcare facilities (other than hospitals)



**Note:** Data shown as a percentage of the population aged 80 years and over in 2014 or latest year available. Data about institutional care in the Czech Republic, Belgium, Denmark, Luxembourg and Sweden are estimated values; data about home care in the Czech Republic, Hungary and Luxembourg, Slovenia and Sweden are estimated values; data for Slovenia correspond to 2013; data for the Czech Republic correspond to 2009; data for home care in Denmark correspond to 2012, and data for home care in Belgium correspond to 2007.

**Source:** OECD Health data (2016).

Figure 14: Difficulties in accessing long-term care because of barriers to access and availability (%)



**Note:** Q56: To what extent did each of the following factors make it difficult for you or not, or someone close to you, to use long-term care services? a) Cost; b) Availability (e.g. waiting lists, lack of services); c) Access (e.g. because of distance or opening hours); d) Quality of care; 1) Very difficult; 2) A little difficult; 3) Not difficult at all.  
**Source:** European Quality of Life Survey (2011).

The extent to which Europeans avail of care homes is influenced by a number of factors, including dependency rates, and the availability of home care and informal care. Data from the third European Quality of Life Survey give an overview of which barriers make it difficult to access long-term care services (including public and private home and residential care services). The data in Figure 14 show that availability barriers are less problematic (that is, less than 50% of service users experiencing difficulties) in Belgium, Cyprus, Denmark, Luxembourg and the Netherlands. Difficulties in access because of distance or opening hours were less widespread (that is, for less than one-third) in Denmark, the Netherlands, Luxembourg and Finland. In contrast, more than 80% of service users in Slovakia, Greece and Slovenia experienced difficulties in availability, while

over 70% of service users in Greece, Bulgaria and Romania had difficulties related to access.

As for the services provided, private care homes in several countries are less likely than public ones to provide specialised medical services. In Malta, most private care homes provide basic nursing services and residents are often expected to contract their own medical specialist for certain conditions. In contrast, public nursing homes provide such additional services as physiotherapy, occupational therapy, speech therapy and geriatric services. In Ireland, public homes are more likely to have specialised services because of the higher nursing numbers available. A national survey of dementia in residential care found, on the whole, that the for-profit sector is the main provider of specialist care to persons with dementia (63% of the total),



followed by the public (30%) and the non-profit sectors (7%). The public sector is more likely to be the main provider of residential respite care (Dementia Services Information and Development Centre, 2015). In Slovakia, the private sector provides residential care mostly orientated in terms of social care (European Commission, 2011). In Greece, some for-profit providers have concentrated more on dementia care or rehabilitation, as opposed to non-profit providers who provide only basic nursing care (AGE Platform Europe consultation). In Romania, private for-profit care homes provide more specialised services and can admit exclusively one type of resident (such as older people with Alzheimer's disease) (AGE Platform Europe consultation).

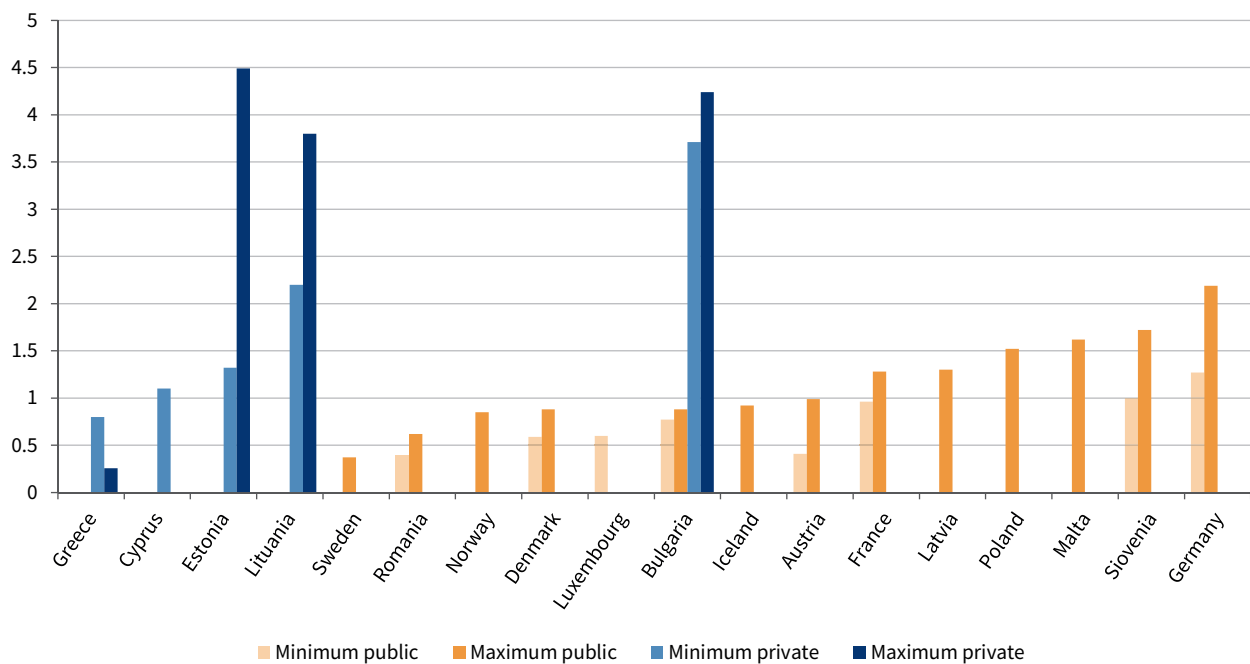
These differences in the services provided by each type of institution can be caused by differences in legislation and/or funding. For instance, in Latvia the scope of services provided by public nursing homes is partly determined by legislation on social services and social assistance, whereas private care homes are free to choose which services they provide. In Belgium (Flanders), only providers whose legal status is non-profit (public or private non-profit) are entitled to receive subsidies from an agency within the Flemish government to organise activities for residents.

## Costs and affordability

Perhaps the more obvious area of difference between public and private services is their affordability. Costs in the form of private insurance and out-of-pocket payments (such as user fees, income-related cost sharing or differences between benefits packages and the price of services) constitute a barrier to accessing private long-term care (European Commission, 2008). Overall, it is difficult to make a direct comparison of the costs associated with public and private provision, as there is a lot of variation among care homes with the same type of ownership, according to the services provided and their quality. Furthermore, services in private care homes may be subsidised or contracted out by the public sector, which can also affect the fee charged to users making out-of-pocket payments. A study of 12 county councils in the UK found that service users who funded their own stay paid over 40% more than those funded by local authorities for the same services (County Councils Network and LaingBuisson, 2015). According to the study's authors, this cross-subsidising of fees is a market response to the fee levels set by local authorities.

Figure 15 shows data about the minimum and maximum fees for publicly subsidised facilities and private residential care in relation to a reference income in several EU Member States, Norway and Iceland

**Figure 15: Ratio of fees for residential care to reference income of service users**



**Note:** Reference income is for service users aged 65 years and over. The reference income is the median net income for a single, elderly person (65+) living on their own.

**Source:** European Commission (2012b) p. 89.

(European Commission, 2012b). Although there is limited information on fees for non-subsidised residential care, the data available confirm that private residential services are much more expensive. In Bulgaria, minimum fees for private institutions are almost four times higher than the reference income. In Cyprus, Estonia and Lithuania, monthly expenses for the cheapest private residential services are at least 10% higher than the country's reference income.

The data in the European Commission study correspond to the years 2003–2009 (most of the data corresponding to 2009). More recent information gathered by the Network of European Correspondents shows that prices have increased since the economic crisis, as detailed below.

**Italy:** With the beginning of the economic crisis and the progressive implementation of an accreditation system, there has been a general increase in the fees of nursing homes. A survey looking at the period 2007–2012 (thus also considering the pre-crisis period) showed that the average cost for private residential facilities increased by 18.5% for the lowest fee and 13% for the highest fee (Montemurro, 2012).

**Germany:** Rothgang (2015) found that the prices in private for-profit care homes were lower than those of non-profit and public providers, and that prices did not increase to the same extent as the prices in the other two types of care homes. Private nursing homes charge on average 10% less than non-profit homes, resulting in lower quality (Geraedts et al, 2016).

**Belgium:** In Flanders, the average price per day for accommodation in a single room in 2012 was €46.50 in a public care home, €49.60 in a private non-profit home and €48.90 in private for-profit care home (Pacolet and De Coninck, 2015). It would appear that prices in the commercial sector are increasing. In 2016, the price in a for-profit care home was €61 per day, as against €55 in a private non-profit care home and €53 in a public home. In Wallonia, in 2014 a public facility cost on average €1,237 per month – €1,381 in the private non-profit sector and €1,388 in for-profit care homes.

**France:** In 2013, private non-profit nursing homes (EHPAD PNL) that are not eligible for social assistance cost on average €2,460 per month in the region Île-de-France and €1,833 outside this region. In public nursing homes, in contrast, the average prices were €2,418 and €1,804 respectively (KPMG, 2015). In 2011, the daily rate for non-care related costs for places without financial support from the regions (*départments*) was €75.10 in for-profit nursing homes, €59.60 in non-profit nursing homes and €51.40 in public nursing homes (DREES, 2014).

**Ireland:** Weekly rates in public nursing homes have stayed at €1,245 since 2011. In private nursing homes, the rates payable under the 'Fair Deal' Nursing Home Support Scheme, under which 79% of residents are funded, averaged €896 in the 2014 Nursing Homes Ireland survey – up 5% since 2009. The average fee payable to public nursing homes under the Nursing Home Support Scheme was €1,407 in 2016. By comparison the average fee payable to private and voluntary nursing homes in October 2016 was €923 (a 53% national average fee differential).

**Slovenia:** The average prices for residential care homes differ according to the type of ownership and the level of dependency of service users. The daily prices of services in 2014 were on average approximately 16% higher in private care homes than in public ones.

**Netherlands:** The costs are higher in for-profit care homes than in non-profit homes. In the for-profit care homes, monthly costs range from €3,000 to €6,000. In non-profit care homes, monthly co-payments range between €159.90 and €2,301.40, depending on the financial situation of the residents. On average, privately financed nursing homes generate 23% more income per resident than regular non-profit nursing homes.

**Spain:** The public price of a place in a residential centre for service users who are not dependent was €18,645.83 per year in 2011, while the publicly subsidised price for a place in a private residential centre was €17,526.99 per year. Subsidised prices of a place for a dependent person or for a person with psychogeriatric needs were higher (€19,897.51 and €24,299.84 respectively) (IMSERSO, 2011).

There are several reasons for these differences in prices. In Germany, private companies have the lowest prices because they have easier access to investment capital. They rarely apply collective agreements and therefore the average wages in private care homes are lower than in non-profit and public care homes (Auth, 2014). Consequently, they are able to offer lower prices and thus get most of the contracts and service users. In this context, non-profit providers need to achieve high occupancy rates, with many resorting to cost-cutting in order to survive economically. In addition, local social welfare departments are legally obliged to take over co-payments from lower income users (who currently make up 40% of all care home residents) (Bode, 2014). In Belgium, service users do not pay for their care but contribute towards the costs of other services (such as room, food and maintenance). Therefore an important determinant of the fees is the area where the care home is located and the condition of the premises.

There is a wide range of measures that are put in place by Member States to ensure the affordability of long-term care by reducing the individual direct costs of care (European Commission, 2008). These include:

- exemptions from co-payment and co-payments based on income
- financial aid and benefits for service users

- state coverage of social long-term care for low-income households within a social assistance framework
- nationwide standardisation of co-payments and state subsidies to use private services.

Table 2 shows how some of these measures are applied differently in public and private care homes.

**Table 2: Measures reducing the individual costs of public and private care homes**

<b>Cyprus</b>	In the case of public assistance recipients, the Social Welfare Services cover the total amount needed for their care. This includes both older people and disabled persons of all ages.
<b>Denmark</b>	For nursing and residential care homes, the public sector subsidises the cost, taking the residents' personal finances into account (there is a maximum cost for a place in a public care facility). In private (for-profit and non-profit) residential care homes ( <i>Friplejeboliger</i> ) the residents also receive public subsidies, but there is no maximum cost for the residents.
<b>Estonia</b>	There is no state-provided financial support for older people in nursing homes. Responsibility for payment falls on the individual or their immediate family. When there are no family members, the local government provides financial assistance.
<b>Finland</b>	The fees for permanent institutional care are based on the Act on Client Fees in Social Welfare and Healthcare, and covers all treatment, care and living expenses. People in long-term institutional care are charged with a monthly fee based on each patient's ability to pay. The act does not apply to privately operated homes for older people, which usually have different price ranges based on their needs. Costs of private services are generally subsidised by the public sector, provided that the individual would be entitled to similar publicly provided services. Municipalities may grant service vouchers or make an outsourced service agreement.
<b>France</b>	Costs may be covered by the housing allowance ( <i>aide personnalisée au logement</i> , APL) and social assistance paid by the <i>département</i> . Care homes need to have an agreement in place in order to avail of this aid, with around one-quarter of for-profit – and two-thirds of public and private non-profit nursing homes – having this type of agreement. If the nursing home does not have an agreement to admit recipients of this benefit, service users can request other benefits such as social housing allowance ( <i>allocation de logement sociale</i> , ALS) or social assistance for accommodation ( <i>l'aide sociale à l'hébergement</i> , ASH) that can fully cover non-care related costs (DREES, 2014).
<b>Hungary</b>	The state covers part of the cost of a person's accommodation in state and public institutions depending on their financial position. The state does not (co)finance accommodation in private institutions.
<b>Ireland</b>	In 2009, the Nursing Home Support Scheme (NHSS) was set up. This scheme involves a care assessment and a financial assessment. One of the benefits of this scheme is that it gives users access to the full range of nursing homes for the same cost, reducing the need for hospital beds for care of older people. The price charged by private nursing homes is agreed in advance with the National Treatment Purchase Fund, with an amount of up to 80% of the user's income used to pay towards the cost of care, with the Health Service Executive paying the rest. Assets (including the family home) to the value of 7.5% of the assets per year of care can also be included in the user's contribution. But if they include land and/or property, that element of the contribution can be deferred and paid to the tax collection agency after the service user's death. The maximum extent to which a principal private residence can be used in this way is up to 22.5% of the property's value (three years of care, regardless of how long the period of care is).
<b>Lithuania</b>	Long-term care insurance can be used to pay for care in public and private care homes. Health insurance covers the expenses related to illness, such as medical treatment, nursing and drugs. Payments are made directly to the care home and the level of payment is determined as hours of care needed per week multiplied by the monetary value of one hour of care. Generally, individuals who live in a care home must cover the costs of accommodation. Those who cannot afford to pay the full cost of long-term residential care may be eligible for public social assistance.
<b>Norway</b>	The public sector subsidises costs for residents in nursing homes, paying 75% of pensions and 85% of capital income. All citizens with a documented need for care (assessed on an individual basis) are eligible; there are no differences in eligibility or cost for residents between private and public sector providers. A few municipalities let service users choose the provider and/or home.
<b>Poland</b>	Care services provided by public nursing homes/residential care homes require a co-payment by the patient. Patients in residential facilities of the healthcare sector pay only for the costs of accommodation and board; medical treatment and nursing are financed by the health insurance. The monthly payment of care recipients is set at the level of 250% of the lowest pension, but the fee cannot be higher than an amount equivalent to 70% of the monthly individual income of the patient. In a residential facility of the social assistance system, the costs are financed by different payers: care receivers (70% of individual income); the family of the care receiver (depending on family income); and local self-government ( <i>gmina</i> ). Private establishments financed from public funds operate in the same way as public ones: they perform public tasks on the basis of a contract. Private establishments without subsidies offer care services at market prices and the patient has to pay the whole fee.

<b>Portugal</b>	With regard to prices, a reference value for residential accommodation for older people is established and regularly revised by the government in dialogue with collective representatives of third-sector organisations (€970 in 2015). Providers can charge at most 15% above this reference value and payment can be shared by the resident and his/her relatives and direct transfers from public funds to the provider. Public funds cover a part of the cost as long as a cooperation agreement exists between the service provider and social security; the part of the cost to be covered depends on the beneficiary's household income and degree of dependence. This applies only to residential care within the framework of the cooperation agreement; all other arrangements are exclusively private and can have different conditions.
<b>Romania</b>	The monthly contribution of older people for nursing and assistance services in public residential care homes should be less than 60% of the monthly personal retirement income. Their contribution shall not exceed the average monthly cost approved for each public care home. If service users or their legal representatives have no income, care and social assistance are given by the local and (since 2016) central budget.
<b>Slovenia</b>	Most of the costs (60%) are covered by the service users; the rest is covered by their insurance. Since 2012, people in residential homes are no longer eligible for financial social assistance. If service users or their relatives cannot afford residential care, the municipalities can pay the difference based upon the decision of the Social Work Centre. In 2014, on average the municipalities provided only 16% of the total costs of care provided by public and private care homes.
<b>United Kingdom</b>	As of 2020 (delayed from 2016), the cost of care will be for the first time capped at £72,000 for those over the age of 65 and eligible for local authority funding, with estimates suggesting that this may benefit one in eight service users. Also in 2020, more people in care homes will become eligible for local authority support, as the threshold of assets has been raised. People who now become eligible for local authority funding may ask local authorities to arrange their care at the local authorities' lower rate (Laing, 2014).

Source: Network of European Correspondents (unless stated otherwise).

Services that are provided, subsidised or commissioned by the public sector may have set prices to ensure that they are affordable, whereas private nursing homes can decide on their fees. This is the case in Belgium, Denmark, France, Greece and Malta. In Germany, daily rates charged by care homes are negotiated between health insurance funds and providers, taking into account the type of services provided by the care home. If other providers in the area can provide services at a lower cost, this can be a negotiating factor. The information provided by public inspections and advertisements can be used by service users to guide their choices (Bode, 2014). One of the objectives of promoting competition between different types of care home providers is to bring down prices. Marczak and Wistow (2016) point out that there is little evidence to indicate that this actually results as foreseen, with some evidence showing that in the UK (England) increased competition did indeed push prices down but also led to a decrease in the quality of care.

### Physical location

Private providers are particularly concentrated in prosperous regions (as in the Netherlands, Norway, Sweden and the UK), in cities and bigger towns (Estonia, Finland, Germany, Italy, Poland and Romania), or in parts of the city in which the housing costs are lower (in the case of Italy). Deloitte (2011) found that in Norway, densely populated (metropolitan) municipalities were more likely to contract out care home services. A review of 47 public tenders from 1997 to 2012 (Herning, 2012) shows that a large majority are conducted in cities – almost half in Oslo.

**Finland:** A similar pattern emerges, with only relatively large urban areas contracting out services. In 2010, there were 106 local authorities (out of a total of 334) who did not contract out services. These municipalities constituted only 10% of the country's population.

**Germany:** There is a higher share of public care homes in rural areas than in other settings – albeit low (about 5%). Towns of a more intermediate density (*verdichtet*) have a higher proportion of private for-profit care homes. Non-profit care homes constitute over half of the total care homes in all settings, being more prevalent in urban areas – 58% of the total in 2012 (Rothgang, 2015). It must be noted that there are also strong regional differences: for-profit providers are more prevalent in the north west of Germany; non-profit organisations in eastern Germany and North-Rhine Westphalia, and public care homes are more widespread in south-west Germany (Rothgang, 2015).

**Ireland:** Public nursing homes tend to be closer to urban amenities, while many private nursing homes tend to be away from transport options and on the edge of towns or cities, especially in rural areas (AGE Platform Europe consultation). Regional disparities are also present in the availability of specialised services. For example, there are many dementia care units in southern and eastern counties in Ireland and counties near the border with Northern Ireland, but relatively few in Dublin and other parts of the country.

**Poland:** A few NGOs operate in the less developed regions of the country (Lubuskie, Zachodniopomorskie and Świętokrzyskie).

**Romania:** There is a lack of interest in building more residential care and nursing homes in rural areas. This is despite the need for such services being greater and this is due to poverty in these regions and to an underdeveloped public care system (AGE Platform Europe consultation).

**UK:** More service users who pay for their own care are found in the south-east and south-west of England (54% and 49% respectively) than overall (41%) (LaingBuisson, 2014, cited in Jarrett, 2016). These are likely to find care in private accommodation.

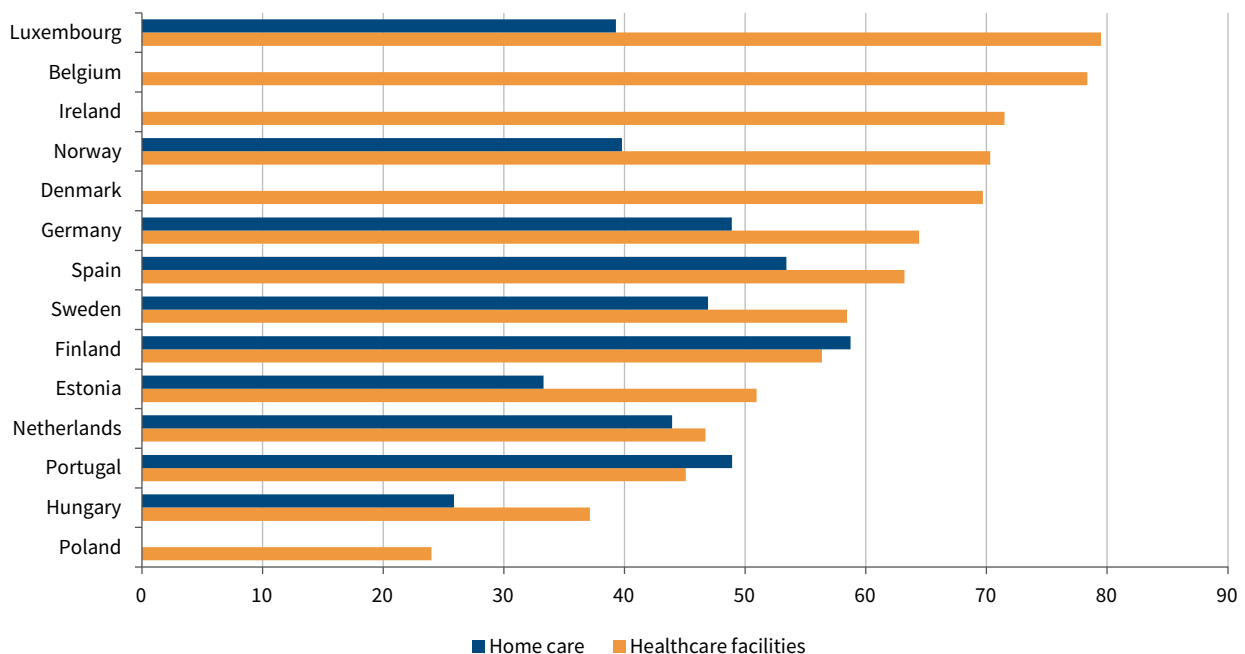
### Characteristics of residents

All these differences translate into the types of patients seen in public and private care homes, with affordability issues exacerbated in the case of private for-profit residential care. This is particularly the case for women, as women statistically live longer than men, are more likely to live alone in old age (and therefore avail less of informal care) and are more affected by co-payments than men (because their average income is lower) (European Commission, 2009c). Overall, older people living alone are more likely to incur out-of-pocket payments and spend a higher share of their income on long-term care (including residential care). The impact of out-of-pocket expenditure on long-term care on a household's income is more severe for poorer

households. The number of people making out-of-pocket payments increases substantially with age, with those aged 80 and over making payments seven times higher than those aged 65–79 (ILO, 2012). This age group constitutes, in most European countries, more than two-thirds of the total number of residents in care homes (Rodrigues, Huber and Lamura, 2012), as shown in Figure 16.

In addition to differences in age and socioeconomic status, reimbursement mechanisms may also influence the level of dependency of care home residents. This is the case in Flanders, where the for-profit sector has fewer residents with a high level of dependency, whereas private non-profit care homes have the highest dependency levels. According to Pacolet and De Coninck (2015), this is partly due to the underfinancing of residents with lower dependency levels (categories O and A in the Katz Index of Independence in Activities of Daily Living – Katz ADL) in comparison with more dependent service users.<sup>9</sup> This explains why the public sector has a higher share of service users with this level of dependency. Furthermore, they have a higher share (17%) than the other types of care homes of high dependency residents (categories B and C in Katz ADL) that are financed as if they have a lower dependency (Pacolet and De Coninck, 2015).

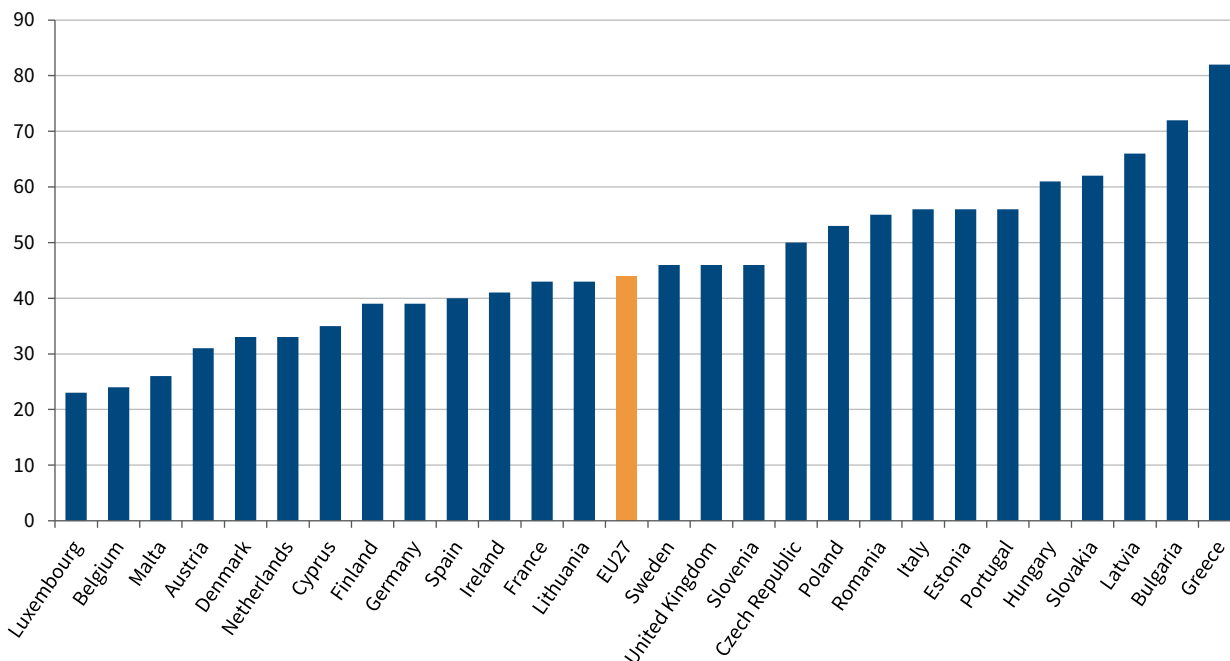
Figure 16: People aged 80 years and over in long-term care (%)



Source: OECD Health Data (2014).

<sup>9</sup> Category O includes those completely independent in all activities and with no cognitive problems.

Figure 17: Poor quality as a barrier: Difficulty accessing long-term care services



Source: Third European Quality of Life Survey (2011).

Martin’s study of 997 nursing homes in France showed that in 2007 dependency levels of residents of public and private non-profit nursing homes were almost identical, with private non-profit nursing homes being less likely to refuse Alzheimer’s patients (Martin, 2014). On the other hand, the 2011 Nursing Homes survey shows that the degree of dependency was slightly higher in for-profit nursing homes than in public or non-profit ones (DREES, 2014).

In Slovenia, the age of residents does not differ greatly between the public and private providers. In 2014, similar proportions of residents in both public and private homes were aged over 80 years (68% and 64% respectively). Private homes did however have a higher percentage of residents aged below 65 years (10%) in comparison with public homes (6%).

## Quality

Quality is a complex and multifaceted subject; global assessments give only some indication of the total picture. Previous research shows that there is a strong relationship between quality and the accessibility of services. Data from the third European Quality of Life Survey (EQLS) show that having fewer difficulties when accessing long-term care services is related to giving those services higher scores of perceived quality. Those who rated the economic situation of their countries more highly, those who are older, and those with a higher level of general satisfaction were more likely to give a high rating to the quality of long-term care in their country. Respondents who were not employed, who live in a country with a lower level of perceived

corruption, and who were more satisfied with the relative financial situation of their household also rated long-term care more highly. On the other hand, deprivation, difficulties in making ends meet and living in an urban area were factors related to lower ratings of quality (Eurofound, 2013b).

Furthermore, for 44% of Europeans using long-term care services, perceived poor quality constituted a barrier to access – see Figure 17 (Eurofound, 2012).

Data from the fourth EQLS show that users of long-term care services gave ratings higher than the rest of the population to the quality of the facilities, the professionalism of staff, personal attention and for communication. Those aged 65 and over had generally more positive views on the quality of long-term care services, especially in relation to the quality of facilities (rated 7.9 out of 10), professionalism of staff (8) and personal attention given (7.9). Global ratings of the quality of long-term care were higher in Luxembourg, Malta and Austria (all above 7), with the mean score being 5 or lower in Bulgaria, Greece, Portugal, Slovakia and Romania (Eurofound, forthcoming).

## Quality of facilities

Given that residents spend a lot of the time within the care home premises, its design, overall level of cleanliness and provision of common areas have an impact on the quality of life of residents. Having a single room with a toilet and hand-washing facilities helps stop the spread of infections, for instance. The same applies to the availability of equipment that provides nursing care or facilitates the mobility, rehabilitation and physical activity of residents.

A recent study involving care homes for older people in six countries (Belgium, Croatia, Germany, Hungary, Lithuania and Romania) found that in general, the physical environment was better in private care homes than in public facilities, although in some countries (such as Lithuania), public settings had a relatively high-quality physical environment thanks to the provision of European structural and investment funds. Private for-profit care homes tended to have a small number of service users residing in a modern building, giving a more homely feel, with a higher proportion of private (single) rooms. In contrast, overcrowding was witnessed in some public homes in Croatia, Hungary and Romania (ENNHRI, 2017). Larger private for-profit care homes in Germany (with more than 60 places) have fewer single rooms (50% of their rooms being single) than do comparable homes managed by non-profit organisations (63% of the rooms being single) (Augurzky and Mennicken, 2011, cited in ENNHRI, 2017).

The information gathered by the Network of European Correspondents about differences between public and private care homes in terms of quality of facilities focused mainly on the number of residents with their own room and the type of common areas available. For example, data from Sweden show that a larger share of older people in public care homes than in private care homes had their own room and rooms with cooking facilities (National Board of Health and Welfare, 2012). For-profit nursing and residential care facilities in Romania are more developed than public care homes in terms of building safety and accessibility, and also in terms of leisure and access facilities (such as well-equipped rooms with a TV, storage, tables, relaxation rooms, a library, workshops and therapy rooms). Similarly in Malta, private for-profit care home facilities offer a higher standard in terms of the overall condition of the building, access to a private room, equipment and leisure facilities such as a library, a TV room, sports facilities and room for visitors (AGE Platform Europe consultation).

Statistical data in LaingBuisson (2014) show that there have been improvements in England in the quality of facilities in for-profit residential homes. This is in terms of the percentage of single rooms as a percentage of beds and the number of beds with en-suite facilities, as a result of new purpose-built facilities or the upgrading of older care homes. This process has been also been driven by government policies, which in 2001 set minimum standards for care homes for older people. Information about the number of beds in each care

home is also relevant to quality, as there is evidence that residents in smaller care homes are more satisfied with the facilities (National Board of Health and Welfare, 2012). A study of long-term care facilities in Ireland showed that the physical environment (for example, separate sitting, leisure and dining rooms) was often poorer in public facilities than in private facilities. A private room was the norm in private nursing homes, while this was rare in public nursing homes (Murphy, Shea and Cooney, 2007). Data from the Belgian region of Flanders show that between 2009 and 2010, there were no major differences between the different types of providers regarding compliance with hygiene standards: 84% of the public facilities complied with hygiene standards as against 85% of private for-profit homes and 91% of private non-profit providers (Zorginspectie, 2012). However, there were differences in relation to buildings and equipment, which are of lower quality in private for-profit care homes (for example, smaller common areas for the residents, less 'sustainable' building techniques and less 'smart' building controls) (Pacolet et al, 2012).

The relation between structural quality and the quality of care was analysed by Weiss, Süderkamp and Rothgang (2014). Through descriptive analysis and a multivariate regression analysis, their study looked at whether structural quality can explain the process quality results. The dependent variables used in the regression were: care (including medical care); dealing with residents with dementia; social care and general attention given to residents; and living standards (such as catering, housekeeping and hygiene). The independent variables used in the analysis are: size of the care home, the population density of the region (*Bundesland*) and the care home ownership type. The study covered for the first time almost all care homes and long-term care providers in Germany. The data were gathered from the inspection care quality reports (*Pflege-Qualitätsberichten*) carried out by the Health Insurance Medical Service (MDK). The study found a slightly positive relationship between size and overall score, with care homes having fewer than 36 residents obtaining scores lower than the regional average. There is also a negative correlation between for-profit ownership and the dependent variables described above, whereas the relationship is positive in the case of non-profit care homes. In the case of public care homes, there is a positive relation except with the variable 'care' (including medical care). However, even though the effects were significant, they are too small to be regarded as relevant.<sup>10</sup>

<sup>10</sup> The population density of the area where the care home resided had no influence on quality. A relevant impact of size, ownership or regional indicators on process quality results cannot therefore be verified.

A UK study focusing on 38 public and private care homes in and around Sheffield, England (Parker et al, 2004) found that higher scores for the domain safety/health were associated with lower scores for enjoyment of activities and for environmental control. This suggests that creating risk-averse environments could have a negative impact on the quality of life of low-dependency residents. Staff morale was not associated with better staff facilities, but with a more personalised and less institutional environment for the residents.

Given the importance of the built environment, several quality frameworks include requirements and standards. For example, in Ireland, standards set for all nursing homes by the inspectorate in 2009 require that at least 80% of residents should have single en-suite rooms, with shared rooms occupied by no more than two residents, and rooms to be reserved for up to six residents who are either highly dependent or transitioning from hospital care. Implementing quality standards in relation to structural quality components can be a very costly process, which may affect public and private care homes differently. In Italy, the implementation of rules on the accreditation of private residential facilities at regional level (for which there was a deadline in early 2011) led to an increase in costs. During the same period, there was a reduction in public expenditure and household purchasing power, which contributed to the lowering of standards of service quality. This created a difficult situation for private nursing homes, which has led – in some care homes – to a lowering of the quality of the services provided. There have also been cases of the relaxation of monitoring activities by public authorities (NNA, 2015).

In Ireland, new standards for all types of nursing homes were applied to all new nursing homes from 2009, with pre-2009 nursing homes given until July 2015 to comply. Many public nursing homes were in older facilities that were not compliant with these standards; there had been little investment in them during the six-year period. At the end of 2015, a decision was made to give non-compliant care homes a further six years to comply, with a €300 million investment programme budgeted for in the government's Capital Investment Plan. By then, most private nursing homes had engaged in the necessary capital investment, with some having closed down due to inability to invest (because of a lack of funds or expansion space). Some smaller private nursing homes closed down as it was not economically viable to meet the standards, given their small size. The Health Information and Quality Authority (HIQA) is currently seeking that the costing and scheduling plans are in place to ensure that the required standards be met by 2021.

Consequently, differences in financing and funding translate into differences between public and private care homes in the built environment. In Estonia, the conditions in public sector care home facilities have been improved with the European Regional Development Fund. According to the President of the Association of Social Care Providers in the Czech Republic, private providers do not have enough resources for investment due to the current system of financing social services. Therefore, facilities tend to be significantly smaller than in the public sector (an estimated average capacity of 60 to 80 beds), the majority of which are more poorly equipped than their public counterparts. In Belgium (Flanders), subsidies for infrastructure are only available for public and private non-profit care homes that are not part of a for-profit holding company. A green paper from the Flemish government in 2016 sought to establish that all types of providers can request an infrastructure subsidy.

It should be noted that there can be trade-offs between the quality of the premises and other aspects of residential care. Martin (2014) argues that the for-profit private sector focuses its offer on the quality of accommodation (for example catering and laundry), on leisure services and on the degree of comfort provided. On the other hand, other aspects of quality have been given less attention (the number of staff per resident is lower in private facilities).

### Quality of staff

Having a manageable staff-to-service user ratio increases the potential personal attention given to service users; it also avoids having a high turnover of staff due to excessive workload. This has been the case in France, where excessive workload is the main reason why nurses and assistant nurses leave their job. Establishments facing labour shortages are also likely to face higher turnover rates (Martin, 2014). A qualitative study (with 51 interviews and participatory observation) conducted by the Upper Austrian branch of the Chamber of Labour in 2016 shows that low staff-to-resident ratios worsened the working conditions of care personnel in nursing and residential homes (Staflinger, 2016). This is the case in several other provinces in which the Chamber of Labour conducted similar studies (Vienna, Lower Austria, Styria and Tyrol).

### Staff-to-resident ratios

One of the criticisms of the private sector is that because care services are labour intensive, profit on publicly financed care services can only be achieved by reducing wages and staff (Ervik, Helgøy and Lindén, 2013). The evidence gathered by Eurofound's Network of European Correspondents shows that the number of employees per resident is lower in the private sector in several of the countries analysed.



**Germany:** In 2013, the ratio of staff (full-time equivalent) to service user was very similar in all three types of providers: 0.57 (slightly more than one member of staff per two service users) in for-profit providers, 0.58 in non-profit providers and 0.61 in public providers. These differences are accentuated if the ratio is calculated in relation to the number of beds. In this case, the ratio is much higher in public care homes (0.79 – more than 1.5 staff per bed) than in for-profit (0.64) and non-profit (0.63) (Rothgang, 2015). Some experts suggest that having more workers at a lower cost is a result of salary dumping. Owners of private care homes refute this assumption, which implies that they finance their extra personnel through other means – for example, by taking residents with severe mental and physical disabilities whose care is subsidised by the state (ENNHRI, 2017).

**Belgium (Flanders):** In order to get public funding, it is necessary to have a minimum ratio of staff to resident. In 2012, public providers had a ratio of 0.4 staff (full time equivalent) to residents (equating to less than one worker per two service users). In private care homes, the ratio was 0.37 in non-profit and 0.3 (less than one member of staff per three residents) in for-profit care homes. These differences are explained, to some extent, by the level of dependency of residents, with more dependent residents requiring more staff. The non-profit sector has a level of staffing 16.7% above the level financed by the Flemish government, while the for-profit sector has 14% more staff than financed. The public sector has a considerably higher percentage of staff (40.4% in 2012) that is not financed. This could be taken as indicative of a lack of efficiency and raises questions about the sustainability and cost efficiency of care in public care homes (Pacolet and De Coninck, 2015). With regard to the compliance with staffing standards, an inspection in 2012 found that only 40% of the for-profit care home providers complied with required standards. This is significantly lower than in the case of non-profit (61%) and public (66%) care homes.

**Sweden:** The number of employees per resident is significantly lower in the private sector (Stolt, Blomqvist and Winblad, 2011), with the ratio of care worker to resident being slightly higher in public care homes (0.9) than in private care homes (0.8) (National Board of Health and Welfare, 2012).

**France:** The staff (in full-time employment) to resident ratio increased from 0.5 in 2007 to 0.54 in 2011 (DREES, 2014). The highest ratio is in public nursing homes (EHPADs) (0.66), followed by private non-profit (0.56) and for-profit nursing homes (0.53).

**Slovenia:** In 2014, the average number of beds per member of staff was 1.97 for public providers and 1.86 for private providers.

**Estonia:** In 2012, public care homes had approximately 4.3 service users per member of staff. By way of comparison, private sector care homes had around 5.7 service users per member of staff and 5.3 in special needs homes (National Audit Office of Estonia, 2014).

**Hungary:** In 2013, the average ratio of residents per nurse was 3.8. There are some slight differences regarding the type of organisation registered to operate as a care home, with all ratios between 3.0 and 4.0 except in the case of non-profit enterprises (4.1), associations (4.4) and foundations (7.4).

**Finland:** In 2013, the recommended staff-to-resident ratio of 0.5 had not been reached in 20% of sheltered housing facilities and residential homes. By 2014, only 10% of the facilities did not fulfil the recommended ratio. The averages of staff per resident are very similar in all types of care homes (slightly above 0.6 in 2014).

### Level of education of care staff

These ratios include different types of workers, with differences regarding their working conditions according to the care home ownership type. According to Eurofound's 2016 European Jobs Monitor (EJM), care workers in residential care have a higher average level of education (reaching ISCED level 3) than their counterparts in home care (ISCED level 2) (Eurofound, 2016). The data from the 2010 European Working Conditions Survey (EWCS) show that the majority of residential care workers (in NACE code 87) feel their present skills correspond well with their duties. The percentage of workers in residential care who report they have received employer-paid training is much higher than in other sectors (Eurofound, 2014a).

The information gathered by the Network of European Correspondents shows similar levels of qualification in all types of care homes.

**Austria:** The lack of certified nurses in care institutions means that employers have little choice when selecting staff. At the same time, certain operators of care homes tend to fill positions with assistant personnel instead of certified nurses, finding loopholes in regulations (Krajic and Schmidt, 2010, p. 37). It can be assumed that this practice happens in non-public institutions due to higher levels of pay in the public care sector.

**Ireland:** The Health Act 2007 stipulates that providers shall ensure that the number and skill mix of staff are appropriate and that includes at all times, at least one registered nurse. Public nursing homes tend to set themselves a target of nurses constituting 60% of care staff, a proportion that is lower in private nursing homes. Because public homes are more likely to provide specialised services like dementia care, they have a higher share of nursing staff. A reliance on non-qualified care staff in private facilities was perceived as a concern in a study carried out in the last

decade (Murphy, Shea and Cooney, 2007). More recent data show that private nursing homes have taken in provision of specialist dementia care while the public sector specialises in respite care (Dementia Services Information and Development Centre 2015).

**Slovenia:** In 2014, some 48.3% of staff in public care homes were social care workers and 48.4% were healthcare workers. In private care homes, 50.5% were social care workers and 47.2% were healthcare workers.

**Czech Republic:** Care assistants working in ‘quasi social care services’ are not required to have any training in caring or nursing and are not formally employed. Their role, as originally intended, was to provide care in clients’ own homes, not in residential facilities.

**Germany:** All types of providers employ more workers in helper/assistant roles (about 65% of the workforce) than in skilled roles, the latter having a slightly higher share in public care homes (Rothgang, 2015). There are also small differences regarding the qualifications level between different types of providers. Overall, it was found that 10–13% of the workers have no qualifications, while 23–26% have qualifications not related to care and social services (Pflegerstatistik, 2013).

**Norway:** There are no documented differences in staff although there are some examples of lower levels of qualifications among staff in private for-profit nursing homes – for example, the extensive use of staff with poor Norwegian-language skills.

**UK:** Data from the National Minimum Data Set in Social Care (NMDS-SC) for care homes in England indicate that direct care staff in local authorities are better qualified than those in the private or voluntary sector: 75% of local authority staff have at least a Level 2 qualification, as against 46% of those in the private sector and 52% of those in the voluntary sector.

**Finland:** In 2014, public care homes had a slightly higher percentage of nurse managers and team leaders, similar percentages of qualified nurses and a higher share of practical nurses than their private counterparts. Staff without any social/healthcare qualification constituted a higher share of staff in private 24-hour sheltered housing (7%; in public facilities it is 3%) but lower in residential homes (1%; in public facilities it is 2%) (National Institute for Health and Welfare, 2015).

**Malta:** In 2016, the private sector (excluding the Church) employed the most carers (420) while the government employs more nurses (116).

**Romania:** The level of qualifications of staff in private (non-profit) care homes was higher than in public homes (ENNHRI, 2017).

## Wages in public and private environments

There are also differences in the wages paid by public and private providers. The EJM provides a ranking of wages in different jobs.<sup>11</sup> In 2016, the wages of personal carers working in residential care activities were ranked in the second-lowest quintile (medium to low paid). In comparison, the wages of personal carers working in home care were ranked in the lowest quintile.

**France:** Salaries are slightly higher in the private sector, but limited by the regulation of prices in contracted facilities. The elasticity of salaries to environmental variables is higher in non-contracted facilities (Martin, 2014).

**Germany:** On average, wages in private care homes are lower than in non-profit and public care homes (Auth, 2014). Due to the high number of low-wage helpers in the care sector, in 2009 the Minister of Labour extended a collective minimum wage agreement on care assistants (*Pflegehilfskräfte*) concluded by the United Services Union ver.di and the non-profit organisation Arbeiterwohlfahrt (AWO). Covering the care assistants/helpers in all residential care homes, in 2016 the agreement provided an hourly wage of €9.75 in western Germany and €9 in eastern Germany; the statutory minimum wage is €8.50.

**Austria:** On average, wages are higher in public-law employment relationships and public institutions than in the private sector. Regulations in the different private sector collective agreements, such as SWÖ, Caritas and Diakonie are similar. Pay is lower in the care sector than in the healthcare sector (with the exception of Vienna) for equally qualified personnel (Krajic and Schmidt, 2010); this can lead to recruitment problems in the care sector.

**Norway:** In the event of a change of providers (from public to private) new employers cannot offer a lower salary, but may change the organisation of the work and have the possibility of rejecting the existing collective agreement) – which in practice may lead to somewhat lower salaries. Non-profit organisations are largely bound by collective agreements that ensure the same wages (and pension) as in the public sector. However, some have changed their type of employer organisation in order to avoid these regulations.

**Ireland:** Pay in public health and social care services tends to be similar to that in private nursing homes (though sometimes lower for nurses), but other benefits such as pension and maternity top-up tend to be higher in the public sector.

<sup>11</sup> This ranking of wages is done on the basis of combining data (mainly on the mean hourly wage) from EU Labour Force Survey and aggregated data from the Structure of Earnings Survey (Eurofound, 2016).

**Sweden:** The Municipal Workers' Union (Kommunal) found that assistant nurses had lower wages when working for a private eldercare provider, a difference amounting to around SEK 900 (around €95 as at 8 August 2017) in 2012.

**UK:** The National Minimum Data Set for Social Care in England shows that care home staff employed in local authorities are better paid (£8.42 per hour – €9.30) than those in the independent sector (£7.29 in the private for-profit sector and £7.74 in the voluntary sector – €8.05 and €8.55 respectively).

## Quality of services

The underlying rationale for allowing competition between different types of providers is that it can increase quality and lower costs. Leichsenring, Nies and van der Veen (2013) assert that there is contradictory evidence regarding whether competition in quasi-markets has actually led to an improvement of the quality of services, given the lack of universally acknowledged indicators and given that commissioning is often based on price rather than quality.<sup>12</sup> They refer to evidence of private care homes being more service oriented, while in contrast monopolies can have a detrimental effect on service quality. Evidence from Austria seems to indicate that competition between public and private providers improves the quality of the latter. Public and non-profit care homes constitute the great majority of care home provision (approximately 80% of the total number of beds available). Their higher quality has a 'radiation effect' on for-profit care homes, which are forced to reach the same standards in order to remain competitive (Neumayr and Meichenitsch, 2011).

According to Marczak and Wistow (2016), evidence shows that private for-profit care homes provide services of poorer quality than public or non-profit homes. The authors make reference to the mixed results in Nordic countries. The review carried out by Gautun et al (2013) on Norway, Sweden and Denmark (as well as the case studies and interviews they conducted), concluded that current research

*does not provide grounds to conclude that there are differences in quality between private commercial providers and municipal services. Some studies show a better quality of care in private care, while others indicate worse quality.*

(Gautun et al, 2013, p. 106)

The studies gathered by the Network of European Correspondents also show very different outcomes.

**Norway:** A study of the consequences of competitive tendering in Oslo (in terms of costs and quality) measured quality with five indicators: proportion of residents with pressure ulcers; new or worsened contractures; severe weight loss; falls; and urinary incontinence (Oslo Economics, 2013). The study found that nursing homes subject to competitive tender by 2010 (privately run) had a somewhat higher average quality than other nursing homes, and improved the most from 2007 to 2010.

**Malta:** The Government of Malta (2013) released the annual report by the Office of the Commissioner for Mental Health and Older Persons on residential homes for older people. It found that the overall quality of the audited homes was quite high, even though the quality of the private and church homes was a little lower than that provided by the government homes – with respect to health services, friendliness of staff and general environment; usually, when there is a medical problem, residents are sent to public hospitals (AGE Platform Europe consultation). In 2015, the government, which had also purchased beds from private homes through a public-private partnership, cancelled this agreement with a private home due to the low-quality standards (Times of Malta, 2015).

**UK:** Gage et al (2009) gathered data from inspection reports in one English county and found that care homes owned by corporate for-profit organisations (which had specialist registrations and higher maximum fees) were more likely to provide better care (in that they failed fewer national standards). On the other hand, small for-profit homes (those registered before 2000, those that provided services to local authority funded residents and those that had registered for nursing care) were more likely to provide poorer care. The study also found evidence that better management was associated with better quality of care. Nursing homes run by non-profit organisations had the highest average quality. In a study of care of people with dementia in the UK, all the NHS continuing care units assessed needed radical changes because of the poor quality of care, while only half of the private facilities were assessed as needing radical improvements (Ballard et al, 2001).

**Ireland:** A study on the quality of life in nursing homes covering non-medical aspects of care showed that lack of choice for residents was more prevalent in public facilities (Murphy, Shea and Cooney, 2007).

<sup>12</sup> Also known as planned markets, these are public sector reforms that aim to promote competition, with providers not necessarily seeking to maximise profit; where choice may be exercised on behalf of the users and where their 'spending power' is determined by the value of a voucher or budget (Institute for Government, 2012).

**Belgium (Flanders):** In 2012, an inspection carried out by the Flemish government gave for-profit care homes lower scores in the areas of nutrition, staffing, continuity of care and preventive health (such as hand hygiene, and recording of falls and of infections). On the other hand, private for-profit care homes were more compliant with care practices (such as medication, wound care, care plans, safety and help with bathing). While the for-profit sector had a market share of 17% of the market in 2012, some 43% of the total complaints received were in relation to for-profit care homes.

**Portugal:** According to a report by the Health Regulation Authority, there were more formal complaints by service users between 2009 and 2015 about private establishments regarding safety and the quality of the care provided than for about public care homes (ERS, 2015).

**Italy:** According to a report by the NNA in 2015, private providers struggle to meet quality standards. Limited regional public expenditure that covers part of the costs, as well as reduced household purchasing power, are lowering service quality standards. However, the definition of quality standards by law, introduced as part of an accreditation process, has led to an increase in costs. The dilemma recently faced by the management of private residential facilities is, therefore, whether to lower the standards to remain competitive in economic terms, or to maintain the same quality standards with higher fees. The report describes regional cases where there is evidence of lower quality services being provided, and of the relaxation of monitoring by public authorities. In many northern regions, for instance, the search for higher profits is managed through the introduction of additional services or by selecting wealthier service users (NNA, 2015).

**Sweden:** Private facilities seem to do better with regard to service aspects, such as participating in the formation of their care plan, reasonable duration between meals, or offering different food alternatives (Stolt, Blomqvist and Winblad, 2011).

### Reported abuse and neglect

The information gathered by the Network of European Correspondents in several countries comes from audits and inspections. These and other quality monitoring tools have been put in place and/or extended to private care homes partly due to the alarm generated by cases of neglect and abuse of residents. For example, in Ireland, a scandal reported in the national media in 2005 about substandard living conditions in Leas Cross, a private nursing home, influenced the establishment of HIQA and the independent regulation of nursing homes.

Very little evidence of reported differences between public and private provision in terms of neglect and abuse was found by the Network of European Correspondents.

**Sweden:** Reported cases of neglect were equally distributed between private and public units (proportional to the number of residents) (National Board of Health and Welfare, 2012).

**Estonia:** There have been considerably more complaints of neglect or mistreatment to the representative bodies from the public sector than the private sector, yet no case has ever reached the courts.

**Romania:** According the President of the Romanian Association of the Managers of Elderly Care Institutions (ADIV), most of the cases of neglect or mistreatment of residents in private care homes concern material deprivation and theft of property. Cases of neglect or abuse were reported in the AGE Platform Europe consultation to be higher in public residential care due to the low staff quality.

**Czech Republic:** In recent years, the Ombudsman has organised systematic visits to homes for older people. The inspection of 'quasi social care services' exposed a range of problems, including: inadequate materials and technical equipment; poor hygiene standards; poor quality of care (staff lacking adequate skills); poor diet and risk of malnutrition; inadequate safeguards; restrictions on the movements of clients; invasion of privacy or insufficient privacy; and financial dependency on the operator (operators do not leave service users a minimum 15% of the balance of income and do not limit the maximum charge for services provided, as do social services providers).

**Poland:** Private facilities were associated with a risk of abuse and mistreatment. Public institutions were seen as stable both financially (not vulnerable to bankruptcy) and institutionally (Jurek, 2012).

### Findings from surveys on quality

Some of the information was gathered through user and relative surveys, which have been criticised for low response rates, selective bias and the fact that many residents suffer from dementia, or may not express negative views for fear of the consequences.

**Norway:** A 2011 user survey shows that 87% of residents in non-profit care homes were (overall) satisfied with the nursing home to a high degree or a very high degree (Oslo Municipality, Helseetaten 2011). In commercially run homes and municipal homes, the score was 85% and 83% respectively. These differences were not present in 2012 when the satisfaction rate was higher (91%). In a next-of-kin-survey, the non-profit providers scored best and commercially run homes scored equal to the municipal homes (Oslo Municipality, Helseetaten 2012).

**Denmark:** A survey in Aarhus, Denmark's second-largest city, shows that a greater proportion of relatives of residents in private (for-profit and non-profit) residential care homes (80% of 141 respondents) were in general satisfied than their public counterparts (74% of 980 respondents). The results of the survey have been criticised by trade unions on the basis that relatives can be biased because they selected the private residential homes themselves and, therefore, have a more positive attitude towards private provision.

**Sweden:** A 2015 user survey showed similar results for all types of care homes regarding overall satisfaction, the possibilities to spend time outside, and trust in staff (National Board of Health and Welfare, 2015).

**Netherlands:** The website [Zorgkaartnederland.nl](http://Zorgkaartnederland.nl) gathers users' views about care institutions. There are 183 private for-profit institutions and 294 non-profit institutions registered on the site, with the former receiving higher rankings.

## Efficiency

The regulation of long-term care quasi-markets entails transaction costs that are difficult to measure (Rodrigues, Leichsenring and Winkelmann, 2014).<sup>13</sup> Several studies comparing the efficiency of public and private care homes come from Norway. One of the reasons for promoting a more diversified provision of services in Norway (and other countries) since the 1990s is the belief that competition has a positive impact on cost efficiency (Vabø et al, 2013). This is an issue discussed at the political level in Norway, where a study by Oslo Economics showed that private nursing homes had significantly lower costs and slightly better quality than municipal homes, and thus were significantly more cost effective (Oslo Economics, 2013). The study has received criticism for not taking into account risks (such as breach of contract and bankruptcy) or transaction costs, which according to another study are usually equivalent to between 5% and 10% of the cost of contracts (Asplan Analyse, 2005).

In a study of the accounts of 21 nursing homes, these lower costs in private nursing homes were attributed to the lower staffing numbers and lower percentage of certified nurses, adjusting working time and lowering pension costs (Havig, cited in Gautun et al, 2013, p. 110 and Vabø et al, 2013). Another study by the Confederation of Norwegian Enterprise (NHO) estimates that a patient in a municipally run nursing home has an average annual cost of NOK 945,000 (approximately

€100,000), as opposed to NOK 775,000 (€83,000) per year for a patient in a nursing home run by its members (privately for-profit). Another study was carried out by the Oslo Municipality, which currently has 15 privately run nursing homes. The current total cost of these homes is NOK 1,013 million (€108 million), with the local authorities estimating that offering these services through public provision would cost an additional NOK 49.5 million per year (€5.3 million) – mainly due to better pension plans in the public sector. Non-profit providers often have higher costs compared to private for-profit providers and often lose to private for-profit companies if the services are tendered out. The Campaign for the Welfare State (*For Velferdsstaten*) only found one competition won by a non-profit actor after examining 47 cases (Herning, 2012). Non-profit organisations tend to struggle in direct competition with for-profit providers as they adhere to the higher pension benefits of the municipally run institutions and usually have higher costs than private for-profit companies. A minimum standard of pay and working conditions is secured by the public procurement legislation regardless of provider, but pension benefits are exempt.

Studies on the situation in Sweden (Swedish Association of Local Authorities and Regions, 2011) and Belgium (Pacolet and De Coninck, 2015) point out the losses incurred by public nursing homes, with public nursing homes in Belgium losing €12.90 per day per resident. In comparison, non-profit nursing homes make a profit of €4.60 per day per resident and private for-profit care homes a profit of €0.90 per day per resident. An important factor in the losses in the public sector are the high staffing numbers (over the level that is reimbursed) and the low reimbursement tariff for the type of service users that tend to avail of public care homes (see section on accessibility for more information).

In addition to staffing numbers, other reasons behind the losses in the public sector identified in the Swedish study include private facilities controversially buying infrastructure at a very low price and private nursing homes being in a more advantageous position when it comes to tax, insurance, negotiating wages or deciding which services they provide – and how. Where private care homes can focus on those areas that are more profitable, public care homes are bound by legislation in their care provision strategies and have a universal responsibility (they must take difficult and/or expensive cases).

13 Transaction costs are those costs incurred in the exchange of good and services.

A microeconomic analysis of cross-sectional data on 997 French nursing homes and a panel of 797 nursing homes observed in 2003 and 2007 shows that economic and cost ineffectiveness raise costs between 5% and 10% in public and in non-profit nursing homes that are not associated with hospitals, with no significant differences between care homes of different ownership type (Martin, 2014).

In addition to cost efficiency, another indicator of efficiency is the occupancy rate.<sup>14</sup> According to a UK study, in 2012 this was higher in private care homes than in public care homes (LaingBuisson, 2014, cited in Grant Thornton, 2014).<sup>15</sup> The lower occupancy rates in care homes run by local authorities are explained by cuts in their budgets, which lead to referrals to the private sector and the reduction in public provision. According to Grant Thornton, overcapacity in private care homes 'should see reduction following the forecast closure of local authority beds and continued closure of older "not fit for purpose" care homes' (Grant Thornton, 2014, p.4). Other factors stimulating demand and occupancy found in the report include the ageing of the population, the transfer of residents in local authority care homes to the for-profit sector and the credit crisis restricting new builds. On the other hand, the increased

use and promotion of home care by the government, as well as its lower costs, may pose a challenge for the private sector.

A study focusing on 40 nursing homes in Lombardy in Italy assessed their efficiency using a data envelopment analysis model over a three-year period (Garavaglia et al, 2011). The model employed two input variables (costs for health and nursing services and costs for residential services) and three output variables (case mix, extra nursing hours and residential charges). Ownership was identified as one of the two factors that affect efficiency, with private nursing homes outperforming public nursing homes. The capacity to implement strategies for labour cost and containment nursing costs greatly affects efficiency scores. Public nursing homes have reduced labour costs to a lesser extent than private nursing homes; this is partly due to trade union negotiations and organisational inertia. The study concludes that the efficiency of public nursing homes is moving towards that of their private counterparts, which confirms the findings of other studies showing that the introduction of competition mechanisms and the creation of a quasi-market for nursing homes do increase efficiency.

---

14 The number of occupied places divided by the total number of places.

15 Occupancy rates were around 90% in the private for-profit sector, 94% in the non-profit sector, 64% in local authority nursing homes and 86% in NHS long-stay beds.

# 3 | Conclusions

## Trends in service provision

Pavolini and Ranci conclude that the result of reforms of long-term care (which include the establishment of a new social care market based on competition) is a convergence in Europe towards a mixed model of provision with an intermediate level of public provision of long-term care (Pavolini and Ranci, 2008). The data provided by Eurofound's Network of European Correspondents show that in nearly all countries for which data are available, the share of private care homes has increased over the last decade (Cyprus, France and the UK (Scotland) are the exceptions to this, the total number of care homes having decreased). This increase has been particularly rapid in Romania, Slovakia and Slovenia and takes place in a context of slower growth (except in the case of Malta and Spain) or negative growth of public care homes. Consequently, this trend in growth is also reflected in the increase of places in private care homes. These increases seem to indicate that the mechanisms introduced to promote competition have indeed increased private provision, and that the reduction in public provision has left room for the expansion of the private sector.

Is care home provision increasingly commercial? Given that data about private care homes are often not disaggregated into for-profit and non-profit categories, it is difficult to get an overall picture of the trends. However, over the last decade the number of for-profit care homes has increased more than non-profit care homes in Germany. In the UK (Scotland) for-profit care homes have decreased to a lesser extent than non-profit ones. In Norway on the other hand the number of for-profit care homes have decreased and it has been the opposite in non-profit care homes. In France, both types of private care homes have grown at the same pace. Looking at the total number of beds, this has increased more in for-profit care homes in Austria and in non-profit care homes in Belgium and Norway. Today, there is a high share of private for-profit provision in the UK, Germany and Ireland, and a very high level of non-profit provision in the Netherlands. Public provision is predominant in Nordic countries and in central and eastern Europe. The projections in the 2015 Ageing Report (European Commission, 2015) foresee an increase in public expenditure in long-term care that could range from 2.7% to 4.1% of GDP by 2060, depending on different scenarios. The projections performed in some individual Member States reflect this need to broaden the coverage of formal care for older Europeans.

**Malta:** Recent forecasts estimate that on average 200 additional beds are needed per year up to 2025 in public retirement homes (Government of Malta, 2015).

**Luxembourg:** A report by the Consultative Commission of Human Rights (2013) states that in 2050, the number of persons living in residential care and nursing homes will increase to between 15,000 and 20,000 individuals (three to four times more than at present).

**Belgium (Flanders):** Another forecast focusing on the region calculated that the sector will have to grow by 46% over 15 years (2014–2029) in order to deal with the ageing population (Pacolet, Vanormelingen and De Coninck, 2014). In 2060, the sector will have to be 2.65 times bigger than in 2014.

**UK:** Grant Thornton (2014) forecast that the share of local authority/NHS beds for residential care will decrease further (falling from 39,000 beds in 2012 to 18,000 in 2020, with private for-profit sector beds increasing from 381,000 in 2012 to 400,000 in 2020). Budget cuts in local authority spending may contribute to the trend in increasing private sector provision. An analysis of the UK long-term care market also expects further increases in private residential care as less care will be delivered by the public sector due to the relative increase of service users who pay for their own care (Technology Strategy Board, 2013). Another study estimated that an extra 71,000 places in care homes will be needed in the next eight years to meet rising demand (Financial Times, 2015)

The need to increase formal supply poses challenges to the sustainability of long-term care funding and spending, and it may lead to higher co-payments from service users. In Ireland, the percentage of a service user's assets that can be used in the Fair Deal scheme increased from 5% in 2009 to 7.5% in 2013. In Italy, some experts have postulated the introduction of new sources of funding, such as private long-term care insurance (NNA, 2011). The introduction of long-term care insurance at the regional level was also discussed in the sixth State Reform in Belgium (Pacolet and De Wispelaere, 2016). In the UK, proposals for service user payment in social care were a major issue in the 2017 general election. The main private for-profit providers of care homes have warned that cuts to public funding for residents will lead towards further closures of care homes (Financial Times, 2017).

Attitudes of the public and of policymakers towards private provision will influence to what extent it develops further:

- A report from Finland by the Ministry of Economic Affairs and Employment (2015) indicates that private provision is well regarded by consumers: it can contribute with innovations and effectiveness and spur the public sector.

- In Romania, changes in waiting lists indicate an increase in demand for private services: in 2008, there were fewer pending requests for private care homes (1,096) than for public care homes (1,630); in 2014, there were 1,472 pending requests for private units and 907 for public units.
- In Sweden, the role that private actors have been allowed to fill in providing public services has, to a large extent, been ideologically driven. In Social Democratic municipalities, private actors in residential care are still not very widespread, while they are quite common in conservative and liberal areas. This indicates that the future role of private providers will be closely connected to developments in Swedish party politics. Further proof of this is that following an intense election campaign in which the role of private actors in the welfare sector was the focus of debate, the current government launched an enquiry about if and how private providers should be allowed to make a profit from public funding. However, the ability to choose service providers is widely appreciated and it appears unlikely that the government will propose to revert to a single-provider system.
- In Norway, the ongoing municipal reform will lead to fewer and larger municipalities, which could be conducive to privatisation as bigger municipalities have more capacity to commission services. However, with 55% of the population preferring municipal service provision if given the choice, and only 20% preferring commercial providers (Gautun et al, 2013), it seems unlikely that large-scale privatisation reforms will take place.

Another factor influencing the expansion of private care homes for older people are developments in the broader long-term care sector. Most European countries have seen a bigger increase in the number of older users of home care than in residential care over the last two decades. This trend is likely to continue since costs of home care are generally lower, most Europeans prefer to be cared for in their own home, and technological developments widen the types of services that can be provided (Eurofound, 2013c). For example, the Romanian government estimates that home care is 11 times less expensive than a care home. However, it must be noted that home care is, in many countries, more expensive than residential care in the case of severe needs and therefore there are limits to the number of hours of home care that are covered by social protection systems (OECD, 2017b).

### Improving the monitoring of service provision

Clear common definitions are essential. In order to better monitor the extent of public and private provision, it is essential to have clear common definitions that allow the gathering of data about the

different types of long-term care services and providers. Definitions and data about public, for-profit and non-profit provision should take into account the legal status, ownership and economic activity of providers.

The source of Eurostat data on beds in residential long term care facilities is the joint questionnaire on non-monetary health care, the data collection that is carried out jointly by Eurostat, OECD and WHO. Unlike the data about beds in hospitals, this information does not include the type of ownership and the inclusion of this variable in the joint questionnaire is not foreseen in the near future. The lack of data disaggregated by ownership does not enable the European institutions to monitor developments in private provision. The fact that many private providers receive public funding to deliver services can make it difficult to draw a clear distinction between public and private providers. Furthermore, care homes can be managed by providers of a different ownership type. In 2013, some 88% of care homes in Italy were managed by their owners but there were also 12% of care homes managed by an organisation from another sector. According to the National Institute for Statistics, around one-fifth of public care homes in Italy have managers from the non-profit sector, and around 4% have for-profit managers, the rest being managed by public servants (ISTAT, 2015). Private companies can be owned by the public sector, as is the case in Estonia (European Commission, 2011).

In many countries the information about the private sector does not specify whether care homes are for-profit or non-profit. This reflects the difficulties in establishing the economic purpose of private providers. It can be the case that care homes that are registered as a non-profit institution actually seek to make a profit through links to a for-profit company. A for-profit company can, for example, own or rent the building from a non-profit provider (or vice versa), with the subsequent finances flowing between both entities. These financial flows can be used to transfer profits to the for-profit provider. A for-profit company can also be a member of the board of directors in a non-profit institution, charge for consulting services or a fee for managing their services. In Austria and Belgium, the federal government tries to capture the ownership and economic purpose rather than the legal status of the institutions (which is the criterion used by the Flemish government). Another study included in this report (Pacolet and De Coninck, 2015), instead of using legal criteria, uses economic criteria and other information (such as the composition of the governing boards).

An additional challenge is the different definitions and classifications of long-term care services used in policy documents at the European level. For example, the European Commission makes reference to institutional care and residential settings as different terms, stating the preference of Europeans for the latter (European



Commission, 2009a), while other EU documents used these terms as synonyms. The guidelines on deinstitutionalisation define institutional care and community care in a way that the classification of care homes as institutions seems to apply only to those care homes that do not respect the autonomy of service users. Community based services or community based care ‘refers to “the spectrum of services that enable individuals to live in the community”’ (European Expert Group on the Transition from Institutional to Community-based Care, 2012, p. 27).

A report on home care from WHO found that

*‘home care’ is understood very differently across countries and sectors. The services included vary considerably among countries and even ‘home’ turns out to be an elastic term. Many studies on home care lack precision in defining the activities, goals and even the target groups of home care . . . . Home care can be conceived of as any care provided behind someone’s front door or, more generally, referring to services enabling people to stay living in their home environment. In some countries, ‘someone’s front door’ can include a home for the elderly.*

(Genet et al, 2012, p. 9)

## Improving the planning and management of services

It is important to analyse possible trade-offs between efficiency, quality and accessibility of services. Several studies highlight how private providers are facing a dilemma between cutting costs by decreasing the quality of service or increasing prices and thus losing competitiveness. Studies that analyse differences between different types of providers need to document whether improvements in one area are done at the expense of others. The studies included in this report give some indication of the implications of an increased role for the private sector in relation to the accessibility, quality and efficiency of services. It seems that private care homes in some countries are less likely to provide specialist services such as dementia care, which is a major issue when a high proportion of residents are aged over 80. The differences in prices of public and private providers show that if the share of private beds continues to grow, this may deepen health inequalities. It also highlights the need for financial support to be given to providers (if they permit lower charges for service users) and to service users themselves.

Two studies focusing on care homes in Flanders and France provided information about the differences in the level of disability of patients in public and private care homes. In the case of Flanders, the differences were caused partly by the costs and reimbursements for each type of patient. Since the level of dependency has an impact on the staff and services needed, it is important to have similar information available in other countries to understand if the needs of service users that are more dependent are being met in all types of care homes. This information can also help to determine the staff-to-resident ratio that is more cost efficient and provide the necessary incentives and requirements to achieve it. There are indications in several Member States of differences regarding the location of care homes according to ownership, with private care homes being more likely to be found in affluent urban areas. This needs to be taken into account when it comes to the planning of services.

There are no unequivocal findings about differences in the quality of services, with results differing from country to country. The results are nevertheless useful in terms of providing an indication as to what aspects of quality may be affected by changes in the market share of each type of provider. Some of the aspects in which there were differences between each type of provider as documented in studies are: having a single room; hygiene; the residents’ choice of food and activities; attitude of staff; nutrition; continuity of care; and preventive health services.

Given the diversity of results from the studies, the different types of evidence and the influence of the context and the funding mechanisms in each country, the assessment of implications of private provision at the national level should seek to aggregate and appraise the findings of studies in a systematic way. An example of how this could be done is the systematic review and meta-analysis carried out in North America by Comondore et al (2009). Their work showed that non-profit care homes have better quality care than for-profit care homes in two respects – staffing and the prevalence of pressure ulcers (bed sores); no differences were found in the use of physical restraint or deficiencies recorded in governmental regulatory assessments. The studies included here could be used as a starting point for further research.



# Bibliography

All Eurofound publications are available at [www.eurofound.europa.eu](http://www.eurofound.europa.eu). All links were accessed on 11 August 2017.

Allen, K., Bednárík, R., Campbell, L., Dieterich, A., Durrett Hirsch, E., Emilsson, T. et al (2011), *Governance and finance of long-term care across Europe*, Interlinks, Birmingham and Vienna.

Asplan Analyse (2005), *Reorganisation processes: What do they cost? What do they require? Project report*, available at [www.fagforbundet.no/file.php?id=1187](http://www.fagforbundet.no/file.php?id=1187).

Aquoras (2014), *La facturación de las residencias para mayores cae por segundo año consecutivo*, web page.

Auth, D. (2014), 'Ökonomisierung der Pflege – Formalisierung und Prekarisierung von Pflegearbeit', *WSI-Mitteilungen*, Vol. 3, pp. 412–422.

Ballard, C., Fossey, J., Chithramohan, R., Howard, R., Burns, A., Thompson, P. et al (2001), 'Quality of care in private sector and NHS facilities for people with dementia: Cross sectional survey', *BMJ*, Vol. 323, No. 7310, pp. 426–427.

Bode, I. (2014), 'Governance and performance in a 'marketized' nonprofit sector: The case of German care homes', *Administration & Society*, Vol. 49, No. 2.

BDO (2014), *Health's ageing crisis: Time for action. A future strategy for Ireland's long-term residential care sector*, Dublin.

Comondore, V.R., Devereaux, P.J., Zhou, Q., Stone, S.B., Busse, J.W. et al (2009), 'Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis', *BMJ*, Vol. 339, No. 2732.

Consultative Commission of Human Rights (2013), *Rapport sur les droits des personnes âgées fragiles en institutions de long séjour*, Commission Consultative des Droits de l'Homme du Grand-Duché de Luxembourg.

Council of the European Union (2012), *Council Declaration on the European Year for Active Ageing and Solidarity between Generations (2012): The way forward*, Brussels.

Council of the European Union (2015), 'Council decision (EU) 2015/1848 of 5 October 2015 on guidelines for the employment policies of the Member States for 2015', *Official Journal of the European Union*, L 268/28, 15 October.

County Councils Network and LaingBuisson (2015), *County care markets: Market sustainability & the Care Act*, London.

Dementia Services Information and Development Centre (2015), *An Irish national survey of dementia in long-term residential care*, Dublin.

Destatis (2013), *Pflegestatistik – Pflege im Rahmen der Pflegeversicherung Deutschlandergebnisse*, Statistisches Bundesamt, Wiesbaden.

DREES (2014), 'L'offre en établissements d'hébergement pour personnes âgées en 2011', *Études et résultats*, No. 877.

European Commission (2015), *The 2015 ageing report: Economic and budgetary projections for the 28 EU Member States (2013–2060)*, Publications Office of the European Union, Luxembourg.

ENNHRI (2017), 'We have the same rights': *The human rights of older persons in long-term care in Europe*, European Network of National Human Rights Institutions, Brussels.

ERS (2015), *Acesso, qualidade e concorrência nos cuidados continuados e paliativos*, Entidade Reguladora da Saúde, Porto, Spain.

Ervik, R., Helgøy, I. and Lindén, T. (2013), 'Strategies to meet long-term care needs in Norway, the UK and Germany: A changing mix of institutional responsibility', Ervik, R. and Lindén, T. (eds), *The making of ageing policy: Theory and practice in Europe*, Edward Elgar Publishing Limited, Cheltenham, p. 304.

Eurobarometer (2007), *Health and long-term care in the European Union*, Special Eurobarometer 283, Wave 67.3, Brussels.

Eurofound (2012), *Third European Quality of Life Survey – Quality of life in Europe: Impacts of the crisis*, Publications Office of the European Union, Luxembourg.

Eurofound (2013a), *Impacts of the crisis on access to healthcare services in the EU*, Publications Office of the European Union, Luxembourg.

Eurofound (2013b), *Third European Quality of Life Survey – Quality of life in Europe: Quality of society and public services*, Publications Office of the European Union, Luxembourg.

Eurofound (2013c), *More and better jobs in home-care services*, Publications Office of the European Union, Luxembourg.

Eurofound (2014a), *Residential care sector: Working conditions and job quality*, Dublin.

Eurofound (2014b), *Access to healthcare in times of crisis*, Publications Office of the European Union, Luxembourg.

Eurofound (2015), *Delivering public services: A greater role for the private sector? An exploratory study in four countries*, Publications Office of the European Union, Luxembourg.

- Eurofound (2016), *What do Europeans do at work? A task-based analysis: European Jobs Monitor 2016*, Publications Office of the European Union, Luxembourg.
- Eurofound (2017), *Delivering hospital services: A greater role for the private sector?*, Publications Office of the European Union, Luxembourg.
- Eurofound (forthcoming), *Fourth European Quality of Life Survey – Overview report*, Publications Office of the European Union, Luxembourg.
- European Commission (2005), *Working together, working better: A new framework for the open coordination of social protection and inclusion policies in the European Union*, COM(2005) 706 final, Brussels.
- European Commission (2008), *Joint report on social protection and social inclusion 2008: Social inclusion, pensions, healthcare and long-term care*, Brussels.
- European Commission (2009a), *Joint report on social protection and social inclusion 2009*, Brussels.
- European Commission (2009b), *Report of the ad hoc expert group on the transition from institutional to community-based care*, Brussels.
- European Commission (2009c), *Access to healthcare and long-term care: Equal for women and men?*, Brussels.
- European Commission (2011), *Study on social services of general interest*, Final report, Brussels.
- European Commission (2012a), *Towards a job-rich recovery*, COM(2012) 173 final, Strasbourg.
- European Commission (2012b), *Long-term care for the elderly: Provisions and providers in 33 European countries*, Publications Office of the European Union, Luxembourg.
- European Commission (2013), *Long-term care in ageing societies: Challenges and policy options*, SWD (2013) 41 final, Brussels.
- European Commission (2014), *Identifying fiscal sustainability challenges in the areas of pension, health care and long-term care policies*, European Economy Occasional Papers 201, Brussels.
- European Commission (2016a), *Age-related fiscal sustainability challenges: A horizontal assessment framework for pension, health care, long-term care policies for the 2016 European Semester*, Note to the Economic Policy Committee, ECFIN/C2, Brussels.
- European Commission (2016b), *Questions and answers on the revision of social security coordination rules*, press release, 13 December.
- European Commission (2016c), *Annual Growth Survey 2017*, COM(2016) 725 final, Brussels.
- European Commission (2016d), *Adequate and sustainable social protection*, web page.
- European Commission (2016f), *Joint report on health care and long-term care systems and fiscal sustainability*, Institutional paper 037, Publications Office of the European Union, Luxembourg.
- European Commission (2017), *Commission Recommendation of 26.4.2017 on the European Pillar of Social Rights*, C(2017) 2600 final, Brussels.
- European Expert Group on the Transition from Institutional to Community-based Care (2012), *Common European guidelines on the transition from institutional to community-based care*, Brussels.
- Financial Times (2015), *Care home owners warn on spending cuts*, 15 March.
- Financial Times (2017), *UK facing shortfall of 71,000 care home places*, 15 August.
- Firgo, M. and Famira-Mühlberger, U. (2014), *Ausbau der stationären Pflege in den Bundesländern. Quantitative und qualitative Effekte des Einsatzes öffentlicher Mittel im Vergleich zur mobilen Pflege*, Austrian Institute of Economic Research, Vienna.
- Gage, H., Knibb, W., Evans, J., Williams, P., Rickman, N., and Bryan, K. (2009), 'Why are some care homes better than others? An empirical study of the factors associated with quality of care for older people in residential homes in Surrey, England', *Health and Social Care in the Community*, Vol. 17, No. 6, pp. 599–609.
- Garavaglia, G., Lettieri, E., Agasisti, T. and Lopez, S. (2011), 'Efficiency and quality of care in nursing homes: An Italian case study', *Health Care Management Science*, Vol. 14, No. 1, pp. 22–35.
- Gautun, H., Bogen, H. and Grødem, A.S. (2013), *Konsekvenser av konkurranseutsetting – Kvalitet, effektivitet og arbeidsvilkår i sykehjem og hjemmetjenester*, Fafo, Oslo.
- Genet, N., Boerma, W., Kroneman, M., Hutchinson, A., and Saltman, R.B. (eds.) (2012), *Home care across Europe: Current structure and future challenges*, Observatory Studies No. 27, World Health Organization, Copenhagen.
- Geraedts, M., Harrington, C., Schumacher, D. and Kraska, R. (2016), 'Trade-off between quality, price, and profit orientation in Germany's nursing homes', *Ageing International*, Vol. 41, pp. 89–98.
- Government of Malta (2013), *Annual report*, Office of the Commissioner for Mental Health and Older Persons, Malta.
- Government of Malta (2015), *Height limitation adjustment policy for retirement homes – Public consultation document*.
- Grant Thornton (2014), *Residential elderly care – UK sector review*, London.

- Hermann, C. and Verhoest, K. (2012), 'The process of liberalisation, privatisation and marketisation', in Hermann, C. and Flecker, J. (eds.), *Privatization of public services: Impacts for employment, working conditions, and service quality in Europe*, Routledge, New York and Abingdon, UK, pp. 6–32.
- Hermansen, A. (2011), *Organisering og eierformer innen pleie- og omsorgssektoren*, Fafo, Oslo.
- Herning, L. (2012), *Konkurransetsatte sykehjem i Norge*, Notat 1/2012, For Velferdsstaten, Oslo.
- Health and Social Care Information Centre (2015), *Personal social services: Staff of social services departments at 30 September - England, 2015: Annex E – Report tables and charts*, (Table 2.1a), available at <http://www.hscic.gov.uk/catalogue/PUB19985>.
- Health and Social Care Information Centre (2016), *Personal social services: Staff of social services departments, England: As at September 2015*, Health and Social Care Information Centre.
- Huber, M., Rodrigues, R., Hoffmann, F., Gasior, K. and Marin, B. (2009), *Facts and figures on long-term care: Europe and North America*, European Centre for Social Welfare Policy and Research, Vienna, Austria.
- ISD Scotland and NHS National Services Scotland (2015), *Care Home Census: Scottish statistics on adult residents in care homes 2006–2015*, Information Services Division, Scotland.
- ILO (International Labour Organisation) (2012), *Can the European elderly afford the financial burden of health and long-term care?*, Assessing impacts and policy implications – ESS Paper No.31.
- IMSERSO (2011), *Servicios sociales dirigidos a personas mayores en España*, Instituto de Mayores y Servicios Sociales, Madrid.
- Institute for Government (2012), *The development of quasi-markets in secondary education*, London.
- ISTAT (2015), *I presidi residenziali socio-assistenziali e socio-sanitari*, Rome.
- Jarrett, T. (2016), *Social care: Recent funding announcements and the state of the care home market (England)*, House of Commons Library briefing paper, number 07463, London.
- Jurek, Ł. (2012), 'Prywatyzacja stacjonarnej pomocy społecznej jako wyzwanie wobec procesu starzenia się ludności w Polsce' [Privatization of residential care facilities as a challenge to the process of population ageing in Poland], *Ekonomia*, Vol 1., No. 18, pp. 116–127. [English-language abstract available at <http://yadda.icm.edu.pl/yadda/element/bwmeta1.element.ekon-element-000171213197>].
- Knight Frank (2014), *European healthcare – Care homes report 2014*, London.
- KPMG (2015), *Ehpad: Vers de nouveaux modèles?*, Paris.
- Krajic, K. and Schmidt, C. (2010), *Gesundheitsförderung als Beitrag zur Entwicklung der österreichischen long term care? Konzeptuelle Überlegungen und ExpertInneneinschätzungen*, Ludwig Boltzmann Institute for Health Promotion Research, Vienna, Austria.
- Laing, W. (2014), *Strategic commissioning of long term care for older people. Can we get more for less?*, London.
- Leichsenring, K., Nies, H. and van der Veen, R. (2013), 'The quest for quality in long-term care', in Leichsenring, K., Nies, H. and van der Veen, R. (eds.), *Long-term care in Europe: Improving policy and practice*, Palgrave Macmillan, London, pp. 167–190.
- Lievesley, N., Crosby, G. and Bowman, G. (2011), *The changing role of care homes*, Bupa and Centre for Policy on Ageing, London.
- Martin, C. (2014), *Concurrence, prix et qualité de la prise en charge en EHPAD en France: Analyses micro-économétriques*, Université Paris Dauphine, Paris.
- Marczak, J. and Wistow, G. (2016), 'Commissioning long term care services', in Gori, C., Fernandez, J-L. and Wittenberg, R. (eds.), *Long term care reforms in OECD countries*, Policy Press, Bristol, UK.
- Meagher, G. and Szebehely, M. (2013), 'Long-term care in Sweden: Trends, actors and consequences', in Ranci, C. and Pavolini, E. (eds.), *Reforms in long term care policies in Europe: Investigating institutional change and social impacts*, Springer, New York.
- Ministry of Economic Affairs and Employment (2015), *Hoito- ja hoivapalvelualan tila ja tulevaisuudennäkymät*, Department of Business and Innovation, Helsinki.
- Ministry of Regional Development and Public Administration (2011), *Applicant's guidelines*, web page, available at: <http://www.mdrap.ro/en/ghidul-solicitantului>.
- Montemurro, F. (ed.) (2012), *Indagine sulle RSA in Italia*, Auser Nazionale, Italy.
- Murphy, K., Shea, E. and Cooney, A. (2007), 'Quality of life for older people living in long-stay settings in Ireland', *Journal of Clinical Nursing*, Vol. 16, No. 11, pp. 2167–2177.
- National Audit Office of Estonia (2014), *Organisation of welfare of the elderly in general nursing homes of municipalities and cities*, Tallinn.
- National Board of Health and Welfare (2012), *Kommunal eller enskild regi, spelar det någon roll? – En jämförelse av utförare av vård och omsorg om äldre*, Socialstyrelsen, Stockholm.
- National Institute for Health and Welfare (2015), *Sosiaalihuollon laitos- ja asumispalvelut 2015*, web page, available at <https://www.thl.fi/fi/tilastot/tilastot-aiheittain/ikaantyneiden-sosiaalipalvelut/sosiaalihuollon-laitos-ja-asumispalvelut>.

- Neumayr, M. and Meichenitsch, K. (2011), 'Sind Non-Profit-Organisationen die guten? Qualitätsunterschiede zwischen gemeinnützigen und gewinnorientierten Alten- und Pflegeheimen', *Kurswechsel*, Vol. 4, pp. 75–85.
- NNA (2015), *L'assistenza agli anziani non autosufficienti in Italia*, Maggioli Editore, Rome.
- OECD (2005), *Long-term care for older people*, OECD Publishing, Paris.
- OECD (2017a), *OECD Health Statistics 2017: Beds in residential long-term care facilities, Definitions, sources and methods*, OECD Publishing, Paris.
- OECD (2017b), *Measuring effective social protection in long term care – OECD Health Working Papers*, No. 93, Paris.
- OECD, Eurostat and WHO (2011), *A system of health accounts*, OECD Publishing, Paris.
- Oslo Economics (2013), *Sykehjemsdrift i Oslo – effekter av konkurranse*, Report for NHO Service, Oslo Economics, Oslo.
- Oslo Municipality, Helseetaten (2011), *Bruketilfredshet blant beboere på sykehjem i Oslo kommune 2011*, Oslo Health Administration, Oslo.
- Oslo Municipality, Helseetaten (2012), *Beboerundersøkelse på sykehjem 2012*, Oslo Health Administration, Oslo.
- Pacolet, J., De Troyer, F., Boeykens, S., De Coninck, A., Vastmans, F. and Buyst, E. (2012), *Een vergelijkende studie naar bouwkost en dagprijs in door VIPA gesubsidieerde en niet- gesubsidieerde woonzorgcentra*, De Vlaamse Gemeenschap, Departement Welzijn, Volksgezondheid en Gezin.
- Pacolet, J., Vanormelingen, J. and De Coninck, A. (2014), 'Tempus Fugit. Een aggiornamento van toekomstverkenningen voor de zorgberoepen in de Vlaamse Gemeenschap', *SWVG-Rapport*, No.17, p. 209.
- Pacolet, J. and De Coninck, A. (2015), 'Financiering van de residentiële ouderenzorg: Het perspectief van de voorzieningen', *SWVG-Rapport*, No. 31.
- Pacolet, J. and De Wispelaere, F. (2016), 'De staat van de verzorgingsstaat in België omstreeks 2015', *Belgisch tijdschrift voor Sociale Zekerheid*, 4e Trimester 2015.
- Pavolini, E. and Ranci, C. (2008), 'Restructuring the welfare state: Reforms in long-term care in western European countries', *Journal of European Social Policy*, Vol. 18, No. 3, pp. 246–259.
- Parker, C., Barnes, S., McKee, K., Morgan, K., Torrington, J. and Tregenza, P. (2004), 'Quality of life and building design in residential and nursing homes for older people', *Ageing and Society*, Vol. 24, No. 6, pp. 941–962.
- Rodrigues, R., Huber, M. and Lamura, G. (eds.) (2012), *Facts and figures on healthy ageing and long-term care: Europe and North America*, European Centre for Social Welfare Policy and Research, Vienna, Austria.
- Rodrigues, R., Leichsenring, K and Winkelmann, J. (2014), *The 'make or buy' decision in long-term care: Lessons for policy*, European Centre for Social Welfare Policy and Research, Vienna, Austria.
- Rothgang, H. (2015), 'Sicherstellung der pflegerischen Versorgung – ohne private Pflegeeinrichtungen möglich?', conference presentation, 10th anniversary of *Interessen-Gemeinschaft der privaten Altenpflegeeinrichtungen* [the interest organization of private providers of care homes for the elderly], 29 October, Kiel, Germany.
- Scottish Social Services Council (2015), *Scottish Social Service Sector: Report on 2014 workforce data*, SSSC, Dundee, UK.
- Skills for Care (2015), *The size and structure of the adult social care sector and workforce in England, 2015*, Leeds, UK.
- Social Protection Committee (2010), *A voluntary European quality framework for social services*, SPC/2010/10/8 final, Brussels.
- Social Protection Committee (2011), *Opinion of the social protection committee on: Reinvigorating the social OMC in the context of the Europe 2020 strategy*, 10405/11, Brussels.
- Social Protection Committee (2012), *Preparation of the 2012 National Social Reports (NSR)*, SPC/2012.2/4, Brussels.
- Social Protection Committee and European Commission (2014), *Adequate social protection for long-term care needs in an ageing society*, Publications Office of the European Union, Luxembourg.
- Staflinger, H. (2016), *Der öö. Mindestpflegepersonalschlüssel für Alten- und Pflegeheime auf dem Prüfstand: Grundlagen – Herausforderungen – Entwicklungsbedarf*, Chamber of Labour, Linz, Austria.
- Stolt, R., Blomqvist, P. and Winblad, U. (2011), 'Privatization of social services: Quality differences in Swedish elderly care', *Social Science & Medicine*, Vol. 72, No. 4, pp. 560–570.
- Szebehely, M. (2014), 'Vinstsyfte i äldreomsorgen', in Björkman, J., Fjæstad, B. and Alexius, S. (eds.), *Alla dessa marknader: Riksbankens Jubileumsfonds Årsbok 2014/2015*, Makadam Förlag, Gothenburg, Sweden, pp. 129–141.
- Technology Strategy Board (2013), *Analysis of UK long term care market*, Swindon, UK.

Theobald, H. (2012), 'Combining welfare mix and New Public Management: The case of long-term care insurance in Germany', *International Journal of Social Welfare*, Vol. 21, No. 1, pp. 561–574.

Swedish Association of Local Authorities and Regions (2011), *Från fattigvård till valfrihet: Utvecklingen av vård och omsorg om äldre*, Swedish Association of Local Authorities and Regions, Stockholm.

Times of Malta (2015), *Home contract ended over its 'poor service'*, 25 February.

WeDO (2012), *European quality framework for long-term care services – Principles and guidelines for the wellbeing and dignity of older people in need of care and assistance*, AGE Platform Europe, Brussels.

Weiss, C., Süderkamp, S. and Rothgang, H. (2014), 'Strukturelle Einflüsse auf die Pflegenoten: eine Analyse nach Anbietergröße, Trägerschaft und regionaler Lage', *Vierteljahreshefte für Wirtschaftsforschung*, Vol. 83, No. 4, pp. 87–105.

WHO (2004), *A glossary of terms for community health care and services for older persons*, World Health Organization, Geneva, Switzerland.

Vabø, M., Christensen, K., Jacobsen, F. and Trætteberg, H.D. (2013), 'Marketisation in Norwegian eldercare: preconditions, trends and resistance', in Meagher, G. and Szebehely, M. (eds.), *Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences*, Stockholm Studies in Social Work 30, Stockholm University.

Wittenberg, R., Sandhu, B. and Knapp, M. (2002), 'Funding long term care: the public and private options', in Mossialos, E., Dixon, A., Figueras, J. and Kutzin, J. (eds.), *Funding health care: Options for Europe*, Open University Press, Buckingham, UK, pp. 226–250.

World Bank (2010), *Long-term care policies for older populations in new EU Member States and Croatia: Challenges and opportunities*, Europe and Central Asia Region Human Development Department, Washington, USA.

Zorginspectie (2012), *Inspectieverslagen woonzorgcentra*, Departement Welzijn, Volksgezondheid en Gezin.





# Annex

## Table A1: Number of care homes by ownership type

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Types of care homes included and source
AT	Public							424								Old age and nursing homes. Ministry of Social Affairs (BMASK)
	For profit							215								
	Non-profit							223								
BE	Public									398						Old age and nursing homes. RIZIV/INAMI, quoted in Pacolet and De Coninck (2015)
	For profit									511						
	Non-profit									631						
CY	Public	40	43	40	40	46	44	44	47	44	44	44	44	44	44	Nursing homes – Social Welfare Services of the Ministry of Labour and Social Insurance
	Private	102	101	100		77	76	73	70	71	71	71				
	Public					376	358	350	360	355	360	360	357			
CZ	Private					87	94	103	106	116	120	131	143			Homes for older people – Ministry of Labour and Social Affairs
	Public	649	628	628	628	565	554	571	571	555	555	599	599			
	For profit	3364	3664	3664	4004	4004	4333	4679	5025	5025	5339	5339	5339			
DE	Non-profit	5157	5157	5431	5690	5690	5987	6319	6648	6648	6777	6777	6777			Care homes for older people. Federal Statistical Agency ( <i>Pflegestatistik</i> )
	Public												925			
	For profit												9			
DK	Non-profit															Independent residential care, nursing homes and residential care homes. Danish Board of Social Services
	Other														136	
															28	
EL	Public															Elderly Care Units. Ministry of Labour, Social Security and Social Solidarity. Department for Protection of the Elderly.
	For profit															
	Non-profit															
ES	Public					1178	1275	1310	1412	1456	1493	1475	1510			Care homes for older people. Spanish National Research Council – <i>Envejecimiento en red</i>
	Private					3661	3839	3793	3909	3936	3981	3863	3803			
	Other					228	195	175	167	107	59	52	27			
FR**	Public					3669	3669	3850	3850	3850	3850	3850	3850			Housing Facility for the Dependent Elderly ( <i>EHPAD non hospitaliers</i> ) and retirement homes ( <i>Maisons de retraite non EHPAD</i> ). DREES
	For profit					1709	1709	1785	1785	1785	1785	1785	1785			
	Non-profit					2283	2283	2451	2451	2451	2451	2451	2451			
HR	Public	46	46	46	46	47	47	46	46	45	45	45	45	45	45	Social welfare homes for elderly and infirm persons. Croatian Bureau of Statistics
	Private	48	57	62	66	74	76	82	79	82	84	83	83	83	83	
	Public															
IE	Public															Designated centres for older people. Health Information and Quality Authority
	For profit															
	Non-profit															

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Types of care homes included and source
LT	Public	61	62	63	63	64	62	60	58	57	52	53	52			Residential care for the elderly. National Statistical Office
	Private	30	30	32	35	35	36	42	41	45	48	53	56			
	Other	3	3	2	2	3	5	3	2	2	2	2	2			
LV	Public											86				NACE codes 87.1 and 87.3. Revised data from the Central Statistical Bureau
	Private											7				
MT	Public						12		15	15	14	14	15	15		Homes for older persons. Directorate for Health Information and Research
	Private						29		30	30	31	31	30	30		
NO	Public						915	912	912	917	909	895	892			Nursing homes and residential care. Statistics Norway
	For profit						46	47	46	43	42	41	41			
	Non-profit						33	34	31	33	37	41	40			
	Other						3	3	3	4	2	2	1			
PL***	Public	638	617	609	614	607	608	601	580	594	593	591				Social assistance houses (DPS).
	Private	206	213	203	245	206	242	216	208	202	213	213				Ministry of Family, Labour and Social Policy
	Non-profit							45	51	50	61	61				
RO	For profit							113	145	169	230	297				
	Public						81	98	95	108	103	105				Nursing homes, residential care. Ministry of Labour, National Statistics Institute
SI	Private						42	51	63	80	95	126	141			
	Public					74		60	60	59	59	59	59	59		Association of Social Institutions of Slovenia
SK	Private					14		34	34	39	39	39	39			
	Public			158	160	184	162	158	164	172	143	169	219			Homes for seniors ( <i>zariadenia pre seniorov</i> ). Central Register of Social Services Providers and National Statistical Office
UK (Scotland)	Private			50	54	37	62	64	72	71	128	131	267			
	Public	185	186	181	181	177	175	177	174	164	163	161	154	150		Care homes for older people. Scottish Care
	For profit	654	648	642	633	631	626	633	637	635	632	633	631	625		Homes Census and Care Inspectorate Registration List
Non-profit	155	152	152	143	141	143	138	132	121	121	117	117	117			

**Note:** \* The two public centres in Chania and Corfu are legal entities of public law created by the two local authorities. These centres are not reflected in official statistics, but they were identified in a telephone interview with the Department for Protection of the Elderly, Ministry of Labour.

\*\*Data on public housing facilities for the dependent elderly include EHPAD hospitals in order to compare with data from 2007

\*\*\*Data on for-profit (economic activity) and non-profit (statutory activity) provision correspond to establishments ensuring 24-hour care (*placówki zapewniające całodobową opiekę*). Since 2011 in the legislation and official statistics on chronic medical care homes and nursing homes no distinction is made between public and private establishments.

Table A2: Number of places in care homes by ownership type

	Public	For-profit	Non-profit	Private	Other	Date	Source
AT	35,525	14,352	24,993			2010	Ministry of Social Affairs (BMASK)
BE	42,298	46,926	54,537			2016	RIZIV/INAMI, quoted in Pacolet and De Coninck (2015)
CZ	26,344			10,298		2014	Ministry of Labour and Social Affairs
EL		5,823	6,192			2015	Ministry of Labour, Social Security and Social Solidarity
ES	97,145			260,566		2014	Spanish National Research Council – <i>Envejecimiento en red</i>
FR	234,760	121,860	191,780			2010	DREES (2014)
IE	6,656			22,342		2014	Nursing Homes Ireland Annual Private Nursing Home Survey
LT	2,755			2,060	470	2015	National Statistical Office
MT	2,699			2,538		2016	Directorate for Health Information and Research
NO	35,921	2,677	2,104		6	2011	Statistics Norway – The unit used in the national statistic is not beds but plasser, meaning places or slots, i.e. patient capacity.
PL	64,918	9,330	2,093	14,092		2014	Ministry of Family, Labour and Social Policy
RO	7,019			5,601		2015	Ministry of Labour, National Statistics Institute (INSSE)
SI	15,375			4,849		2016	Association of Social Institutions of Slovenia
SK	9,022			4,015		2013	Central Register of Social Services Providers
UK (Scotland)	4,474	30,017	3,673			2015	Number of registered places for older people. Scottish Care Homes Census and Care Inspectorate Registration List

Table A3: Number of service users by ownership type (most recent year)

	Public	For profit	Non-profit	Private	Other	Year	Data include
EL		5,115	5,426			2015	
DE	44,404	285,781	461,353			2013	
CY	510			791		2014	
LT	2,593			1,952	467	2015	
FR	292,609	108,087	153,618			2011	Residents over 65 in EHPADs
RO	5,892			4,657		2014	
FI	29,518			18,771		2014	Residents in 24-hour sheltered housing ( <i>tehostettu palveluasuminen</i> ) and residential homes ( <i>vanhainkodit</i> )
HU	43,497			26,938		2013	Residents in long-term residential social institutions ( <i>tartós elhelyezést nyújtó intézmények</i> )
HR	13,725			5,066		2014	Residents in social welfare homes for older and infirm persons
PL	63,976	6,754	1,760	13,765		2014	
SE	70,800			17,103		2015	Residents in special/sheltered housing ( <i>särskilt boende</i> )
UK (Scotland)	3,373	24,920	3,254			2015	Long-stay residents (older people)



With people living longer, the need for affordable care of high quality to support Europe's population increases. Over the last ten years there has been an expansion of the private sector in terms of the number of care homes and the places they provide. This increase takes place in a context of decrease or very slow growth in the services provided in public care homes. This report examines services in the public and private sectors, how they differ in the services they provide in terms of the quality, accessibility and efficiency of services. As private provision increases, costs to users are likely to become a more significant barrier issue unless there is an increase in public benefits to subsidise use. There are also some differences in the location of different types of care homes, with private care homes more likely to be found in affluent urban areas. Differences in the types of residents are influenced by the profitability of the services they require.

---

**The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency, whose role is to provide knowledge in the area of social, employment and work-related policies. Eurofound was established in 1975 by Council Regulation (EEC) No. 1365/75, to contribute to the planning and design of better living and working conditions in Europe.**