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The Politics of Long-Term Care in Southern Europe: A Cross-Case Comparison of Spain, Italy and Portugal

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EXECUTIVE SUMMARY

Long-term care (LTC) has emerged as one of the most politically revealing domains of European welfare states. Positioned at the intersection of social and health policy, the sector lies at the centre of broader social and demographic pressures affecting population health, care needs, and social protection. The growing share of older people is only part of the story. The increasing labour market participation of women, alongside the rising prevalence of chronic conditions and multimorbidity, has reinforced the centrality of LTC both as a policy challenge and as a field of scholarly inquiry. What explains the formulation and outcomes of LTC reforms? How do political and social actors position themselves on this issue, and how does this positioning shape reform outcomes? While sociological and institutional research on LTC has expanded rapidly in recent years, political science research has remained comparatively undertheorised. This dissertation addresses the gap in the analysis of political dynamics in the LTC sector by examining how configurations of power and ideational resources – in interaction with institutional and contextual factors— among social and political actors shape policy development across national contexts. By challenging dominant political science explanations of welfare state development, the dissertation investigates the evolving configurations of politics in three Southern European countries. In doing so, it not only provides a novel interpretative framework for understanding political dynamics in the LTC field, but also offers broader analytical leverage with potential for inference beyond the cases examined, extending to other national contexts and social policy domains. Overall, the study contributes to the long-standing debate on the trajectories and distinctive features of the Southern European welfare state.

Focusing on Southern Europe, this dissertation asks why, under comparable demographic pressures and similar policy legacies, Spain, Portugal, and Italy have nonetheless followed divergent institutional trajectories in the reform of LTC. The central claim is that LTC reform is driven less by gradual, path-dependent institutional change than by strategic political exchange: contingent bargains between governments and organised actors that convert temporary windows of opportunity into moments of reform, each shaped by specific coalitional alignments and negotiation dynamics. The formation—and subsequent interaction, convergence, or conflict—of competing coalitions ultimately determines reform outcomes. These three trajectories yield three analytical payoffs. Policy change emerges from a negotiated compromise that reflects the balance among competing interests: Partisan politics continues to matter, but its role is conditional and mediated by coalition-building dynamics. Political actors pursue reform not primarily as an expression of ideological preferences, but insofar as partisan strategies are instrumental to assembling viable coalitions and securing specific policy outcomes.

This argument builds on the limitations of dominant theoretical explanations. Functionalist accounts identify ageing, increased longevity, and women's labour market participation as powerful problem pressures, but cannot explain divergence across otherwise similar contexts. Historical institutionalism highlights path dependence—such as the legacy of cash benefits, multi-level veto points, and

entrenched provider networks—yet tends to understate agency and the timing of change. Actor-centred and ideational approaches add important nuance but encounter difficulties in a sector where beneficiaries are politically weak, public salience is low, and policy frames are selectively mobilised. A political-exchange perspective integrates these insights. Preferences are elastic; coalitions are constructed rather than given; and reform becomes possible when heterogeneous actors accept compensatory compromises that diffuse costs while distributing visible benefits within already established institutional boundaries.

Three policy features make this mechanism particularly consequential in the case of LTC.

First, low mass salience. The principal beneficiaries—frail older adults and informal caregivers—have limited capacity for collective mobilisation and weak agenda-setting power, making ambitious reform electorally unrewarding when pursued in isolation. Moreover, the risk of care dependency cuts across heterogeneous social groups and income classes, hindering the formation of cohesive and coordinated constituencies. At the same time, the LTC sector includes a dense landscape of well-organised social and economic actors—both for-profit and non-profit providers, professional associations and medical orders, mutual organisations, and health insurance funds. As a result, the composition and alignment of organised demand become central to understanding political dynamics and explaining policy outcomes.

Second, high policy complexity. LTC spans the boundaries between health and social care, requires extensive multi-level coordination, and involves matching highly differentiated needs with a combination of cash benefits and service-based instruments. This complexity generates a dense web of overlapping interests and institutional stakes. Actors must therefore deploy differentiated strategies to protect or expand their areas of influence, while operating within existing institutional rules and governance arrangements. Reform in this field rarely entails the introduction of entirely new policy instruments (as in the case of minimum income schemes). Rather, changes tend to be layered onto pre-existing institutional pillars—most notably disability, invalidity, and pension programmes.

Third, fragmented interests, a feature closely connected to the previous two characteristics. The analysis points to the presence of at least three dominant coalitional orientations in the LTC sector: (i) actors supporting the expansion of the public sector; (ii) actors favouring market expansion and private provision; and (iii) familist-conservative actors. These coalitions reflect distinct policy logics. The first emphasises the expansion of public provision, regulatory capacity, and the professionalisation of care. The second promotes outsourcing, accreditation mechanisms, and plural or competitive provision. The third prioritises cash benefits, user autonomy and flexibility of choice, as well as solutions that reinforce the role of families, informal caregivers, and home-based care. In such a context, governments tend to minimise political risk by brokering hybrid policy packages. These typically combine cash transfers and services, encourage plural provision under relatively weak national standards, and provide partial recognition—often symbolic as much as material—of caregiving roles.

The comparative analysis of Spain, Italy, and Portugal from 1980 to 2024 traces how broadly similar structural pressures were filtered through distinct institutional legacies and political compromises. In Spain, the 2006 *Ley de Dependencia* crystallised at a critical juncture in which a cohesive pro-reform coalition—comprising the PSOE, major trade unions, disability and caregiver organisations, and some Autonomous Communities—successfully reframed care dependency as a universal social right, explicitly articulated as the “fourth pillar” of the welfare state. Passage of the reform, however, rested on a series of compensatory bargains. Regional governments secured shared governance arrangements and wide discretionary authority through the *Consejo Territorial*, while market actors obtained access to pluralistic provision and a cash-for-services benefit conditional on the purchase of care on the market—a solution also supported by trade unions insofar as it aligned with the goal of professionalising the long-term care sector. This articulated institutional structure proved resilient in the face of subsequent shocks, including the economic and financial crises of 2008 and 2011-2012 and, later, the COVID-19 pandemic. Beyond fluctuations in service provision—largely driven by fiscal retrenchment during the austerity period—the recognition of an enforceable subjective right generated a new constellation of interests committed to defending long-term care as a distinct policy domain, institutionally separated from pension policy and from schemes linked to disability or work-related injury.

In Italy, the long-standing *Indennità di accompagnamento* entrenched an invalidity-centred policy frame and sustained a powerful distributive constituency, channelling reform dynamics towards gradualism and incremental adjustment rather than genuine path departure. The COVID-19 crisis, combined with the conditionality of the EU’s Recovery and Resilience Facility, briefly opened a window of opportunity. Under the Draghi government, an unusually broad advocacy coalition—the *Patto per un Nuovo Welfare sulla non autosufficienza*—succeeded in raising political salience, providing a technically coherent reform blueprint, and securing the adoption of Delegated Law 33/2023, which formally established a national long-term care framework. This process unfolded within a distinctive socio-political configuration, analysed in detail in Chapter 6, in which the *Patto* interacted not only with the ministerial *apparatuses* of the Ministry of Labour and Social Policies and the Ministry of Health, but also with three *ad hoc* ministerial commissions explicitly mandated to address non-self-sufficiency. The alternation to the Meloni government in 2022, however, re-politicised the agenda and reshaped policy formulation: subsequent decrees narrowed the scope of the reform, recentring familist and cash-first logics. The resulting outcome was a selective expansion that preserved the universalism of cash transfers while largely reaffirming the familistic organisation of long-term care, introducing no substantial change to service provision. Although the policy architecture was formally codified, financing and service expansion remain limited, with territorially fragmented delivery and continued reliance on household-managed care.

In Portugal, the *Rede Nacional de Cuidados Continuados Integrados* (RNCCI, 2006) followed an alternative trajectory. A negotiated compromise among policy experts, professional groups (scientific societies), and sectoral trade unions representing physicians, nurses, and social workers led to the

gradual institutionalisation of an integrated health-social care system addressing non-self-sufficiency. Reform rested on a corporatist bargain in which hospitals and medical hierarchies retained clinical primacy, while *Misericórdias* and other *Instituições Particulares de Solidariedade Social* secured long-term contractual arrangements and stable tariffs. Government alternation affected the pace but not the direction of reform, as subsequent expansions—into palliative, paediatric, and mental-health long-term care—proceeded through programmatic layering within existing networks. Universal entitlements did not emerge, and responsibility for care remained structurally embedded within families. In the absence of new individual rights or dedicated funding streams, coordination efforts reflected a form of corporatist pluralism: the state steered and co-financed the system while delegating provision, thereby achieving incremental gains in governance capacity without inducing systemic de-familialisation. As in the other cases, the configuration of socio-political demand and its interaction with governing parties proves central to explaining this trajectory.

The empirical findings lead to the formulation of three theoretically grounded reflections supported by empirical evidence. These reflections underpin the main inference of the thesis and generate analytical propositions that are applicable to other policy areas and institutional contexts.

First, ideas matter through coalitions rather than in isolation. Policy ideas operate as coalition-building devices: they function as cognitive and normative “magnets” that enable actors to converge around shared problem definitions and, subsequently, around acceptable modes of policy design. In this sense, ideas can represent both a source of policy opportunity and a binding constraint, particularly when they are misaligned across actors or crystallise into narrow micro-constituencies that delimit the boundaries of feasible reform. From this perspective, puzzling is not only the process of generating ideas, solutions, and proposals, but also a strategic resource for mediating powering: ideas are used strategically to build, stabilise, and transform coalitions in order to achieve a desired reform outcome.

Second, the strategic activation of political cleavages aligns ideas with interests within a given institutional context. Cleavages such as state-family, state-market, state-church, or centre-periphery are selectively mobilised by actors to reorient political strategies and assemble coalitions that extend beyond ideational affinity alone. Framing processes can broaden political support, but not without cost: they typically entail concessions to familist, market-based, or territorial actors, which in turn leave a durable imprint on policy design. From this perspective, powering provides the key lens through which to interpret conflicts among actors. Power relations are shaped both by the “rules of the game” —that is, political institutions—and by the distribution of interests that predate the reform process.

Third, reform outcomes are shaped by partisan configurations, notably the party in office and the composition of parliament, especially in contexts characterised by a divided left and, where present, high levels of party-system polarisation. Partisan dynamics play a decisive role not only in conditioning the strategies of socio-political demand but also in shaping the ideational repertoire underpinning reform, thereby redefining the boundaries of what is politically feasible. The interaction between these

two mechanisms—puzzling and powering—defines the scope of possible strategic exchange. It is this interaction that ultimately explains reform outcomes.

Two implications follow. Explanatory: similar functional pressures may generate divergent outcomes because coalitions differ in their internal cohesion, resource endowments, and in the range of concessions that governments are able to negotiate. Predictive: reforms are most likely when executives are able to (i) assemble minimally sufficient hybrid coalitions that align family-, market-, and public-oriented actors; (ii) construct a shared narrative of the policy problem that encourages political and social actors to converge around a common reform frame and to recognise compatible interests and incentives within that frame; and (iii) a strong and loud organized social demand can strategically influence political competition so as to politicize the issue, while at the same time ensuring the governability of the decision-making process. In the absence of these conditions, policy change is more likely to occur through layering rather than substitution, and through incremental adjustment rather than path departure.

Methodologically, the research combines policy analysis with comparative historical analysis and process tracing. Policy analysis is employed to identify the key analytical dimensions specific to long-term care policy. Comparative historical analysis focuses on the period from 1980 onwards—and, where relevant, earlier phases—to reconstruct institutional constraints and reform opportunities within distinct socio-political contexts, understood as the “rules of the game.” Process tracing is applied to the major structural reforms of the sector in the three Southern European cases—Spain (2006), Portugal (2006), and Italy (2023-2024). Evidence is triangulated from parliamentary and policy documents, administrative records, media archives, stakeholder materials, and sixty-one elite interviews conducted between 2023 and 2025.

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“There’s room at the top, they are telling you still.” (J. Lennon in Working Class Hero)

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LIST OF ABBREVIATIONS

ADL: Activities of Daily Living

AGENAS: Agenzia Nazionale per i Servizi Sanitari Regionali

ADI: Assistenza Domiciliare Integrata (IT) / Apoio Domiciliario ao Idoso

A-IV-RE: Azione - Italia Viva - Renew Europe

ATS: Aziende per la Tutela della Salute

AVS: Alleanza Verdi e Sinistra

BE: Bloco de Esquerda

CC.AA.: Comunidades Autónomas

CC.OO: Comisiones Obreras

CDS-PP: Centro Democrático e Social - Partido Popular

CEOE: Confederación Española de Organizaciones Empresariales

CEOMA: Confederación Española de Organizaciones de Mayores

CEPYME: Confederación Española de la Pequeña y Mediana Empresa

CERMI: Comité Español de Representantes de Personas con Discapacidad

CIPA: Cabina di Regia per l'Invecchiamento Attivo e la Non Autosufficienza

CiU: Convergència i Unió

CISL: Confederazione Italiana Sindacati Lavoratori

CISAAD: Consejo Interterritorial del Sistema para la Autonomía y Atención a la Dependencia

COCEMFE: Confederación Española de Personas con Discapacidad Física y Orgánica

CPO: Causal Process Observation

DC: Democrazia Cristiana

DPCM: Decreto del Presidente del Consiglio dei Ministri

EE.LL.: Entes Locales

EMU: Economic and Monetary Union

ERC: Esquerra Republicana de Catalunya

FDI: Fratelli d'Italia

FEAPS: Confederación Española de Organizaciones en favor de las Personas con Discapacidad Intelectual o del Desarrollo

FI: Forza Italia

FNA: Fondo per le Non Autosufficienze

FNAM: Federação Nacional dos Médicos

FNPS: Fondo Nazionale per le Politiche Sociali

FNSE: Federação Nacional de Solidariedade e Educação

FNP CISL: Federazione Nazionale Pensionati CISL

GALI: Global Activity Limitation Indicator

HCP: Home Care Premium

IADL: Instrumental Activities of Daily Living

ICV: Iniciativa per Catalunya Verds

IdA: Indennità di accompagnamento

ILO: International Labour Organization

IMSERSO: Instituto de Mayores y Servicios Sociales

INPS: Istituto Nazionale della Previdenza Sociale

INSERSO: Instituto Nacional de Servicios Sociales

ISTAT: Istituto Nazionale di Statistica

IU: Izquierda Unida

LAPAD: Ley de Autonomía Personal y Atención a la Dependencia

LEA: Livelli Essenziali di Assistenza

LEPS: Livelli Essenziali delle Prestazioni Sociali

LTC: Long-Term Care

M5S: Movimento 5 Stelle

NGO: Non-Governmental Organization

NNA: Network Non Autosufficienza

OE: Ordem dos Enfermeiros

OECD: Organisation for Economic Co-operation and Development

OM: Ordem dos Médicos

PAI: Piano Assistenziale Individualizzato

PCM: Presidenza del Consiglio dei Ministri

PD: Partito Democratico

PD-IDP: Partito Democratico - Italia Democratica e Progressista

PEAP: Prestación Económica para Asistencia Personal

PECEF: Prestación Económica para Cuidados en el Entorno Familiar

PEVS: Prestación Económica Vinculada al Servicio

PF: Partido Popular

PIA: Programa Individual de Atención

PNNA: Piano Nazionale Non Autosufficienza

PNV: Partido Nacionalista Vasco

PP: Partido Popular

PRT: Power Resource Theories

PS: Partido Socialista

PSC: Partit dels Socialistes de Catalunya

PSOE: Partido Socialista Obrero Español

PSD: Partido Social Democrata

PUA: Punto Unico di Accesso

RNCC: Rede Nacional de Cuidados Continuados

RSA: Residenze Sanitarie Assistenziali

SAAD: Sistema para la Autonomía y Atención a la Dependencia

SAD: Servizio di Assistenza Domiciliare (IT) / Serviço de Apoio Domiciliário (PT)

SEGG: Sociedad Española de Geriatria y Gerontología

SIM: Sindicato Independente dos Médicos

SNAA: Sistema Nazionale per la Popolazione Anziana Non Autosufficiente

SNS: Serviço Nacional de Saúde

SPI CGIL: Sindacato Pensionati Italiani CGIL

SSN: Servizio Sanitario Nazionale

SVP-PATT: Südtiroler Volkspartei - Partito Autonomista Trentino Tirolese

UAI: Unidade de Avaliação Integrada

UDP: Unión Democrática de Pensionistas y Jubilados de España

UCD: Unión de Centro Democrático

UGT: Unión General de Trabajadores

UIL: Unione Italiana del Lavoro

UILP: Unione Italiana del Lavoro Pensionati

UMP: União das Misericórdias Portuguesas

UVM: Unità di Valutazione Multidimensionale

UVG: Unità di Valutazione Geriatrica

VAMNA: Valutazione Multidimensionale della Non Autosufficienza

VNB: Valutazione Nazionale di Base

VoC: Varieties of Capitalism

WHO: World Health Organization

Chapter 1. The Politics of LTC in Southern Europe: An Introduction

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1. Introduction

While the “new social risks” literature has highlighted the growing centrality of need-based programmes within post-industrial systems of social protection, the politics of LTC remains comparatively under-theorised (Ranci & Pavolini, 2015; Maino, 2024). Caution is therefore warranted when directly applying analytical frameworks developed for core welfare programmes—such as pensions or healthcare—to the field of LTC. By design, LTC occupies a hybrid position between universalistic healthcare and residual social assistance. Across countries, it combines universal potential coverage with selective access rules, including needs-based eligibility assessments, means-tested co-payments linked to household resources, and, in some cases, mandatory social insurance financing (as in Germany, Japan, South Korea, and Luxembourg).

Its primary constituency—non-self-sufficient older adults and their families—generates structurally cross-pressured demands, fragmenting preferences between cash and service provision and between public, private, and family-based forms of care. This complexity gives rise to at least two analytical implications.

First, electoral coalitions in LTC are weakly predictable and highly context-specific. Support for reform depends less on traditional class-based cleavages than on the interaction between family norms, gendered care arrangements, and territorial configurations—dynamics that partly resemble, though in distinct ways, the politics of childcare. Although both LTC and childcare target population groups that are often inactive in the labour market, older adults in need of care frequently possess contributory histories that ensure a degree of economic security. By contrast, their family caregivers—children, sons- or daughters-in-law, other relatives, or close acquaintances—are typically middle-aged and economically active, as they remain embedded in the labour market. This asymmetry contributes to ambivalent political demands and complicates the formation of stable, mass-based reform coalitions.

Second, depending on the political-institutional context, the configuration of relevant actors varies substantially. The intrinsic complexity of LTC policy tends to involve a wide and heterogeneous set of

institutional and non-institutional actors, including civil society organisations, professional and scientific associations, trade unions, service providers, and other stakeholders. As a result, policy negotiation is expected to unfold through processes of exchange and bargaining, shaped by institutional and fiscal constraints that may operate either as opportunities or as binding limits, depending on the broader socio-political context.

Building on these two considerations, this dissertation contends that purely functionalist explanations are insufficient to account for variation in LTC reform outcomes. Population ageing, the rise of chronic multi-morbidity, and the contraction of the pool of informal caregivers—partly driven by women’s increased participation in the labour market—have undoubtedly generated strong problem pressures. Yet such pressures, on their own, have not produced major reform. Nor has the presence of left-wing governments automatically translated into LTC expansion: even when aligned with broadly pro-welfare coalitions, long-term care has frequently remained marginal or absent from political agendas. Reflecting this puzzle, some scholars have argued that power resources theory offers limited explanatory leverage in this policy domain (Morel, 2007), instead emphasising state-region conflicts as more decisive drivers of reform dynamics (Theobald & Kern, 2011).

Ideational and cultural factors also warrant consideration. Processes of policy learning and diffusion—central to explaining the emergence of new frames in other welfare domains—have contributed to reshaping how LTC has been problematised, particularly by challenging entrenched cognitive frames around family responsibility and the role of the state. However, their explanatory reach remains limited. When applied to LTC, ideational approaches alone struggle to account for divergent policy trajectories, as the politics of care is shaped by the interaction of multiple forces: deeply embedded institutional legacies, the mobilisation of organised actors, fiscal constraints, and strategic coalition-building. While learning and diffusion processes help illuminate important discursive shifts, they cannot by themselves explain why some countries experienced path departure, whereas others remained locked into inertia or adopted only selective forms of expansion.

Even state-region explanations, however, prove insufficient when reforms are formulated primarily at the national level. As this thesis argues, what ultimately matters is the activation of deeper political and social cleavages—family-state, church-state, market-state, and urban-rural—which structure the formation of strategic coalitions around specific reform options. These coalitions reflect negotiated balances among political and societal actors’ interests, mediated by pre-existing institutional legacies and dominant cognitive frames. Accordingly, reform outcomes are best explained by jointly examining the organisation of demand—through stakeholder mobilisation, resource endowments, and ideational claims—and the configuration of supply, namely governing coalitions and party-system dynamics.

Finally, it is important to clarify the scope of the analysis. The thesis focuses on policy formulation rather than implementation, and thus prioritises actor interaction during the agenda-setting and decision-making phases. Within this analytical lens, both material resources and ideas emerge as crucial vehicles through which stakeholder preferences are translated into policy outputs. While long-term care

extends across the life course, the empirical focus is placed on older people, who constitute an emblematic site of distributive conflict—particularly in terms of intergenerational tensions—and represent both the fastest-growing segment of the population and a core electoral constituency, as well as the primary recipients of LTC programmes.

This introductory chapter is structured as follows. Sections 2 and 3 define the analytical and conceptual boundaries of long-term care and establish its relevance within the academic debate. Section 4 sets out the research questions, while Section 5 introduces the core argument of the dissertation. Section 6 presents the research design, including the methodology and case selection. Finally, Section 7 provides an overview of the structure of the thesis.

2. LTC: Concepts and Analytical Dimensions

Historically, LTC has emerged relatively late as a distinct domain within social policy, especially when compared to more established areas addressing traditional social risks such as work-related injuries, sickness, or maternity (Greve, 2018; Österle & Rothgang, 2021). For much of the 20th century, LTC needs were typically addressed through general healthcare or social assistance systems, without explicit recognition of LTC as a separate policy field (Ranci & Pavolini, 2015; Scheil-Adlung, 2015; Feng, 2019). Over the past few decades, however, this has changed: A growing number of countries—particularly in Europe but also globally—have implemented targeted LTC reforms, developed dedicated policy frameworks, and established institutional structures in response to the increasing care demands associated with aging populations and the rising prevalence of chronic conditions (Peng & Yeandle, 2017; Matus-López & Chaverri-Carvajal, 2021).

From a definitional standpoint, the World Health Organization (WHO, 2022a) adopts a broad and inclusive understanding of LTC. It defines LTC as a set of personal, social, and medical services designed to help individuals experiencing—or at risk of—a significant loss of intrinsic capacity due to illness, disability, or age-related decline. The overarching aim is to preserve functional ability in a manner consistent with fundamental rights and human dignity. This perspective emphasizes continuity of care across various stages of decline and settings, incorporating preventive, rehabilitative, and supportive functions. Crucially, it encompasses both informal care—provided by relatives, friends, or community members—and formal care delivered in homes, communities, residential facilities, or hospitals. Complementing this view, the European Commission (2021) offers a more operational and service-oriented definition. It frames LTC as a system of services for individuals who, due to physical or mental frailty or disability, require sustained assistance with daily living or continuous nursing care. This includes medical and nursing support, personal assistance, and social services aimed at enabling independent living when possible, or ensuring appropriate care in residential settings when self-sufficiency is no longer viable (Barber et al., 2021).

To further clarify the scope of LTC, it is essential to define the concept of dependency more precisely. This involves differentiating among three interrelated but distinct conditions: Loss of autonomy, illness,

and disability (Kessler, 2010). Loss of autonomy refers to the inability to perform essential daily activities—such as dressing, eating, or walking—without external support. It is typically associated with chronic decline or advanced age. Illness denotes a temporary pathological condition requiring treatment, while disability implies a long-term reduction in physical or mental capacity, which may or may not result in the need for care.

Based on these distinctions, the need for LTC arises when individuals experience a substantial and often prolonged decline in functional capacity, necessitating external assistance. Such needs may be congenital, arise suddenly at any point in life, or develop progressively due to chronic illness, physical or cognitive impairment, or aging. Moreover, individual health trajectories are influenced not only by life-course factors but also by unpredictable events (e.g., accidents), as well as structural and environmental conditions—such as exposure to pollution or unequal access to healthcare infrastructure—which vary significantly across geographic contexts (see Table 1.1).

Table 1.1. The Risk of Long-Term Care: Dependent and Independent Variables.

Type of variable	Label	Description
Dependent Variable	<i>Risk of Dependence</i>	Probability or likelihood of requiring LTC services due to loss of autonomy, chronic illness, disability, or frailty.
Independent Variables	<i>Sociodemographic Factors</i>	Age (<i>i.e.</i> , older age increases risk).
		Gender (<i>i.e.</i> , women often have higher LTC needs due to longevity)
		Socioeconomic status (<i>i.e.</i> , low SES linked to poorer health outcomes).
	<i>Health Events</i>	Accidental health issues (<i>i.e.</i> , it can arise suddenly at any point in the life course).
		Gradual onset of illness, disability, or frailty (progressive development over time).
	<i>Territorial Context</i>	Environmental factors: High pollution (negative externalities).
		Spatial factors: Rural vs. urban areas (proximity to healthcare services, infrastructure access).

Source: Author's elaboration.

While disability and dependency are closely intertwined, they are not entirely synonymous. Disabilities—whether long-term or temporary—can manifest across the life course, whereas LTC is generally associated with chronic, often severe conditions that lead to enduring care needs. These needs may arise not only from behavioral or relational factors, but also from genetic predispositions and unforeseen life events beyond individual control (Kessler, 2010). As such, although it is difficult to predict in advance who will require LTC, it is broadly accepted that LTC primarily addresses persistent illness or disability, with varying levels of severity (Defever, 1991).

The assessment of individual care needs commonly relies on two standardized measures: Activities of Daily Living (ADLs), which refer to basic self-care functions such as mobility, feeding, dressing, personal hygiene, and continence (Edemekong et al., 2023), and Instrumental Activities of Daily Living (IADLs), which encompass more complex tasks including managing finances, handling transportation, meal preparation, household maintenance, communication, and medication management (Bleijenberg et al., 2017; Edemekong et al., 2023). These indices are instrumental in delineating the profiles of LTC recipients, facilitating the development of personalized care plans, and addressing the complex challenges associated with multimorbidity and chronic health conditions (Kane et al., 1998; Kaye et al., 2010).

As emphasized by Rogero García (2010), the evaluation of ADLs and IADLs enables not only the stratification of individuals into graded levels of dependency—ranging from moderate to severe and profound—but also the construction of functional clusters, which are crucial for care planning and the allocation of resources (Rogero García, 2010). Although these metrics are widely adopted for administrative assessments at the national and regional levels, they also intersect with critical theoretical debates. Some scholars argue that the term “dependency” carries medicalized and deficit-oriented connotations, and instead advocate for alternative frameworks such as “interdependence,” which better capture the relational and reciprocal nature of care (Fine & Glendinning, cited in Rogero García, 2010: 29). Nonetheless, the concept of dependency remains fundamental within socio-health and policy domains, as it effectively signifies the concrete need for assistance in everyday functioning.

Building on the preceding discussion, the literature identifies four main analytical categories for defining and characterising LTC policies: temporality, type of intervention, care setting, and type of provider. Together, these dimensions capture both the inherent complexity and the multidimensional nature of LTC measures. At the same time, they provide analytical leverage to distinguish long-term care from primary and secondary healthcare interventions, as well as from broader social support services aimed at facilitating daily living.

The first dimension is temporality, referring to the duration of care provision. LTC policies address sustained needs—typically lasting more than six months, or even lifelong, according to WHO definitions (Kirwin, 1988). As autonomy loss tends to increase with age, the likelihood of experiencing dependency is tightly linked to population aging and longevity—the latter not always being associated with improved health outcomes (Costa-Font et al., 2015; Costa-Font & Raut, 2022). Thus, extended longevity may entail a prolonged phase of dependency in later life.

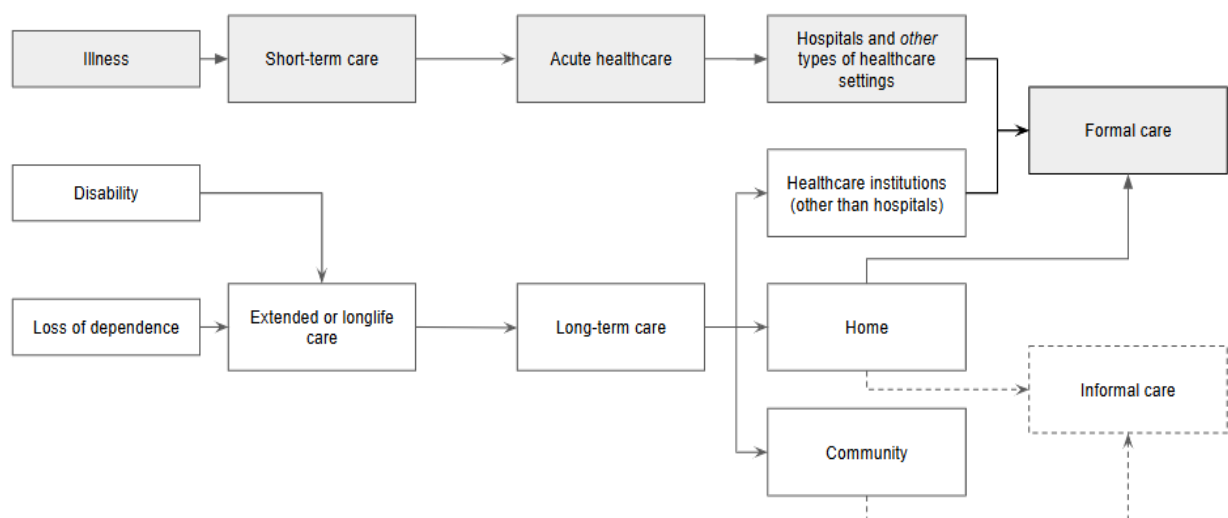
The second analytical dimension concerns the type of intervention. Here, the distinction lies between acute care—which involves short-term medical treatment—and long-term care, which encompasses ongoing assistance with daily functioning over an extended period (Kane et al., 1998). While both forms of care can coexist (as older adults often require both acute and chronic care), they differ in both temporal scope and content. LTC is embedded in the everyday lives of dependent individuals, extending beyond medical support to include personal, social, and household assistance (Norton, 2000).

The third dimension focuses on care settings, i.e., the physical and social environments where care is delivered (Morris et al., 1987). LTC may occur in private homes, hospitals, residential care facilities, or community settings. The level and type of need—such as difficulties with ADLs or IADLs—often determine the appropriate setting. Home-based care represents a non-institutional approach, while institutionalization implies relocation to care facilities (Colvez & Blanchet, 1981). Community-based care aims to integrate formal services with informal support networks, helping to preserve autonomy and social ties (Kodner & Spreeuwenberg, 2002). Although traditional debates have focused on institutional vs. non-institutional care, current scholarship increasingly emphasizes the value of community-based models, particularly in response to the growing population of the "old-old". With improvements in health and living conditions, the onset of terminal dependency has been delayed, and active life expectancy extended. Nonetheless, there has also been a rise in the duration and proportion of life spent in long-term hospital stays (Stout & Crawford, 1988; Siegler et al. 2015).

The fourth and final dimension concerns care providers. Beyond identifying specific actors, LTC provision can be classified into formal and informal categories. Informal care—typically provided by family members, spouses, neighbors, or members of civil or religious communities—continues to play a central role alongside formal, professional services delivered by health and social care personnel (Kane et al., 1998; Kaye et al., 2010).

Figure 1.1. summarizes the intersections of these four analytical dimensions, which together delineate the conceptual contours of long-term care policies. These categories will be examined in greater depth in the following section (§3).

Figure 1.1. Intersecting Analytical Dimensions in Explaining the Boundaries of LTC Policies.



Source: Author's elaboration.

3. Understanding LTC Policies: Core Objectives and Functions

The conceptual and analytical dimensions outlined above help clarify the objectives and functions of LTC measures within the broader and more complex landscape of LTC policy systems. As previously discussed, early literature on LTC focused predominantly on the healthcare-related aspects of care provision. Over time, however, a more nuanced and multifaceted understanding has emerged, particularly with the expansion of integrated health and social care services at the community level. Since the early 1990s, significant progress has been made toward the functional and territorial integration of services for older adults (Defever, 1991). As a result, a paradigmatic shift has occurred: Studies have shown that social support services—those which help individuals maintain routines, social relationships, and independent living—are often valued more highly by recipients than purely medical services (Derek et al., 1997). The evolution of LTC policy classifications has thus been strongly shaped by initial, sector-specific definitions that were heavily anchored in healthcare frameworks. In light of this, three primary objectives of LTC policies can be identified, each corresponding to different consequences of the loss of autonomy.

First, health maintenance and stabilization: LTC policies aim to manage chronic and often irreversible conditions that compromise an individual's ability to live independently. Second, social support and relief: These policies address the emotional, relational, and practical burdens that arise from long-term dependency, both for care recipients and their families. Third, income protection: LTC systems often include financial assistance for those unable to work, as well as for retirees who must allocate significant portions of their income to access necessary care services. These objectives are intrinsically linked to the long-term and often permanent nature of care needs. Unlike acute or rehabilitative interventions, LTC is characterized by prolonged support, typically extending beyond six months and, in many cases, lasting for the remainder of the individual's life.

While preventive measures—such as active aging strategies or primary and secondary healthcare prevention—are frequently considered within the broader continuum of care, they differ fundamentally from the core objectives of LTC. These measures target individuals who are not yet functionally impaired but may be at risk in the future. For this reason, they fall outside the immediate focus of the present analysis, which is concerned with individuals already experiencing long-term, sustained dependency.

The core objectives of LTC policies are summarized in Box 1.1.

Box 1.1. Long-Term Care: Core Policy Objectives

- **Ensuring health maintenance:** Alleviating or stabilizing the care recipient's chronic and irreversible health conditions, addressing long-term states of non-self-sufficiency, and ensuring ongoing medical or rehabilitative support where recovery is not feasible.
- **Ensuring social relief:** Addressing the social, relational, emotional, and practical consequences of long-term dependency, including assistance with daily living, reducing social isolation and supporting mobility.
- **Ensuring income protection:** Mitigating the risk of income reduction or loss resulting from an inability to work or from the need to purchase services on the care market.

In virtue of stated core objectives, LTC is structured around three main functions: Health-related alleviation/maintenance; social-related support and income protection. These functions are part of the broader framework of social protection and regulatory measures provided by the welfare state and extend not only to care recipients but, where relevant, also to informal family caregivers. The first two functions are indeed contextualized in the assessment and diagnosis of care needs—specifically and follows a multidimensional evaluation of individuals' conditions of dependency. As widely established in the literature, this assessment relies on standardized measures such as ADLs and IADLs, which capture levels of functional limitation.

The first function of LTC, maintenance and medical rehabilitation, includes a range of interventions and services aimed at preserving or enhancing individuals' physical and cognitive functioning. This encompasses not only direct medical treatment, but also rehabilitative care intended to delay or mitigate the progression of chronic conditions and promote greater autonomy. The second function, social relief and support, addresses the social implications of dependency that arise from the loss of autonomy. It includes services designed to ease the burdens of social isolation, caregiver stress, and economic hardship. In practice, these two dimensions—medical and social—frequently intersect within LTC provision. Effective systems strive to ensure continuity of care, that is, the coordinated and integrated delivery of medical and social services to provide consistent and holistic support for care recipients.

The first two core functions (*i.e.*, maintenance and medical rehabilitation; social relief and support) are mostly delivered through in-kind services: Institutional or residential care on one hand, and health, socio-health, and social services at home or through community-based care on the other.

Within institutionalized care, two primary forms can be distinguished: Hospital care and residential care. Hospital care is typically associated with acute care and is delivered in hospitals or clinical settings. It involves the diagnosis, treatment, and management of acute health episodes—such as

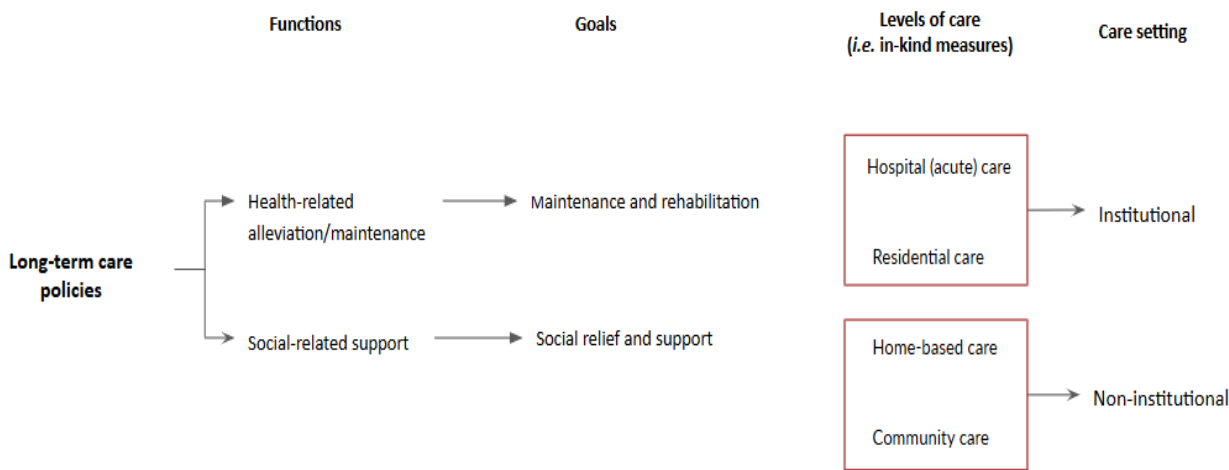
surgeries, emergency interventions, or complex diagnostics—aimed at rapid stabilization or cure. This level also includes long-stay hospitals, including psychiatric institutions. Clinical and policy literature consistently emphasizes that the hospital setting is oriented toward acute, rather than long-term, care—making it fundamentally distinct from LTC, which is concerned with sustained support for chronic conditions, functional impairments, and social participation.

Residential care refers to institutional environments offering continuous assistance to individuals unable to live independently due to age, disability, or chronic illness. This includes nursing homes that provide skilled care, intermediate care facilities for individuals with intellectual or developmental disabilities (increasingly referred to using person-centered terminology), and other residential settings such as board-and-care homes, which primarily offer non-medical assistance. By contrast, non-institutionalized care takes the form of home-based or community-based care. Home-based care is the principal setting for informal care, typically provided by family members or unpaid caregivers. It generally covers four main areas: (1) ADLs, such as bathing, eating, and toileting; (2) IADLs, including housekeeping, transportation, and managing finances; (3) emotional support and companionship; and (4) basic medical or nursing tasks, such as administering medications or operating medical equipment (Reinhard et al., 2012). Long-term care needs frequently extend beyond the care recipient to include their informal caregivers, who may themselves—especially if elderly or providing intensive care—face heightened risks of physical and mental health decline, social isolation, and economic precarity (Eurocarers, 2016; Bom et al., 2019; 2021; OECD, 2021, 2023).

Community-based care has gained increasing attention in recent years, particularly under the policy framework of “aging in place” (Lewis, 2020), which promotes interventions enabling older adults and individuals with functional limitations to remain in their homes and communities, thus avoiding or delaying institutionalization. Already in the 1990s, Nolan (1996) underscored the crucial role of services such as respite care, counseling, and caregiver training, which are essential for alleviating the strain on informal carers. Community-based care includes a wide range of predominantly social services delivered at the local level to promote independent living, enhance autonomy, and strengthen social networks (Maino & De Tommaso, 2021; Lodi et al. 2023). Examples include transportation assistance, personal care, homemaking services, information and referral programs, nutritional counseling, case management, outreach, chore services, and legal aid. As Siegler et al. (2015) emphasize, such care not only supports dependent individuals but also explicitly addresses the needs of their caregivers.

Accordingly, the four types of care identified—hospital care, residential care, home-based care, and community-based care—can be understood as four distinct levels of care that, across European contexts, are operationalized in concrete services (Figure 1.2.). As previously discussed, hospital and residential care represent institutionalized care, whereas home-based and community-based care fall within the broader category of non-institutional care, closely tied to the aging in place paradigm. This distinction reflects varying degrees of formalization in care provision and raises crucial questions about who provides LTC to older adults with functional limitations. In non-institutional settings, care is frequently delivered by informal caregivers, often without formal recognition or support.

Figure 1.2. Health and Social Functions of Long-Term Care.



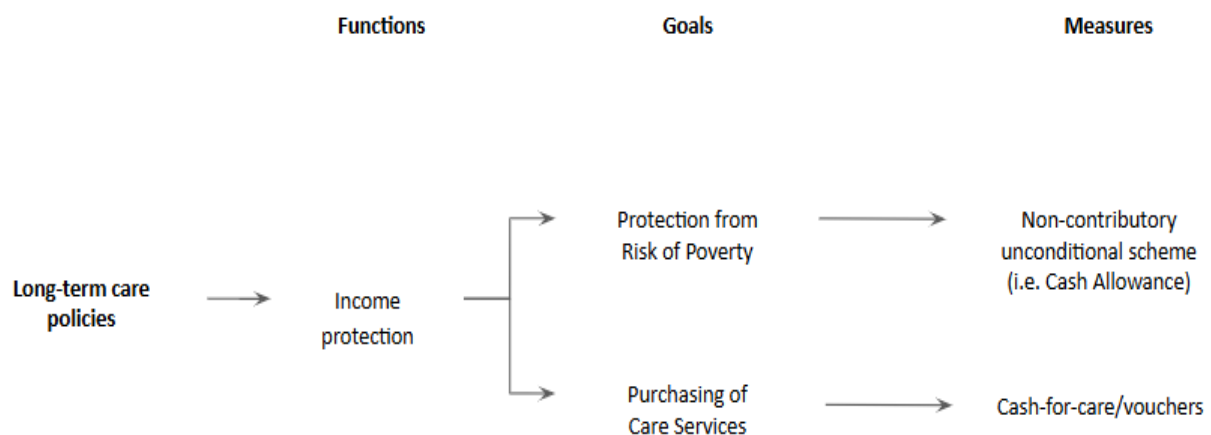
Source: Author’s elaboration.

With regard to care provision, and in order to capture its inherent complexity, it is useful to adopt a framework that crosses two analytical dimensions: Remuneration (paid versus unpaid) and degree of professionalisation (formal versus informal). Drawing on the typology proposed by the World Health Organization (WHO, 2022b), four main types of caregivers can be identified. The first category comprises paid, formal, and professional care workers, who are employed under formal contracts, receive wages and social protection benefits, and typically undergo vocational or professional training in care work. Unpaid, formal, volunteer, care providers who operate within formal organizational structures, often possess relevant training, but do not receive financial remuneration. Paid, informal, live-in carers or family members who provide care through informal or semi-formal arrangements with households or the state. They are usually compensated but may lack systematic training. Unpaid, informal caregivers, such as family members, friends, or neighbors, who offer unpaid assistance within personal relationships and generally have no formal training. Despite this, they play a central role in sustaining the everyday functioning and well-being of care recipients. This classification helps illustrate the diversity of caregiving arrangements and highlights the blurred boundaries between health, social, and family-based care.

In relation to the third core objective of LTC policies—income protection—two main functions can be distinguished (Figure 1.3.). First, income protection aims to prevent poverty among individuals who, due to non-self-sufficiency, experience a loss of earnings or reduced pension entitlements. Second, it seeks to support access to care services, particularly when individuals must rely on market-based provision due to insufficient informal support or inadequate public supply. The first function is typically fulfilled through non-contributory benefits, such as disability pensions or attendance allowances, which are not linked to prior employment history and are geared toward poverty alleviation. The second function, in contrast, involves demand-side financing mechanisms—such as *cash-for-care* schemes or care vouchers—that enable beneficiaries to purchase services in the formal care market. These

measures are intended to enhance choice, flexibility, and equity in access to care, while acknowledging the increasing financial burden associated with long-term dependency.

Figure 1.3. Income Protection Functions of Long-Term Care.



Source: Author's elaboration.

In summary, the preceding sections have outlined the conceptual structure of LTC systems by examining their core objectives, functions, operational levels, and organizational settings. It is important to emphasize that the distinction between objectives and functions, while analytically useful, is often blurred in practice. For instance, the provision of public services may simultaneously reduce poverty risk and serve an income protection function, depending on how care is financed and delivered. These overlapping dimensions underscore the complexity of LTC systems and highlight the interconnected nature of their policy instruments. Taken together, these elements provide a structured yet nuanced understanding of how LTC services are organized, delivered, and experienced—as well as the institutional configurations and actors involved in their implementation.

As outlined in the Introduction, this thesis focuses on long-term care measures directed towards the older population, according to the definitions adopted in each national context. Older adults are the primary beneficiaries of such measures and constitute the most salient case of intergenerational distributive conflict: On the one hand, due to their growing weight within the electorate of Western democracies; on the other, because of the significant implications their dependency entails for families who provide care.

4. Research Questions and Objectives

The research questions addressed in this study are both theoretically and empirically grounded. They arise from the difficulty of explaining why, in countries with broadly similar institutional and socio-political characteristics, LTC policies have followed markedly divergent trajectories, both in terms of institutional design and actor constellations.

Traditionally, LTC has been conceptualised as a residual and selective policy sector, marked by vertical and horizontal fragmentation, limited fiscal capacity, and a heavy reliance on the healthcare system (as will be further detailed in Chapter 2). In Southern European countries—taken here as the cases under study—this residual character was particularly evident: Until the early 2000s, these countries, together with Eastern European states, were the only ones lacking an integrated national legal and policy framework for LTC (see Section 5). Policy interventions rested on functional equivalents, such as healthcare and pension schemes, or, in the Italian case, on institutional pillars inherited from post-Second World War arrangements that addressed war invalids and the disabled. Yet, at the turn of the century, change began to emerge. In 2006, both Portugal and Spain introduced structural reforms in the LTC sector, though with distinct characteristics as it will be shown in Chapter 5 and 8, while in Italy the introduction of a national reform was repeatedly discussed between 2000 and 2019, only entering the political agenda in 2020 with outcomes significantly different from those envisaged at the outset of the policy process.

Analytically, the study of LTC policies in the twenty-first century is complicated by the fact that they did not emerge *ex novo*. Care dependency has long been recognised as an “old social risk,” and contemporary LTC interventions have largely developed through processes of layering upon pre-existing institutional arrangements. These arrangements were predominantly rooted in non-contributory social assistance schemes, the healthcare and social care sectors, and, finally, in programmes linked to work-related disability and occupational injury. In the absence of comprehensive national frameworks, subnational entities—such as regions in Italy and Spain or provinces in Portugal—had already developed relatively robust LTC systems. These institutional legacies constrained subsequent state intervention, while in Italy, a universal cash benefit at the national level had long been in place.

Consequently, the analytical interest lies less in the mere introduction of structural reforms than in the specific design of individual measures. As argued in Section 1, the overarching objectives of LTC policy are to protect individuals from excessive reliance on family care and from income loss resulting from dependency. The balance between these two functions—examined in detail in Chapter 2—lies at the core of governmental decision-making in the field of long-term care. Whether policymakers prioritise reducing dependence on the family or strengthening income protection shapes the direction of LTC reform, in interaction with the interests of organised actors in the social and healthcare sectors. From this perspective, an analytical puzzle emerges.

Contrary to what historical neo-institutionalism would predict, Spain’s 2006 reform represented a significant departure from the Southern European model. It established a more balanced mix between cash transfers and services, adopting a cognitive frame misaligned with the traditional “cash-heavy” and familistic configuration of Mediterranean welfare regimes. Italy and Portugal, by contrast, followed divergent trajectories—one reinforcing cash transfer, the other expanding service provision.

The thesis addresses the following research questions.

RQ1. How can LTC policies be conceptualised? This question seeks to clarify the analytical dimensions required to define and categorise different types of policy change in the field of LTC.

RQ2. How can departure from—or persistence of—a residual LTC policy be explained in contexts where strong particularistic interests and organised healthcare and social care actors would be expected to inhibit expansive reform? This question guides the analysis of substantive policy change across the three countries and seeks to identify the contextual and political factors shaping divergent reform trajectories.

The objectives of this research are threefold:

1. To trace and compare the trajectories of LTC policy development in Spain, Italy and Portugal.
2. To identify the constellation of actors and their preferences within the LTC field.
3. To reconstruct the political dynamics shaping policymaking processes and final reform outcomes.

The study makes both empirical and theoretical contributions. Empirically, it provides a comprehensive reconstruction of the LTC sector in Southern Europe over the past four decades (1980-2024) and an in-depth mapping of the constellation of actors and their preferences, achieved through the triangulation of multiple sources. Theoretically, it advances the literature by uncovering the political dynamics underpinning a policy domain that has been consistently overlooked in both academic research and political debate, thereby filling a significant gap in comparative welfare state scholarship. This dissertation argues that explaining such deviations requires moving beyond institutional stickiness alone and examining how coalitional dynamics, ideational framing, and partisan configurations interact with inherited institutional constraints.

5. Theoretical Argument and Hypothesis

The analytical framework underpinning this research rests on the assumption that policy change is a byproduct of political competition (Schumpeter, 1942). It foregrounds the concept of political exchange: Negotiated interactions between political actors—seeking electoral support—and organised social groups—seeking access to resources and institutional recognition—through which trajectories of social policy development are shaped (Stoppino, 2001; Ferrera, 2005; Natili, 2019). Within the wider literature on “new social risks,” the analysis acknowledges mounting pressures generated by demographic aging, rising life expectancy, the growing incidence of chronic multi-morbidity, the expansion of women’s labour market participation, and the weakening of family-based care arrangements. Functionalist accounts explain LTC expansion primarily in these terms—pointing to the rising share of older people (Hwalek et al., 2008), the decline in informal caregiving associated with female employment (Saraceno, 2008), and broader socio-demographic, economic, and cultural transformations (Ranci & Pavolini, 2013, 2015; Eggers et al., 2020). As Guillén and Álvarez (2004) and Lopes (2013) observe, these shifts are tied to changing household structures, gender roles, urbanisation,

and enduring norms of kinship obligation, all of which intensify unmet care needs. Yet such functional pressures, while necessary, are insufficient to account for reform. They are filtered through national institutions and political contexts, producing distinct diagnoses and divergent trajectories even under broadly similar socio-demographic conditions.

The Southern European experience illustrates the interplay between exogenous pressures and endogenous constraints. Since the early 1990s, the “Maastricht process” and the institutional requirements of the European Monetary Union imposed fiscal discipline and institutional recalibration, placing strain on the so-called “European Social Model” (Branco et al., 2024). At the same time, societal demands for in-kind eldercare and work-life balance grew, while globalisation and the post-Fordist transition weakened the traditional regulatory capacity of social democratic parties, pushing welfare programmes in a more market-oriented direction (*ibidem*). These pressures interacted with intra-left conflicts and the rise of a populist new left, creating new cleavages around LTC.

Historical institutionalism reminds us that welfare trajectories are embedded in long-standing structures. Familism, as the infrastructural logic of Southern European welfare states, represents a self-reinforcing path dependency. It has fostered the expansion of private services, the centrality of the family as caregiver, and significant administrative fragmentation, yielding a resilient but non-expansive model (Leitner, 2003). Reform must therefore confront entrenched social expectations and high costs of institutional change. Within this constrained environment, LTC politics is typically one of “low salience” (Bonoli, 2007): It attracts limited public attention, minimal ideological contestation, and rarely becomes a high-intensity issue outside moments of crisis (e.g., pandemics). In such contexts, decision-making is shaped less by electoral pressures than by technocratic negotiation, sectoral compromise, and the mobilisation of organised actors with resources, legitimacy, and technical know-how (Kingdon, 1984; Pierson, 2001).

Policy change in LTC thus depends not solely on functional necessity or ideological alignment but on the ability of collective actors to strategically mobilise and dominate coalitional dynamics. According to the political exchange perspective, reforms are the contingent outcome of negotiated bargains between governments and organised stakeholders—parties, unions (confederated and pensioners’), employer associations, NGOs, professional groups, and scientific communities. Reform trajectories are determined by which coalition prevails, how interests are aggregated or fragmented, and whether critical junctures can be converted into opportunities for institutional realignment.

Building on these insights, this thesis conceptualises reform strategies as the short-term policy orientations adopted by governments—whether favouring expansion or inertia—that both reflect immediate political bargains and shape longer-term institutional trajectories through processes of layering, transformation, or continuity. Within this framework, three ideal-typical logics of conflict can be identified.

The first concerns coalitions in which expansion-oriented actors prevail. In these cases, governments grant new entitlements, expand service provision, and promote the formalisation of care in exchange for political support and policy legitimacy.

The second configuration emerges when pro-market actors are influential, particularly under conditions of fiscal constraint. Governments respond through targeted retrenchment or selective expansion, introducing reforms that commodify care through vouchers, outsourcing, and co-financing mechanisms, while maintaining a degree of public regulation and oversight to preserve political legitimacy.

The third configuration arises when conservative, family-oriented actors dominate. Here, governments trade stability for consensus by preserving familialist arrangements, typically through low-conflict cash allowances, incremental adjustments, and the discursive framing of care as a moral responsibility of families.

The core hypothesis is that the formation of these coalitions is neither random nor predetermined. Rather, actors align strategically around specific reform outcomes. Such alignments emerge from the interaction between puzzling and powering: a process that combines the development of shared problem interpretations and policy solutions with strategic efforts to advance interests and reshape existing power relations. Ideas, in this perspective, do not merely reflect power structures but can contribute to their reconfiguration. The hypotheses are operationalised through causal-process observations, as detailed in Chapter 4, and provide the analytical foundation for the empirical analysis of LTC reform trajectories in Southern Europe.

6. Research Design, Methodology and Case Selection

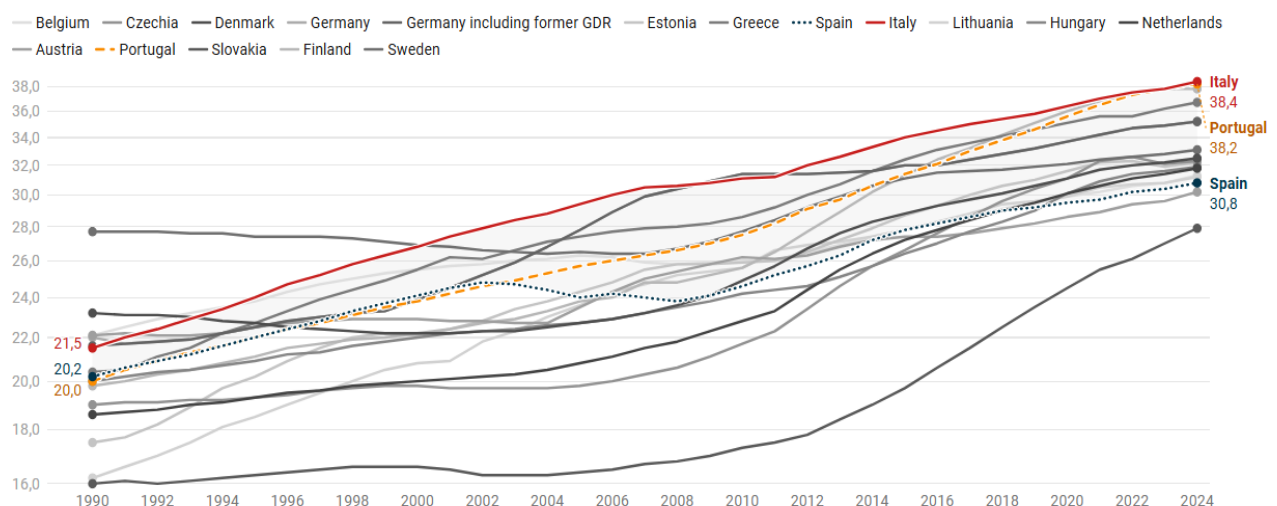
The research design is based on a most-similar systems comparative design. The comparative focus on Spain, Italy, and Portugal is not only justified by their classification within the Southern European welfare regime (Ferrera, 1996; Ferrera & Gualmini, 2004), but also by the ways in which their common structural legacies map directly onto the hypotheses advanced in this study. These countries share key features that make them ideal testing grounds for theorising LTC reform trajectories: Relatively underdeveloped welfare states marked by a persistent gap between statutory rights and effective implementation (Leibfried, 1992); the enduring centrality of the family as a welfare provider, with significant gendered implications (Saraceno, 1994; Moreno, 1996, 1997; Trifiletti, 1999); and a social culture deeply influenced by Catholic social doctrine, which has historically reinforced solidaristic yet familistic orientations (Castles, 1994, 1995; van Kersbergen, 1995). In all three cases, pensions and healthcare became the dominant welfare pillars, overprotecting old age while relegating family benefits and LTC to a residual position (Ferrera, 1993; 1996). These commonalities provide the structural background against which the three hypotheses—on inertia, path departure, and selective expansion—can be tested.

The political-institutional configuration of these systems further strengthens their comparability: Proportional representation, coalition governments, relatively strong trade unions, high

commodification of labour markets coupled with high familisation, and the relatively late introduction of National Health Systems (Italy in 1978, Portugal in 1979, Spain in 1986). Such similarities allow us to hold constant systemic variables while observing how political exchange and coalition dynamics account for divergent LTC reform trajectories. Historical legacies of authoritarian rule add a further explanatory layer. Italy (1922-1943), Spain (1936-1975), and Portugal (1933-1974) all experienced right-wing dictatorships that left enduring institutional imprints. Despite regime-specific differences, these authoritarian experiences fostered corporatist insurance systems, hindered the development of social assistance, and entrenched a familial model with rigid gender divisions of labour. As Ferrera (1996) underlines, such legacies also undermined administrative autonomy, weakened state capacity, and contributed to delayed economic modernisation.

Beyond cultural explanations—such as the role of family norms and the influence of the Catholic Church in shaping the development of social services—Italy, Spain, and Portugal also share significant similarities in terms of functional pressures and care regimes. With regard to the former, at the beginning of the 1990s all three countries exhibited comparable levels of population ageing, with the share of people aged 65 and over reaching 21.5% in Italy, 20.2% in Spain, and 20% in Portugal, and they have since followed a broadly similar trajectory over the past three decades (Eurostat dataset) (Figure 1.4.).

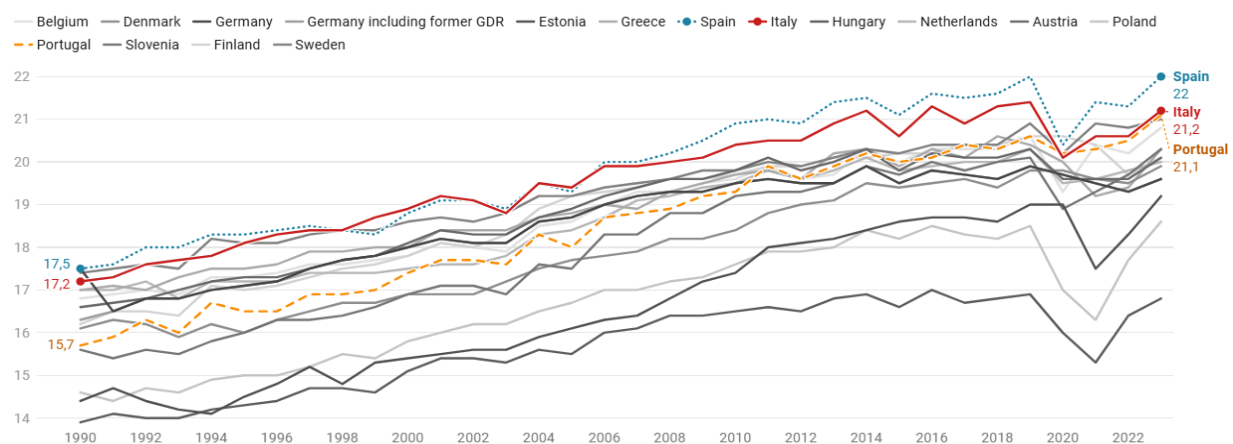
Figure 1.4. Ageing population in Europe, 1980-2024.



Source: Author's elaboration on Eurostat.

Longevity rates display a similarly convergent trend. In 1990, Spain (17.5%) and Italy (17.2%) were nearly identical, while Portugal recorded a slightly lower figure (15.7%), around 1.5 percentage points below its counterparts (Eurostat dataset) (Figure 1.5.). Nevertheless, all three countries were classified within the same cluster, underscoring their shared demographic profile.

Figure 1.5. Life expectancy at 65 y/o, 1990-2024.



Source: Author's elaboration on Eurostat.

Regarding care regime, Spain, Italy and Portugal are situated within the Mediterranean familialistic regime, a model that also encompasses Portugal and Greece (Camacho et al., 2009; Simonazzi, 2009; Haberkern & Szydlik, 2010; Bettio & Verashchagina, 2012). In this regime, families remain legally or implicitly responsible for supporting dependent older people, while public involvement has traditionally been limited. State intervention has largely taken the form of cash allowances rather than services, with formal LTC provision remaining comparatively modest.

In the early 2000s, coverage levels in Italy, Spain, and Portugal were strikingly low: Only 1.3% of older people in Italy and 1% in Spain received home care services, while 2% and 2.8% respectively lived in residential care. Portugal showed comparable levels, with residential coverage around 4% of those aged 65 and over and home care at a similar level (Haberkern & Szydlik, 2010). More recent data confirm that residential care coverage across these countries rarely exceeds 5%, while home care remains close to 4-5% (Bettio & Verashchagina, 2012). These data stand in stark contrast to Northern and Continental Europe, where coverage ranges from 14% in Austria to 21% in the Netherlands.

Reliance on informal care is particularly visible in situations of high dependency. In Spain, Italy and Portugal, over 60% of older adults rely exclusively on family members, compared to fewer than 30% in Northern and Continental Europe. This reliance reflects both cultural norms and legal obligations: Surveys in the early 2000s showed that only about one-fifth of respondents in Italy (21.1%) and Spain (22.9%) believed the state should be primarily responsible for eldercare (Haberkern & Szydlik, 2010). Caregiving is also strongly gendered: In Italy, daughters were more than twice as likely to provide care compared to the European average (odds ratio 2.09 gross; 1.59 net), while in Spain the probability was similarly elevated (1.79 gross; 1.26 net). Sons were far less involved, underscoring persistent gendered divisions of labour, confirmed also in Portugal.

Under demographic ageing, women's increased labour market participation, and the shrinking availability of informal caregivers, Spain, Italy and Portugal shifted toward what Bettio and

Verashchagina (2012) term the “migrant-in-the-family” model. In this configuration, families moved from being direct providers to acting as care managers, administering cash transfers and employing predominantly female migrant workers. In Italy, by 2005, around 200,000 migrants regularised through an amnesty were employed as domestic workers, many in eldercare. The overall eldercare workforce numbered approximately 934,000 in 2004, with irregular migrants forming a substantial share. Spain displayed a parallel pattern: In 2003, around 150,000 were employed in eldercare, while up to one-third of the market operated in the underground economy, heavily dependent on undocumented migrants.

These patterns illustrate the defining traits of the Southern European LTC regime: Limited formal coverage, strong cultural and legal obligations on families, persistent gendered divisions of care, and structural reliance on migrant labour. Familism has thus remained a core feature, albeit in a transformed form, shifting from direct family provision to hybrid arrangements in which households act as coordinators of care while increasingly outsourcing responsibilities to formal private providers, both for-profit and non-profit (Léon & Palomera, 2023).

Based on a comparative most-similar design system, this study combines policy analysis with process tracing. Policy analysis is employed to address the first research question by identifying the key analytical dimensions of LTC systems and classifying their policy trajectories, specifically assessing whether reforms have reproduced institutional inertia or constituted a departure from the established model. This analysis is grounded in a systematic literature review (Chapter 2), which initially screened 99 academic contributions and retained 21 for in-depth examination. It is further complemented by the analysis of policy documents and international datasets, including Eurostat, the OECD, MISSOC, and European Commission sources.

A comparative historical reconstruction and analysis was systematically applied over the period 1980-2024. Process tracing was conducted throughout the period of reforms, with a particular focus on the three key reforms that constitute the empirical core of this thesis: Spain and Portugal in 2006, and Italy in 2023-2024. This method enables the reconstruction of causal mechanisms linking actor strategies, institutional constraints, and reform outcomes. The conclusions place particular emphasis on the post-2006 period in Spain and Portugal, highlighting the evolution of reform implementation and adjustment. While the Italian reform (2020-2024) forms the empirical *nucleus* of the analysis, earlier developments (2007-2019) are also reconstructed to illuminate path-dependent specificities and contextualise the decision-making process. Following Mahoney (2012), causal-process observations are treated as diagnostic evidence within temporal sequences to assess the plausibility of the hypothesised causal mechanisms.

Evidence is triangulated from multiple qualitative sources, including parliamentary archives, electoral manifestos, press releases, stakeholder documents, and national and local newspapers. For each country, documentary material was collected for the periods preceding and corresponding to the main reform episodes (2000-2006 for Spain and Portugal; 2018-2024 for Italy). All primary and secondary

sources consulted are fully documented in the References section of this dissertation and are explicitly cited throughout the country-specific analytical chapters. In addition, sixty-one semi-structured interviews with policymakers, experts, and stakeholder representatives were conducted between 2023 and 2025 across the three countries. In Italy, participation in more than thirty formal and informal meetings during the policymaking process (2020-2024) provided direct access to political negotiations and decision-making dynamics. In Spain, the author attended the annual conference of the *Asociación Estatal de Directores y Gerentes de Servicios Sociales* in November 2024, which offered further insight into the perspectives of senior practitioners and policy actors in the long-term care sector.

While qualitative analysis offers depth and fine-grained causal reconstruction, it necessarily raises questions of external validity. The purpose of this research is not to construct a universal theory of LTC development but to explain the specific reform trajectories of Southern European countries, situating them within broader debates on the politics of care regimes. By doing so, the thesis contributes to refining our understanding of when and why inertia or path departure prevails. Table 1.2. summarizes *explananda*, case selection and methods per each RQs (Section 4).

Table 1.2. Research questions, Explananda, Case Selection and Methods.

Research Questions	Explananda	Case selection	Methods
RQ1	Y1: Policy dimensions	EU-27 countries	Policy analysis through systematic literature review
RQ2	Y2: Policy trajectory	Comparative most-similar-design system	Comparative historical analysis and process tracing

Source: Author's elaboration.

7. An Overview of the Work

The dissertation is structured as follows. The first part develops a comparative policy study aimed at constructing a typology capable of capturing the *explanandum*—namely, the policy trajectories of long-term care. This is based on a systematic literature review that identifies a set of analytical dimensions, which are then used to elaborate a policy typology situating the trajectories of Italy, Spain, and Portugal within the broader European landscape. Once these analytical dimensions are defined, Chapter 3 traces the foundational and institutional trajectories of the three countries between 1980 and 1999, comparing pre-2000 conditions and clarifying the divergence of later trajectories, net of variation in the explanans. Chapter 4 identifies the relevant explanans, providing a comprehensive review of the political science literature and the possible causal mechanisms underpinning reform. The argument developed here emphasises the interaction between socio-political demand and political supply, analysing the strategic exchanges between political and non-political actors and the ways in which competing claims are negotiated. Chapters 5, 6, and 7 examine the selected case studies in depth, offering detailed analyses of political exchange and empirical evidence of the causal mechanisms

underlying reform in Spain (*Ley de Dependencia*, 2006), Italy (*Legge Delega* 33/2023 and *Decreto Legislativo* 29/2024), and Portugal (*Decreto-Lei* 101/2006). The final part of the dissertation concludes by reflecting on the post-2006 trajectories of reform, especially in Spain and Portugal, and considers the broader implications for causal inference, both within Southern Europe and in relation to comparable social policy fields.

Chapter 2. Dimensions of Cross-National Variation: A Typology of LTC Policy

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1. Introduction

Over the last two decades, LTC has gained visibility as a distinct and increasingly urgent area of social policy in Europe. Driven by a combination of demographic, social, and economic transformations—including population aging, the feminization of both paid and unpaid care work, and shifts in family structures—European welfare states have faced growing pressure to provide sustainable, equitable, and effective responses to care needs. As the number of older people experiencing loss of autonomy rises steadily, and as traditional care arrangements based on family provision become less reliable, questions of how to organize, finance, and deliver long-term care have become more central to welfare state agendas.

Despite this growing importance, LTC remains one of the most institutionally fragmented and analytically underdeveloped areas in comparative welfare state research. Unlike more codified pillars such as pensions or healthcare, LTC is characterized by a hybrid architecture that crosses multiple policy sectors (social protection, health, housing, and labor), involves a wide range of actors (public, private, non-profit, and informal), and reflects deep territorial variation both within and between countries. The coexistence of formal services and informal provision, the combination of in-kind and in-cash support, and the diversity of governance arrangements contribute to making LTC a “hard case” for both classification and comparison (Ranci & Pavolini, 2015; Greve, 2017).

This chapter addresses that challenge by proposing a systematic framework for analyzing LTC policies across its dimensions of variation. The core assumption is that LTC policies can be meaningfully compared—and their trajectories of change understood—by identifying a set of key institutional

dimensions along which they differ. These dimensions do not aim to produce a rigid typology or to force convergence into ideal models. Rather, they are intended as analytical tools that make it possible to observe and interpret differences and changes in how European welfare states define entitlements, organize responsibilities, allocate resources, and structure care delivery.

The chapter builds on insights derived from a systematic literature review of comparative LTC research, with the goal of reconstructing how scholars have approached the analysis of change in this field. The review revealed that, while there is growing interest in LTC policy developments, empirical analyses often focus on single-country cases or specific instruments, without providing a common vocabulary or shared metrics for assessing reform patterns across contexts. To address this gap, the chapter identifies five core dimensions of policy variation that can serve as entry points for structured comparison. These dimensions have emerged as particularly salient in the literature for capturing both the institutional design of LTC policies and the directions of policy change.

Moving from the selected dimensions of variations—i.e., financing and coverage, eligibility criteria, instruments, governance, regulation of care provision—the chapter provides a comprehensive map of the institutional features through which LTC policies can be compared and analyzed. They also allow for the identification of patterns of change, such as the expansion of coverage, the decentralization of responsibilities, or the formalization of previously informal care arrangements. By applying this framework, the chapter offers both a descriptive account of how LTC systems vary and an interpretative lens for understanding the drivers and implications of reform processes.

In doing so, this chapter seeks to contribute to the expanding body of research that no longer treats LTC as a marginal or residual component of the welfare state, but rather as a key policy domain where broader tensions—between care and employment, public and private responsibility, formal and informal provision—are negotiated and reshaped. The chapter is structured as follows. Section 2 delves into the relationship between LTC and welfare state development more broadly, focusing in particular on the key dimensions of variation that shape national care arrangements and the different trajectories of change observed across Europe. Building on this analysis, Section 3 presents a typology of LTC policy that aims to classify and compare European countries according to their institutional features and configurations. Finally, Section 4 offers concluding reflections, summarizing the main findings.

2. LTC and the Welfare State: A Systematic Literature Review

Since the 1990s, a growing and increasingly sophisticated body of literature has sought to classify LTC policies through typologies that capture variations in institutional arrangements, financing models, and care practices. Early foundational contributions—such as those by Alber (1995), Anttonen & Sipilä (1996), and Bettio & Plantenga (2004)—proposed ideal-type models of social care, often merging childcare and eldercare within a unified analytical framework. While these approaches offered important insights, particularly from a gender-sensitive perspective, they were later criticized for

conflating distinct care logics and overlooking the specific institutional, demographic, and ethical challenges associated with LTC. In response, recent scholarship has called for LTC-specific frameworks that better reflect the singular nature of eldercare needs and governance structures (Ochiai, 2009; Fischer et al., 2021).

Building on this conceptual foundation, a second strand of research has emphasized the empirical construction of LTC typologies. Comparative studies by Pacolet et al. (1999), Pfau-Effinger (2005), and Pavolini & Ranci (2008) highlighted the increasing hybridization of care systems, resulting from trends such as commodification, informalization, and the proliferation of cash benefits. More recent contributions have used statistical techniques to identify regime types: For example, Kraus et al. (2010) and Halásková et al. (2017) used cluster analysis to classify systems by expenditure patterns and informal care reliance, while Damiani et al. (2011), through Multiple Factor Analysis, linked care infrastructure with population needs and spending. Among the most comprehensive efforts, Ariaans et al. (2021) conducted 24 cluster analyses across 25 OECD countries to develop a multidimensional typology based on institutional design, generosity, and quality. Similarly, Pavolini (2021), in a report for the European Commission, offered a comparative framework focusing on eligibility criteria, benefit types, service organization, and funding models.

A third and complementary research strand has explored the interaction between policy instruments, care practices, and actor configurations. Using mixed-method approaches, studies by Da Roit & Le Bihan (2010), Da Roit & Weicht (2013), and Colombo et al. (2011) have analyzed how instruments such as cash-for-care schemes, the increasing use of migrant labor, and the persistence of informal caregiving have reshaped care regimes in practice. These studies—drawing on qualitative comparative analysis, policy document reviews, and interviews—highlight the complex and often contradictory effects of LTC reforms. Related contributions by Bettio & Verashchagina (2012) and Camacho et al. (2008) have emphasized the gendered implications of care arrangements, focusing particularly on the growing reliance on female and migrant workers. Meanwhile, Lamura et al. (2008), Eggers (2023), and Fekete et al. (2022) have directed attention to care recipients' experiences, examining issues such as accessibility, user satisfaction, and subjective well-being. Finally, a more recent line of inquiry has begun to address the measurement and classification of LTC needs themselves. Tinios & Valvis (2023) proposed a unified metric of care intensity by combining ADL and GALI indicators, thereby enhancing cross-national comparability. Complementarily, van Damme et al. (2025) applied latent profile analysis to classify care regimes according to levels of defamilialization and institutional support.

The following sections present the results of the systematic literature review. Section 2.1 outlines the methods, selection criteria, and the set of articles included. Section 2.2, along with its subsections, discusses the dimensions of variation identified in the literature with respect to long-term care.

2.1. The Systematic Literature Review: Methods, Criteria and Selection

The expanding literature on LTC policy reform can be organized along two principal analytical dimensions: The methodological orientation of studies and the dependent variables they examine. From

a methodological perspective, contributions range from conceptual and theoretical frameworks (e.g., Alber, 1995; Fischer et al., 2021), to empirically grounded, cross-national analyses (e.g., Kraus et al., 2010; Ariaans et al., 2021), and practice-oriented studies that assess the real-world impacts of policy reforms (e.g., Colombo et al., 2011; Da Roit & Weicht, 2013).

Substantively, typologies vary depending on the dependent variable selected. These include:

1. Service provision and financing arrangements (e.g., Kraus et al., 2010; Halásková et al., 2017; Ariaans et al., 2021).
2. Care regime typologies and institutional trajectories (e.g., Pavolini & Ranci, 2008; Fischer et al., 2021).
3. User-level outcomes, such as access to services, satisfaction, and well-being (e.g., Lamura et al., 2008; Fekete et al., 2022).
4. Care needs and intensity, including indicators of dependency and functional limitations (e.g., Tinios & Valvis, 2023).
5. Care labour configurations, especially the division between formal and informal care work (e.g., Camacho et al., 2008; Da Roit & Weicht, 2013).

Despite this thematic diversity, the concept of policy change itself is inconsistently treated across the literature. Theoretical assumptions, methodological strategies, and data sources vary considerably, resulting in heterogeneous ways of defining and operationalizing change. In many cases, it remains unclear whether policy change is conceptualized as an institutional event (e.g., a legislative reform), a process (e.g., institutional reconfiguration), or an outcome (e.g., expansion of services or benefits). This lack of conceptual clarity and common measurement standards limits the comparability of findings and hinders cumulative knowledge development. This systematic literature review seeks to address that gap by examining how policy change is defined, conceptualized, and measured as a dependent variable in the LTC field. Specifically, it asks: How does the academic literature measure change in the field of long-term care?

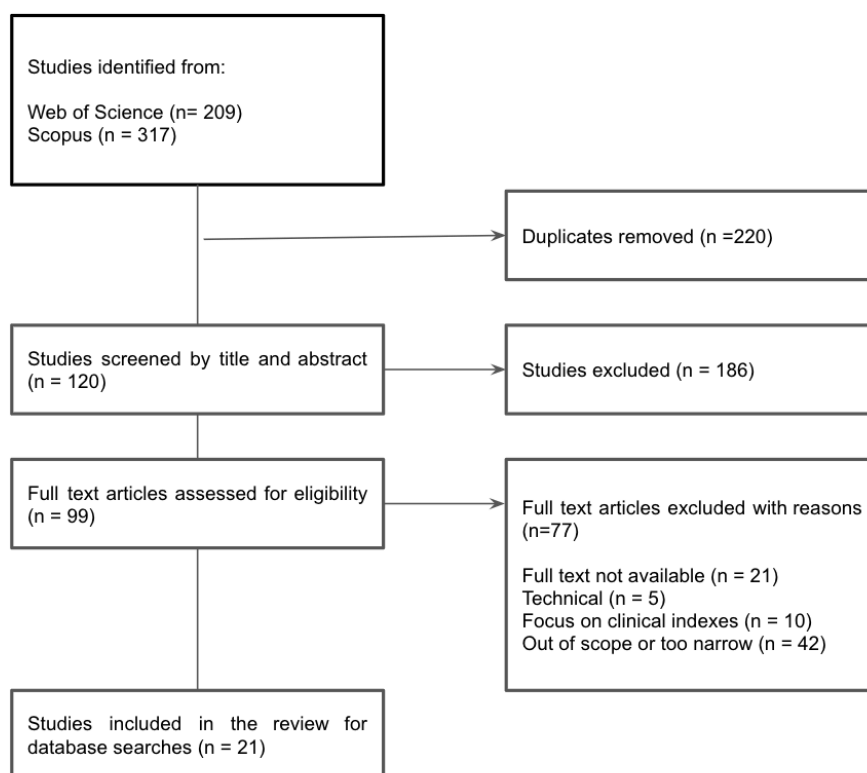
To answer this question, the review adopts a structured and transparent methodology. Inclusion criteria are: (i) peer-reviewed publications between 1995 and 2025; (ii) explicit focus on LTC policy change; (iii) change as a central analytical focus; (iv) studies published in English or Italian; and (v) studies focused on European or OECD contexts. Exclusion criteria include clinical or purely individual-level studies; non-methodological opinion pieces; and articles that mention policy change without providing a clear definition or method of assessment. The literature search has been conducted across major academic databases—Scopus and Web of Science—using a tailored search string that includes keywords related to LTC, policy reform, and measurement strategies¹. The search results were refined by applying

¹ Query for Scopus is: ("long-term care" OR "LTC") AND ("measurement" OR "indicator*" OR "conceptualization" OR "typology" OR "classification" OR "clustering") AND ("Europe" OR "European Union" OR "EU" OR "OECD" OR "high-income countries"). Query for Web of Science is: TS=("long-term care" OR LTC) AND TS=(measurement OR indicator*

filters for publication date (from 1990 onward), document type (peer-reviewed articles), language (English), and subject area (social sciences).

The study selection process occurred in two stages. First, titles and abstracts have been screened for eligibility. Second, full-text articles have been reviewed for final inclusion. Once the final sample had been established, data were extracted using a standardized template. Initially, 99 papers were selected; this set was subsequently narrowed to 21 in line with the study's objectives (see note 1). For each study, information has been collected on: Authorship, title, year, main contribution, national context (if applicable), and most importantly, how policy change is defined, operationalized, and measured. The review will also record the independent variables used to explain or correlate with policy change (e.g., demographic trends, political dynamics, institutional reforms), as well as the methodological approach (qualitative, quantitative, or mixed methods). Figure 2.1. presents a flow diagram illustrating the number of studies identified and selected for the systematic literature review.

Figure 2.1. Systematic Literature Review: Flow Diagram.



Source: Author's elaboration.

OR evaluation OR definition OR conceptualization OR typolog* OR classification) AND TS=("Europe" OR "European Union" OR EU OR OECD OR "high-income countr*").

This systematic mapping enabled a clearer understanding of how policy change is currently addressed in LTC scholarship (Table 2.1.). Ultimately, the reviews lead to a more coherent and comparable knowledge base on policy change in the long-term care domain.

Table 2.1. A Systematic Literature Review on the Classification of Long-Term Care Policy Dimensions: The Selected Articles.

Authors' name	Title	Year	Brief summary	Case studies	Dependent variable	Independent variables	Methods
Alber, J. (1995)	A Framework for the Comparative Study of Social Services	1995	Proposes a framework for studying social services, shifting focus from transfers to service provision, using Rokkan's model.	N-small; Services for older people in EU countries	Level and type of social service provision	Regulatory, financing, and delivery modes	Conceptual framework and empirical illustration
Anttonen, A., & Sipilä, J. (1996)	European Social Care Services: Is It Possible to Identify Models?	1996	Explores differences in social care services across Europe and proposes potential models based on service volumes and policies.	N-small; Scandinavia and EU countries (late 1980s)	Volume and type of social care services	State policies, women's employment rates	Quantitative comparison using available statistics
Pacolet, J., Bouten, R., Lanoye, H., & Versieck, K. (1998)	Social Protection for Dependency in Old Age in the 15 EU Member States and Norway	1998	Maps existing provisions and debates on social protection for dependency among older persons across Europe.	N=16; 15 EU countries + Norway	Extent and type of social protection for dependency	Service availability, affordability, public-private mix	Comparative policy study combining macro, institutional, and case-level data
Pfau-Effinger, B. (2005)	Welfare State Policies and the Development of Care Arrangements	2005	Argues that informal care persists due to cultural values and not only due to lack of formal services.	N-small; 8 European countries	Extent of formal vs. informal care	Cultural values, gender equality policies	Cross-national qualitative comparison
Lamura, G., Mnich, E., Nolan, M., Wojszel, B., Krevers, B., Mestheneos, L., & Döhner, H. (2008)	Family Carers' Experiences Using Support Services in Europe: Empirical evidence from the EUROFAMCARE Study	2008	Examines experiences of family carers in six countries; highlights disparities in service use and challenges across care regimes.	N=6; Germany, Greece, Italy, Poland, Sweden, UK	Use of support services by family carers	Care regime, carer characteristics, availability and accessibility of services	Quantitative survey; comparative cross-national analysis
Pavolini, E., & Ranci, C. (2008)	Restructuring the Welfare State: Reforms in Long-term Care in Western European Countries	2008	Examines LTC reforms across six countries, showing convergence toward mixed models of provision.	N=6; France, Germany, Italy, Netherlands, Sweden, UK	Long-term care service models and coverage	Reform types, funding mechanisms, family care support	Comparative policy analysis at macro, meso, micro levels
Da Roit, B., & Le Bihan, B. (2010)	Similar and Yet So Different: Cash-for-Care in Six	2010	Analyzes cash-for-care schemes in LTC, showing variation in design, impact,	N=6; Austria, France, Germany, Italy,	Configuration of cash-for-care in LTC	Policy context, scheme regulation, view of care work	Policy document analysis and systematic

	European Countries' LTC Policies		and national policy contexts.	Netherlands, Sweden			literature review
Riedel, M., & Kraus, M. (2010)	A Typology of Long-Term Care Systems in Europe	2010	Proposes a typology of LTC systems in Europe based on institutional and service characteristics.	N=21; European countries	Type of LTC system	Financing mode, service provision, regulation	Typological classification via comparative institutional analysis
Colombo, F., et al. (2011)	Help Wanted? Providing and Paying for Long-Term Care	2011	OECD report addressing LTC system sustainability, financing, workforce, and service models.	N=29; OECD countries	LTC sustainability and coverage	Demographic trends, financing schemes, workforce policies	Mixed-method: Policy questionnaire, statistical and longitudinal survey analysis
Damiani, G., et al. (2011)	Patterns of Long-Term Care in 29 European countries: evidence from an exploratory study	2011	Identifies LTC patterns based on organizational features, needs, and spending across 29 countries.	N=29; EU27 + Norway and Iceland	Pattern of LTC system alignment	Older people needs, care expenditure, formal/informal balance	Multiple Factor Analysis (MFA)
Bettio, F., & Verashchagina, A. (2012)	Long-Term care for the elderly. Provisions and Providers in 33 European Countries	2012	Compares LTC systems in 33 European countries focusing on gender, affordability, and care regimes.	N=33; EU27 + candidate and EFTA countries	LTC availability and equity	Provision type, affordability, gender roles	Comparative policy analysis using national expert reports and EU data
Da Roit, B., & Weicht, B. (2013)	Migrant Care Work and Care, Migration and Employment Regimes: A Fuzzy-Set Analysis	2013	Analyzes how migration, care, and employment regimes shape migrant care work in 9 European countries.	N=9 (small); various EU countries	Patterns of migrant care work	Care regimes, migration regimes, employment conditions	Fuzzy-set qualitative comparative analysis
Halásková, R., Bednář, P., & Halásková, M. (2017)	Forms of Providing and Financing Long-Term Care in OECD Countries	2017	Analyzes LTC provision and financing in OECD countries using multivariate methods.	N=OECD countries	LTC provision and financing models	Recipients, institutional vs. home care, expenditure types	Principal Component Analysis and Cluster Analysis
Ariaans, M., Linden, P., & Wendt, C. (2021)	Worlds of Long-Term Care: A Typology of OECD Countries	2021	Develops a typology of LTC systems in OECD countries based on supply, public-private mix, access regulation, and performance.	N-large; OECD countries	LTC system type	Supply, access, performance, public-private mix	Cluster analysis using OECD data and institutional indicators
Fischer, J., Frisina Doetter, L., & Rothgang, H. (2021)	Comparing Long-Term Care Systems: A Multi-Dimensional, Actor-Centred Typology	2021	Presents a conceptual framework for LTC systems based on actor responsibility in provision, financing, and regulation.	Illustrative (3 countries); typology conceptual	LTC system type	Primary actor in financing, regulation, provision	Theoretical typology construction using care/welfare mix

Pavolini, E. (2021)	Long-Term Care Social Protection Models in the EU	2021	Assesses LTC models in EU based on organization, provision, eligibility, and financing; builds updated typology.	N-large; EU Member States	LTC system type	Organization, benefit types, eligibility, financing	Comparative analysis based on four-dimensional framework
Pfau-Effinger, (2022)	Gaps in the Provision of Long-Term Care Across Europe	2022	The paper explores the gaps in LTC provisions across seven European countries.	N-large: Seven European countries, Norway, Germany, Spain, Italy, United Kingdom, Estonia, Hungary	Care gap	Generosity of LTC policies, policy implementation, cultural factors regarding care provision, and quality perceptions of extra-familial care.	Comparative and multidimensional approach using both quantitative data and qualitative analysis
Fekete, M., Patyán, L., Hüse, L., Huszti, É., & Takács, P. (2022)	Differences of Subjective Well-Being in European Long-term Care Regimes	2022	Establishes new LTC regime categories based on subjective well-being (QoL) among older people in different countries.	N=SHARE countries; clustered as Minimisers, Optimisers, Maximisers	Subjective well-being (QoL) of older people	Level and type of LTC services	Secondary analysis of CASP-12 data from SHARE
Eggers, T. (2023)	Social Risks and Active Social Citizenship: A Cross-National Comparison of Long-Term Care Policies	2023	Develops a typology linking LTC policy designs to social risks and concepts of active social citizenship.	N=5; Denmark, England, Germany, Italy, Poland	Social risks faced by older people	Extent of active citizenship, generosity of LTC rights	Comparative institutional analysis; typology construction
Tinios, P., & Valvis, Z. (2023)	Defining Long-Term-Care Need Levels for Older Adults: Towards a Standardized European Classification	2023	Proposes a new 4-scale classification to harmonize LTC needs across the EU, improving comparability and planning.	N=EU countries; SHARE dataset	Levels of LTC needs	ADL and GALI indicators	Statistical calibration and typology development
van Damme, M., Spijker, J., & Pavlopoulos, D. (2025)	A Care Regime Typology of Elder, Long-Term Care Institutions	2025	Classifies 26 European countries into care regime types using dimensions of defamilialisation and familialism.	N=26; European OECD countries	Care regime classification	Defamilialisation, familialism (supported/default)	Latent profile analysis

Source: Author's elaboration.

Building on the articles classified in the systematic review, the following section (2.2.) examines the key dimensions of variation in long-term care policies as shaped by welfare state interventions.

2.2. Dimensions of Variation in the LTC Policies

Building on the systematic literature review, this section aims to reconstruct and analytically disentangle the principal dimensions of variation that characterize LTC policies. The goal is to provide a structured overview of the institutional components through which welfare states shape and regulate access to care, organize service provision, and allocate financial resources.

Drawing on empirical typologies and comparative frameworks, the analysis focuses on five interrelated dimensions. Section 2.2.1. examines the financing mechanisms and coverage models, analyzing how LTC systems are funded (e.g., through general taxation, social insurance, or mixed schemes) and the extent to which populations are included within these arrangements (universal vs. occupational or means-tested coverage). Section 2.2.2. addresses eligibility criteria, exploring how need, age, and income thresholds determine access to services and benefits. It highlights the role of multidimensional assessment tools and the distributive implications of restrictive or expansive access conditions. Section 2.2.3. presents the instrumentation of LTC provision, distinguishing between in-kind services and in-cash transfers (e.g., cash-for-care schemes, care allowances). It discusses the conditions under which these instruments are deployed and their impact on care choices, user autonomy, and professionalization of care. Section 2.2.4. turns to multilevel governance, detailing the vertical and horizontal coordination mechanisms that structure the interplay between national, regional, and local institutions. Finally, Section 2.2.5. examines the regulatory framework of public-private provision, with particular attention to the division of labor among state actors, market providers, non-profit organizations, and informal caregivers. The section employs the “care diamond” model to classify governance configurations and delineate actor responsibilities.

All sections are supported by qualitative-quantitative data related to the respective dimension under analysis. The aim is to outline the current situation regarding the development of each dimension across the 27 EU member states and, subsequently, to define a typology for the study of policy dimensions.

2.2.1. Financing and Coverage

Financing constitutes what Rothgang et al. (2010) describe as the “second basic function” of LTC². Unlike healthcare systems—where financing usually takes the form of direct monetary payments for services—LTC financing frequently includes implicit and non-monetary dimensions. This is particularly evident in the case of unpaid informal care, where financial inputs are not expressed through formal transfers, but through the allocation of time and personal effort. These contributions can be economically assessed in terms of opportunity costs, such as lost earnings or reduced labour force

² The delivery or provision of care is the “basic function” that constitutes the ultimate goal of any LTC system, whereas financing, as a means to remunerate care providers, can be considered a “second basic function” (Rothgang et al. 2010).

participation (WHO, 2015, p. 131). This broader conceptualization of financing underscores the importance of capturing both formal and informal inputs within comprehensive LTC policy frameworks.

Within health and social care systems, it is essential to distinguish between funding and financing, as they refer to different dimensions. Funding refers to the origin of financial resources—e.g., taxation, social contributions, or private payments—while financing refers to the mechanisms through which these resources are collected, pooled, and allocated to service providers or recipients. Although closely related, this distinction has analytical relevance: A service may be publicly funded but privately financed (e.g., through insurance premiums or co-payments), or vice versa. Policy reforms frequently affect one dimension without altering the other.

In most European countries, LTC is predominantly publicly funded through general taxation. Yet, this is not the only model. The literature distinguishes between *ex-ante* and *ex-post* financing mechanisms. *Ex-ante* mechanisms, such as insurance schemes or savings plans, involve the collection of resources before care needs arise. Among these, social insurance is widely regarded as an effective LTC financing model, given the uncertainty surrounding both the probability of care needs and the associated costs (Barr, 2010). Unlike private actuarial insurance—often inaccessible due to high premiums—social insurance allows for broader risk pooling and more equitable access (Norton, 2016).

Currently, only a few OECD countries—the Netherlands, Germany, Japan, and South Korea—have developed dedicated, publicly funded LTC social insurance schemes. These are typically financed through payroll-based contributions that are proportional to income and mandatory for the working population. While the core design is similar, variations exist in contribution rates, revenue collection methods, and eligibility criteria, reflecting divergent institutional contexts and policy goals related to demographic aging and fiscal sustainability.

In countries without stand-alone LTC insurance schemes, care services are funded through a mix of taxation and existing social protection mechanisms. For instance, in France, LTC health-related expenses are covered by social health insurance, while broader care services are financed through the *Allocation Personnalisée à l'Autonomie*, a needs-based allowance. Despite public funding, beneficiaries often bear substantial out-of-pocket costs, unless they qualify for income-based exemptions. In such cases, private LTC insurance is used to supplement public support. A similar hybrid system exists in Switzerland, where medical costs in residential care are funded through mandatory health insurance, and home-based care relies on means-tested benefits and municipal support.

Overall, private LTC insurance plays a marginal role in Europe, accounting for less than 2% of total LTC expenditure (Colombo & Mercier, 2012). Its development is constrained by both public system design and cultural norms of intergenerational solidarity. Without targeted subsidies or incentives, private coverage remains out of reach for most lower-income groups. Notable exceptions include the United States, where roughly 10% of older adults are privately insured (Le Corre, 2012), and France, where approximately 3.5 million individuals—around 20% of people aged 60 and over—hold private policies (*ibidem*). Yet, these two markets differ substantially in terms of insurance design and benefit structure.

Beyond insurance, individual savings represent another ex-ante strategy, often used by risk-averse individuals during their working years. However, this approach is generally limited to higher-income groups and becomes less viable in older age, when income-generation capacity is reduced. Along the public-private continuum of LTC financing, at least four major models can be identified, varying in how they allocate financial risk and service costs. According to the OECD (2004), two key principles are essential for assessing these models: Prepayment (the advance collection of funds before service use) and risk pooling (the collective distribution of financial risk across a population) (Table 2.2.).

Table 2.2. Private Financing Mechanisms in Long-Term Care.

		Prepayment	
		No	Yes
Pooling	No	Out-of-pocket	Medical Savings Accounts
	Yes	Spontaneous charity	Healthcare insurance (public or private) or Mutuals (collective) or health private funds

Source: Adapted from OECD (2004).

Ex-post financing mechanisms refer primarily to tax-based social care systems, which are characteristic of Nordic countries such as Norway, Sweden, Denmark, and Finland. These systems are predominantly funded through general taxation and provide universal, comprehensive LTC benefits, typically delivered by local or regional authorities. Within tax-based systems, cost-sharing arrangements are common, either universally or through means testing. Despite their public funding base, many European LTC systems remain fragmented and partial in coverage, requiring significant out-of-pocket contributions from individuals and families. These dynamics have resulted in hybrid systems, where public subsidies, cash allowances, and private expenditures coexist. In Italy and Poland, for instance, user contributions complement public benefits, while in Ireland, access to institutional care is conditioned by income-related eligibility criteria.

Additional forms of LTC financing include self-funded mechanisms. In countries with high homeownership rates, reverse mortgages have been explored as a potential source of funding for long-term care needs. Informal care and family support also play a central role, particularly where public provision is limited or underdeveloped.

Connecting these arrangements to broader welfare state typologies, three principal LTC financing mechanisms can be identified, each associated with a different model of coverage. The contributory-occupational model, based on employment-related contributions, typical of social insurance systems. Tax-based and universalistic financing and coverage, funded through general revenues. Private financing, relying on out-of-pocket payments or individual savings.

These mechanisms correspond to different coverage models—occupational (linked to employment status) and universalistic (linked to citizenship or residency). Within universalistic systems, means testing may still apply, introducing social assistance logic into access and cost-sharing decisions. Importantly, no European country operates a purely singular model of LTC financing. Instead, national systems blend multiple sources of funding and financing mechanisms. Colombo et al. (2011) offer a helpful framework for classifying the organizational structure of LTC systems, distinguishing between: (a) centralized systems, where a single program oversees financing and provision; (b) multiple benefit schemes, which fragment provision across different programmes; (c) constellations of services, composed of diverse and often overlapping benefits and delivery channels. A centralized model offers advantages in terms of broad access, equity, and coordination but tends to entail higher public expenditure due to the scope of universal provision. In contrast, mixed or fragmented systems rely on a plurality of programmes—some universal, others means-tested or targeted—tailored to specific population groups or care needs. These systems often lack a unified delivery mechanism, reflecting institutional complexity and policy layering.

The typology of financing schemes builds on the framework developed by Colombo et al. (2011), distinguishing between single and mixed models depending on whether LTC is financed through one or multiple mechanisms. Importantly, within a given system, different types of measures—such as services in kind or cash benefits—may be financed through parallel schemes. The analysis considers financing schemes formally established at the national level, including those based on general taxation, social contributions, pension contributions, or hybrid models.

The concept of coverage refers to the population included within each financing arrangement. Coverage may be: Universal, when the entire population is entitled to benefits; targeted, when access is restricted to vulnerable or high-risk groups; occupational, when coverage is limited to workers (including, in some cases, the self-employed). Table 2.3. provides a comparative overview of the LTC systems in the 27 EU member states, detailing the configuration of funding and financing schemes, the population covered, and the eligibility rules applied. This multidimensional mapping offers a basis for cross-national analysis of how LTC responsibilities are organised, financed, and accessed across different institutional settings.

Table 2.3. Types of Schemes, Financing Models, and Coverage of Long-Term Care in EU Countries.

Type of Scheme	Financing	Coverage	Countries
Single scheme	General taxation	Universalism	Denmark, Finland, Latvia, Lithuania, Sweden + Italy and Spain ³
		Targeted universalism	Bulgaria, Croatia, Cyprus, Estonia, Greece, Hungary, Malta, Romania, Slovakia
	Payroll contributions	Occupational	Belgium, Germany, Luxembourg
Mixed scheme	General taxation and payroll contributions	Universalism and occupational	Austria, Czechia, France, Ireland, Poland, Portugal, Slovenia

Source: Author's elaboration on MISSOC (2024).

Table 2.4. presents data on public expenditure on LTC—encompassing both the social and healthcare components—across OECD countries that are also members of the EU-27. Among these, the Netherlands allocates the highest share of its GDP to LTC, followed by Finland, Sweden, Denmark, Belgium, and France.

A longitudinal analysis reveals a notable increase in public LTC spending in several countries, particularly in the Netherlands, Finland, and Sweden, and more recently in Czechia, Slovenia, and—though to a lesser extent—Spain. In contrast, countries such as Italy, Portugal, Greece, Austria, Luxembourg, Bulgaria, and Hungary have maintained relatively stable levels of expenditure over time. Meanwhile, Ireland and Romania have experienced declines in public LTC spending.

Despite these varied trajectories, concerns about the adequacy and sustainability of LTC funding remain widespread across Europe, particularly in light of demographic pressures and increasing care needs.

Table 2.4. Total Public Expenditure on Long-Term Care: Social and Health Components in Selected Years, OECD Countries.

	2005	2008	2011	2014	2017	2020	2022
Netherlands	3,1	3,1	3,6	3,8	3,6	4,4	3,8
Finland	1,8	1,9	2,3	2,4	2,1	2,2	3,1
Sweden	0,6	0,6	3,0	3,2	3,2	3,3	3,0
Denmark	2,0	2,1	3,0	3,0	2,9	3,1	2,8
Belgium	1,4	1,8	2,0	2,2	2,5	2,2	2,2
France	1,4	1,6	1,8	1,9	1,9	2,1	2,0
Germany	1,0	1,0	1,1	1,2	1,5	1,8	1,8
Czechia	0,2	0,2	1,3	1,3	1,4	1,7	1,6
Slovenia	0,8	0,8	0,9	0,9	0,9	1,1	1,2

³ Italy and Spain are classified among the countries with a universalistic system, despite the fact that Italy imposes limitations on access to certain in-kind services (e.g., social home care services), and Spain requires proof of means for access to monetary support measures for purchasing services.

Luxembourg	1,2	1,1	1,1	1,1	1,0	1,1	1,1
Austria	1,0	1,0	1,2	1,2	1,1	1,3	1,1
Ireland	n.d.	n.d.	1,9	1,7	1,3	1,3	1,1
Lithuania	0,6	0,9	0,9	0,9	0,9	1,2	1,1
Spain	0,5	0,6	0,8	0,7	0,7	0,9	0,8
Italy	n.d.	n.d.	n.d.	0,7	0,7	0,7	0,7
Latvia	0,4	0,2	0,3	0,4	0,4	0,5	0,5
Poland	0,4	0,4	0,4	0,3	0,4	0,5	0,5
Portugal	0,3	0,3	0,4	0,5	0,4	0,5	0,5
Estonia	0,3	0,4	0,4	0,4	0,4	0,5	0,5
Bulgaria	0,2	n.d.	n.d.	0,0	0,0	0,2	0,3
Romania	0,5	0,6	0,2	0,3	0,4	0,3	0,3
Hungary	0,3	0,3	0,2	0,3	0,2	0,3	0,2
Greece	0,0	0,0	0,1	0,1	0,1	0,2	0,1

Note: The data are arranged in descending order based on their 2022 values. Some of the values reported in this table may differ from Eurostat data due to methodological discrepancies in measuring public expenditure on the social care component of long-term care. This discrepancy is particularly evident in countries such as Italy, where Eurostat estimates public LTC spending at 1.5% of GDP in 2022. Moreover, both OECD and Eurostat figures do not fully capture regional co-financing mechanisms, which—while sometimes mandatory and legally established through predefined thresholds—can significantly affect overall spending levels. As discussed in Chapter 4, this is particularly relevant in the case of Spain, where actual public expenditure on LTC may be substantially higher than reflected in the aggregated data presented here.

Source: Author's elaboration based on OECD data.

Table 2.5. presents data on out-of-pocket expenditure—defined as costs directly borne by the households of LTC beneficiaries—across European OECD countries. The data highlight significant disparities among EU Member States in the share of OOP spending on LTC, measured as a percentage of total health expenditure between 2005 and 2022.

Countries such as Bulgaria, Greece, and Latvia consistently report the highest out-of-pocket expenditure shares, often exceeding 30%, reflecting a strong reliance on private payments and limited public financial support for LTC services (as also reflected in Table 2.5.). Bulgaria stands out in particular, with values regularly surpassing 35%, and peaking at 44.5% in 2011, signalling a persistent and substantial financial burden on households. By contrast, Western and Northern European countries—including France, Luxembourg, the Netherlands, and Sweden—exhibit significantly lower out-of-pocket expenditure shares, typically below 15%, suggesting the presence of more comprehensive, publicly funded LTC systems. Italy and Portugal fall into a mid-range category, with household contributions ranging between 21% and 29%, while countries such as Poland, Germany, and Ireland show a declining trend over time. This may reflect the effects of policy interventions aimed at expanding public coverage and alleviating the financial burden on individuals.

Table 2.5. Out-of-Pocket Expenditure as a Percentage of Total Healthcare Spending: Selected Years, OECD Countries.

	2005	2008	2011	2014	2017	2020	2022
Bulgaria	38,9	42,6	44,5	40,2	42,2	35,5	35,1
Greece	36,9	32,2	31,2	37,2	35	33,4	33,5
Lithuania	32,8	28,2	28,2	31,5	32,6	28,7	31,8
Latvia	41,7	37,3	34,3	39,1	41,8	31,9	30,7
Portugal	23,7	26,4	26,7	29,3	29,7	28	29,6
Hungary	25,8	26,4	28,2	28,4	27,2	26,1	24,3
Estonia	23	21,4	22,5	23,5	24,8	21,4	23,1
Italy	21,6	21,3	22	22,5	23,8	21,5	22,7
Romania	18,5	18,2	24,3	20,3	20,5	19	21,4
Belgium	20	19,9	19,6	19,5	18,4	17,2	20
Spain	21,7	20,6	20,4	23,1	22,2	19,7	19,2
Poland	27,7	24,4	24	23,1	22,7	19,5	18,8
Finland	19,6	18,6	18,2	17,6	19	16,5	16,1
Austria	19,2	18,2	18,7	19,1	19,2	16,5	16
Czechia	11,1	16,1	14,2	14,5	14,1	11,1	14,3
Denmark	14,7	14,1	13,9	13,4	13,7	13,4	13
Sweden	16,6	16,3	14,6	14,9	14,1	12,8	12,9
Slovenia	13	12,6	12,2	13	12,3	12,5	12,4
Germany	14	14	13,8	12,9	12,7	12	10,7
Ireland	13,6	11,9	13,7	14,1	12,6	10,9	10,7
Netherlands	9,9	9,9	9,5	11,6	11	9,3	10
France	7,4	10	10,2	10,1	9,9	9	8,9
Luxembourg	12,9	10,1	10,9	11,1	10,7	8,4	8,7

Note: The data are arranged in descending order based on their 2022 values.

Source: Author's elaboration on OECD data.

2.2.2. Eligibility Criteria

Access to LTC is inherently shaped by eligibility criteria, most fundamentally by the presence—or absence—of an assessed care need (Llena Nozal et al., 2025). Unlike *ex-ante* financing models, such as preventive insurance or savings accumulated in anticipation of possible dependency, nearly all publicly operated LTC systems rely on *ex-post* eligibility, whereby services are granted only once a need has been formally recognized. Thus, access to care is frequently contingent upon a predefined assessment of dependency.

Within this framework, eligibility rules represent a core structural component of LTC systems. They determine not only who qualifies for care, but under what conditions, and with what level of public support. In addition to need-based assessments—typically governed by national or local evaluation grids—LTC systems may apply income-based (means-tested) or age-based (age-tested) criteria. As noted by the European Commission (2021; 2024), European countries display considerable variation in both the generosity of coverage and the restrictiveness of access conditions.

Restrictive eligibility criteria, as discussed by Grages & Pfau-Effinger (2022), can lead to a range of “care gaps”. These refer to institutional barriers that limit not only access to care but also the extent and adequacy of the support provided. In many cases, public financial assistance is reserved for individuals with severe dependency, leaving those with moderate or emerging needs without meaningful support. As a result, care responsibilities often shift to families, generating high levels of uncompensated informal caregiving or leading to unmet needs, especially among socioeconomically disadvantaged groups (Grages et al., 2021; 2023). In such contexts, targeted and restrictive eligibility may result in social exclusion from care, rather than promoting equity or efficiency. Table 2.6. summarizes the eligibility criteria associated with access to long-term care measures. A combination of these three criteria is possible.

Table 2.6. Eligibility Criteria in the Long-Term Care Sector.

Eligibility Criteria	Definition
Need-based	Access granted based on assessed level of functional or cognitive dependency (see IADL or ADL level)
Income-based	Access determined by an individual's or household's income/assets; typically for low-income groups.
Age-based	Eligibility restricted to individuals above a certain age threshold (e.g., 65+).

Source: Author’s elaboration.

In LTC systems, eligibility requirements play a pivotal role in determining access to services and the scope of public financial support. While the assessment of care needs—typically through standardized evaluation tools—remains the primary entry criterion, many systems also impose additional conditions, such as age thresholds (e.g., over or under 65), income or asset limits, and residency or insurance status. To reconcile the goal of providing adequate LTC with the imperative of fiscal sustainability, most OECD countries have adopted multi-dimensional eligibility frameworks that combine clinical, demographic, and socio-economic criteria.

These frameworks frequently incorporate means-testing, age-based restrictions, assessments of living arrangements, or requirements related to employment and contributory history. As such, eligibility rules do not merely govern access, but also shape the extent of cost coverage by public sources. As noted by Gori & Luppi (2024), countries have increasingly resorted to strategies such as tightening eligibility thresholds, raising co-payments, adjusting service mixes, and reducing service intensity in response to demographic and fiscal pressures. However, they caution that such cost-containment

measures must be carefully calibrated, as poorly designed reforms risk producing adverse effects on older populations and may ultimately lead to higher long-term expenditure in both LTC and healthcare systems.

These additional eligibility filters are often justified on equity grounds, as they aim to prioritise access for the most vulnerable or economically disadvantaged groups. For example, age-based criteria may focus services on older adults, while income thresholds are used to target support toward lower-income individuals and households. Yet, such rules also introduce an added layer of complexity and variability within and across national systems, reflecting diverse policy traditions and distributive logics. Ultimately, eligibility design is about balancing fairness, accessibility, and resource allocation, ensuring that LTC systems remain both financially viable and responsive to the needs of those requiring care most. Table 2.7. summarizes the eligibility criteria for accessing LTC systems across the 27 EU Member States.

Table 2.7. Eligibility Criteria in the Long-Term Care Sector Across European Countries.

	Eligibility Requirements	Country
Mono-dimensional criteria	<i>Need-based (or dependency-based)</i>	Belgium, Denmark, Germany, Italy ⁴ , Sweden + Latvia, Lithuania ⁵
	<i>Age-tested</i>	Finland
	<i>Means-tested</i>	—
Bi or three-dimensional criteria	<i>Need-based and means-tested</i>	Greece, Hungary, Austria, Bulgaria, Croatia, Cyprus, Estonia, Portugal , Romania, Slovakia, Slovenia, Spain , Czechia
	<i>Need-based and age-tested</i>	France
	<i>Need-based, means-tested and age-tested</i>	Malta, Poland, Ireland

Source: Author's elaboration on MISSOC database (2024) & Llena Nozal et al. (2025).

It is important to underscore that eligibility criteria in LTC vary significantly depending on the specific type of measure under consideration. For example, access to cash allowances is often subject to means-testing, while eligibility for certain services may be determined by additional criteria such as age, type of disability, or the level of functional dependency. Further cross-national variation emerges in how countries define and apply income thresholds for service access. Some systems assess only income, while others include wealth components such as property or savings. These strategies range from setting caps on user copayments to adjusting benefit levels in proportion to individual financial resources.

⁴ Social assistance is means-tested (i.e. SAD).

⁵ In Latvia and Lithuania, access to certain tangible LTC services is restricted to individuals with severe or specific disabilities. As a result, despite being embedded within ostensibly universalistic systems, these countries exhibit notable exceptions to universal access.

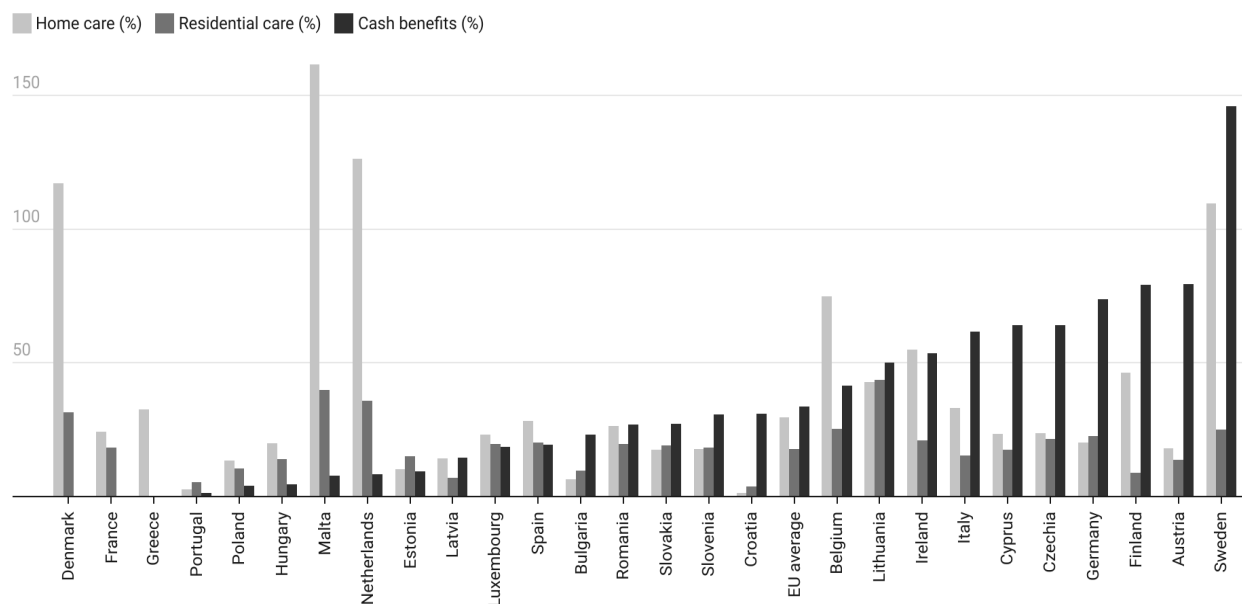
Such institutional variation reflects diverse national policy choices aimed at balancing equitable access with the fiscal sustainability of LTC systems. A widely adopted mechanism involves requiring beneficiaries—particularly in residential care settings—to contribute a fixed proportion of their income toward the cost of services. This aligns personal contributions with financial capacity, while public schemes cover the residual costs. According to OECD estimates (2024), out-of-pocket payments remain a significant factor shaping the accessibility and affordability of LTC across member countries.

The strictness of eligibility criteria is thus not a marginal detail: It directly affects both effective access to LTC and the coverage of social risks. Even in systems formally based on universal principles—such as those funded through general taxation—restrictive eligibility rules can result in substantial coverage gaps. Figure 2.2. illustrates this dynamic by showing the share of the potentially dependent population aged 65+ that receives at least one form of LTC support. The figure provides disaggregated estimates for three main categories: Home care, residential care, and cash benefits.

The index measures the percentage of the dependent population that benefits from each form of assistance. In-kind services include both home-based care and institutional care, as well as ancillary supports such as home adaptations or assistive technologies. Cash benefits, on the other hand, are monetary transfers that recipients may use to purchase care services independently, or to compensate informal carers, particularly within familial care arrangements.

In Nordic countries (e.g., Denmark, Finland, Sweden), support is primarily provided in the form of services. In others—such as Austria, Cyprus, Ireland, Italy, and Romania—LTC coverage is based predominantly on cash benefits. Some countries, including Germany, offer beneficiaries a choice between in-kind services, cash transfers, or a combination of both. Importantly, lower levels of LTC coverage in some countries can often be traced to stringent eligibility criteria, even in systems that are universal in principle. These variations in eligibility design have distributional consequences, limiting access to care particularly for individuals with complex needs or insufficient financial resources.

Figure 2.2. Share of Potential Recipients Aged 65 and Over Receiving Home Care, Residential Care, or Cash Benefits.



Source: Author's elaboration on Ageing Report (2024).

2.2.3. Instruments: In-Cash and In-Kind

The delivery of LTC services across welfare systems typically follows two principal modalities: Services in kind and cash-based transfers. As outlined in Section 3, services in kind refer to publicly or privately provided professional care services—either at home or in institutional settings—usually funded or subsidised by the state and often delivered through regional or municipal entities (Anttonen & Sipilä, 1996; Colombo et al., 2011). These services offer structured, often regulated support, typically through care professionals employed by public or contracted providers. Countries with universalist traditions, such as Sweden and Denmark, rely heavily on this model, ensuring broad access to formal care through local governments (Timonen, 2005; Fischer et al., 2021). Services in kind represent a formalisation of care responsibility, aiming to reduce the care burden on families and to ensure a degree of standardisation and equity in access. However, their provision is not immune to challenges such as territorial disparities, workforce shortages, and fiscal constraints, especially in decentralised systems (Pavolini & Ranci, 2008; Damiani et al., 2011).

In contrast, cash-based transfers can take two distinct forms. First, cash allowances are unconditional monetary transfers provided to individuals with care needs, who are free to use the funds at their discretion—whether to compensate informal carers, purchase private services, or cover care-related expenses. This model prevails in countries such as Italy, where benefits like the *Indennità di accompagnamento* are provided without restrictions on their use and often without means testing. Such allowances promote user autonomy but are also associated with limited state oversight and can fuel informal care arrangements, particularly in the absence of accessible public services.

Second, cash-for-care schemes involve conditional cash transfers, in which recipients are required to use the benefit to purchase eligible care services or to compensate formally recognised caregivers. These schemes aim to steer users toward the formal care market while preserving a degree of flexibility. For instance, in Germany, recipients can choose between in-kind services, a reduced cash benefit (*Pflegegeld*), or a combination of both, but the cash option is subject to mandatory counselling and quality monitoring (Bettio & Verashchagina, 2012). In Belgium, the *zorgbudget* is explicitly earmarked for care-related expenses and is subject to administrative control (OECD, 2021). These conditional schemes reflect a hybrid logic: They combine elements of marketisation and formalisation, seeking to empower users while maintaining service standards and public accountability.

A key feature of both models—especially in familialist or mixed welfare regimes—is their potential to support informal care. In countries like Italy and Austria, cash benefits may be used to employ family members, effectively transforming unpaid caregiving into paid labour (Da Roit & Le Bihan, 2010). This process has been referred to as the commodification of care, whereby cash transfers function as “routed wages” (Ungerson & Yeandle, 2007), formalising familial care arrangements. The dynamics of such schemes are particularly salient in contexts where (a) familial responsibility is normative, (b) formal services are insufficient or unaffordable, and (c) cash transfers—whether conditional or not—replace rather than complement public provision (Österle & Rothgang, 2021). In these settings, families often act as care coordinators, using public funds to manage care relationships, employ private providers, or contract migrant live-in carers (Da Roit & Weicht, 2013; Maino & De Tommaso, 2021).

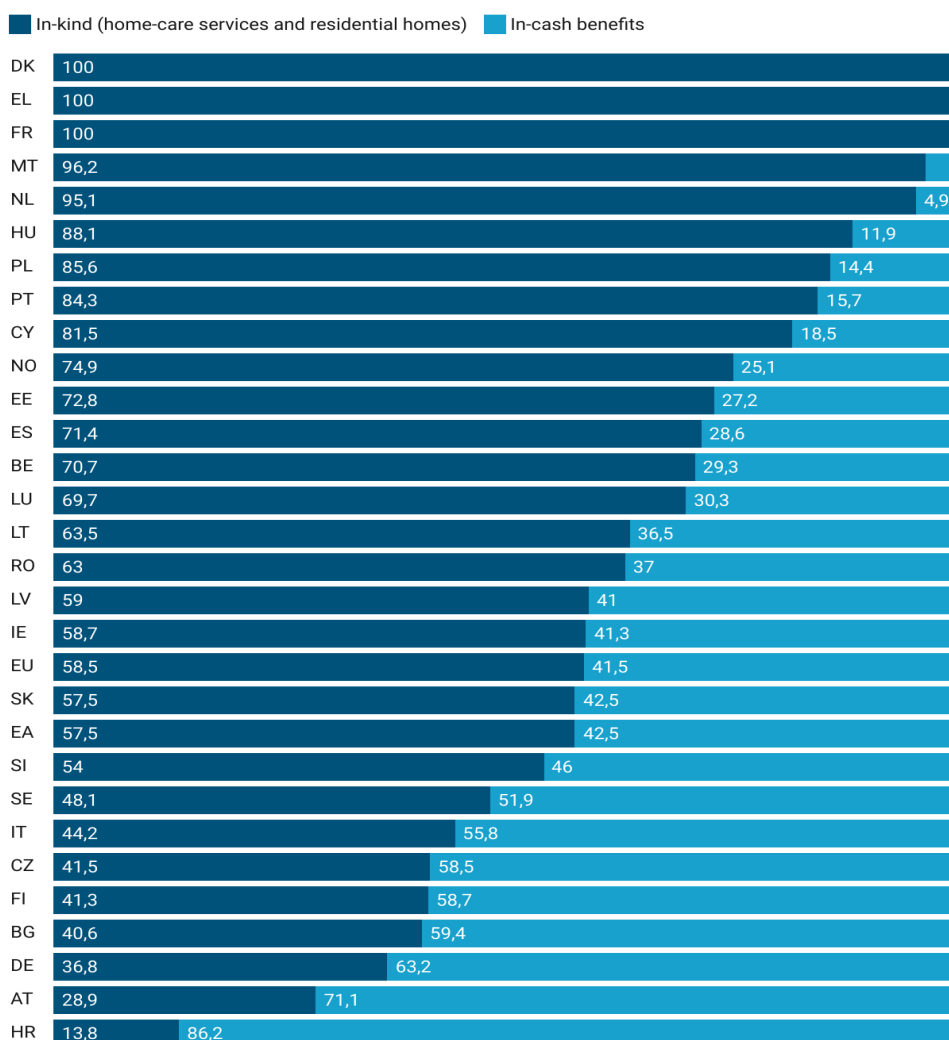
While services in kind and cash-based transfers are often framed as opposing models, in practice they are increasingly intertwined. Hybrid systems are emerging in which cash supplements formal care or vice versa. Yet this hybridisation presents ambivalent effects. On one hand, cash transfers enhance user choice and support ageing in place; on the other, they may reinforce gendered care norms, informal labour markets, and, where regulation is weak, dependence on undocumented or underpaid care workers, particularly migrants (Pfau-Effinger, 2005; Bettio & Verashchagina, 2012; Da Roit & Weicht, 2013).

Thus, the distinction between services in kind, unconditional cash allowances, and conditional cash-for-care schemes is not merely technical. It reflects deeper questions of governance design, welfare state priorities, and the evolving boundaries between state, market, and family in the organisation of care. As noted, the horizontal and vertical distribution of governance responsibilities affects not only access, but also the policy tools employed—namely, the balance between direct service provision (in-kind) and financial transfers (in-cash). As illustrated in Figure 2.3., EU countries vary widely in how they allocate LTC support and can be grouped into four broad clusters according to their dominant mix of instruments.

The first cluster includes countries such as Denmark, Greece, France, and Malta, where LTC is provided almost exclusively through in-kind services. These systems are characterised by strong public involvement in professional or institutional care and limited reliance on financial transfers. The second cluster consists of countries such as the Netherlands, Hungary, Poland, Portugal, and Cyprus, where in-

kind services remain predominant, but are complemented by modest in-cash benefits. These systems maintain a service-oriented model with some flexibility for users. A third group includes Belgium, Luxembourg, Estonia, Norway, Spain, and Lithuania, which operate hybrid systems offering a balanced mix of in-kind and in-cash provisions. These models are designed to support both formal service access and user autonomy, allowing beneficiaries to tailor care arrangements to personal or household needs. The fourth cluster includes cash-oriented or highly flexible systems, where in-cash benefits dominate. This includes Italy, Czechia, Finland, Germany, Austria, and Croatia. In these contexts, LTC policies prioritise financial autonomy and informal caregiving over direct public provision. For instance, in Germany and Austria, more than two-thirds of beneficiaries receive in-cash benefits, while in Croatia, formal services account for only a minor share of LTC support.

Figure 2.3. Share of LTC Beneficiaries Receiving In-Kind Services Compared to Cash Benefits Across Europe.

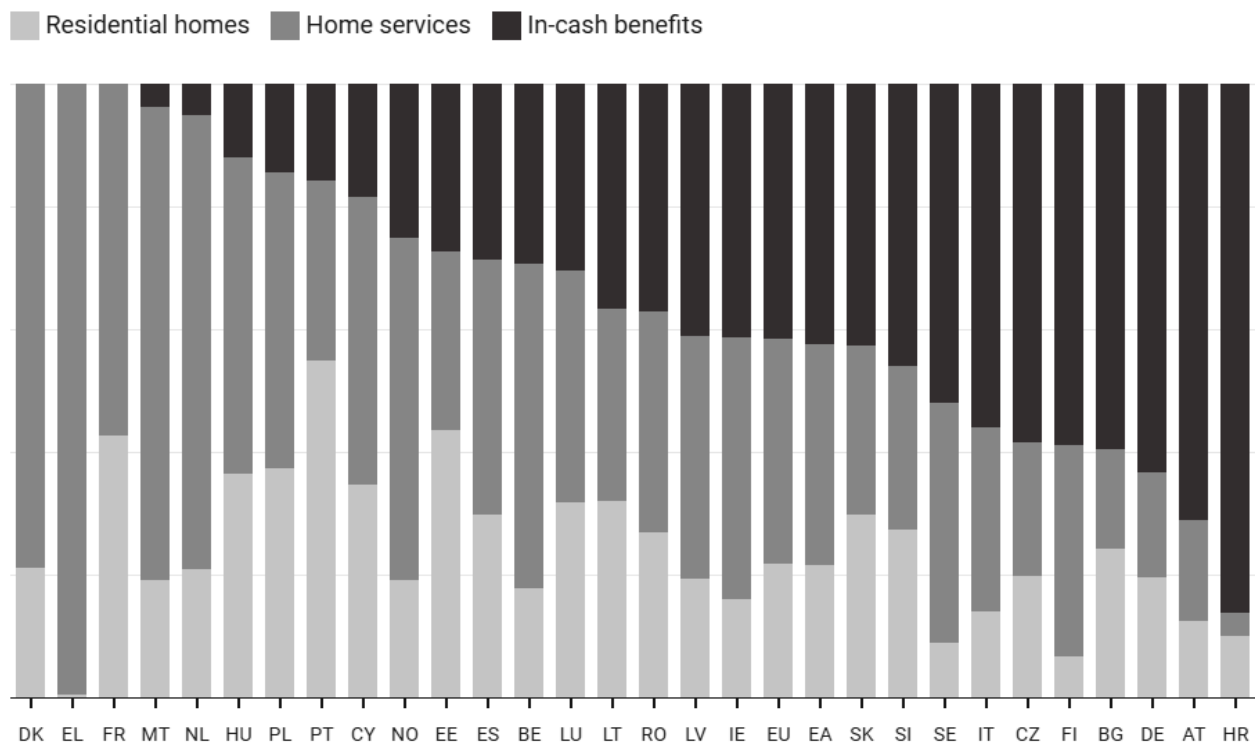


Source: Author's elaboration on Ageing Report (2024).

Figure 2.4. illustrates the relative share of LTC beneficiaries receiving residential care, home-based services, or in-cash benefits across European countries. This visualization enables a more robust clustering of national systems based on the dominant form of provision and the internal balance

between care modalities.

Figure 2.4. Share of LTC Beneficiaries by Type of Support: Residential Care, Home-Based Services, and Cash Benefits in European Countries.



Source: Author’s elaboration on Ageing Report (2024).

A more nuanced classification of European LTC systems reveals four distinct clusters based on the dominant mode of benefit delivery—whether in-kind or in-cash—and the relative balance across modalities. These clusters highlight significant differences in how countries operationalize LTC support and distribute responsibility between the state, families, and the market.

The first cluster comprises countries where in-kind services dominate almost entirely, with negligible or no use of cash transfers. This model is exemplified by Denmark, Greece, and France, where LTC provision is primarily service-based, with a strong emphasis on residential and home care. Malta and the Netherlands are closely aligned with this cluster, albeit with marginal use of in-cash benefits. The second cluster includes countries with a mixed in-kind orientation, where both home-based and residential services are widely available, but cash benefits play a non-negligible role. This group encompasses Hungary, Poland, Portugal, Cyprus, Norway, Estonia, Spain, Belgium, Luxembourg, and Lithuania. While in-kind services remain central, cash benefits—particularly those supporting informal carers—suggest hybrid models that introduce a degree of user flexibility. The third cluster consists of systems that exhibit a more balanced distribution across all three modalities (home care, residential care, and cash benefits), including Romania, Latvia, and Ireland. The fourth cluster includes countries where in-cash benefits are the dominant form of LTC support, often accounting for the majority of beneficiary coverage. This applies to Slovakia, Slovenia, Italy, Czechia, Finland, Bulgaria, Germany, Austria, and Hungary.

Austria, and Croatia. In these systems, access to formal services—both residential and domiciliary—is relatively limited, and the burden of care tends to shift toward families. While in some cases this reflects an explicit policy to promote user autonomy, in others it signals the absence of sufficient public care infrastructure.

These clusters reflect distinct institutional logics: Service-intensive models imply strong public sector capacity and investment in formal care infrastructure, while cash-dominant systems often correlate with limited-service coverage and increased reliance on informal and family-based care. The instrumental design of LTC thus offers critical insights into national welfare trajectories, fiscal priorities, and societal expectations regarding ageing and dependency.

Beyond the primary in-kind vs. in-cash distinction, further variation exists within in-kind services, particularly in the balance between home-based and residential care. This internal differentiation reflects national priorities around ageing in place, institutionalization, and the structure of formal care networks. Countries with a strong emphasis on home-based services—including Denmark, Sweden, the Netherlands, and Malta—often report higher coverage rates than the estimated dependent population. These systems reflect a firm commitment to supporting ageing in place, underpinned by robust investment and professional domiciliary infrastructure. Ireland and Finland similarly favor home care, but within a hybrid model that combines cash support with service provision. Conversely, countries such as Lithuania, France, and Luxembourg maintain a more residential-oriented profile, suggesting either a historical reliance on institutional care or slower development of community-based alternatives. A third group—Belgium, Estonia, Spain, Cyprus, Norway, and Portugal—follows a balanced in-kind approach, offering access to both home and residential services, complemented by moderate cash transfers. These systems represent efforts to combine user choice with structured professional care. Finally, a number of countries—Hungary, Poland, Latvia, and Romania—show lower overall coverage across all modalities. Among these, Latvia leans more heavily toward residential care, while Hungary and Poland offer modest but relatively balanced service provision, often constrained by limited institutional and fiscal capacity.

In the most cash-oriented systems—including Italy, Germany, Austria, Czechia, Slovakia, Slovenia, Bulgaria, and Croatia—public provision of both home and residential care is minimal, with families acting as primary care providers. While Austria and Germany retain some institutional care, countries like Croatia and Slovakia rely almost entirely on in-cash benefits, with limited investment in formal services. Even within this group, however, internal variations exist, illustrating diverse national preferences within an overarching cash-based care model. Table 2.8. summarizes the four clusters of LTC systems identified above, based on the predominant modality of benefit provision (in-kind vs. in-cash), the internal composition of services (residential vs. home-based care), and the relative balance between the three main delivery channels. Countries are grouped according to shared structural characteristics and policy orientations.

Table 2.8. Clusters of Long-Term Care Policies Based on the Mix of In-Kind Services and Cash Transfers.

Cluster	Description	Countries
<i>Service-dominant (In-kind only)</i>	High reliance on residential and especially home-based services; minimal or no cash benefits; strong public provision.	Denmark, Greece, France, Malta, Netherlands
<i>Mixed in-kind + limited in-cash</i>	Broad availability of residential and home care services; cash benefits present but not dominant; hybrid approach supporting informal care.	Hungary, Poland, Portugal, Cyprus, Norway, Estonia, Spain, Belgium, Luxembourg, Lithuania
<i>Hybrid-balanced</i>	Roughly equal distribution of in-kind and in-cash benefits; transitional or balanced governance models.	Romania, Latvia, Ireland
<i>Cash-dominant</i>	Cash benefits dominate; limited formal care infrastructure; reliance on family-based or informal care.	Slovakia, Slovenia, Italy, Czechia, Finland, Bulgaria, Germany, Austria, Croatia

Source: Author's elaboration.

Building on the framework recently developed by van Damme et al. (2025), the characteristics of LTC systems can be conceptualised through the lens of defamilialisation. This concept provides the analytical foundation for constructing a typology of European care models based on outcome data. Defamilialisation refers to the extent to which the state assumes or mitigates family caregiving responsibilities, thereby reducing intergenerational dependency. Such state involvement may take the form of direct provision of LTC services (e.g., residential facilities, home care coverage, professional personnel) or of financial transfers and leave schemes that substitute for, or compensate, family-provided care.

On one side, drawing on the seminal contributions of Leitner (2003) and Esping-Andersen (1999), the analysis assesses the degree to which formal LTC services are developed and accessible. In familialised systems, care remains predominantly a family responsibility due to the limited availability of publicly funded or formally organised services. Conversely, in defamilialised contexts, legal entitlements, substantial public investment, and a formal care infrastructure facilitate the transfer of care responsibilities from households to the state or other institutional actors.

On the other side, building on Esping-Andersen's (1990) classic framework, the concept of commodification captures the degree to which care-dependent individuals must rely on the market—or on their own financial means—to obtain care. In a more recent contribution focused specifically on care, Claassen (2011) argues that (de)commodification does not necessarily coincide with defamilialisation: Even where the state alleviates families of care duties, beneficiaries may still be dependent on the market, or alternatively, shielded from it. In this perspective, decommodification denotes the extent to which individuals can maintain a dignified standard of living without purchasing care services on the market. Decommodified systems provide public cash benefits that mitigate the financial risks associated with dependency—either by compensating income loss or subsidising care costs. In contrast, commodified systems offer limited or no financial support, leaving individuals exposed to market dynamics and personal financial constraints.

2.2.4. LTC Multilevel Governance

The governance of LTC systems is characterized by multilevel arrangements that involve a complex interplay between central, regional, and local institutions. Far from being the exclusive responsibility of national governments, LTC policy is typically co-produced through vertically differentiated layers of authority. As Johnson (1999) suggests, the term “state” should be understood as an umbrella concept encompassing a constellation of public institutions operating across the political-administrative spectrum. Within this multilevel framework, diverse forms of delegation, decentralisation, and devolution shape how LTC services are regulated, financed, and delivered. For instance, as highlighted by Béland and Marier (2020), LTC in Canada is primarily managed at the provincial level, while in Latvia, municipalities play a leading governance role (Rajevska, 2018). These arrangements are not merely administrative; they reflect institutional legacies and political choices about where responsibility for care should reside.

Multilevel governance is therefore not simply a matter of institutional design but a central explanatory factor in understanding cross-national and intra-national variation in LTC. As Fischer et al. (2021) argue in their actor-centred typology, effective analysis of governance must consider who governs, at which level, with what authority, and through which institutional configurations. Their framework distinguishes between the functions of provision, financing, and regulation, and highlights the roles of both public and non-public actors. Importantly, decentralisation can both enable tailored responses at the local level and reproduce territorial inequalities if not supported by adequate coordination and redistribution mechanisms.

While vertical governance arrangements have received much attention, horizontal coordination is equally crucial—particularly at the central level. In many systems, LTC policy spans multiple domains, including healthcare, social protection, and labour, and is often jointly managed by ministries of health, ministries of social affairs, and other sectoral agencies. The effectiveness of LTC systems frequently depends on the degree of inter-ministerial coordination, as fragmented or siloed governance can hinder the integration of services and dilute accountability. For example, in several European countries, tensions between health and social care ministries complicate the implementation of integrated care pathways, especially for older adults with complex needs.

Colombo et al. (2011) emphasize that countries with strong vertical and horizontal coordination mechanisms—such as national LTC insurance schemes or inter-ministerial task forces—are better equipped to ensure consistency in service delivery and equitable access. By contrast, systems that rely heavily on local discretion without mechanisms of financial equalisation or cross-sectoral integration often suffer from fragmentation and regional disparities. Pavolini (2021), through a comparative typology based on eligibility, benefit types, service organisation, and financing, highlights the wide variation in central-local arrangements across EU member states. His analysis stresses the importance of distinguishing between formal decentralisation and the *de facto* capacity of institutions to implement and govern LTC effectively. Empirical research further supports this view. Studies by Damiani et al. (2011) and Ariaans et al. (2021) show that multilevel governance is often a latent but decisive variable

in shaping LTC typologies. The same policy instrument—such as a cash-for-care scheme—may yield different results depending on the level of governance and the surrounding institutional context. Similarly, Da Roit and Weicht (2013) demonstrate how multilevel dynamics influence not only public provision, but also the regulation of migrant care labour, a core component of many European LTC regimes.

As noted above, the division of responsibilities in the regulation and implementation of LTC policies can significantly influence the design of policy measures, including the definition of eligibility criteria and—as will be further explored below—the mix of instruments employed (Damiani et al., 2011; Ariaans et al., 2021). In many countries, the cross-sectoral nature of LTC results in shared administrative authority, typically between the Ministry of Social Affairs and the Ministry of Health, or between different levels of government. In such cases, access criteria may vary depending on whether the need is classified as health or social-related.

This co-responsibility in the governance of LTC has important political and institutional implications, which are examined in greater detail in the following chapters. These dynamics often stem from the distinct policy legacies that have developed within the healthcare and social protection sectors, and are shaped by broader welfare trajectories and institutional configurations at the national level.

Table 2.9. provides an overview of the countries in which the responsibility for LTC policy is either concentrated within a single ministry or distributed across two or more ministries. This institutional variation is a critical factor in understanding the diversity of LTC governance models across Europe.

Table 2.9. Horizontal Governance in the Implementation of Long-Term Care Policies in European Countries.

Horizontal governance (among Ministers)	Countries
<i>Unitary</i> [LTC responsibility up to 1 Minister]	Denmark, Finland, Sweden, Austria, Belgium, Germany, Ireland, Luxembourg, Malta, Netherlands, Spain, Greece, France, Poland, Portugal, Romania, Slovakia, Slovenia
<i>Separated</i> [LTC responsibility up to 2 or more Ministers]	Bulgaria, Croatia, Cyprus, Czechia, Estonia, Hungary, Italy, Latvia, Lithuania

Source: Author's elaboration on MISSOC (2024).

Vertically, the governance of LTC is often more complex than it may initially appear. Responsibilities related to beneficiary selection, financing, and service provision are frequently fragmented across different levels of government, producing at least four distinct models of vertical governance, as summarised in Table 2.10. The establishment of multi-level governance structures has significant implications for access, equity, and consistency in LTC provision. Territorial fragmentation—as seen in countries such as Spain and Italy—can result in substantial regional disparities, with highly differentiated access to services depending on local regulations, funding capacities, and administrative priorities. These territorial variations may also foster political contestation over responsibility

allocation and resource distribution, leading to unequal outcomes within national systems.

Beyond the question of financing mechanisms, Table 2.10. further illustrates how institutional responsibilities are distributed between central and subnational levels of government. In highly centralised systems, such as Germany, Luxembourg, and the Netherlands, LTC is typically managed through employment-based social insurance schemes administered by a single, centralised agency. By contrast, universalistic or mixed models tend to rely on shared governance arrangements, wherein responsibilities for both funding and service delivery are distributed across multiple layers of government.

This multilevel configuration is often designed to enhance policy adaptability and administrative scalability, enabling LTC systems to respond to diverse institutional, demographic, and territorial challenges. However, it also introduces risks of coordination failure and unequal coverage, particularly where financial equalisation mechanisms are weak or absent. Table 2.10. provides a comparative overview of the distribution of responsibilities for LTC across EU member states, mapping the levels of government involved in policy design, financing, and service implementation, and highlighting the institutional logics underlying each national model.

Table 2.10. Allocation of Responsibility for Beneficiary Selection, Financing, and Service Provision in European Countries.

Responsibility for Recipient Selection	Financial Responsibility	Responsibility for Service Provision	Countries
Local	Central and local	Local	Sweden, Denmark, Finland, Spain, France
Central	Central	Central	Austria, Czech Republic, Germany, Luxembourg, Netherlands, Luxembourg ⁶
Central and local	Central and local	Local	Poland, Italy, Bulgaria, Croatia, Cyprus, Czechia, Estonia, Hungary, Latvia, Lithuania
Local	Local	Local	Hungary, Slovakia, Slovenia, Portugal, Ireland, Greece

Source: Author’s elaboration on Lee et al. (2024).

2.2.5. Regulatory Aspects: Public-Private Provision

The provision of care represents the foundational function and normative core of any LTC policy. It involves the direct delivery of support, ranging from medically oriented tasks—such as administering medication and assisting with personal hygiene—to broader dimensions of care, including domestic tasks, emotional support, and efforts to foster social inclusion (Fischer et al., 2021). While provision is

⁶ Luxembourg operates under an occupational-based social insurance system, centrally administered by the *Assurance Dépendance*. This arrangement reflects a highly centralized model of long-term care governance, where coverage is closely tied to employment status and contributions.

the most visible aspect of LTC, it is deeply embedded within wider systems of financing and regulation, which fundamentally shape the scope, quality, and accessibility of care.

Regulation, understood as the structured influence on behaviour through rules, norms, and institutional arrangements (Koop & Lodge, 2017), differs from both financing and provision in that it does not involve direct resource transfers or service execution. Nonetheless, regulatory frameworks are central to defining eligibility criteria, quality standards, and the division of responsibilities among different actors. Although typically associated with the state, regulatory authority can also be exercised by professional organisations, market actors, community networks, and international bodies (Braithwaite et al., 2007).

Drawing on Fischer et al. (2021) and adopting a “care diamond” framework (Pijl, 1994; Razavi, 2007 in Fischer et al. 2021), four principal actor types can be identified in LTC governance: The state, the market, the family or household, and the voluntary or third sector.

In this typology, the state is the most comprehensive actor, capable of intervening across all three LTC functions—financing (via taxation), provision (via public agencies), and regulation (via legislation and policy frameworks). Sweden exemplifies such a public universalist model (Timonen, 2005; Theobald & Ozanne, 2016). Alongside state actors, societal actors—including mutual aid societies, religious organisations, and non-profit foundations—play a significant role in many contexts, both in universalist and residual welfare systems (Alber, 1995; OECD, 2011). These organisations not only deliver and finance care but can also assume regulatory functions, particularly where state oversight is weak. A further category of societal actor is represented by social insurance institutions, which, though often formally independent from government, are central players in countries such as Germany, Japan, and South Korea. These bodies collect contributions, pool risk, and may set benefit levels and access rules (Joshua, 2017).

Within the private realm, two distinct actor types can be identified: For-profit providers and private individuals. For-profit actors deliver LTC services under market conditions, including residential care, home care, and insurance products. Their role has grown in parallel with marketisation trends and cash-for-care policies (De Roit et al., 2016), and they increasingly influence LTC policymaking, especially in the insurance sector (Norton, 2000).

Private individual actors—mainly family members or friends—remain the primary providers of unpaid informal care (Daatland & Herlofson, 2003). Their involvement is shaped by welfare regimes, the structure of entitlements, and the availability of formal services. Although their caregiving is often unregulated, it carries significant financial and emotional burdens, including lost income and out-of-pocket expenses. In some contexts, these individuals also coordinate and fund private care solutions. The boundary between individual and market actors can be blurred, particularly in the case of live-in migrant care workers, who combine characteristics of both: Relational proximity and contractual arrangements. These actors are more accurately situated in the for-profit category, despite their hybrid nature (Lyon & Glucksmann, 2008; Simonazzi, 2009; King-Dejardin, 2019).

In terms of regulation, private actors—both for-profit and individual—may engage in self-regulation, especially in the absence of strong public oversight. However, their regulatory influence remains limited compared to public and institutional actors. The distinction between the regulatory roles of these two private categories is often empirically ambiguous, and for analytical clarity, this framework adopts a unified category of “private actors” for the regulatory dimension. Finally, as Gough (2013) has noted, LTC governance should also be analysed in supranational terms. While international influence is relatively modest in LTC compared to other welfare domains, global actors—including international organisations, international NGOs, transnational corporations, and migrant care chains—are becoming increasingly relevant. In the Global South, INGOs and bilateral aid agencies are already involved in both LTC provision and financing (Kaasch & Martens, 2015; Loichinger & Pothisiri, 2018). International organisations such as the WHO, ILO, and OECD also contribute to the diffusion of norms, data systems, and policy models (Colombo et al., 2011; WHO, 2015; Esquivel, 2017). As global demographic trends and care needs intensify, recognising the role of transnational actors will be increasingly essential to understanding the future evolution of LTC systems.

In analysing the configuration of LTC systems across Europe, two additional dimensions merit particular attention: The regulatory balance between public and private actors, and the instrumental mix through which support is delivered—namely, the relative use of in-cash benefits versus in-kind services. The first dimension, often associated with the privatization of care, is analytically complex and difficult to quantify. However, a useful proxy is the level of out-of-pocket expenditure, which offers indirect evidence of the extent to which households must mobilise private resources to compensate for gaps in public provision (see Table 2.6.).

Building on the work of Palomera and León (2023), European LTC systems reveal distinct regulatory trajectories, shaped by institutional legacies and welfare regime types. The diffusion of quasi-markets and New Public Management principles has transformed the governance of care, leading to varied configurations of public-private interaction. In Nordic countries—especially Sweden and Denmark—universalist traditions of public service provision have evolved into hybrid systems that maintain strong public funding and regulatory oversight while incorporating provider pluralism, including for-profit and not-for-profit actors, to enhance user choice and flexibility.

By contrast, liberal welfare states such as the United Kingdom adopted quasi-markets more extensively. The introduction of demand-side subsidies (e.g., care vouchers) and the outsourcing of services resulted in a care system heavily dominated by for-profit providers, particularly in residential care. While these reforms promoted individual choice, they also raised concerns regarding equity, quality, and public accountability.

In Southern and Continental Europe—including Italy, Spain, and Germany—market-based reforms emerged more gradually, often in the context of underdeveloped public care infrastructures. In many cases, quasi-markets served primarily to expand coverage without expanding public supply, particularly following the 2008 financial crisis. Cash-for-care schemes and competitive contracting were used to

mobilise private providers and alleviate fiscal pressure. This dynamic has frequently fostered the emergence of informal care markets, heavily reliant on migrant labour, with uneven levels of regulation and quality control. Germany represents a more institutionalised version of this model: A social insurance-based system coexists with a regulated quasi-market, in which both nonprofit and for-profit providers operate under public supervision. Yet even here, growing concern exists about the role of multinational investment funds, particularly in residential care, raising issues related to transparency, market concentration, and responsiveness to user needs.

3. A Proposed Typology for Understanding Institutional Change in the LTC Policies

Building on the preceding systematic literature review, this section develops a typology of institutional change in LTC policy⁷. The typology draws on the cross-national variation identified in the review and seeks to capture distinctive policy configurations. Since this dissertation focuses on institutional dynamics at the national level (see Chapter 1), the typology is designed to trace countries' policy trajectories following the introduction of reforms.

To examine distributive conflicts in structural LTC reform, the typology relies on two core dimensions: (1) eligibility rules, which define who can access benefits and thus signal horizontal or vertical equity in access, and (2) the instrumental dimension, which distinguishes between in-kind services and in-cash transfers. Eligibility highlights the inclusiveness or restrictiveness of entitlement structures, while the instrumental dimension reflects governments' investment priorities—whether privileging services or monetary transfers.

Other institutional dimensions are analytically relevant but less suitable for a parsimonious typology. The financing dimension, though central, is diffuse and multi-layered, spanning contributory, tax-based, and out-of-pocket sources, which makes it analytically unstable as a single axis of comparison. Multilevel governance, while politically salient, introduces context-specific dynamics given the territorial variation in national, regional, and local responsibilities, resisting systematic operationalisation. The regulatory dimension, which captures the balance between public and private provision, is similarly difficult to compare due to the institutional heterogeneity of market actors, non-profit organisations, and informal providers across Europe.

By contrast, eligibility rules and the instrumental mix of benefits are codified at the national level, systematically documented, and comparatively tractable. Crucially, they directly capture distributive choices: Eligibility defines the inclusiveness of access, while the instrumental mix reveals governments' priorities in allocating resources between services and transfers. Together, they provide the most

⁷ In this section, the term “policy” is used rather than “system”, as the aim is to capture the political direction expressed through regulatory choices and policy objectives in the field of long-term care. Accordingly, the variables identified are designed to serve this analytical purpose.

robust and theoretically meaningful lens through which to analyse institutional change in LTC policies.

This typology builds on the structural characteristics of policy instruments—what Esping-Andersen (1990) called “output dimensions”—rather than on performance or outcome indicators. In contrast to much of the literature privileging evaluative or outcome-based metrics (e.g., Colombo et al., 2011; OECD, 2023), the focus here is on the architecture of LTC instruments—how they are designed, governed, and regulated. This approach is consistent with scholars such as Pavolini and Ranci (2008), who argue that institutional outputs are a more reliable lens for identifying long-term shifts in welfare state configurations, especially in policy fields like LTC, where outcomes are shaped by multiple intervening variables. While this perspective does not resolve the well-known divergence between formal provisions and their practical effects (the output-outcome gap), it offers a systematic framework to trace institutional evolution at the national level.

To ground the analysis, it is useful to recall the three core policy objectives of LTC policies (see Chapter 1): (1) Promoting health maintenance, (2) Providing social relief and assistance, and (3) Ensuring income protection for individuals facing care dependency. The first two objectives are typically operationalised through in-kind services (e.g., domiciliary and residential care), whereas the third is addressed through monetary transfers (e.g., care allowances or compensatory benefits).

Building on van Damme et al. (2025), the analysis incorporates the defamilialisation dimension of LTC (see section 2.2.4.). In addition, and consistent with the third policy objective of *income protection*, it introduces the dimension of decommodification. This captures the degree to which policies shield individuals from market dependence when facing care needs and thereby provides a means to infer the distributional interests underpinning policy trajectories. Two orthogonal axes can therefore be identified: Familialisation/defamilialisation and commodification/decommodification. The latter derives from the institutional role of cash benefits in protecting household income against the costs of purchasing care services. In this context, decommodification refers to the extent to which individuals are able to maintain a socially acceptable standard of living without reliance on participation in the care market—that is, without the need to purchase care services privately.

The two axes intersect but cannot be collapsed into one another. LTC policies simultaneously redistribute care responsibilities and shape individuals’ exposure to market risks. For instance, in-kind services provided or subsidised by the state both defamilialise care (by substituting for family labour) and decommodify beneficiaries (by reducing reliance on the market). Similarly, cash transfers may relieve households’ financial burden, but their level, conditionality, and regulation determine whether they genuinely insulate individuals from market dependence or instead expose them to unregulated and precarious care arrangements.

For these reasons, decommodification constitutes an analytically distinct and complementary dimension alongside defamilialisation. It broadens the analytical scope beyond the family-state nexus to assess the degree to which individuals are protected from commodified care. Taken together, the two axes provide a robust framework for mapping institutional variation and tracing welfare state

trajectories in European LTC policies.

Accordingly, two analytical *continua* are proposed to capture the degree of policy development along these dimensions:

- Familialization vs. De-familialization of Care Responsibilities.

This *continuum*, drawing on the seminal work of Leitner (2003) and Esping-Andersen (1999), assesses the extent to which formal LTC services are developed and accessible. As said in Section 2.2.4., in familialised systems, care remains primarily a family responsibility due to the limited availability of publicly funded or formally organized services. In de-familialised contexts, by contrast, legal entitlements, substantial public investment, and formal infrastructure support the externalization of care responsibilities from households to the state or other institutional actors.

- Commodification vs. De-commodification of Income Protection.

Building on Esping-Andersen's (1990) seminal framework, this *continuum* captures the extent to which care-dependent individuals must rely on the market—or on their own financial resources—to secure care. In a more recent contribution specifically focused on care, Claassen (2011) argues that (de)commodification does not coincide with defamilialisation: Even when the state relieves families of care responsibilities, beneficiaries may still remain dependent on the market or, alternatively, be protected from it. In this sense, decommodification denotes the extent to which individuals can maintain a dignified standard of living without having to purchase care services on the market. Decommodified systems provide public cash benefits that mitigate the financial consequences of dependency, either by offsetting income loss or by subsidising care costs. By contrast, commodified systems offer limited or no financial assistance, leaving individuals exposed to market forces and personal financial constraints.

For the purpose of this typology, the focus is placed on cash transfers. The decision not to concentrate directly on in-kind benefits reflects well-documented challenges of comparability. In-kind services are characterised by significant heterogeneity across countries in terms of coverage, governance, and quality standards (Béland & Marier, 2020). Data on welfare effort in this sector are equally fragmented and often shaped by multi-level governance arrangements, complicating systematic cross-national operationalisation. By contrast, cash benefits are predominantly codified at the national level and regulated through national legislation, with clearer entitlement rules and more standardised reporting. This makes them a more suitable basis for cross-country comparison and for capturing institutionalised distributive commitments. To empirically position countries along the proposed continua, two macro-institutional indicators are employed. A third indicator—namely, the share of public expenditure devoted to in-kind services and cash transfers—is used to quantify the welfare effort, thereby capturing the extent of state commitment within the relevant policy domain.

First, eligibility criteria for monetary benefits capture the inclusiveness of access. Universal eligibility implies broad access regardless of income, age, or care dependency, reflecting a universalistic

orientation. By contrast, categorical eligibility involves a combination of criteria—such as age and dependency level, or income and care needs—thus restricting entitlement to specific subgroups. Finally, systems defined as residual restrict access strictly through means-testing, irrespective of assessed need or age, embodying a selective approach to income protection.

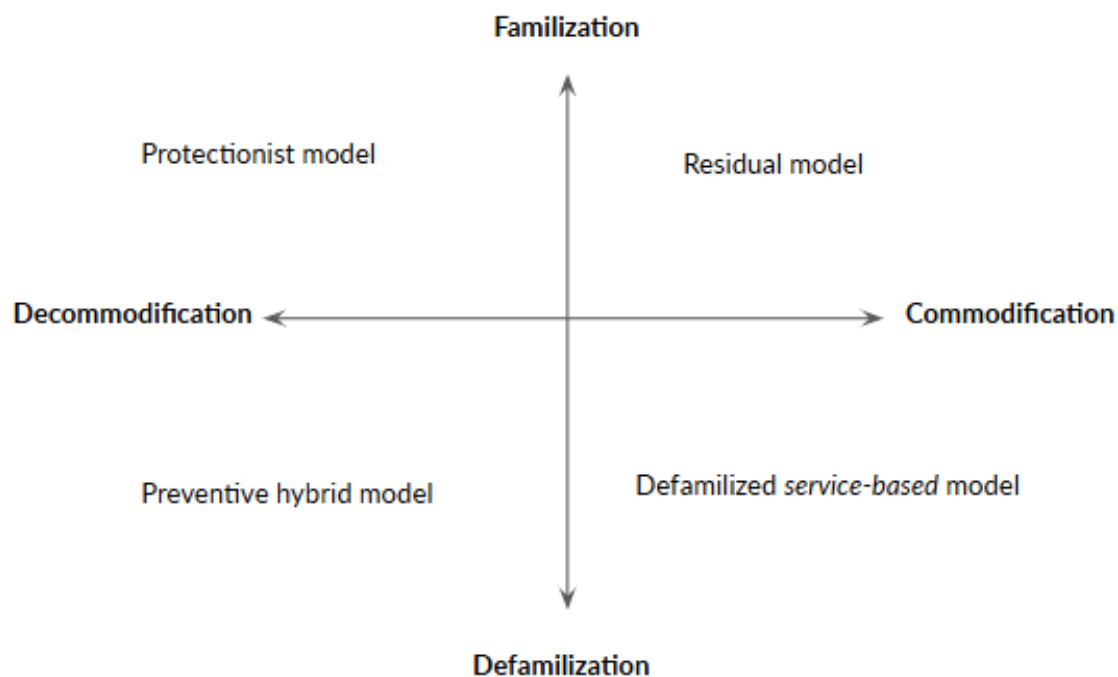
Second, the conditionality of cash transfers—that is, whether benefits are tied to the purchase of formal services or can be freely spent—captures the governance logic underpinning LTC policies. As highlighted in the literature on quasi-markets and user choice (Da Roit & Le Bihan, 2010), conditionality indicates whether states retain a strong steering role by channelling demand toward regulated service provision, or whether they prioritise consumer autonomy by allowing benefits to operate as *de facto* subsidies for informal caregiving or as mechanisms of income compensation.

Third, the share of public expenditure allocated to in-kind services and to monetary transfers, as reported in OECD Health Statistics (2024) and reinforced by Pavolini (2022), provides a proxy for governments' fiscal priorities. This indicator directly links institutional commitments to resource allocation strategies, signalling whether states privilege service provision or income protection.

This analytical focus on cash transfers should not be interpreted as downplaying the relevance of service-based criteria. Rather, it reflects a pragmatic and theoretically informed choice: Cash benefits offer a clearer institutional window into distributive logics, while in-kind services remain central but are analytically less tractable in comparative perspective. Moreover, the degree of conditionality in cash transfers serves as a valuable proxy for assessing the balance between autonomy and regulation in LTC governance, thereby linking micro-level user choice with macro-level state steering. Finally, it is important to emphasise the scope of this typology. By privileging the institutional architecture of cash transfers, the analysis inevitably abstracts from the heterogeneity of service provision, which remains a fundamental component of LTC policies. The typology should therefore be interpreted as capturing national-level institutional commitments, rather than as a comprehensive measure of overall welfare effort or lived care outcomes.

Figure 2.5. presents a synthetic typology of LTC policies by mapping countries along two key institutional dimensions: The degree of familialisation (i.e., the extent to which care responsibilities remain within the family) and the degree of commodification (i.e., the extent to which access to care and income protection depends on private market resources). The intersection of these continua yields four ideal-typical models, offering a systematic framework for tracing institutional variation and trajectories in European LTC policies.

Figura 2.5. Ideal-Typical Models of Long-Term Care Policies in Europe.



Source: Author's elaboration.

The upper-left quadrant represents the *protectionist model*, characterised by a strong emphasis on income support through monetary transfers and comparatively limited investment in formal service provision. These policies prioritise income protection for dependent individuals—typically through universal or means-tested cash benefits—yet do not substantially defamilialise care responsibilities.

The lower-left quadrant captures the *preventive hybrid model*, where countries combine a developed infrastructure of in-kind services with non-negligible cash transfers. These policies aim to balance income protection and service provision, enabling user choice and supporting informal caregivers while simultaneously investing in preventive and home-based care.

The upper-right quadrant reflects *residual policies*, defined by limited public investment in both services and monetary support, alongside restrictive and categorical eligibility criteria. In these contexts, care provision relies predominantly on informal arrangements, resulting in high levels of familialisation and commodification.

The lower-right quadrant encompasses *service-oriented or de-familialised models*, in which formal care services—particularly in-kind provisions—are well developed and strongly supported by public funding. In some cases, cash benefits are also included, but these are typically conditional and tied to the use of formal care, thereby reinforcing the state's steering role in care governance.

This section applies the typology by operationalising the proposed analytical dimensions—familialisation

versus defamilialisation and commodification versus decommodification—through a set of macro-institutional indicators. Table 2.11. presents the selected items and variables, drawing on the most recent data available (European Commission, 2021). Additional information on eligibility criteria and the conditionality of cash transfers has been integrated using the 2024 MISSOC comparative tables.

Table 2.11. Dimensions of Variation: Public Spending on LTC Measures, Access Criteria, and Conditions for Cash Benefits.

Country	Eligibility criteria for cash transfers	Conditionality of cash transfers	Public spending on in-kind services (% GDP)	Public spending on cash transfers (% GDP)
BE	Categorical	Yes	2,1	0,2
BG	Categorical	No	0,5	0,1
CZ	Categorical	Partially (for some dependency levels)	1	0,5
DK	None	None	3	0
DE	Universal	Yes (Level I allows cash; higher levels favour services)	1,2	0,7
EE	Categorical	No	0,4	0
IE	Categorical	No	0,9	0,3
EL	Categorical	No	0,1	0
ES	Categorical	Yes	0,7	0,1
FR	Universal	No	1,8	0,1
HR	Categorical	No	0,3	0,2
IT	Universal	No	0,8	0,9
CY	Categorical	No	0,1	0,1
LV	Categorical	No	0,3	0,1
LT	Categorical	No	0,6	0,4
LU	Universal	Yes	1	0,1
HU	Categorical	No	0,4	0,1
MT	Categorical	No	1,1	0
NL	Universal	Yes	2,6	1,2
AT	Universal	No	0,8	0,8
PL	Categorical	No	0,5	0
PT	Categorical	No	0,5	0
RO	Categorical	No	0,3	0
SI	Categorical	Yes	0,8	0,2
SK	Categorical	Partially	0,5	0,5
FI	Universal	Yes	1,9	0,2

SE	Universal	No	3,1	0,1
NO	Universal	No	2,3	0,1

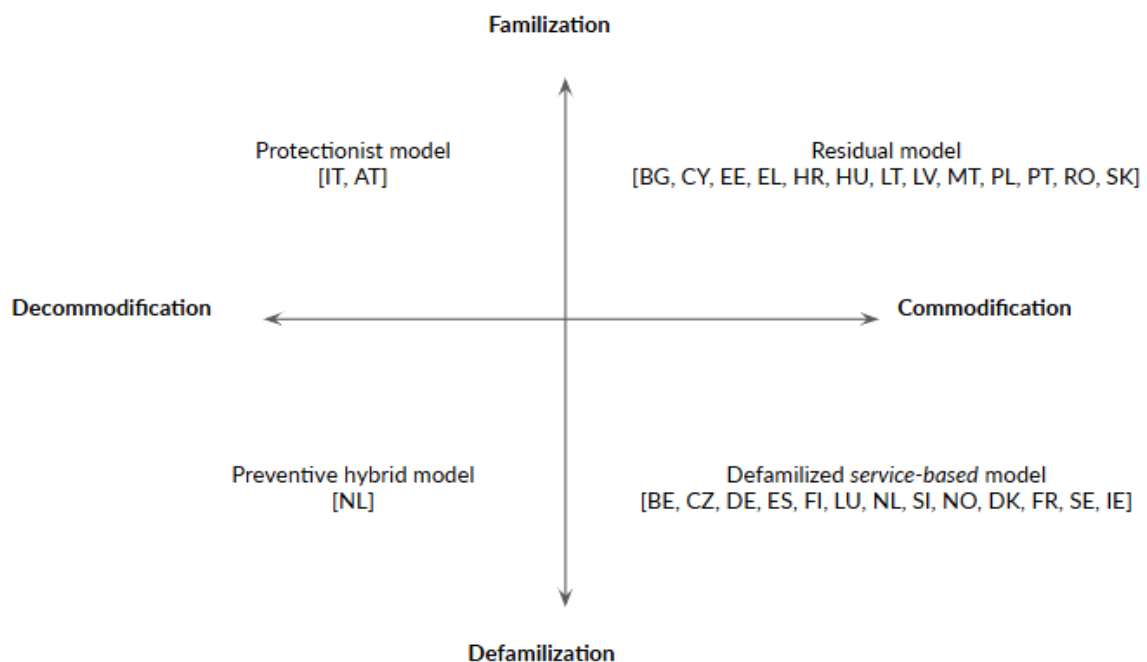
Source: Author's elaboration on Ageing Report (2024), Llena Nozal et al. (2025) e MISSOC (2024).

The typology identifies four ideal-typical models of LTC policies in Europe, each representing a distinct configuration of service provision, income support, and the distribution of care responsibilities. Figure 2.6. illustrates the positioning of EU countries within these models, based on the indicators presented in Table 2.11.

Therefore, the resulting classification distinguishes between:

- **Protectionist models**, where income support is emphasized through cash transfers under universal eligibility and minimal conditionality, yet with limited investment in formal services.
- **Residual models**, marked by low or fragmented public intervention, categorical or means-tested access, and a high reliance on informal care.
- **Preventive hybrid models**, characterized by a balanced mix of services and cash benefits, inclusive access, and a moderate degree of user autonomy.
- **Defamilized service-based models**, where strong investment in formal care is combined with conditional cash transfers that steer users toward regulated service use.

Figure 2.6. An Application of Ideal-Typical Models of Long-Term Care Policies in Europe.



Source: Author's elaboration.

The protectionist model is exemplified by Italy and Austria. Here long-term care policies are primarily oriented around substantial cash transfers, provided under universal eligibility criteria and without conditionality on their use. The preventive hybrid mode is characterised by a relatively balanced

distribution of public expenditure between in-kind services and cash benefits. Among the countries surveyed, the Netherlands best fits this model. The defamilialised service-based model, public spending is clearly skewed toward formal, in-kind services, and cash benefits—if available—are typically subject to conditionality. This model includes a diverse set of countries—Belgium, the Czech Republic, Germany, Spain, Finland, Luxembourg, Slovenia, Norway, Denmark, France, Sweden, and Ireland—all of which display a strong institutional role in the delivery of services, accompanied by steering mechanisms that constrain how monetary support may be used. Finally, the residual model is characterised by limited overall public investment in long-term care, with low levels of support both in terms of services and cash benefits. Eligibility is typically categorical, and conditionality, where present, is not a defining factor. In these contexts, families remain the primary providers of care, and individuals face limited protection from market dependency or out-of-pocket expenditure. Countries such as Bulgaria, Cyprus, Estonia, Greece, Croatia, Hungary, Lithuania, Latvia, Malta, Poland, Portugal, Romania, and Slovakia are representative of this model, where the state plays a minimal role and long-term care remains largely informal and under-resourced.

4. Conclusion

This chapter has advanced a comprehensive framework for the analysis of LTC policies in Europe, grounded in a multidimensional understanding of their institutional architecture. Recognising LTC as a hybrid and evolving policy field—one that cuts across traditional boundaries between health and social care, public and private responsibility, and formal and informal provision—the chapter has sought to render this complexity analytically tractable. Rather than approaching LTC as a residual or marginal sector, it positions it as a central arena in which broader welfare state transformations are negotiated.

To this end, five key dimensions of institutional variation have been identified through a systematic review of the literature: Financing and coverage, eligibility criteria, instruments, governance structures, and regulation of public-private provision. These dimensions have been reconstructed and integrated to capture the institutional logics that shape national care regimes. Building on this foundation, the chapter has developed a typology of LTC policies designed to identify patterns of convergence and divergence among European countries. Crucially, the typology moves beyond descriptive metrics such as spending levels or demographic indicators, and instead emphasises institutional design, policy priorities, and the configuration of care responsibilities.

The typology reveals how European countries cluster around distinct care orientations: Some prioritise public responsibility and de-familialisation through formal services, while others rely more heavily on familial care, often supported by cash transfers or subsidies for private provision. These models reflect not only structural arrangements but also underlying political and normative tensions. Two dimensions emerge as especially salient for both scholarly and political debates: The degree of familialisation *versus* de-familialisation, and the extent of commodification *versus* decommodification. Together, they capture the contested boundaries of responsibility between state, family, and market.

It is essential, however, to clarify the scope and conditions of this typology. The framework is not intended to provide an exhaustive measure of welfare effort or lived care outcomes; rather, it offers a comparative lens focused on institutional commitments at the national level. By privileging codified rules and resource allocation patterns—especially in the domain of cash transfers—it abstracts from the heterogeneity of service provision that is often shaped by decentralised governance or local implementation. This abstraction is deliberate: it enables systematic cross-national comparison while acknowledging that service quality, accessibility, and outcomes remain vital yet analytically distinct dimensions.

The typology should therefore be understood as a heuristic device for mapping institutional configurations and policy orientations under comparable conditions. It is best suited for tracing institutional change and distributive conflicts in contexts where reforms have redefined the balance of care responsibilities, whether by recalibrating eligibility, reshaping benefit instruments, or altering the division of labour between public, private, and familial actors.

In conclusion, this chapter has laid the conceptual and empirical groundwork for a comparative analysis of institutional change in European LTC policies. The proposed typology provides a robust analytical tool for classifying national models, interpreting their internal logics, and situating them within broader welfare state trajectories. As the following chapters will demonstrate, this framework enables the identification of reform paths, degrees of path dependency, and the political conditions under which significant transformations—or resilience—have taken place.

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1. Introduction

Over the later decades of the twentieth century, LTC began to emerge—gradually, unevenly, and often marginally—as a critical policy field within Southern Europe. Within this region, Spain, Italy, and Portugal shared a common heritage of undeveloped LTC systems characterized by institutional neglect, fragmented service delivery, and a deeply entrenched familialist model of care. Unlike Northern and Central European counterparts—where LTC had begun to be framed as a specialized public policy

subject by the 1970s—these three nations continued to rely heavily on private households, predominantly women, to provide essential care for older adults and people with disabilities. The absence of a coherent institutional framework, low levels of public expenditure, and a policy focus on income maintenance via contributory pension schemes collectively reinforced a residual approach to dependency.

The causes behind the delayed recognition of LTC as a public responsibility in these countries lie in both structural and ideational factors. From a structural perspective, the welfare regimes of Spain, Italy, and Portugal were shaped by democratic transitions, the dominance of corporatist pension systems, and limited fiscal capacity. Their social policies evolved under the influence of normative expectations that caregiving was a family obligation, and a gendered division of care responsibilities further exacerbated the invisibility of dependency in the public sphere. Ideationally, Catholic social doctrines emphasized intergenerational solidarity, reinforcing the notion that care was a moral rather than a policy concern. Legally, long-term care was virtually absent from early social welfare legislation, signifying its marginal role in comparative policy discourse.

Nonetheless, beginning in the 1980s and intensifying throughout the 1990s, LTC began to reveal itself as a growing social and political problem across all three contexts. Rapid demographic ageing, increasing female labour participation, and the stress on informal caregiving networks called attention to the inadequacies of existing arrangements. In addition, broader transformations in the political-administrative landscape—including democratic consolidation in Spain and Portugal, decentralization reforms, and a gradual embrace of European social standards—created institutional opportunities to reconceptualize dependency as a public issue. Civil society, disability rights groups, academic networks, and ageing advocacy organizations began to frame LTC as a matter of social rights rather than family responsibility, thus pressuring governments to act. Employing a structured, focused comparison, the chapter deciphers the divergent national pathways within a shared welfare paradigm, drawing out systemic continuities and critical junctures within this formative period.

Methodologically, this chapter adopts a historical-institutionalist lens, interpreting LTC policy formation as a result of path dependency, institutional layering, and constrained agency within context-specific configurations. The comparative strategy emphasizes within-country historical narratives followed by cross-country synthesis. Each national case is reconstructed through historical reconstruction of events and primary legislation, building an integrated narrative of both incremental shifts and punctuated reforms.

The chapter unfolds as follows. Section 2 undertakes a detailed reconstruction of the Spanish case. It begins with the transition to democracy and the constitutional decentralization of social policy competences, which enabled regional governments—*Comunidades Autónomas* (CC.AA.)—to experiment with emergent LTC models. The articulation of aging as a social problem culminated in strategic planning frameworks such as the *Plan Gerontológico* (1991) and the *Acuerdo Marco* (1993), marking a nascent but territorially uneven shift from informal to quasi-formal care provision. This section traces

the expansion of service delivery infrastructures, the interplay between national and regional policies, and the structural limitations that persisted well into the 1990s.

Section 3 analyzes the Italian trajectory, which centered on the introduction of the *Indennità di accompagnamento* in 1980. As a universal, non-means-tested cash benefit aimed at individuals with severe disability or dependency needs, this instrument became the cornerstone of national LTC policy. While politically durable and widely accessible, it also instilled a compensatory logic that constrained the development of a service-oriented system and hindered inter-sectoral coordination. The section comprehensively reviews legislative milestones, ideological rationales, judicial interventions, and regional disparities that shaped the Italian case.

Section 4 explores the Portuguese experience, characterized by a slower and more fragmented reform path. Portugal's LTC policy lacked both the legal formalization seen in Italy and the regional experimentation observed in Spain. Instead, it was shaped by incremental health-sector reforms—such as community nursing pilots and continuity-of-care initiatives—combined with the public role of non-state providers, namely Catholic charities and *Misericórdias*. The analysis traces how demographic ageing gradually entered policy discourse, how pilot projects informed coordination between the National Health Service and social agencies, and how limited fiscal commitment maintained LTC in a covert and informal state. Particular attention is given to how administrative capacity, and civil society shaped a policy field that remained embryonic at century's end.

Section 5 synthesizes these national developments through comparative analysis. It examines how similar structural pressures—demographic ageing, fiscal constraint, democratic transition—produced divergent institutional responses. Three central axes of variation are examined in depth: (a) the degree of decentralization and intergovernmental coordination, which determined regional diversity or national uniformity; (b) the balance between cash transfers and service development, influencing both equity and system capacity; and (c) the nature of socio-political mobilization, which shaped policy framing and public recognition of dependency. This comparative reflection foregrounds both the internal logics of each trajectory and the shared characteristics that define the Southern European model of LTC. It also situates these trajectories within broader theoretical debates about welfare expansion and policy layering.

In conclusion, the chapter reflects on how the patterns identified between 1980 and 1999 structured subsequent developments in LTC—foreshadowing the more formalized, service-rich regimes of the twenty-first century. Spain's trajectory provided institutional precedents for the 2006 Dependency Act; Italy's generous cash model entrenched a compensatory paradigm resistant to development of services; and Portugal's experience highlighted the limits of informal expansion in the absence of state capacity. This introduction thus sets the stage for a detailed analysis of policy trajectories, exploring how path dependency, institutional designs, and normative frames intersected to produce three distinct trajectories within the Southern European welfare regime.

2. The LTC in Spain (1980-1999)

This section reconstructs the policy trajectory that shaped the emergence of Spain's LTC system during the final two decades of the twentieth century. The analysis is structured into three main parts. Section 2.1. sets the stage by examining the historical configuration of long-term care provision in Spain, highlighting its residual and fragmented nature within the broader conservative-corporatist and familialist welfare regime. Section 2.2. explores the main policy innovations introduced during the 1980s and 1990s. Finally, Section 2.3. offers a retrospective synthesis of the period. This section also provides analytical ground for understanding the policy choices that would later culminate in the landmark 2006 Dependency Act (*Ley de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia*), presented in Chapter 5 of this thesis. Together, these components offer a comprehensive overview of the complex and uneven path through which long-term care gradually entered the Spanish policy agenda.

2.1. The Origins of a Residual and Fragmented LTC System in Spain

The foundational social, economic, and institutional structures of the Spanish welfare state were established during the 1960s and extended through the political and democratic transition. Between 1977 and 1990, Spain underwent a prolonged and intensive period of reform that ultimately resulted in a welfare state characterized by incomplete universal coverage and limited protection (Moreno, 1997; Moreno, 2003; Rodríguez Cabrero, 2011). The legitimacy of the Francoist regime—who brought together a heterogeneous alliance of conservative and fascist groups—founded on the support of the Army and the Catholic Church⁸. Under Franco's authoritarian rule, the State emphasized the family as the primary provider of welfare, especially for vulnerable populations such as the older people, children, and individuals with disabilities (Moreno, 1997; Moreno, 2003; Espuelas Barroso, 2022). To sustain minimal State intervention, the Catholic Church promoted family solidarity, traditional gender roles, and the expectation that women would assume unpaid caregiving roles within the household (Cazorla Sánchez, 2002).

The welfare state inherited by the Franco regime was a strongly centralized and underdeveloped version of the Bismarckian model (Guillén, 2010). The worker was considered as a unit of economic production and, accordingly, was entitled to receive social protection against unexpected risks: The Spanish welfare state was based on a corporatist and occupation-based system, providing limited, fragmented, and selective social security (Moreno, 2000). Benefits were tied to employment through contributory schemes funded by employers and employees, following a Bismarckian model of social protection (*ibidem*) while vulnerable groups, particularly agricultural workers and women without

⁸ In 1937, Franco declared "Our State must be Catholic *in the social*. The *obra social* (social work) was set up in order to bring joy and bread to the Spanish families" (Moreno, 1992: 5).

formal employment, were often excluded from coverage. Public spending on social welfare was minimal, and the state's involvement in providing social care, especially for the older people, remained restricted, fostering a deeply ingrained reliance on family structures for care (Guillén, 1992; Moreno & Sarasa, 1992; Espuelas Barroso, 2022).

The long-term care sector was primarily limited to social provisions for old age (primarily through pensions) and work-related disability. In 1939, the SOVI (*Seguro Obligatorio de Vejez e Invalidez* - Compulsory Insurance for Retirement and Invalidity) was introduced to offer benefits to low-wage workers. This public insurance scheme operated alongside a voluntary system of mutual benefit societies, which eventually collapsed. In 1942, statutory sickness insurance was implemented, though it imposed a fixed duration of coverage regardless of the claimant's health condition. The implicit objective was to encourage employees to return to work as quickly as possible.

Following Recio & Roca (1998), Francoism's approach to social policy can be divided into two eras: Autarky and developmentalism. During the autarkic era, social policies were minimal and focused on ideological conformity through paternalistic measures. Economic isolation and scarcity limited the state's capacity to expand social welfare, with initiatives aimed at reinforcing traditional family structures and legitimizing the regime. The developmentalist phase marked a shift towards economic modernization and integration into global markets. Increased industrialization and urbanization necessitated expanded social services, including healthcare, education, and early forms of dependency care. The regime adopted a pragmatic approach, using social policies to address social dislocations caused by rapid economic changes and to appease emerging middle-class demands. This shift highlights how economic strategies shaped the regime's priorities in social policy development. The Franco regime changed political allies to maintain power. Initially supported by the traditional rural noble class, it later relied on an emerging urban bourgeoisie (from 1959 to 1975).

Between 1959 and 1975, during the years of *desarrollismo* ("economic developmentalism"), several youth organizations evolved into radical Catholic institutions that collaborated with Marxist groups in opposition to Franco's regime (Moreno & Sarasa, 1992). In 1963, a pivotal development in social policy was the enactment of Ley 193/1963, also known as the *Ley de Bases de la Seguridad Social*. This law aimed to establish a universalist approach to social security, though its fiscal reform was limited. The *Ley* allowed for the creation of complementary benefits in addition to the basic provisions (V clause), which encompassed services such as occupational health and safety, preventive medicine, rehabilitation and retraining for people with disabilities, and educational initiatives (XV clause). The law's principal goal was to establish a unified and integrated model of social protection based on redistribution, public management, and State involvement in funding. Despite these guiding principles, many of which were incorporated into the 1966 *Ley de Seguridad Social* (effective in 1967), older contributory systems persisted. Additionally, the lack of regular benefit revaluations and the continued existence of numerous overlapping institutions impeded progress towards a unified system.

During this period, several decrees led to the establishment of targeted social services. In 1968, a Social Service for the Assistance of Mentally Disabled Minors was created, though its activities were limited to providing financial aid to families for educational and rehabilitative expenses. In 1970, the Social Service for Assistance to the Older People⁹ (*Servicio Social de Asistencia a Los Ancianos*), originally outlined in the *Ley de Bases de la Seguridad Social* of 1963, was formally implemented. This initiative provided comprehensive gerontological support, including home care services and access to residential facilities, aimed at addressing the diverse needs of the aging population. In the same year, Decree 2531/1970 established the *Servicio de Recuperación y Rehabilitación de Minusválidos* (SEREM) and the *Servicio de Asistencia a Personas con Discapacidad* (SAP).

However, the 1972 Financing and Improvement of Protective Action Act aimed to address the financial challenges within the social security framework but inadvertently worsened them by expanding benefits without securing adequate funding. Consequently, comprehensive reforms to the Social Security system did not materialize until the democratic transition and the ratification of the Spanish Constitution. During Spain's transition to democracy (1975-1978), the first democratically elected government, led by Adolfo Suárez in 1977 under the Unión de Centro Democrático (UCD), enacted significant reforms. Among these, the Royal Decree-Law 36/1978, in alignment with the Moncloa Pacts¹⁰, established a system of institutional participation for social actors, promoting transparency, rationalizing Social Security, and implementing a new management framework.

The Royal Decree-Law focused on the institutional management of Social Security, health, and employment, and led to the creation of the National Institute of Social Services (Instituto Nacional de Servicios Sociales - INSERSO). INSERSO¹¹ integrated the SAP and SEREM, as well as other Social Security management bodies, forming the initial unified structure for the management, monitoring, and

⁹ This Social Service established an "organización de asistencia o ayuda domiciliaria a los beneficiarios" (Art. 2°, Section b. of the aforementioned regulation). Furthermore, the Order issued by the same Ministry on February 26, 1971, approved the National Social Security Plan for Assistance to the Older People, one of whose areas of action focused on the development of home assistance. This was established as a benefit within the Spanish Social Security System and, therefore, aimed at affiliated workers. However, its provision was limited to the most vulnerable sectors of the population. Nevertheless, the initiatives that were launched during the 1970s as a result of this legislation were isolated projects that, certainly, did not achieve any statistical significance (Moreno & Sarasa, 1992).

¹⁰ The Moncloa Pacts (in Spanish: *Pactos de la Moncloa*) were agreements signed at the Moncloa Palace between various social groups and the main Spanish political parties in October 1977, during Spain's transition period. Their aim was to agree on the drafting of a new constitution and to address the socio-economic problems of that time.

¹¹ Subsequently, Royal Decree 140/1997, dated January 31, redefined the institution as the Instituto de Migraciones y Servicios Sociales (Institute of Migration and Social Services), expanding its remit to include immigration services. Finally, Royal Decree 1600/2004, issued on July 2, which established the basic organizational structure of the Ministry of Labor and Social Affairs, set its current designation as the *Instituto de Mayores y Servicios Sociales* (IMSERSO, Institute for the Older People and Social Services). Today, IMSERSO operates under the auspices of the Ministry of Social Rights, Consumer Affairs, and the 2030 Agenda.

evaluation of social services in Spain, particularly those addressing the needs of the older people (see *infra*). This restructuring consolidated services for old age and disability under INSERSO, a quasi-autonomous public agency within the Ministry of Labor. In the same year, the neo-government established the General Directorate for Social Action and Social Services (*Dirección General de Acción Social y Servicios Sociales*) within the Ministry of Health and Social Security. This new body assumed responsibility for social assistance and public charity work, previously distributed across various central government departments. The General Directorate also managed the Social Assistance Fund (*Fondo de Asistencia Social*), which provided non-contributory benefits for old-age and disability pensions, serving as a primary instrument of social assistance during this period.

The 1978 Constitution was instrumental in reshaping Spain's welfare system, laying a legal foundation for expanded social rights and access to healthcare and social security (Sueiro Seoane, 2004). Articles 49 and 50 of the Constitution indirectly addressed dependency, safeguarding the rights of people with disabilities and ensuring economic security for the older people (Abramovich & Courtis, 2002; Alonso Seco & Alemán Bracho, 2017; Holgado González, 2021). Specifically, Article 50 obliges the State to promote citizens' well-being in old age "through a system of social services¹² that will address their specific health, housing, cultural, and recreational needs."

The *Ley de Seguridad Social* in 1978 provided further regulation for permanent disability, including provisions for "severe disability" (*gran invalidez*), which applies to workers with disabilities requiring assistance from another person for essential daily activities. Individuals classified under this category are entitled to a lifelong pension, supplemented by an additional allowance intended to support the caregiver (Art. 139.5). Additionally, Article 181(a) specifies an economic allowance for each child under 18 or for individuals over 18 with a disability of 65% or higher, to be paid to the eligible beneficiary.

Despite the attempt to modernize and democratize the social security system, building on prior reforms and aligning with the principles of the 1978 Spanish Constitution, which enshrined social rights as fundamental, as noted by Moreno & Sarasa (1992), the welfare reforms implemented in Spain since 1977 were shaped significantly by features inherited from the Francoist welfare system, often characterized as "despotic corporatism"¹³ (see also Esping-Andersen, 1990). In fact, social spending in

¹² This concept of social services would later become a source of contention between the State and the CC.AA. in the management and implementation of long-term care policies following the 2006 reform (see Section 5).

¹³ Despotic corporatism, as seen during the Francoist regime in Spain, combined centralized control, corporatist labor management, and reactionary social policies. Rooted in traditional Catholic doctrine and fascist ideology, it promoted hierarchical social structures while suppressing independent labor movements and emphasizing obedience and conformity. Welfare policies were paternalistic, offering limited benefits tied to employment and excluding marginalized groups, while prioritizing capitalist accumulation over social equity. This model preserved social stratification through selective welfare distribution, aligning with conservative Catholic values and emphasizing charity over universal rights (Moreno & Sarasa, 1992).

Spain remained notably limited; by the end of the Franco regime, the Spanish welfare system was underdeveloped relative to the core Western European countries.

Although expenditures increased, Spain's social spending remained well below the EEC average, which reached 25,9% in 1982. Furthermore, in 1977, only 4% of social spending was funded from the national budget, with the remaining share financed through direct contributions from employers and employees. This reliance on contributory funding contrasted sharply with Western Europe, where approximately 30% of social spending came from national budgets (Espuelas Barroso, 2022).

That means, the Spanish welfare state thus retained a dualistic structure in which non-contributory benefits were generally less generous than their contributory counterparts, and the efficiency of social services was undermined by inadequate coordination among the various governmental agencies involved. Social benefits were structured around the “income maintenance” principle, with a general affiliation regime established for employees in all industrial and service sectors. In terms of social services, as previously mentioned, the limited services introduced in the 1970s lacked universal coverage and were financed entirely through employer and employee contributions to the social security system. These services suffered from inefficiencies primarily due to poor interagency coordination; community-based care services were non-existent, except for a few small programs managed by the Catholic Church.

In practice, decentralization became an essential reform strategy during this period, enabling Autonomous Communities to assume a significant role in shaping social policy through multi-year plans coordinated within the Sectoral Conference on Social Affairs (León & Migliavacca, 2013). Simultaneously, local authorities continued to administer various social assistance programs, many of which were legacies of traditional public charities and beneficence (Marbán Gallego, 2008). Private institutions, particularly those linked to the Roman Catholic Church, also remained active, providing charitable donations and specific services. With Spain's transition to democracy, there emerged a renewed demand for the establishment of comprehensive social services, coupled with a mobilization of social workers dedicated to developing a modernized framework for service provision (Sarasa, 1993; Casado et al., 1994). This period marked a shift from a Bismarckian welfare model towards a universalistic regime, laying the groundwork for addressing social reproduction and enhancing political legitimacy (Guillén, 1992; 1996). Nonetheless, regional disparities and deeply rooted gender biases continued to impede the development of a fully state-supported caregiving model, thereby reinforcing the family's significant role in the provision of welfare (Moreno, 2000; Moreno & Rodríguez Cabrero, 2007).

In terms of policy outcome, from 1960 public spending on social welfare increased substantially (Alcaide Inchausti, 1988; Cazorla Sánchez, 2002; Espuelas, 2022). Spending on old-age pensions rose steadily from 1.2% of GDP in 1960 to 4.45% by 1979. Survivorship pensions also increased from 0.18% to 1.68%, and invalidity pensions expanded from 0.24% to 1.68% during this period, indicating a heightened recognition of the need to protect individuals incapacitated by long-term disabilities. Furthermore,

healthcare spending demonstrated one of the most substantial increases: Rising from 0.92% in 1960 to 4% in 1978. While family-related policies showed fluctuations, with notable peaks in 1967 and declines in subsequent years. Meanwhile, expenditure on unemployment and active labor policies remained relatively low throughout the period: Unemployment spending saw a marked increase toward the late 1970s, indicating an emerging recognition of unemployment as a critical social issue requiring enhanced public intervention.

Although democratic reforms and the 1978 Constitution laid the groundwork for expanded rights and services, persistent challenges—including regional disparities, limited funding, and gender biases—continued to hinder the realization of a fully integrated welfare system. The family thus remained a central pillar of support, highlighting the ongoing tension between state-provided and family-based care in Spanish social policy. These were the foundations that guided the reforms of the 1980s and 1990s. Table 3.1. summarizes the main laws and decrees in the period under review.

Table 3.1. Main Spanish Legislative Steps from 1939 to 1978.

Law or Decree	Year	Description
Seguro Obligatorio de Vejez e Invalidez	1939; 1947	Compulsory insurance for retirement and invalidity, providing benefits to low-wage workers alongside a voluntary system of mutual benefit societies. It applied to those who do not qualify for benefits under the general social security system.
Seguro Obligatorio de Enfermedad	1942; 1944	Sickness insurance with fixed-duration coverage. It was compulsory sickness insurance, providing workers with access to basic healthcare.
Ley de Bases de la Seguridad Social	1963	It established the foundational framework for Spain's modern social security system. It unified disparate welfare schemes into a cohesive structure, providing comprehensive coverage for healthcare, pensions, unemployment, and other social benefits.
Ley de Seguridad Social	1966	It was built upon the 1963 Ley de Bases de la Seguridad Social, formalizing the unified Spanish social security system. It provided a more detailed regulatory framework, consolidating various welfare programs into a single system that guaranteed comprehensive social protection, including healthcare, pensions, unemployment benefits, and disability support.
Servicio Social para Menores con Discapacidad Mental	1968	It aimed to integrate educational and social services for minors with mental disabilities, ensuring specialized attention, inclusive education, and access to resources for their development.
Social Service for Assistance to the Older People	1963 (i.e. <i>Ley de Bases de la Seguridad Social</i>); 1970	It established a gerontological support service, including home care and residential facilities for the older people.
Servicio de Recuperación y Rehabilitación de Minusválidos (SEREM) and Servicio de Asistencia a Personas con Discapacidad (SAP)	1970	It established an organization and program dedicated to serving individuals with disabilities.
Asistencia a Pensionistas de la Seguridad Social	1974	It expanded access to healthcare services through the Compulsory Health Insurance (SOE), which covered medical consultations and subsidized medications. Additionally, the system reinforced economic support for widowhood and disability and enhanced home assistance programs under the supervision of the National Institute of Social Security (INP).
Gestión Institucional de la Seguridad Social, la Salud y el Empleo	1978	It was enacted to modernize and democratize Spain's welfare institutions in line with the principles of the Spanish Constitution of 1978. It aimed to decentralize and improve the efficiency of the administration of social services by restructuring the management of Social Security and aligning it with democratic governance.

Source: Author's elaboration.

2.2. The Spanish Reforms of the Eighties and Nineties

Between the 1980s and 1990s, Spain's welfare state evolved from a fragmented, corporatist model rooted in the Franco regime into a more universalist system, though significant limitations persisted. Under Franco (1939-1975), welfare provisions were minimal, employment-linked, and heavily reliant on family and Church-based care, reinforcing gendered caregiving and excluding vulnerable groups.

Modest reforms in the 1960s aimed to expand coverage but failed to overcome structural fragmentation.

Democratic reforms post-1975 laid the groundwork for broader welfare expansion. A major turning point came in 1986 with the creation of the National Health Service under the PSOE government, signaling a shift toward universal healthcare. However, family benefits remained limited and increasingly means-tested, with Spain maintaining one of the lowest levels of expenditure in this area among EU countries.

Throughout the 1980s and 1990s, social spending stabilized at levels closer to the European average, thanks to earlier fiscal reforms. Yet the system retained strong familialist traits, with public provision uneven and highly regionalized—a legacy that continued to shape long-term care policy development. This phase followed the rapid expansion of social spending during the democratic transition and maintained expenditure growth without dramatic acceleration or reduction, ensuring sustainability through fiscal reforms implemented in 1977¹⁴. Section 2.2.1. identifies the foundational pillars of the Spanish LTC system, focusing on the early mechanisms—both in-cash and in-kind—that provided partial responses to growing dependency needs. Section 2.2.2. explores the pivotal role of *Comunidad Autónomas* in structuring and delivering LTC services, highlighting how decentralization fostered territorial variation but also policy innovation. Section 2.2.3. traces the gradual political and societal recognition of ageing as a distinct social risk, catalyzing fragmented but meaningful responses. Finally, Section 2.2.4. analyses the development of Ageing Plans, discussing whether these were joint or parallel efforts by the Ministry of Social Policy and the Ministry of Health, and their significance in consolidating a strategic vision for older people care.

2.2.1. The Foundational Pillars of LTC System in Spain

The period from 1982 to 1992 is widely recognized as one of paradigmatic transformations in Spanish social policy (Guillén, 2010; Guillén & León, 2011; Del Pino, 2020). During this decade, characterized by sustained socialist leadership under Prime Minister Felipe González—marked by successive absolute majorities—significant strides were made in the expansion of the welfare state¹⁵.

In the early 1980s, political pressure from various advocacy groups for people with disabilities, led by Catalan politician Ramón Trías Fargas, resulted in the approval of a structural reform in the sector. In

¹⁴ This reform introduced a more redistributive approach by increasing the importance of income taxes over social contributions, which were considered regressive (Espuelas Barroso, 2013: 2).

¹⁵ In its 1982 electoral manifesto, the PSOE stated: “The socialist social services program will develop the following lines of action [...]: Community promotion and engagement; welfare support for families and children without an adequate family environment; welfare services for the older people and individuals with physical, psychological, and sensory disabilities [...]” (PSOE Electoral Manifesto, 1982).

1982, Law 13, the *Ley de Integración Social del Minusválido*¹⁶ (hereafter, LISMI - Law on Social Integration of the Disabled) was enacted. Targeted specifically at citizens with disabilities, LISMI established the first comprehensive framework for social rights concerning temporary and long-term disabilities.

In 1984, Royal Decree 383 was enacted to regulate the system of social and economic benefits established under Article 16 of the LISMI. Within the framework of non-contributory benefits related to disability and incapacity for work, the *Subsidio por Asistencia a Tercera Persona* was introduced as financial support for individuals with disabilities who required third-party assistance for basic activities, such as dressing, mobility, and eating. The *Subsidio* was designed to function either as a complementary benefit or independently of the three other subsidies outlined in Article 16 of LISMI: The *Subsidio de Garantía de Ingresos Mínimos*¹⁷, *de movilidad y compensación por gastos de transporte*¹⁸, and *de Asistencia sanitaria y prestación farmacéutica*¹⁹.

The *Subsidio por Asistencia a Tercera Persona* was allocated to adults aged eighteen or older with a disability rating of 75% or higher, whose condition necessitated the assistance of another person for essential daily life activities. For purposes of eligibility (*i.e.*, invalidity), the *Subsidio* targeted individuals not covered under the Social Security System, did not reside in an institutional care setting, with personal economic resources that did not exceed 70% of the annual calculation of the *Indicador Público de Renta de Efectos Múltiples* (IPREM) in effect at the time. The initial amount of the *Subsidio* was set at 5,000 pesetas per month (around 30 euros) when the Royal Decree 383/1984 was enacted.

In 1985, the *Orden de 16 de mayo de 1985*, established the *Estatuto Básico de los Centros de Tercera Edad*, a foundational framework that structured these centers, outlining the roles of directors and participatory governance mechanisms like user assemblies and boards. Centers were categorized based

¹⁶ It is important to note that the concepts of disability and non-self-sufficiency are distinct and do not necessarily overlap (see Chapter 2 for further discussion). An individual may experience disabilities without being classified as non-self-sufficient.

¹⁷ Introduced in Law 13/1982 and then regulated in 383/1984, the *Subsidio de Garantía de Ingresos Mínimos* was a non-contributive in-cash transfer offering last-resort economic benefits aimed at preventing poverty and ensuring a basic standard of living for individuals and their dependents when no other means of subsistence are available or when these means are insufficient (Frazer & Marlier, 2016). Recipients were required not be covered by the Social Security system due to unemployment or receive similar benefits from other public bodies unless these are of lower value, in which case the difference is paid. Personal income must not exceed 70% of the annual income, with a 10% increase per dependent up to 100%. Applicants must be 18 years or older and have a disability rating of at least 65%, preventing suitable employment opportunities.

¹⁸ A periodic subsidy designed to cover the costs associated with travel outside the usual residence of individuals with disabilities who, due to their condition, face severe difficulties in using public transportation.

¹⁹ Healthcare and pharmaceutical assistance aims to provide services that preserve and restore the health of beneficiaries. Eligible recipients include individuals with a disability rating of 33% or higher, who are not entitled to healthcare or pharmaceutical benefits under any other mandatory or voluntary scheme, whether as primary recipients or dependents, within the general or special regimes of the Social Security system.

on the level of assistance required, differentiating day centers from residential facilities. By 1986, regulations evolved to include a sophisticated points-based admissions system, prioritizing applicants according to socio-familial circumstances, degrees of physical and mental disability, and economic need. In 1987, further refinement introduced a structured financial contribution system for residents, with provisions to support those facing economic hardship. Additionally, a mandatory three-month adaptation period was established to assist new residents with integration into the centers.

In its second term (1986-1989), the Socialist government increasingly focused on social policy amidst growing pressure from trade unions such as UGT and Comisiones Obreras (CC.OO.), who urged the implementation of PSOE's campaign commitments, including reforms to health services and the restructuring of public administration (Moreno & Sarasa, 1992). Reflecting this policy shift, the government created the Ministry for Social Affairs in 1988. Social policy measures during this period, such as expanded unemployment coverage and improvements in retirement pensions, contributed to what scholars describe as the "social transition" within Spanish democracy (*ibidem*).

Toward the end of the 1980s, further progress was made with the approval of the *Acción Concertada del Instituto Nacional de Servicios Sociales* in 1989, which regulated contractual agreements with private residential centers for the older and disabled. This quasi-market arrangement allowed INSERSO to contract spaces in private facilities to accommodate individuals in need of care. The *Acción Concertada* prioritized centers in urban areas and required facilities to meet both national and regional standards, ensuring quality residential care. Additionally, co-payment criteria were established: INSERSO reserved up to 50% of contracted places for beneficiaries residing in the province where each center was located. Importantly, INSERSO retained the right to select individuals for these spaces, ensuring equitable access based on beneficiaries' needs.

A key milestone for the universalization of non-contributory benefits and the development of the Spanish long-term care system was the enactment of Law 26/1990, which incorporated non-contributory benefits into the General Social Security Law. Law 26/1990 established economic assistance for dependents over the age of 18 with a disability of 65% or greater (Art. 181-184); the classification of "severe disability" (as per Law 26/1990, on Non-Contributory Benefits); and third-person assistance benefits (originally established by Law 13/1982 on the Social Integration of Disabled Persons) (Marbán Gallego, 2012). Importantly, the integration of non-contributory benefits preserved the management of social services by the CC.AA., which retained exclusive competence in social services, classified as non-contributory provisions under Law 26/1990.

However, non-contributory invalidity pensions under Law 26/1990 offered care allowances only as a complement to these pensions and introduced an upper age limit of 65 for eligibility. Disabilities arising after age 65 were not covered; instead, support for such cases was limited to tax deductions under IPREM, primarily benefiting families who lived with a dependent member. In other words, for the new beneficiaries, it incorporated the *Subsidio de Ayuda a Tercera Persona*, which—although limited—constituted an explicit support measure for long-term care needs.

2.2.2. The Devolution of Power to *Comunidad Autónomas* in the Provision of the LTC

In the late 1980s and early 1990s, Spain's CC.AA. began establishing regulations for social services aligned with competencies granted by the Spanish Constitution. This decentralization initiated a fragmented but gradually evolving system of social care, where EE.LL., including municipalities and provincial councils, assumed an increasingly active role in delivering community-based services. Although the Spanish Constitution provides a broad interpretation of "social services" the long-term care sector was notably shaped by Article 148.1.20°, which allowed the CC.AA. to assume responsibilities in "social assistance"—a concept distinct from "social services" at the time of the Constitution's enactment. Leveraging this provision, the CC.AA. crafted their own social services frameworks, resulting in unified objectives nationwide. Between 1982 and 1992, Spain's first-generation social services laws were enacted in multiple CC.AA., followed by second-generation laws, including those in Galicia, the Basque Country, Valencia, La Rioja, Asturias, Madrid, and Murcia, which expanded regional social services landscapes. Despite these laws designating services as universal and accessible, they often constituted a rhetorical right, lacking enforceability and the same weight as established rights in other social protection systems (Rodríguez Rodríguez, 2006: 50).

A crucial development in this regional social services framework was the *Plan Concertado de Prestaciones Básicas de Servicios Sociales en España* of 1988, which promoted intergovernmental cooperation among the central state, CC.AA., and local entities (EE.LL.) (Gutiérrez Resa, 2001). The *Plan Concertado* established a decentralized structure to deliver core social services, aimed at accessibility, essential service provision, and fostering regional and local engagement in welfare. The Plan had a particular focus on vulnerable groups, especially the older, who increasingly required services as Spain's population aged. Its goal was to create a universal framework for essential services accessible to all citizens regardless of region, covering services such as home care²⁰, telecare, day centers, and residential homes (*ibidem*).

Under the *Plan Concertado*, the central government provided funding and set minimum standards, while the CC.AA. took on co-financing, implementation, and management roles, allowing regional adaptation to meet demographic and local needs. In regions with significant older populations, like Galicia and Castilla y León, CC.AA. invested heavily in care for the older people, developing infrastructure and programs suited to local demographics. This decentralized approach enabled innovative region-specific solutions in care for the older people, such as telecare systems and intergenerational support programs. Municipalities were empowered to deliver these services directly, making them well-positioned to respond to the specific needs of aging residents by administering home care, day centers, and telecare. However, financial constraints often required additional support from the CC.AA., especially in rural or low-density areas.

²⁰ Services included assistance with daily activities such as cleaning, meal preparation, and personal hygiene, allowing the older persons to remain at home longer and delaying or preventing institutionalization.

2.2.3. The Gradual Recognition of Ageing as a New Social Risk

In the 1990s, a series of national initiatives played a pivotal role in shaping Spain's approach to long-term care. For the very first time in Spanish history, a Ministry of Social Affairs was created in 1988. This was a crucial step, as the Ministry tried to concentrate social service action in one body. Yet, the Ministry had scarce means and maneuverability capacity due to the decentralization of social services undertaken during the 80's. Within the Ministry it was understood that decentralization had impeded the development of plans to organize and secure the universality of the system of social services. Moreover, the effects of the decentralization of social services were generally evaluated in negative terms due to the lack of control over policies and budgets. The need for intervention mechanisms for the creation of infrastructure was also recognized, through the agreement with other administrations and governmental organizations. Consequently, the Ministry decided to focus its intervention on Plans that entailed common guidelines of action among the different administrations. The Ministry also pursued coordination with other governmental bodies through the development of other General Action Plans (*i.e.*, Old-Age, Drugs, Equal Opportunities). These Plans provided indicative lines of action with no legal obligation, combined with financial resources to accomplish Plan's aims. The Basque Country did not agree with the financial distribution of resources.

The process began with the *Plan Gerontológico* in 1991, followed by the *Acuerdo Marco* in 1993, which aimed at integrating social and healthcare services, and culminated in the establishment of the *Consejo Estatal de las Personas Mayores* in 1994 and the recognition of the "ageing issue" in the *Pacto de Toledo* in 1995.

The Plan Gerontológico and the Acuerdo Marco por Modelos de Atención Sociosanitaria

One of the Ministry's main priorities at that time was the planning of a coherent approach to the consequences of an ageing population. The result of this political priority was the *Plan Gerontológico* (IMSERSO, 1993). This Plan can be considered as the main point of departure regarding current debate about ageing as a global new social risk in Spain. It was elaborated by the IMSERSO between 1988 and 1991, with relevant discussion and observance of other international experiences, and launched in 1992. Its aim was to give an integral and coordinated answer, as between the three administrations, to the needs derived from ageing and to guarantee older people's full integration in society.

The *Plan*, launched by Spain's Ministry of Social Affairs in 1988 and implemented from 1991 to 2000, was adopted by both the Sectoral Conference on Social Affairs and the Interterritorial Health Council. It set forth a strategic framework with five focus areas: Pensions, healthcare services, social services, culture and leisure, and social participation. At the time of its development, a lack of empirical data and resources limited the ability to accurately assess the needs of individuals over 65. Interdisciplinary research on aging was still emerging, with key studies such as the Informe Gaur (1975) and the 1982 First World Assembly on Aging providing only a foundational understanding. Consequently, the *Plan*

sought to fill these gaps by outlining specific objectives, strategies, and actionable measures, delegating responsibility to relevant institutions.

On one hand, the *Plan* responded to the reality of an aging Europe. Spain was experiencing rapid demographic shifts, with growth rates projected of 0.46% between 1996 and 1998 and a slight increase to 1.05% from 1998 to 2000. These changes underscored the urgency of establishing a comprehensive system to support the older. On the other hand, as Requejo Osorio (2009) observed, the older persons were becoming an influential social group with growing impact on labor issues, pensions, healthcare planning, and, importantly, the political landscape through their increasing voting power. A core component of the *Plan* was its emphasis on integrating health and social care services for the older people. It established standards for service coverage, including the creation of day centers and alternative housing options, while formally recognizing the essential role of family caregivers. Additionally, the Plan promoted coordination between healthcare and social services, the inclusion of gender perspectives, and the encouragement of social and cultural engagement for older adults. De facto, the *Plan Gerontológico* was a non-binding framework, providing guidelines and standards adaptable to regional contexts. It recommended milestones to be achieved by CC. AA: *i.e.* the average of 3.5 residential care places per 100 older individuals.

Scholars like Rodríguez Cabrero & Marban Gallego (2013) argue that it represented an effort to align Spain with the European agenda on active aging and intergenerational solidarity. At the same time, the *Plan* incentivized the development of long-term care services at the regional level. As a result, the *Plan* spurred many CC.AA. to develop their own *Planes Gerontológicos*, contributing to a more localized approach to aging policies (see Section 3.2.). The *Plan* required the establishment of Senior Citizens' Councils at multiple levels, institutionalizing older adults' involvement in governance and underscoring the need to address healthcare, economic security, social support, and opportunities for personal development (see above).

This first initiative was accompanied by a second major policy development, in the area of socio-health coordination. This was the 1993 *Acuerdo Marco por Modelos de Atención Sociosanitaria*, an interministerial agreement between the Ministry of Health and Consumer Affairs and the Ministry of Social Affairs. This initiative aimed to meet the rising demand for long-term care due to an aging population and increased chronic illness prevalence. The *Acuerdo Marco* introduced socio-health area commissions, facilitating coordinated care across health and social services for vulnerable groups, particularly the older people and disabled.

The agreement promoted a person-centered care model²¹, with CC.AA. leading implementation efforts. It encouraged collaboration among healthcare providers, social workers, and community organizations to deliver comprehensive services tailored to individual needs. Despite its ambitions, the *Acuerdo Marco* encountered challenges related to financial constraints, coordination difficulties within

²¹ This model will be at the core of national strategies in the post-Covid period (see Chapter 5).

decentralized systems, and professional barriers that limited-service integration (Rodríguez Cabrero & Monserrat Codorniú, 2002). One of the cornerstones of this *Acuerdo* was the promotion of active ageing and quality of life in the community, which constituted a change from the existing policy approach. During the 80's, while some countries in Europe had already been fighting the battle against deinstitutionalization for years, Spain was living in the golden age of construction of high-capacity and well-equipped residential homes for self-sufficient people with multiple socio-economic deficits. However, since the end of the 80's, conceptions of services supporting the advantages of offering attention within the community started to gain ground in Spain. Consequently, an important shift in the policy discourse with respect to the older people took place, and attention was shifted from residential homes to the development of community services.

The Consejo Estatal de las Personas Mayores

A third key development was the *Consejo Estatal de las Personas Mayores* in 1994, via *Real Decreto* 2171/1994. This institution was created to formally integrate older citizens into the policymaking process, drawing inspiration from recommendations of the World Assembly on Aging and Spain's First National Assembly for the Older Persons. Building upon previous regulatory efforts, including *Real Decreto* 1433/1985 and 1856/1979, it aimed to create a centralized advisory body within the Ministry of Labor and Social Affairs.

The *Consejo* was designed to ensure broad representation, incorporating voices from public administrations, civil society, and Spain's CC.AA. It was composed of a president, two vice-presidents, a secretary, and 60 councilors representing different sectors. Notably, the president and first vice-president were senior officials—the Secretary of State for Social Services and the Director-General of IMSERSO, respectively. Civil society representatives were crucial in ensuring that the perspectives of older adults were consistently included in the policymaking process.

Consejo's primary role was to facilitate collaboration between the state and the older, serving as a conduit for older citizens' needs and contributing to the development of policies related to care for older, healthcare, and social inclusion. Beyond advising on legislative issues, it contributed to service development, promoted effective public fund allocation, encouraged research, and supported non-profit initiatives. The *Consejo* also advocated for high-quality standards in care for older people and fostered public-private partnerships to enhance service provision. It operated through a *Plenaria*, meeting biannually, and a *Comisión Permanente*, which ensured continuous representation. This body played a significant role in representing Spain's older population at both national and international levels, especially within the European Union, advocating for their voices in decision-making processes.

The "Ageing Issue" in the Pacto de Toledo

The fourth development, albeit initially indirectly related to long-term care policies, was the *Pacto de*

Toledo. In 1995, The Congress of Deputies approved a document titled “Analysis of the Structural Problems of the Social Security System and the Main Reforms to be Undertaken,” which had previously been approved by the Budget Committee. This approval originated from a non-legislative proposal by *Convergència i Unió* to include a report on the Social Security issue within the Congress’s Budget Committee. This marked the beginning of what is known as the *Pacto de Toledo*²².

The consensus, achieved during a highly turbulent period in Spanish politics, collected representatives from the PSOE, the PP, CiU, and IU came together with a clear objective: To remove the social protection system from partisan controversy, aiming for the highest possible level of agreement when implementing reforms in the system. The document outlined the evolution of the Spanish pension system, identified future factors that could impact it, and proposed a set of fifteen recommendations at a time when the system was relatively well-established, offering more benefits and new forms of coverage, though concerns remained about the funding model. In this agreement, social partners and all parliamentary groups reinforced and reaffirmed the contributory and redistributive nature of the system, recognizing it as the most suitable means to provide protection and coverage to Spanish society, and they committed to defending it.

Therefore, this agreement primarily sought to ensure the sustainability of Spain’s social security system amid growing concerns over pension stability due to an aging population. While the Toledo Pact focused on distinguishing between contributory and non-contributory pensions, it also addressed the financial pressures associated with rising demand for long-term care. The Pact acknowledged that changing family structures—such as the increase in single-person households, childless couples, and urban migration—were weakening traditional family-based care for older, thereby intensifying demands on public health and long-term care systems. In response, the Pact recommended policy adjustments, including recognizing caregiving periods (such as child-rearing or caregiving for dependents) in pension calculations, to adapt to the evolving social landscape and mitigate strain on the social security system.

2.2.4. Ageing Plans: Separate and Joint Initiatives of Ministry of Social Policy and the Ministry of Health

From 1991 onward, the Ministry of Social Policy and the Ministry of Health in Spain implemented a series of initiatives, both independently and collaboratively, to address the growing LTC needs of the older and dependent populations. These efforts, which included the establishment of the *Acuerdo Marco* and other targeted reforms, played a pivotal role in advancing LTC policy in Spain. While many of these initiatives were introduced during the 1990s, their implementation often extended into the early 2000s, reflecting the ongoing evolution of LTC frameworks in response to demographic and social

²² The initial recommendations were embodied in the 1997 Law on the Consolidation and Rationalization of the Social Security System, which, among other measures, set a 15-year period for calculating pensions, indexed contribution bases from years further from retirement age to the Consumer Price Index, and introduced the requirement to build reserves for the system when there are surpluses (the origin of the Reserve Fund).

challenges.

In the realm of social policy (Table 3.2.), the 1999 Evaluation Report on the *Plan Gerontológico* underscored the pressing need for continuous protection mechanisms for dependent older individuals. This evaluation catalyzed discussions on enhancing safeguards for this vulnerable demographic, highlighting the importance of sustained support within Spain's social security and care systems. Simultaneously, the Alzheimer's and Other Dementias Care Plan (1999-2005) represented a significant milestone in addressing the challenges posed by cognitive disorders, particularly Alzheimer's disease. This initiative introduced structured support systems specifically designed for individuals affected by dementia, emphasizing the necessity of specialized long-term care services. The plan marked a critical step in recognizing and addressing the distinct care requirements associated with cognitive impairments.

Building on these initiatives, the Action Plan for the Older Persons²³ (2000-2005) sought to establish a more comprehensive and integrated system of support for dependent individuals. A key objective of this plan was the incorporation of dependency risks into Spain's social security system, demonstrating an increased awareness of the intersection between long-term care needs and broader social protection policies. This initiative aimed to promote a comprehensive approach to dependency by integrating health and social care systems, while also fostering greater alignment with active aging principles and intergenerational solidarity.

Table 3.2. The Spanish Initiatives of the Ministry of Labor and Social Policy for the Older and Long-Term Care Sector, 1991-2000.

Title	Start of the initiative	Brief description
The Plan Gerontológico	1991	It addressed healthcare and social issues related to dependent individuals. It focused on the integration and coordination of healthcare and social services.
Evaluation Report on the National Plan Gerontológico (MTAS)	1999	It evaluated the results of healthcare service integration and coordination with social services, emphasizing socio-health coordination programs in various regions. It promoted debate on socio-health coordination and dependency protection.
Alzheimer's and Other Dementias Care Plan	1999	It was a specific plan under development for individuals with Alzheimer's and other dementias, due to the high social, economic, and familial impact. It aimed to address the needs of both the affected individuals and their families.
National Plan Gerontológico: Action Plan for the Older Persons	2000	In "Equal Opportunities," Area 1, the plan outlined strategies to develop an integrated care system for dependent individuals. It aimed at better coordination with other plans and the inclusion of dependency risk in social security coverage.

Source: Author's elaboration adapted from Rodríguez Cabrero (2002: 7-8).

In the realm of health policy (Table 3.3.), between 1993 and 1999, Spain's healthcare policies advanced significantly in response to the growing need for long-term and integrated care for the elderly. The *Acuerdo Marco* (1993) represented a foundational step in this process, establishing inter-ministerial

²³ This Plan is considered only for the sake of consistency, as it is linked to the preliminary decisions presented in Table 3.2. It is specified here since its approval date (2000) falls outside the time frame defined in this chapter.

collaboration to optimize the organization and delivery of socio-healthcare resources. A key outcome of this agreement was the creation of Socio-Health Commissions across various INSALUD health areas, which were tasked with improving the allocation, planning, and evaluation of care programs. These commissions sought to ensure that resources were effectively managed and directed toward addressing the needs of dependent populations, marking a critical early effort in fostering socio-healthcare integration.

Building upon the principles of the *Acuerdo Marco*, the Criteria for the Organization of Healthcare Services for the Older Persons²⁴ (INSALUD, 1995) introduced a comprehensive framework for care for older people. This framework emphasized an interdisciplinary and rehabilitative approach, with a particular focus on older individuals classified as fragile or high-risk. It aimed to provide holistic care that integrated medical, social, and psychological support, shifting the focus from reactive to preventative and rehabilitative care. By addressing the full spectrum of care needs for older, the framework sought to enhance both quality of life and health outcomes.

The INSALUD Strategic Plan (1997) further reinforced the importance of socio-healthcare coordination as a core pillar of Spain's healthcare system. This plan prioritized the integration of healthcare and social resources, promoting interdisciplinary collaboration and recognizing the centrality of primary care in the delivery of socio-health services. It emphasized early intervention and the necessity of close coordination between healthcare providers and social workers to ensure comprehensive and personalized care for the older people. By positioning primary care as the cornerstone of the socio-health framework, the plan sought to improve accessibility and responsiveness, particularly for individuals requiring long-term care or living with chronic conditions.

To ensure the quality, accountability, and transparency of these services, the INSALUD Quality Plan (1999) introduced service charters in accordance with Royal Decree 1259/1999. These charters established clear standards for service delivery and measurable goals to enhance reliability and user trust in socio-healthcare services. Additionally, the creation of Home Support Teams (*Equipos de Soporte de Atención Domiciliaria*, ESAD, 1999) marked a significant innovation in care for older people. These multidisciplinary teams, composed of primary care and hospital-based professionals, provided intensive home-based care for individuals who were severely dependent or terminally ill. By delivering medical and social support in a home setting, ESAD teams aimed to improve the quality of care for vulnerable populations while alleviating pressure on institutional services.

²⁴ The National Health Institute (INSALUD) was the public entity responsible for the provision and management of healthcare in Spain from its establishment in 1978 until the formation of the current National Health System. Its creation in 1978 marked the dissolution of the former National Institute of Social Security. In 2002, Insalud was subsequently dissolved, coinciding with the establishment of health departments within the autonomous communities.

Table 3.3. Spanish Initiatives of the Ministry of Health for the Elderly and Dependency Sector, 1995-1999.

Title	Start of the initiative	Brief description
Criteria for the Organization of Healthcare Services for the Older People (INSALUD)	1995	It outlined a comprehensive, interdisciplinary, and rehabilitative care scheme for older individuals, particularly those classified as fragile or high-risk, such as those aged 80 or older and geriatric patients aged 75 or older with disabling conditions. The Socio-Health Commission coordinates these programs.
INSALUD Strategic Plan	1997	It adopted Socio-Healthcare Attention as a key strategy, focusing on the integrated coordination of healthcare and social resources, interdisciplinary collaboration, and the responsibility of Primary Care in socio-health services.
INSALUD Quality Plan	1999	It developed the strategic plan and established service charters (Royal Decree 1259/1999).
Creation of Home Support Teams (ESAD)	1999	It established primary and hospital-based care teams for the older people, especially those who are highly dependent or terminally ill.

Source: Author's elaboration adapted from Rodríguez Cabrero (2002: 7-8).

2.3. The Spanish LTC Policy Trajectory: A Retrospective of the 1980s and 1990s

During the 1980s and 1990s, Spain's long-term care policy developed through an incremental and multi-layered process marked by institutional reconfiguration, gradual expansion of social services, and limited central steering. Compared to Italy (Section 3), Spain pursued a service-oriented and regionally driven trajectory.

A key feature of the Spanish model was the absence of a single universalistic in-cash benefit for dependent individuals. While non-contributory allowances such as the *Subsidio por Asistencia a Tercera Persona* (established in 1984 and later incorporated into Law 26/1990) provided targeted support to individuals with severe disabilities, their impact remained limited. The allowance was means-tested, restricted to people under 65, and often insufficient to meet actual care needs. Unlike Italy, where the *Indennità di Accompagnamento* created a *de facto* universal monetary entitlement based solely on care needs (see *infra*), Spanish policy retained a selective and stratified approach well into the 2000s.

At the same time, Spain invested systematically in developing an institutional and strategic infrastructure for older people and disability care. The creation of the Ministry of Social Affairs in 1988 marked a turning point in central efforts to coordinate policy, followed by the adoption of planning instruments such as the *Plan Gerontológico* (1991-2000) and the *Acuerdo Marco por Modelos de Atención Sociosanitaria* (1993). These initiatives emphasized the need to integrate social and healthcare interventions, introduce community-based alternatives to institutionalization, and recognize ageing as a growing social risk. However, their non-binding nature and the decentralized configuration of Spain's welfare governance limited their practical effectiveness and created substantial regional disparities in implementation.

The decentralization of social services, constitutionally enshrined and politically reinforced throughout the 1980s, played a defining role in shaping Spain's LTC architecture. By the early 1990s, most CC.AA. had enacted their own social services laws, assuming exclusive competences over long-term care

delivery. Instruments such as the *Plan Concertado* (1988) facilitated multi-level coordination between central, regional, and local governments, and enabled targeted investments in infrastructure and service provision in regions like Galicia or Castilla y León. Nevertheless, the lack of a common legal framework—partly due to resistance to centralization and fears of overstepping constitutional boundaries—resulted in uneven access, variable eligibility criteria, and fragmented service coverage across the country.

These developments occurred in a context of expanding but still limited social protection expenditure. By the early 1990s, Spain's public spending on social welfare (20.6% of GDP) approached the European average (21.8%) (Espuelas Barroso, 2013), reflecting the consolidation of the welfare state under a social-democratic leadership. Yet, within this broader expansion, LTC services remained modestly funded, and the provision of care continued to rely heavily on familial networks, particularly women. Public efforts focused primarily on pensions, healthcare, and disability-related programs, while services for chronic dependency and multimorbidity remained underdeveloped.

This family-centered model persisted despite growing awareness of changing demographic and social conditions. The *Pacto de Toledo* (1995)—although primarily aimed at pension reform—recognized the pressures placed on informal caregivers and suggested the introduction of caregiving credits in pension calculations. Such measures, however, were compensatory rather than transformative and did not alter the fundamental structure of care provision. Likewise, while initiatives such as the Alzheimer's and Other Dementias Care Plan (1999-2005) acknowledged emerging needs, their scope and funding remained limited.

3. The LTC in Italy (1980-1999)

This section provides an analytical reconstruction of the Italian LTC system as it gradually took shape during the 1980s and 1990s. In this period, Italy did not develop a unified or integrated LTC framework, but rather pursued a path of partial, stratified, and often fragmented reforms that reflected the broader traits of its welfare regime—namely, strong familialism, residual public intervention, and a high degree of institutional inertia.

The chapter is structured into three main parts. Section 3.1. introduces the historical legacy of Italy's welfare state and the roots of its residual and segmented approach to long-term care. It highlights how the Italian model relied heavily on informal caregiving—particularly within families—and on scattered, unevenly distributed services across regions and municipalities, with little coordination between health and social care sectors.

Section 3.2. explores the major policy interventions of the 1980s and 1990s across three critical axes: The development of home-based care assistance in the aftermath of the establishment of the *Servizio Sanitario Nazionale* (3.2.1.), which laid the groundwork for a more universalistic approach to health-

related support; the institutionalization and growing reliance on the *Indennità di accompagnamento*, a cash allowance that became the financial cornerstone of the Italian LTC model despite its lack of means-testing or service linkage (3.2.2.); and the emergence of tentative, albeit limited, reforms in the social assistance sector during the 1990s, which began to signal a growing awareness of dependency as a public policy issue—albeit without producing a systemic response (3.3.3.).

Lastly, Section 3.3. offers a retrospective interpretation of these decades, drawing connections between the institutional legacies of the period and the structural features of Italy’s current LTC landscape. It reflects on how the coexistence of universal healthcare, non-means-tested cash benefits, and residual local services produced a protectionist but uncoordinated model, where families remained the primary providers of care and public action was largely compensatory. This is the basis for understanding 2023 reform, as described in Chapter 6 and 7.

3.1. The Origins of a Residual and Fragmented LTC System in Italy

Despite the secularizing influence exerted by the unified Italian state established in 1861, social policy throughout the nineteenth century remained largely under the control of the Catholic Church. Basic poor relief was primarily managed by national and local charitable organizations, while confessional schools continued to serve as the main providers of education, particularly in central and southern regions. The liberal state confined itself to a regulatory role, supervising ecclesiastical and voluntary actors, including mutual aid societies. It was not until the early twentieth century that the so-called “social question” gained political salience, prompting a gradual redefinition of the state’s responsibilities in welfare provision (Ferrera, 1984).

The construction of the Italian welfare state unfolded across two major political periods: The Liberal regime (1861-1922) and the Fascist regime (1922-1943). In line with broader European patterns of socio-economic modernization, both regimes retained a Bismarckian architecture of social protection, characterized by occupationally fragmented and contribution-based insurance schemes (Jessoula & Alti, 2010). A key turning point came in 1919 with the passage of Law No. 603/1919, which introduced mandatory insurance for invalidity, old age, and unemployment, and established severance pay provisions—later consolidated in the form of the *Trattamento di Fine Rapporto* (Ferrera et al., 2012).

The rise of fascism marked a turning point in the development of Italian social policy. Initially, the regime curtailed welfare expansion by suspending planned sickness insurance reforms and halting the extension of unemployment benefits to agricultural workers. Eligibility criteria for existing benefits were also tightened. However, this restrictive approach was reversed following the institutionalization of the corporatist state in 1927, with the Charter of Labour signaling a more expansive social policy orientation. Social expenditure increased from 3.9% of public spending in 1922 to 14.4% in 1940 (Ferrera, 1984). This shift aimed at consolidating social consensus through corporatist cooperation between capital and labour under the aegis of the National Fascist Party.

The enactment of Legislative Decree No. 636/1939 formally codified eligibility for old-age and invalidity pensions, although the definition of disability remained narrowly tied to permanent loss of work capacity, excluding broader socio-healthcare considerations. Assistance functions were centralized within corporatist institutions such as the *Enti Comunali di Assistenza*, the *Opera Nazionale Maternità e Infanzia*, and the *Opera Nazionale Balilla*. Despite the regime's authoritarian nature, it maintained a strategic alliance with the Catholic Church, which retained substantial autonomy in caring for vulnerable populations, especially children and the poor. This configuration reflected the enduring hybrid structure of Italian welfare—relying on a fragmented mix of public and non-state actors (Ascoli, 2011).

Following the Second World War, the Italian welfare system was restructured under public management with the creation of the Istituto Nazionale della Previdenza Sociale (INPS). Organized into multiple occupational funds (*casse*), the system progressively expanded coverage for old age, disability, sickness, and unemployment throughout the 1950s and 1960s, including to self-employed workers. However, the care of non-self-sufficient older adults remained primarily a family responsibility, with support from the Church or local charities. Residential care homes (*case di riposo*), administered by religious institutions or municipalities, provided mostly custodial care with minimal medical services.

This period reinforced what Ferrera and Maino (2011) describe as a “particularistic-clientelist” model of welfare, where access to benefits was conditioned by occupational status and political affiliation. Although the 1948 Constitution recognized fundamental social rights—most notably Articles 32 (right to health) and 38 (right to assistance in cases of need)—these rights were implemented unevenly. Rather than pursuing universalism, the postwar welfare system preserved its insurance-based logic, underpinned by full (male) employment and sustained economic growth. Italy thus developed a Southern European “familialist” model, where care responsibilities continued to fall primarily on families—particularly women (Esping-Andersen, 1999; Saraceno, 2000).

The political realignment following the 1948 elections further impeded reform. The Christian Democratic victory and Cold War dynamics dampened any momentum for systemic transformation. Instead, prewar institutional arrangements were largely restored, and welfare policy remained marginal in public debate. Incremental and often clientelist reforms prevailed, resulting in a fragmented welfare landscape marked by selective expansion and deep institutional legacies.

As Ferrera (1996) noted, this trajectory produced a “dual distortion”: Functionally, by disproportionately prioritizing pensions over family, unemployment, or long-term care services; and distributively, by reinforcing cleavages between protected insiders (e.g., public sector workers) and unprotected outsiders (e.g., informal workers, women, and the unemployed). Pension policy exemplified both the strengths and imbalances of the postwar model: Generous early retirement options, particularly for public employees, expanded social protection while exacerbating fiscal burdens and intergenerational inequalities. Disability policy—often a precursor to long-term care—evolved within the same insurance-based framework. Law No. 350/1898 had introduced a voluntary

pension scheme for disability and old age, later made compulsory by Law No. 603/1919. The corporatist codification of disability in Decree No. 636/1939 retained a narrow focus on work incapacity. This criterion persisted into the postwar decades, failing to address the broader socio-medical needs of individuals with functional limitations unrelated to employment.

The 1960s marked the beginning of a slow shift toward the medicalization of social assistance. In 1970, with the establishment of the Regions through Law No. 281 of May 5, 1970, the issue of reorganizing the structures and functions of local authorities arose. Two years later, Presidential Decree No. 9 of January 15, 1972, transferred to the Regions the state administrative functions related to public welfare and assigned oversight responsibilities to the Coreco (a Regional Control Committee). Less than five years later, Presidential Decree No. 616 of July 24, 1977, redefined the concept of public welfare to include all activities related to social security. Article 25 of the decree transferred to individual or associated municipalities the functions, personnel, and assets of the Ipab (Institutions of Public Assistance and Charity) operating at the regional level. A special commission was tasked with identifying the Ipab institutions to be excluded from this transfer, specifically those “primarily engaged in educational and religious activities.” Essentially, a distinction was made between welfare services and assistance services, with the latter being further divided into healthcare and social care. The former remained under the responsibility of specific national bodies, while the latter fell under the jurisdiction of local authorities.

A crucial development came with Law No. 118/1971, which expanded eligibility for civil invalidity benefits to minors and adults with impairments that limited their functioning by at least one-third. The law introduced integrated home care services (*Assistenza Domiciliare Integrata* - ADI), outpatient treatments, and economic measures such as disability pensions and attendance allowances. Though still embedded in a Bismarckian logic, it expanded the welfare system's scope to partially address long-term care needs. The most significant institutional milestone was the creation of the National Health Service (*Servizio Sanitario Nazionale* - SSN) via Law No. 833/1978. This reform established universal healthcare coverage and aimed to integrate preventive, rehabilitative, and curative care. It also introduced a decentralized governance model: Legislative and planning authority was transferred to regions, while service delivery was assigned to Local Health Units (*Unità Sanitarie Locali* - USL). However, the SSN did not fully address the needs of non-self-sufficient individuals, nor did it provide mechanisms for the effective integration of health and social care.

Taken together, these historical and institutional developments shaped a long-term care system that remains highly fragmented, residual, and categorical. Italy's LTC trajectory reflects the broader features of the Southern European welfare regime: A limited universalistic ethos, persistent dependence on informal care, weak integration between social and healthcare services, and stark territorial disparities (Ranci & Pavolini, 2013). Table 3.4. summarizes the main laws and decrees in the period under review.

Table 3.4. Main Italian Legislative Steps from 1939 and 1978.

Decree/Law	Year	Description
Legislative Decree No. 636	1939	Codified eligibility criteria for pensions; defined disability narrowly as permanent work incapacity.
Italian Constitution (Articles 32 and 38)	1948	Enshrined the right to health and social assistance in cases of need; limited implementation followed.
Law No. 281	1970	Established the Regions as new administrative units; initiated decentralization of welfare governance.
Law No. 118	1971	Extended eligibility for civil invalidity benefits; introduced integrated home care (ADI) and care allowances.
Presidential Decree No. 9	1972	Transferred administrative functions related to public welfare to the Regions; oversight assigned to Regional Control Committees (Coreco).
Presidential Decree No. 616 (Article 25)	1977	Redefined public welfare to include social security; transferred functions and assets of Ispab to municipalities, except for institutions with religious or educational purposes.
Law No. 833	1978	Established the National Health Service with universal healthcare and regional decentralization.

Source: Author's elaboration.

Despite substantial growth during the “golden age” of European welfare states, the Italian welfare model remains characterized by fragmentation and reliance on traditional family structures. This hybrid system blends corporatist principles with limited universalism, creating persistent inequities and inefficiencies that continue to shape social policy debates in Italy. These dynamic parallels caregiving models in Spain and Portugal, where familism remains a central feature. Consequently, public support for caregiving remains limited, perpetuating socio-economic and gender disparities (Saraceno & Keck, 2010; Saraceno, 2016).

3.2. The Italian Reforms of the Eighties and Nineties

By 1980, Italy exhibited a high level of government social expenditure, accounting for 25% of GDP (Ferrera et al., 2012). Most of this expenditure was directed toward pensions and healthcare, reflecting the prioritization of income security and health services. During the same period, 13.5% of the population was older, representing one-fifth of the working-age population, while fertility rates were notably low at 1.6 children per woman, comparable to levels in the Federal Republic of Germany (*ibidem*). Despite these demographic challenges, care for non-self-sufficient older individuals and individuals with disabilities—whether temporary or permanent—was primarily managed at the family and municipal levels.

The section is structured as follows. Section 3.2.1. examines the introduction and expansion of the *Indennità di Accompagnamento*, which emerged as the main institutional pillar of the Italian LTC system. Subsection 3.2.2. explores key developments within the social assistance sector, highlighting tentative shifts toward community-based services and the formalization of residential care. Finally, subsection 3.2.3. analyzes the major healthcare reforms of the 1990s, with particular attention to the

introduction of the *Livelli Essenziali di Assistenza*, which progressively incorporated LTC-related services into the broader health policy framework.

3.2.1. The Pillar of the Italian LTC: The *Indennità di Accompagnamento*

In 1980, the Italian government introduced the Attendance Allowance (*Indennità di Accompagnamento*, hereafter IdA), which, as will be further discussed, is now regarded as the pillar of Italy's LTC system. Before examining the substance and implications of this reform, it is essential to retrace the key regulatory and legislative milestones that shaped its development.

In the late 1970s, disability activism in Italy underwent a significant transformation with the establishment of the *Lega Nazionale per il Diritto al Lavoro degli Handicappati* (National League for the Right to Work for the Disabled) by the *Partito Radicale Invalidi* (Radical Party for Persons with Disabilities). This organization brought together a coalition of formal and informal advocacy groups from cities such as Turin, Milan, Genoa, Trento, and Rome, aiming to challenge the limitations of Law No. 482/1968, also known as the Law on Mandatory Employment Placement for People with Disabilities. Criticized for its residual and paternalistic approach, the law failed to recognize the professional potential of individuals with disabilities and largely confined itself to passive forms of support. By the early 1980s, this mobilization culminated in the collection of over 100,000 signatures—twice the number legally required—for a legislative initiative. This milestone marked a paradigmatic shift from a welfare-based logic to a rights-based framework, laying the groundwork for more inclusive reforms in both the professional and social domains.

This wave of mobilization laid the foundation for a broader rethinking of the state's role in supporting individuals with severe disabilities, culminating in the introduction of the IdA—a non-contributive, flat-rate cash benefit granted to individuals in need of continuous care, regardless of their socio-economic status. The origins of the IdA can be traced back to Laws No. 313 and No. 406 of 1968, which initially restructured war pensions and extended targeted support to the severely disabled, including blind individuals. These provisions introduced a so-called “super-disability allowance” for war-disabled persons and specific allowances for those affected by tuberculosis-related disability. Law No. 585/1971 refined this framework by allowing allowances to cover informal care expenses, including those incurred by family caregivers, though it remained limited to specific beneficiary categories such as war-disabled individuals.

Amid the economic turmoil of the 1970s—particularly in the aftermath of the oil crisis—awareness grew about the inequities created by this fragmented and status-based system. Civilian invalids emerged as a distinct beneficiary group, separate from war-disabled, work-disabled, or sensory-impaired individuals, often facing more restrictive access to benefits. In response, a reform proposal was introduced in 1979 by members of the *Democrazia Cristiana*, aiming to unify and extend the attendance allowance to severely disabled civilians and blind individuals, including those over the age of 18 who

were previously excluded for not meeting war-related eligibility criteria. Drawing on prior legislative work by the Chamber's Interior Commission, the draft bill targeted individuals whose functional impairments required continuous assistance with daily life.

Fiscal constraints played a critical role in shaping the design of the reform. While Treasury officials resisted the abolition of means-testing and opposed full universalization, the legislation adopted an incrementalist strategy focused on those with the most severe dependency needs. Article 3 of the proposal tasked the Minister of Health with harmonizing disability assessments nationwide—a reflection of broader equity concerns amid economic austerity. The proposed allowance amounted to 300,000 lire, paid in thirteen monthly installments, and was impairment-based, meaning that it did not consider income or employment status. This approach aligned the benefits of severely disabled civilians with those traditionally reserved for war-disabled individuals and extended coverage to children unable to perform age-appropriate activities.

Parliamentary debate framed the IdA as a critical measure to ease the caregiving burden on families and to compensate for the delay in implementing community-based care services envisaged by Law No. 118/1971. Despite resistance from the Committee on Economic Planning and Budget, the bill received broad bipartisan support—including from the *Partito Comunista Italiano*—and was ultimately enacted as Law No. 18 of 1980. The law formally established the IdA as a non-transferable, state-funded benefit for individuals with total physical or mental disabilities requiring continuous care, in 1988 (with Law No. 508/88) it was also expanded eligibility to individuals over 65 and to those with some residual work capacity but profound functional limitations.

The introduction of the IdA marked a pivotal shift in Italy's long-term care model, characterized by two key features. First, it broke from contributory and work-based logics, offering a flat-rate, non-means-tested allowance purely based on care needs. Second, while the allowance covered children, working-age adults, and the blind, its applicability to older individuals with dependency was limited. The legislation's cultural and political focus clearly reflected the priorities of disability rights advocacy, rather than broader concerns about aging and non-self-sufficiency. As Ranci (2004) and Costa (2013) note, this asymmetry was partly the result of underdeveloped socio-healthcare infrastructures and the persistent relegation of elder care to the domain of pension policy.

In subsequent years, the IdA became a symbolically and materially significant benefit within Italy's LTC landscape. However, it also faced recurrent threats. During the Spadolini and Goria Governments, proposals to tax or restrict the allowance sparked widespread opposition, leading to the creation of a National Coordination of Associations to defend its integrity. As discussed in the next sections, while the IdA remains a cornerstone of Italy's care policy for severely dependent individuals, its reliance on a fragmented regional governance framework and its limited integration with broader eldercare services underscore persistent systemic weaknesses. These limitations highlight the structural challenges of reconciling incremental, category-based reforms with the need for a comprehensive and

universal long-term care system (Gori, 2006). Table 3.5. reports the main legislative steps then conducting to the approval of IdA.

Table 3.5. Main Legislative Steps Conducting to Indennità di accompagnamento.

Laws	Year	Description
Laws No. 313 and No. 406	1968	Restructured war pension provisions, introducing support for individuals with severe disabilities (e.g., blind individuals) and included allowances for those disabled by tuberculosis.
Law No. 585	1971	Allowed allowances to cover caregiving expenses, including support provided by family members, though still limited to specific categories (e.g., war-disabled individuals).
Law No. 18	1980	Formally established the IdA as a non-contributive, impairment-based benefit, independent of socio-economic conditions. Expanded eligibility to older individuals and minors.
Law No. 508/88	1988	Extended eligibility for the IdA to individuals over the age of 65 with total disability and in need of continuous assistance

Source: Author's elaboration.

3.2.2. Tentative Signs of a Late-Century Shift in Social Assistance

In the late 1980s, the Prime Minister's Decree of 22 December 1989, issued under Article 20 of the 1988 Finance Act (Law No. 67/1988). This decree formally defined *Residenze Sanitarie Assistenziali* (RSAs) as non-hospital facilities intended to provide healthcare, rehabilitation, accommodation, and social support to older individuals with high levels of dependency. A ten-year investment plan was launched with the aim of establishing 140,000 RSA beds nationwide. Subsequent regulatory acts refined the model by setting criteria for admission, staffing ratios, quality standards, and facility size—capped at 60 residents per unit—thus marking a transition from custodial to individualized, dignified care provision.

By the early 1990s, however, Italy's LTC system remained deeply fragmented. Responsibilities were dispersed across multiple governance levels. At the national level, the IdA functioned as a universal, non-contributory cash benefit for individuals with severe dependency, offering a foundational layer of economic support. Meanwhile, regional authorities managed services such as *Assistenza Domiciliare Integrata* (see below) and social-care residential facilities, both targeting individuals with moderate to severe care needs. While ADI was fully funded by the public healthcare system, it lacked standardized intensity thresholds, limiting its effectiveness. Residential services, in turn, were subject to cost-sharing arrangements between beneficiaries and Local Health Units, leading to uneven access. At the municipal level, social services played a supplementary role, often providing basic home assistance in conjunction with ADI. These services were highly variable across regions, reflecting disparities in fiscal capacity and local policy priorities.

The fragmentation of Italy's LTC system occurred alongside broader transformations in the national welfare regime. During the 1990s, the traditional income-transfer-based model came under increasing scrutiny as Italy faced new social risks linked to labor market instability, demographic shifts, and fiscal

pressures. Scholars such as Fargion (2000; 2004) and Brandolini (2005) identified a growing need to expand underdeveloped sectors, particularly social services, to address rising economic and social vulnerabilities. The European integration process, notably the Maastricht Treaty, added further urgency by imposing strict limits on public spending. This spurred political debates over rebalancing the welfare budget—long dominated by pensions—in favor of neglected areas such as LTC and social assistance (Ferrera & Gualmini, 2004).

Political developments at the national level also facilitated reform. The *Tangentopoli* scandal and the subsequent *Mani Pulite* investigations into systemic corruption led to the collapse of Italy's traditional party system, weakening institutional actors that had historically resisted structural change (Ferrera, 2006). The emergence of technocratic governments—most notably under Giuliano Amato and Lamberto Dini—provided a window of opportunity for more radical policy interventions, including pension reform and reallocation of welfare resources.

Amid these transformations, disability policy underwent a major reorientation. Reform efforts throughout the 1970s and 1980s had largely failed due to ideological conflicts—particularly concerning the vast assets controlled by the *Ipab* institutions, many of which were linked to the Catholic Church (Fargion, 2004). However, the early 1990s saw a convergence of political will and civil society mobilization. Advocacy organizations such as the *Coordinamento delle Associazioni per la Disabilità* intensified public campaigns to expose inefficiencies and fragmentation in disability governance. In response, Minister Rosa Russo Iervolino, then serving in the Andreotti VI and VII cabinets, convened a national commission of experts to draft a comprehensive reform proposal.

This process culminated in the passage of Framework Law No. 104 of 1992, proposed by the Parliamentary Group of the *Partito Socialista Italiano*. The law was the result of extensive parliamentary debate (1987-1992) and was passed with broad political support. Inspired by international norms on social inclusion—particularly those set by the United Nations—the legislation aimed to integrate disabled individuals, both adults and minors, into society and the labor market. While it did not explicitly address the issue of population aging, it laid critical foundations for the reorganization of LTC.

The law marked a conceptual and institutional departure from prior assistance-based approaches. It formally recognized chronic and permanent disabilities as distinct from temporary impairments or work-related conditions. It introduced the right to personal assistance services, encompassing home-based and community-based support beyond the medical sphere. Moreover, it strengthened socio-health integration by dividing responsibilities between the Ministry of Health (for clinical care) and the Ministry of Social Policy (for social and functional support), as initially delineated in the Decree of 8 August 1985. To support implementation, the law established a national fund and delegated key administrative functions to municipalities and regions.

Although the law focused primarily on persons with disabilities, it also introduced institutional mechanisms that indirectly benefited older dependent individuals. These included multidisciplinary

assessment commissions, comprising representatives from disability associations, responsible for evaluating care needs and disability status. ADI services were also expanded to include psychological and educational components. Notably, the introduction of personalized care plans helped address longstanding inconsistencies in service provision at the municipal level.

The political process surrounding the law's approval revealed tensions over financial resources. Disability advocacy groups and unions strongly supported the initiative, while the *Partito Comunista Italiano* criticized its limited funding. Budget cuts during this period had affected key areas such as physical rehabilitation and disability pensions, prompting public protests. Although some reductions were eventually reversed, the PCI and *Democrazia Proletaria* abstained from the final vote due to unresolved concerns about long-term financing.

3.2.3. Health Sector Reform and the Introduction of Essential Levels of Care

In parallel with disability reform, the 1990s saw significant restructuring of Italy's healthcare system. Law No. 421 of 23 October 1992 authorized a comprehensive reorganization of the sector, leading to the adoption of Legislative Decree No. 502 of 30 December 1992 and Legislative Decree No. 266 of 30 June 1993. Legislative Decree No. 502/1992 introduced a series of managerial reforms. Municipalities were removed from direct control over health services, while local health units were consolidated and brought under regional governance. The figure of the Director General, appointed by regions based on meritocratic criteria, replaced politically influenced leadership structures. Large hospitals were granted administrative autonomy, and a competitive framework was introduced, with both public and private providers operating under accreditation and tariff-based reimbursement models. These changes aimed to promote efficiency, accountability, and responsiveness, and to create a more flexible service infrastructure that could better accommodate the complex needs of an aging population.

Follow-up measures further refined this architecture. Legislative Decree No. 517 of 7 December 1993 made technical adjustments to the 1992 reforms, while Decree No. 229 of 1999 deepened regionalization and reintroduced core principles from Law No. 833/1978, particularly those related to service quality and integrated care pathways. Municipalities were reintegrated in consultative and supervisory roles, tasked with contributing to regional health planning and evaluating healthcare managers. This renewed emphasis on inter-institutional cooperation reflected a growing awareness of the need for coordinated responses across health and social domains.

A key step was the formal introduction of Essential Levels of Care (LEA). Although conceptually introduced in 1992, LEAs were legally codified in 2001. They guaranteed all citizens access to a nationally defined baseline of health and social services, with the explicit goal of minimizing territorial disparities. Long-term care services—including ADI and RSAs—were formally included within this framework. The LEA model emphasized dignity, equity, and cost-effectiveness, aligning national goals with regional delivery capacities as articulated in successive National Health Plans. Its implementation

also signaled an intention to institutionalize long-term care as a core component of the public healthcare offer, rather than treating it as a residual or supplementary area of intervention.

Despite these systemic improvements, progress in long-term care for older people remained limited. Following the institutionalization of RSAs in the late 1980s, no major national reforms were enacted during the 1990s. The 1992 *Progetto Obiettivo Tutela della Salute degli Anziani*, later incorporated into the 1994 National Health Plan, articulated important goals: Expanding ADI, promoting home-based care, and establishing Geriatric Evaluation Units (*Unità Valutative Geriatriche*, UVGs). However, the project lacked dedicated funding, resulting in poor implementation and leaving the growing problem of older non-self-sufficiency largely unaddressed. As a result, the transformative potential of the broader healthcare reforms remained only partially realized in the domain of long-term care.

3.3. The Italian LTC Policy Trajectory: A Retrospective of the 1980s and 1990s

Between 1980 and 2000, the development of LTC policy in Italy followed a fragmented and incremental trajectory. Rather than emerging as a distinct and strategically coordinated field, LTC provision gradually took shape through a series of partial and sector-specific measures. Two key developments during the 1980s laid the groundwork for this evolving architecture: The establishment of the SSN in 1978, which institutionalized a framework for domiciliary assistance—though not specifically tailored to long-term care—and the introduction of the *Indennità di accompagnamento* through Law No. 18/1980.

The IdA, introduced in response to sustained mobilization from disability advocacy groups, represented a significant departure from traditional contributory welfare models. It established a non-contributory, flat-rate cash benefit based solely on functional dependency, without income testing or prior employment requirements. Initially designed for individuals with severe disabilities, the benefit was extended in 1988 to include persons aged 65 and over who demonstrated similar care needs. This extension marked a formal, albeit limited, recognition of age-related dependency within the broader disability framework. Nonetheless, the IdA remained conceptually anchored in the disability policy domain, and its role within a wider eldercare strategy remained underdeveloped.

Efforts to expand service-based care provision in the same period were limited and territorially uneven. The creation of *Residenze Sanitarie Assistenziali* in 1989, together with the partial rollout of *Assistenza Domiciliare Integrata* under the SSN, signaled attempts to address the needs of non-self-sufficient individuals through institutional and home-based services. However, these initiatives were hindered by the absence of national coordination, the lack of uniform standards regarding service intensity, and the continued reliance on cost-sharing mechanisms. The broader context of administrative decentralization—initiated in the 1970s and further consolidated in the 1990s—contributed to substantial regional variation in both service provision and eligibility, reinforcing territorial disparities in access to care.

During the 1990s, a series of health sector reforms—particularly Legislative Decrees No. 502/1992, No. 517/1993, and No. 229/1999—restructured the governance of the healthcare system. These reforms introduced managerial and organizational innovations, including the corporatization of service providers, performance-based appointments of health executives, and competitive funding models for public and private actors. While not directly focused on long-term care, these reforms contributed to the institutional framework within which LTC services could be further developed. The formal inclusion of services such as ADI and RSAs within the *Livelli Essenziali di Assistenza*, legally codified later in 2001, reflected an emerging policy orientation toward establishing a minimum standard of care across regions. Nevertheless, these measures remained largely aspirational throughout the 1990s, constrained by limited fiscal capacity and the relatively low visibility of LTC in political and public agendas. Within this evolving context, disability policy advanced more coherently, culminating in the passage of Framework Law No. 104/1992. By contrast, policies targeting eldercare remained institutionally diffuse, split among healthcare providers, municipal social services, and households. This fragmentation was further compounded by limited integration between clinical and social support services, despite the formal establishment of multidisciplinary assessment teams and joint planning mechanisms.

By the end of the 1990s, Italy's LTC system exhibited several defining characteristics: A strong emphasis on monetary transfers (notably through the *IdA*), limited and uneven service provision, and continued reliance on informal family-based caregiving, particularly by women. Public support for LTC remained primarily compensatory in nature, with formal care provision varying significantly across regions. Although the period witnessed important institutional developments—especially in disability rights and healthcare governance—long-term care continued to evolve in the absence of a unified policy vision or comprehensive strategic framework.

4. The LTC in Portugal (1980-1999)

This section reconstructs the policy trajectory that shaped the roots of Portugal's long-term care policy over the last two decades of the twentieth century. The analysis is structured into three main parts. Section 4.1. provides the historical backdrop, examining the residual, fragmented, and often informal configuration of long-term care within the broader conservative and familialist features of the Portuguese welfare state. Section 4.2. investigates the main policy developments of the 1980s and 1990s. Finally, Section 4.3. offers a retrospective synthesis of the period, identifying the main structural legacies and institutional constraints that would later influence the formal establishment of Portugal's National Network for Integrated Continuous Care (*Rede Nacional de Cuidados Continuados Integrados* - RNCCI) in 2006, as described in Chapter 8 of this thesis.

4.1. The Origins of a Residual and Fragmented LTC System in Portugal

As in Spain, the Portuguese welfare state was deeply shaped by the legacy of an authoritarian and corporatist regime that fostered a fragmented, moralised, and exclusionary approach to social protection. The *Estado Novo*, in place from 1933 to 1974, developed a welfare model exhibiting all the defining characteristics of conservative-corporatist systems, as later defined by Esping-Andersen (1990). Under this model, social protection was neither conceived as a universal right nor grounded in citizenship. Instead, access was conditional upon occupational status or perceived moral deservingness, thereby systematically excluding large segments of the population.

The ideological foundations of this welfare regime were enshrined in the Constitution of 1933 and operationalised through the *Estatuto do Trabalho Nacional* (Decree-Law No. 23 051 of 23 September 1933). These instruments institutionalised a vision of society based on social hierarchy, national unity, and professional corporatism. Within this framework, the family—not the state—was recognised as the cornerstone of social support. Social entitlements were mediated through professional categories and subordinated to a paternalistic conception of state intervention. The Law No. 1884 of 1935 codified this institutional design by establishing four main pillars of welfare provision: Corporatist welfare bodies affiliated with occupational sectors; pension and retirement funds; mutual aid associations; and charitable institutions, most notably the *Misericórdias*, which maintained strong connections to the Catholic Church and a long-standing presence in the provision of social assistance.

Misericórdias played a particularly prominent role in elder care, especially in rural areas where formal state services were absent. Operating largely outside any coordinated public policy framework, they offered assistance based on moral evaluation rather than objective criteria of need. As Moreira (2008) explained, this system of care was deeply exclusionary, leaving informal workers, women, agricultural labourers, and the urban poor effectively outside meaningful protection. The very architecture of the *Estado Novo*'s welfare system served to reinforce social hierarchies, uphold traditional gender roles, and legitimize the regime's conservative-paternalist ideology. Care provision for dependent older persons during this period was, by default, informal and gendered. Where institutional care was available, it was administered by religious or philanthropic entities operating under discretionary rules. Amaro (2018) highlighted how access to charitable institutions was mediated by notions of “deservingness,” leading to selective admission criteria rooted in moral scrutiny rather than social rights. As Maia (1985) noted, these facilities imposed strict behavioural standards and codes of conduct, effectively pathologizing dependency and reinforcing discipline rather than providing dignified support. Dependency was framed not as a social condition requiring collective response, but as a moral failure or familial breakdown.

Despite some expansion of contributory mechanisms in the mid-20th century—most notably through the creation of the *Caixa de Previdência* in 1946, which offered health insurance to workers in the formal sector—the system remained highly segmented and exclusionary. According to Ferreira (2006), even as late as 1960, social expenditure represented only 4% of GDP, the lowest level in Western Europe at the time. Although expenditure began to increase during the 1960s, much of it was still directed toward

pensions and survivor benefits, with very limited investment in services such as health or social care. Between 1959 and 1973, the share of social expenditure devoted to health never exceeded 1.6% of GDP. This limited reach underscored the occupational and territorial disparities entrenched in the corporatist welfare architecture. Health services remained curative in focus, hospital-based, and heavily urbanised, making them ill-suited to the needs of older people with chronic conditions or long-term care requirements.

This institutional and ideological neglect of long-term care was codified in the *Estatuto da Assistência e Saúde* (Law No. 2120 of 1963). The statute reinforced the principle of subsidiarity, affirming that social assistance was to be provided by families, religious entities, and mutualist associations, with the state intervening only when all other avenues had been exhausted. Santos (1990) described this statute as emblematic of a conservative utopia in which solidarity was privatised and moralised. Welfare was framed as charity, not entitlement, and individual virtue was prioritised over structural responsibility. This familialist conception of care embedded deep gender asymmetries into the system, as caregiving was overwhelmingly assigned to women, particularly those outside formal employment.

Although the late 1960s witnessed limited attempts to modernise the system—most notably during the so-called “Primavera Marcelista” under Prime Minister Marcelo Caetano—these reforms were largely superficial. The Reform of Social Security undertaken through Law No. 2115 of 1962 sought to centralise and harmonise existing social insurance schemes, but it failed to expand coverage or address the absence of care services for dependent older persons. By 1970, only 60% of the active labour force was formally covered by the social security system, and by the fall of the regime in 1974, coverage had reached just 42% of the total population (Capucha, 2005). As Ferreira (2000; 2006; 2010) noted, the overall growth of social spending in the 1970s occurred in a context of rising inequality and fiscal underinvestment. The political logic behind these reforms was defensive and legitimacy-oriented, not transformative. They were designed to consolidate regime authority rather than address emerging social risks such as population ageing or increasing female labour force participation.

The transition to democracy in 1974, initiated by the Carnation Revolution, marked a fundamental shift in the normative foundations of Portuguese social policy. The Constitution of 1976, particularly Article 63, recognised the right to health, social security, and social assistance as essential to the full exercise of citizenship. These provisions laid the legal and philosophical foundation for a universalist welfare state, repudiating the selective and moralised approach of the *Estado Novo*. In the ensuing years, the democratic governments implemented a series of redistributive reforms aimed at expanding coverage and mitigating poverty. These included the introduction of minimum income supports, the extension of unemployment insurance, and the broadening of pension and family allowance schemes.

The most transformative reform in this period was the creation of the *Serviço Nacional de Saúde* (SNS) through Decree-Law No. 56, enacted in 1979. The SNS established a tax-financed, universal health system modelled on the principles of equity, solidarity, and comprehensiveness, replacing the fragmented occupational health insurance system. As Guibentif (1985) observed, this marked a decisive

break with the corporatist logic of the past and aligned Portuguese health policy with broader European trends. However, it is crucial to underline that the SNS did not include long-term care within its remit. The focus remained on curative and hospital-based services, and no parallel expansion of LTC infrastructure, financing, or regulation was undertaken.

As a result, long-term care continued to be treated as a private matter to be resolved within the family. As Moreira (2010) underscored, LTC remained marginal in political discourse and policy development throughout the 1980s and 1990s. No specific administrative bodies, budgetary allocations, or strategic plans were devised to address the care needs of older persons with chronic illness or functional limitations. The burden of care remained concentrated within households—primarily on women—thereby reproducing the familialist welfare legacy (Silva, 2002; Carolo & Pereirinha, 2010).

The broader institutional landscape of care provision during this period was defined by subsidiarity and delegated governance. In the absence of a comprehensive public system, service delivery was increasingly entrusted to *Instituições Particulares de Solidariedade Social* (IPSS) and the long-established Misericórdias, which grew significantly in number and influence. While these organisations received state subsidies and tax exemptions, they were not integrated into a national strategy for care provision. Instead, they operated in a quasi-autonomous manner, creating a pluralistic but uneven network of services, marked by sharp disparities in availability, quality, and coordination.

This institutional configuration produced what might be termed a geography of unequal care. In urban centres, particularly in the southern and coastal regions, denser networks of IPSS and public-private partnerships allowed for somewhat broader access to services. By contrast, rural and inland areas remained systematically underserved, exacerbating regional inequalities (Ferrera, 1996). At the same time, the dual dynamic of territorial and gender inequality effectively precluded the emergence of a coherent, rights-based long-term care policy. The state lacked both the institutional mechanisms and the political will to reconceptualise care as a collective responsibility embedded in the broader social contract. Table 3.6. Illustrates the main laws and decrees approved between 1935 and 1979.

Table 3.6. Main Portuguese Legislative Steps from 1935 to 1979.

Reform/Decree	Year	Description
Law No. 1884	1935	Codified the corporatist model through four main pillars: Occupational welfare bodies, pension funds, mutual aid, and charity institutions.
Law No. 2115	1962	Aimed to centralise and harmonise fragmented social insurance schemes
Law No. 2120	1963	Reinforced subsidiarity and privatised welfare logic, placing care responsibility on families and charitable institutions.
Constitution of the Portuguese Republic	1976	Enshrined the right to health, social security, and social assistance as core components of citizenship in post-authoritarian Portugal.
Decree-Law No. 56	1979	Created the SNS, a universal, tax-funded health system based on equity and solidarity, excluding LTC.

Source: Author's elaboration.

4.2. The Portuguese Reforms of the Eighties and Nineties

In the 1980s and 1990s, this period saw a shift from an assistance-based, largely informal model—anchored in familial obligations—to one where public authorities and nonprofit institutions gradually assumed structured roles in providing and coordinating care for dependent older adults.

The early 1980s were marked by efforts to universalize healthcare access following the 1974 Carnation Revolution and the approval of the 1976 Constitution, which recognized health as a citizen's universalistic right and a state obligation (Guibentif, 1985). The establishment of the SSN in 1979, followed by the expansion of *centros de saúde* and the decentralization of healthcare governance, laid the groundwork for future integration between healthcare and social support services (Ferreira, 2000). Alongside these developments, Portugal introduced new legal frameworks that institutionalized the role of *Instituições Particulares de Solidariedade Social* (IPSS) through Decreto-Lei No. 119/1983, conferring upon them the status of public utility entities and formalizing their partnerships with the state.

Throughout the 1990s, public policy became increasingly attuned to the growing complexity of elder care. Chronic illnesses, population ageing, and extended hospital stays—often exacerbated by inadequate discharge planning and the lack of community-based alternatives—placed pressure on the SNS and exposed gaps in service coordination (Lopes, 2016). In response, experimental programs emerged to pilot home care, rehabilitative services, and intermediate care models, albeit without systemic consolidation. The problem was not a lack of recognition, but a lack of integration: Healthcare remained institutionally and administratively distinct from social care, despite the increasing overlap in their target populations.

Yet, unlike other Southern European countries, Portugal began to develop a hybrid and pragmatic model, combining state financing with nonprofit provision. This model was facilitated by the *Lei de Bases da Segurança Social* (Lei No. 28/1984), which formalized the tripartite structure of the Portuguese welfare state (contributory, non-contributory, and social action) and opened the door to structured collaborations between the state and IPSS in delivering elder care and domiciliary support (Santos, 1990; Wall et al. 2001).

This section offers a detailed analysis of the main policy, institutional, and normative reforms affecting long-term care in Portugal during the 1980s and 1990s, as structured around three core axes: The expansion and reform of the *Serviço Nacional de Saúde* as pivotal axis in the long-term care sector; the consolidation and functional integration of IPSS into the national welfare system; the emergence of early forms of care coordination and pilot programs for intermediate care. These developments, while often fragmented and underfunded, nonetheless established the institutional scaffolding that would later support the creation of the *Rede Nacional de Cuidados Continuados Integrados* in 2006—a national integrated care network rooted in ideas and pilot experiences developed during these decades (Hernández-Quevedo et al., 2018).

The section is structured as follows. Subsection 4.2.1. examines the early and cautious engagement of the Portuguese state with long-term care through reforms in the National Health Service, emphasizing the emergence of continuity as a guiding principle in health policy. Subsection 4.2.2. shifts focus to the social care domain, highlighting the pivotal—yet often overlooked—role of civil society and religious organizations in addressing care needs in the absence of a comprehensive public system. Finally, 4.2.3. explores the introduction of experimental programs and early coordination efforts between health and social sectors, marking the first tentative steps toward an integrated approach to long-term care in Portugal.

4.2.1. A “Timid” Approach Towards LTC in the Health Sector

As previously observed, the establishment of the SNS in 1979 marked a paradigmatic shift in the development of the Portuguese welfare state, consolidating the constitutional right to health as enshrined in Article 64 of the 1976 Constitution. Conceived as a universal, tax-funded healthcare system, the SNS sought to overcome the segmented, corporatist, and exclusionary health provisions inherited from the *Estado Novo* regime (Guibentif, 1985). Its creation was driven by the political momentum of the First Constitutional Government, led by Prime Minister Mário Soares of the Socialist Party (PS, centre-left).

Yet, the early phase of implementation in the 1980s revealed numerous limitations. Infrastructure remained unevenly distributed, particularly in rural and peripheral areas; there was a marked shortage of qualified health professionals; and the persistence of a fragmented ecosystem—including public, mutualist, and charitable providers—hampered institutional coherence (Ferreira, 2000; 2006).

To address these structural shortcomings, subsequent governments began to articulate a dual strategy: On the one hand, strengthening the public provision of primary care; on the other, introducing legal and institutional reforms to improve system coordination and governance. A key milestone came in 1983 with *Decreto-Lei No. 56/1983*, which established a nationwide network of *centros de saúde* (health centres) to serve as decentralized hubs for general medical care, preventive services, maternal and child health, vaccination programmes, and public health education—particularly in underserved regions (Pereira, 2014) implemented during This initiative was implemented during Soares government.

A further turning point came with the approval of the *Lei de Bases da Saúde* (Law No. 48/1990) in 1990, under PSD government. This foundational law reaffirmed the core values of the SNS—universality, equity, and solidarity—while also introducing notable innovations. Among these were the granting of autonomy to hospitals, the adoption of regional health planning, and the possibility of contracting private and non-profit providers under public oversight (Lei No. 48/1990; Carvalho, 2021). Particularly significant was Article 10, which explicitly recognised the principle of “*continuidade de cuidados*” (continuity of care), thus expanding the remit of the SNS beyond acute medical services to include rehabilitation, palliative care, and long-term support for dependent individuals. While largely

aspirational at the time, this provision signalled an important normative shift away from a purely curative paradigm toward a more integrated vision of healthcare delivery (Ministério da Saúde, 1990).

Throughout the 1980s, the *centros de saúde* became the operational backbone of the SNS, playing a vital role in expanding access to care. However, their ability to respond to the increasingly complex needs of an ageing population—particularly those with multiple chronic conditions—remained limited. The absence of appropriate geriatric and community-based follow-up services contributed to an over-reliance on hospital care, often resulting in unnecessary admissions and prolonged stays that generated inefficiencies and rising costs.

In response, the state initiated further decentralisation efforts aimed at improving governance and territorial responsiveness. A major step in this direction was the *Decreto-Lei No. 309/1993*, under PSD government, which created the *Administrações Regionais de Saúde* (ARS)—regional health administrations with planning and supervisory responsibilities. The ARS were tasked with tailoring healthcare provision to local demographic and epidemiological conditions and facilitating collaboration between the public system, municipalities, and third-sector actors such as IPSS and *Misericórdias* (Pereirinha & Murteira, 2019).

That same year, albeit through sub-legislative instruments such as ministerial directives, the government also institutionalised the *Unidades de Gestão de Altas* (hospital discharge management units). These multidisciplinary teams—comprising doctors, nurses, and social workers—were introduced to coordinate discharge planning, assess post-hospital care needs, and facilitate transitions to community or residential care. While still in an embryonic form, these units represented a meaningful step toward integrated care by linking acute hospital treatment with the longer-term support often required after discharge (Calado et al., 2019).

Parallel to these domestic initiatives, Portugal increasingly capitalised on European Union structural and cohesion funds to experiment with integrated care solutions. Programmes such as PRODEP, INTERREG, and Saúde XXI funded pilot projects in areas ranging from community rehabilitation to mobile multidisciplinary teams and hybrid health-social care units. These initiatives frequently involved collaboration between ARS, local governments, and civil society organisations. However, in the absence of a national regulatory framework or long-term funding mechanisms, many of these experiments remained localized and failed to evolve into a coherent LTC strategy (Moreira & Glatzer, 2022).

By the end of the decade, demographic ageing and the rising burden of chronic diseases prompted a more systematic reconsideration of the acute care model that had long dominated Portuguese health policy. This rethinking found expression in the *Plano Nacional de Saúde 1998-2002*, under PS government. Though not a legislative act, the plan held significant normative weight. It called for the reorganisation of care for older adults, highlighting priorities such as the preservation of autonomy, prevention of dependency, and the promotion of community-based solutions. While implementation remained uneven, the plan laid important conceptual foundations for future reform in the area of long-term care.

In sum, the two decades between 1980 and 1999 saw the progressive emergence of a policy discourse and institutional architecture increasingly attuned to the needs of an ageing society. Although the central focus remained on health system expansion and modernisation, important elements relevant to long-term care—such as decentralisation, care continuity, and coordination mechanisms—began to take shape. However, the absence of a dedicated LTC system or comprehensive regulatory framework meant that these developments, while significant, still represented scattered innovations rather than the consolidation of an integrated model of care.

4.2.2. Social Care on the Margins: Civil Society and the Construction of LTC

The transformation of Portugal's social sector in the 1980s and 1990s was significantly influenced by the institutionalization of civil society organizations, particularly the IPSS. Rooted in religious, charitable, and local associative traditions—especially the historic *Misericórdias*—these organizations had long provided informal and semi-formal support to vulnerable populations, particularly the older persons, in the absence of a comprehensive state infrastructure (Santana et al., 2016). The post-authoritarian transition created an opportunity for their formal integration into public policy, reflecting both ideological commitments to subsidiarity and pragmatic responses to limited state capacity.

The legal foundation for this integration was established by Decreto-Lei No. 119/1983, which recognized IPSS as legal entities of public utility. The decree defined four main categories: (1) solidarity associations (*associações de solidariedade social*), (2) social centers (*centros sociais*), (3) religious institutions, and (4) the *Misericórdias*. It granted these organizations access to public funding, tax exemptions, and technical assistance, contingent upon registration and compliance with defined quality standards (Pereira, 2014; *Decreto-Lei No. 119/1983*). This arrangement marked a critical innovation in welfare governance by acknowledging the state's constitutional responsibility to ensure access to social services while delegating provision to community-embedded non-state actors (Sousa Santos, 1990).

This model was institutionalized further through the *Lei de Bases da Segurança Social* (Law No. 28/1984), which codified the tripartite structure of the Portuguese welfare state: A contributory system, financed through social security contributions; a non-contributory system, providing basic protections for low-income individuals; a social action subsystem, oriented toward vulnerable populations—particularly dependent older adults—through services delivered by accredited IPSS (*Lei No. 28/1984*).

Within this third pillar, IPSS emerged as indispensable actors due to their territorial reach—many operated in rural or underserved areas—and their moral authority, especially where state legitimacy remained weak. Between 1981 and 1986, over 1,000 new IPSS were formally registered, many affiliated with local parishes or volunteer networks (Fonseca et al., 2023). These organizations managed residential homes for the older people (*lares de idosos*), day-care centers (*centros de dia*), and home

support services (*Serviço de Apoio Domiciliário, SAD*), with substantial state co-financing but under private or ecclesiastical governance.

Public-private cooperation was operationalized through program contracts (*acordos de cooperação*) between each IPSS and the *Centro Distrital de Solidariedade e Segurança Social*. These agreements specified funding allocations, user eligibility, service modalities, and reporting requirements. The CDSS, as decentralized entities of the Ministry of Social Solidarity, served both supervisory and mediating roles, balancing national policy goals with localized implementation (Pereira, 2014).

A major inflection point in this trajectory was the launch of the *Programa de Apoio Integrado a Idosos* in the early 1990s. PAII aimed to expand and modernize elder care services by financing capital investments and operating subsidies for SAD programs, improving transportation, and adapting physical infrastructure in IPSS-run facilities. It also encouraged municipal co-responsibility, fostering local partnerships and reinforcing the decentralized governance model.

This partnership-based approach facilitated rapid service expansion but also reflected a degree of strategic ambivalence. On one hand, it enabled the state to scale up coverage using pre-existing community networks. On the other, it externalized service provision, thereby avoiding the fiscal and administrative burdens of expanding public sector employment in the social domain (Ferreira, 2000). This arrangement resonated with broader European trends of the 1990s, wherein states sought to curb direct expenditures by contracting regulated third-party providers—a logic framed in terms of efficiency and pluralism (Esping-Andersen, 1999).

Nevertheless, structural tensions remained. IPSS were excluded from policymaking in the contributory branches of social security and often faced unstable or delayed public funding. Quality control mechanisms were weak, and there was significant variation in standards across institutions (Lopes, 2016). Yet, despite these constraints, the institutional consolidation of IPSS in the 1980s and 1990s laid a foundational architecture for Portugal's LTC system. These organizations not only filled critical service gaps but also shaped the ideological consensus that elder care was a shared societal responsibility involving families, the state, and civil society. This governance model—blending subsidiarity with state steering—remained a defining feature of Portugal's LTC regime at the close of the twentieth century.

A parallel development in the 1990s was the formal incorporation of cash-based support for dependent individuals through the establishment of the *Complemento por Dependência* (Dependency Supplement). Introduced by Decree-Law No. 265 of 14 July 1999, this benefit addressed the financial consequences of moderate to severe dependency, particularly among older adults already receiving old-age, disability, or survivors' pensions. Embedded within the non-contributory subsystem of the social security framework, the measure marked a crucial step in recognising dependency as a distinct social risk, thereby warranting state intervention beyond health services or institutional care.

The benefit was granted to pensioners covered under the general contributory scheme, the non-contributory system, and the special agricultural scheme. It aimed to offset part of the costs associated with long-term care—whether delivered informally by family members or through formal channels—and to symbolically acknowledge the unpaid labour frequently assumed by women within households. Access to the benefit was not contingent on prior employment or contributions, ensuring alignment with the universalist logic of the welfare state's social assistance arm (Law No. 28/1984).

The *Complemento por Dependência* was structured in two levels. Level I was awarded to individuals requiring regular assistance from a third party for essential daily activities (e.g., personal hygiene, mobility, feeding). Support had to be regular but not continuous. Level II targeted individuals with profound functional or cognitive impairments requiring permanent and continuous supervision and care, such as those with severe physical disabilities or advanced dementia. Eligibility was determined through multidisciplinary assessments conducted by teams from the *Instituto da Segurança Social* (ISS), including medical, psychological, and social work professionals. Applicants or their legal representatives were required to submit a formal application with medical documentation. Once approved, the benefit was disbursed monthly as a top-up to the base pension and indexed annually to reflect changes in the minimum pension threshold. Benefit values ranged between €100 and €180, depending on the level of dependency.

Although modest in monetary terms, the benefit served a role in partially mitigating the economic burden of dependency. It did not substitute for formal services nor was it linked to the uptake of institutional care. Instead, it reinforced the prevailing familialist model by presuming that care responsibilities would remain within the household, primarily undertaken by women. The measure was thus consistent with the principle of subsidiarity that governed Portuguese LTC policy, whereby the state played a compensatory role, delegating primary caregiving to families and third-sector actors.

Despite its importance, the *Complemento por Dependência* faced several structural limitations. The financial support offered was insufficient to cover the actual costs of care or meaningfully compensate unpaid caregivers. Access to the benefit was further hampered by administrative barriers, lengthy assessments, and limited dissemination of information. Moreover, the lack of coordination between the cash benefit and existing service provision limited its integration within a comprehensive LTC strategy. Beneficiaries of the complement were not prioritised for services such as SAD or institutional placements, revealing a persistent fragmentation between monetary and in-kind support systems.

Nevertheless, the establishment of the *Complemento por Dependência* represented a normative and institutional turning point in the development of Portugal's LTC framework during the 1990s. It constituted the first formal recognition within the social security system of dependency as a basis for entitlement. By embedding dependency within the pension-linked architecture of social rights, it contributed to the gradual de-privatisation of elder care and affirmed the principle that care needs are a collective social responsibility rather than a private family matter. The *Complemento por*

Dependência remains an essential, if under-resourced, element in the late twentieth-century evolution of Portugal’s long-term care system. Main legislative steps are summarized in Table 3.7.

Table 3.7. Legislative Steps from 1980 to 1999 in Portugal.

Reform/Decree	Year	Description
Decreto-Lei No. 119	1983	Recognized IPSS as legal entities of public utility, granting access to public funding, tax exemptions, and technical support.
Lei de Bases da Segurança Social (Lei n. ° 28)	1984	Codified the tripartite structure of the welfare system: Contributory, non-contributory, and social action, with IPSS central to service delivery for vulnerable groups.
Programas de Apoio Integrado a Idosos (PAII)	1990	National program to support older adults by funding home care services (SAD), improving infrastructure, and encouraging municipal co-responsibility.
Decreto-Lei No. 265	1999	Established the Complemento por Dependência, a cash benefit for pensioners with moderate to severe dependency, embedded within the non-contributory social protection scheme.

Source: Author’s elaboration.

4.2.3. Early Forms of Care Coordination and Pilot Programs in the LTC

A third, crucial axis in the trajectory of Portugal’s LTC development during the 1980s and 1990s concerned the incipient coordination between the health and social protection systems. Although these domains remained institutionally and operationally distinct, the mounting strain on both sectors gradually fostered a climate conducive to experimentation, discourse, and partial integration. At the heart of these developments was a growing recognition—among policymakers, professionals, and civil society actors—that effective care for older adults with chronic conditions and functional limitations could no longer be segmented across bureaucratic or sectoral divides.

The institutional separation inherited from the *Estado Novo* regime had long hindered integrated responses to complex care needs. However, as hospitals began facing chronic “bed-blocking” scenarios—where older patients remained hospitalized due to a lack of adequate discharge alternatives—the dysfunctions of this fragmented system became starkly visible. This phenomenon, which had deleterious effects both on patient well-being and system efficiency, was exacerbated by a fragile primary care network, limited geriatric specialization, and an underdeveloped *continuum* of care outside the acute setting (Santana, 2010).

In this context, the expansion of SAD represented one of the first practical efforts to bridge health and social care. These home-based services, primarily delivered by IPSS and co-funded by the Ministry of Social Solidarity, offered personal care, hygiene support, meals, and basic health monitoring. Although formally part of the social protection system, SAD operations increasingly required coordination with local health centers—particularly through family physicians and community nurses stationed in *centros de saúde*. This informal and locally negotiated collaboration marked the first step toward a *de facto* model of integrated care, even in the absence of national regulatory instruments.

Despite the *Unidades de Gestão de Alta* and *Administrações Regionais de Saúde* (ARS), the absence of clear eligibility rules for continuing care, lack of financing mechanisms, and dependency on personal networks with IPSS and municipalities to secure post-discharge services. In parallel, as in the case of Spain, a series of *protocolos de colaboração* between the Ministry of Health and the Ministry of Social Solidarity were initiated in the early-to-mid 1990s. These interministerial agreements allowed for joint implementation of pilot projects, often in territories with high dependency rates or service shortages. In some cases, health professionals from public services were temporarily assigned to IPSS-run facilities, helping to bridge clinical and social care domains. While these arrangements remained largely ad hoc and uncoordinated at the national level, they laid the foundation for a shared understanding of dependency as a multidimensional risk requiring integrated responses (Pereira, 2014).

This phase also marked the emergence of a more structured policy discourse around *cuidados continuados* (continuing care). Heavily influenced by evolving European welfare paradigms and guided by international agendas on ageing and health system sustainability (OECD, 1996; WHO, 1999), Portuguese policymakers began to use this terminology to describe an emerging *continuum* of rehabilitative, palliative, and long-duration services and culmination came with the *Plano Nacional de Saúde* 1998-2002. These central initiatives were accompanied by a proliferation of experimental projects at the local level. Particularly in central and northern Portugal, pilot *unidades de cuidados continuados* emerged with co-financing from municipalities, IPSS, and European structural funds. These units offered medium-term rehabilitation, palliative care, and support for individuals transitioning from acute care. While not yet integrated into a national network, these experiences demonstrated both feasibility and relevance, serving as testbeds for what would eventually become the *Rede Nacional de Cuidados Continuados Integrados* in 2006.

Importantly, these experiments were often documented through academic partnerships or internal evaluations, highlighting the growing role of research institutions and professionals in co-producing LTC knowledge. This co-production—spanning state actors, civil society, and the academic community—was essential in reframing dependency as a shared social responsibility and in legitimizing the future construction of an integrated LTC regime. From modest SAD services to hospital discharge planning units, and from interministerial protocols to national strategy documents, the period laid both the discursive and institutional foundations for the more consolidated system that would follow. Despite fragmentation and uneven implementation, this era was pivotal in shifting care for dependent individuals from a peripheral concern to an emerging axis of welfare state modernization.

4.3. The Portuguese Policy Trajectory: A Retrospective of the 1980s and 1990s

Looking back at Portugal's LTC trajectory in the 1980s and 1990s, it becomes clear that the foundations of the system were laid not through a deliberate, top-down reform, but through a gradual process of institutional bricolage, normative redefinition, and territorially uneven experimentation. The country entered the 1980s with a welfare state still deeply shaped by the legacy of the authoritarian *Estado*

Novo regime. Social protection remained fragmented, occupational, and paternalistic, with access often mediated by moral criteria rather than citizenship rights. Although the creation of the *Serviço Nacional de Saúde* in 1979 marked a decisive shift toward universalism in health care, LTC for dependent persons remained peripheral, informal, and largely privatized within family networks.

This early landscape was characterised by a strong reliance on unpaid family caregiving—primarily performed by women—and on the longstanding role of religious and associative organisations, particularly the *Misericórdias*. These actors filled critical service gaps but did so in the absence of a coherent policy framework, operating under a model of moral assistance rather than rights-based provision. The notion of dependency as a public social risk was still absent, and care was treated as a private responsibility, with state intervention seen as residual and discretionary.

Nevertheless, the 1980s witnessed important institutional developments. On the social side, Decreto-Lei No. 119/1983 and the *Lei de Bases da Segurança Social* (Law No. 28/1984) recognised IPSS as public utility entities and integrated them into the delivery of welfare services. Through formal agreements (*acordos de cooperação*) with the state, IPSS became central to the expansion of domiciliary support, day centres, and residential care. This cooperation allowed the state to outsource service delivery while avoiding the costs of building a large public infrastructure. However, it also entrenched territorial disparities and created significant variation in service quality and coverage across municipalities.

Unlike Italy, which introduced the *Indennità di Accompagnamento* in 1980 as a universal, non-means-tested monetary entitlement, Portugal delayed the recognition of financial dependency support until the very end of the 1990s. The *Complemento por Dependência*, created through Decreto-Lei No. 265/1999, marked the first monetary measure specifically targeting dependent individuals, albeit only those already receiving pensions. While modest in value and limited in reach, it symbolised a discursive and normative turning point, shifting the framing of dependency from a private burden to a condition of public concern warranting compensation and state recognition.

Parallel to the expansion of IPSS-run services, the healthcare system also began to tentatively engage with LTC issues. *Lei de Bases da Saúde* (Law No. 48/1990) introduced the principle of *continuidade de cuidados* (continuity of care), and in 1993, the government launched hospital discharge management units (*Unidades de Gestão de Altas*), aimed at preventing prolonged hospital stays for older patients without adequate community care. These were among the first institutional attempts to coordinate health and social care and directly addressed the phenomenon of “bed-blocking,” which had become a growing concern due to insufficient alternatives outside hospitals.

Despite these efforts, structural barriers persisted: Administrative separation between ministries, lack of common eligibility criteria, absence of shared budgets, and weak data-sharing mechanisms. Integration occurred mainly at the local level, often based on personal relationships and informal coordination between SNS professionals and IPSS staff. In this sense, the 1990s can be seen as a transitional decade, where pragmatic solutions to practical problems began to reveal the need for systemic change.

Crucially, this period also saw the emergence of a new policy language. The concept of *cuidados continuados* (continuing care), imported from international discourse on chronic illness and ageing, began to frame the debate. It created space for conceptual convergence around a continuum of care that spanned acute, rehabilitative, and long-term services. The *Plano Nacional de Saúde* 1998-2002, under the Socialist government of António Guterres, institutionalised this shift by placing continuity, functionality, and autonomy at the core of public health planning. Although not legally binding, the Plan gave strategic visibility to LTC and reflected growing recognition of the systemic burden posed by chronic disease and population ageing.

By the end of the 1990s, Portugal had not yet developed a unified or fully regulated LTC system. There was no national strategy, no statutory entitlement to services, and no comprehensive funding model. Yet the building blocks of a hybrid, community-oriented, and multi-actor system were in place. The combination of state financing, nonprofit delivery, and household caregiving defined what would become Portugal's LTC model: A negotiated and pluralistic regime grounded in subsidiarity and sustained by partnerships across sectors.

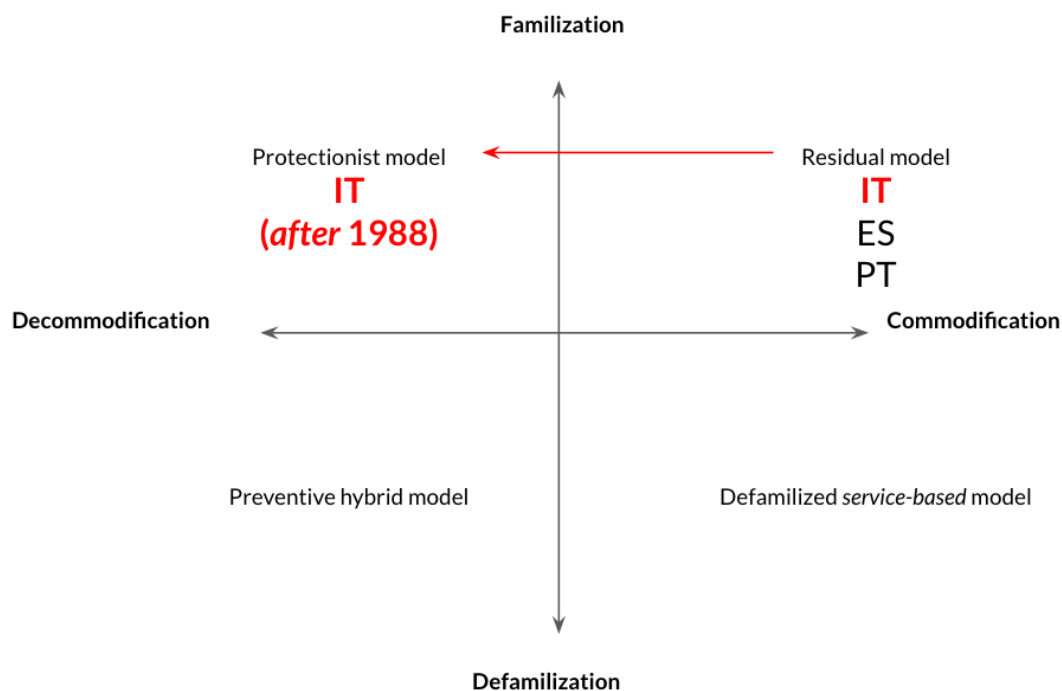
In comparative perspective, Portugal's path differed markedly from Italy's cash-based universalism and Spain's decentralised service expansion. It followed a hybrid and incremental model, shaped by institutional legacies and constrained state capacity, but also by a strong civil society sector and the availability of EU cohesion funds that supported experimental projects. These early pilots—ranging from SAD expansion to intermediate care units—provided the empirical and organisational groundwork for the launch of the *Rede Nacional de Cuidados Continuados Integrados* in 2006, which would formalise integration between health and social care sectors.

In sum, the 1980s and 1990s should be understood as a formative phase in the construction of Portugal's LTC regime. While lacking a master plan, this period produced critical innovations—conceptual, legal, and institutional—that redefined care for dependent persons as a shared public responsibility. These decades did not merely anticipate later reforms; they made them thinkable and actionable.

5. Understanding *Status Quo Ante* LTC Reform in Spain, Italy and Portugal

Despite their distinct explanatory trajectories, all three countries initiated reform processes from a shared baseline: A residual, fragmented, and family-based care model, characteristic of Southern European welfare regimes. Figure 3.1. illustrates the policy trajectories undertaken by Spain, Italy, and Portugal between 1980 and 1999, as classified according to the typology introduced in Chapter 2 of this dissertation.

Figura 3.1. Policy Trajectories in Southern European Countries (1980-1999).



Source: Author's elaboration.

In Spain, the long-term care sector prior to the democratic transition was shaped by the authoritarian corporatism of the Franco regime (1939-1975). Social protection followed a fragmented, employment-based Bismarckian model, with benefits tied to formal labor market participation and little provision for non-contributory groups. The regime emphasized the family as the natural provider of welfare, a stance ideologically reinforced by Catholic doctrine. As a result, care responsibilities—particularly for the older, disabled, and chronically ill—were privatized within households, while public services remained rudimentary and often administered by Catholic institutions.

During the autarkic period (1939-1959), welfare policy served more to control than to support the population. A shift occurred in the developmentalist era (1959-1975), which saw the adoption of some modernizing measures, including the *Ley de Bases de la Seguridad Social* (1963) and the creation of disability services (SEREM, SAP) in the early 1970s. However, these efforts lacked cohesion and remained underfunded. The democratic transition (1975-1978) under Prime Minister Adolfo Suárez initiated a broader welfare expansion, codified in the 1978 Constitution. The creation of INSERSO in the same year marked the institutional consolidation of fragmented social assistance efforts, though LTC remained largely informal. The system retained a dual structure: Contributory benefits for formal workers, and basic, often inadequate, social assistance for everyone else.

The real turning point came in the 1980s and 1990s, under successive PSOE governments led by Felipe González (1982-1996). Spain underwent a wave of welfare state building, including the establishment of a universal National Health System (1986) and, crucially for LTC, the passage of Law 13/1982 (LISMI) on the social integration of persons with disabilities. This law introduced the *Subsidio por Asistencia a*

Tercera Persona, a precursor to later LTC allowances. During the 1990s, ageing began to be framed as a public concern. The *Plan Gerontológico* (1991-2000)—developed by the newly created Ministry of Social Affairs—aimed to coordinate regional efforts and promote social-healthcare integration. The 1993 *Acuerdo Marco*, signed between the Ministries of Health and Social Affairs, sought to improve coordination for dependent populations. These reforms laid the groundwork for more robust LTC policies in the following decade, though regional disparities persisted due to Spain’s deep decentralization.

Italy’s welfare state before the 1980s exhibited many of the same characteristics as Spain’s—limited-service provision, heavy reliance on family-based care, and a preference for cash transfers over direct services. Yet Italy’s trajectory was also defined by its early statehood, its fascist-era welfare structures, and post-war clientelism. Social protection was developed through occupationally segmented schemes, with limited coordination across sectors. Institutions like the ECA and OMNI managed local assistance, while religious charities continued to provide the bulk of care for dependent individuals. Although the 1948 Constitution formally recognized the right to health and assistance, implementation was gradual and uneven. Welfare expansion in the post-war decades prioritized pensions over other areas. LTC was not conceptualized as a distinct policy domain but fell under the broader umbrella of invalidity and old-age support. A shift occurred with Law 118/1971, which recognized “civil invalidity” and introduced limited home-based services. However, structural integration remained elusive. The 1978 creation of the SSN marked the institutionalization of universal healthcare but failed to coordinate with social assistance frameworks at the municipal level.

The decisive development came in 1980, with Law 18, which introduced the IdA—a flat-rate, non-means-tested cash benefit for individuals with severe functional limitations. Initially designed for disabled civilians, it was gradually extended to older dependent individuals, becoming the core of Italy’s LTC strategy. While the IdA ensured wide coverage, it also entrenched a compensatory and familialistic model: Beneficiaries received financial support, but the actual provision of care remained a private responsibility. During the 1990s, under the premierships of Giulio Andreotti, Carlo Azeglio Ciampi, and especially Romano Prodi (1996-1998), Italy implemented several structural welfare reforms, including the 1992 Amato pension reform and the 1999 introduction of LEA. The LEA outlined minimum standards for healthcare provision, including for chronic and long-term conditions. Nonetheless, LTC remained only partially addressed. There was no national LTC strategy, and the gap between formal health services and informal family care persisted. In addition, strong regional inequalities and limited investment in community services undermined any shift toward a more service-based model.

Portugal entered the democratic era with the weakest welfare system of the three. The authoritarian *Estado Novo* regime (1926-1974), led by Salazar and later Marcelo Caetano, prioritized conservative family values and social control. Welfare provision was highly corporatist and selective, with the Catholic Church—particularly the *Misericórdias*—occupying a central role in caring for the poor, older people, and disabled. Dependency was viewed as a moral issue rather than a public responsibility. The

Carnation Revolution of 1974 triggered a period of profound institutional reform. The SNS was created in 1979, guaranteeing universal healthcare access. However, LTC remained institutionally neglected. There was no legal recognition of dependency, and care continued to be delivered almost exclusively by families and religious or charitable organizations.

Throughout the 1980s and early 1990s, Portugal lacked a national LTC framework. Still, incremental changes began to emerge under Socialist and Social Democratic governments (led by Mário Soares, Aníbal Cavaco Silva, and António Guterres). The SNS Reform of 1990 (Law 48/1990) attempted to reorganize health services and introduced a focus on continuity of care, though primarily from a clinical perspective. During Guterres' first term (1995-1999), new partnerships between the Ministry of Health and the Ministry of Social Affairs gave rise to pilot programs aimed at better coordination of care for dependent individuals. These included community nursing services and integrated care teams, which laid the foundation for future reforms.

Nevertheless, service provision remained highly fragmented and dependent on non-profit actors. Public funding was limited, regulation uneven, and access inconsistent. The *Misericórdias* continued to operate the majority of residential care facilities, often with minimal state oversight. Unlike Spain and Italy, there was no centralized planning initiative or national strategy for LTC in the 1990s. The institutionalization of LTC would only begin with the 2006 creation of the *Rede Nacional de Cuidados Continuados Integrados*.

The three countries entered the 1990s with long-term care systems that were institutionally weak, highly familialistic, and largely unregulated. With the partial exception of Italy—which introduced and later expanded a universalistic, compensatory cash benefit through the *Indennità di Accompagnamento* in 1980 and 1988—Spain and Portugal largely remained anchored to uneven, residual, and fragmented service provision. Notwithstanding Italy's turn, the service dimension of long-term care in all three countries continued to be characterised by limited coverage, strong territorial disparities, and a persistent reliance on informal family care. Public expenditure remained focused on pensions and healthcare, while support for dependent individuals was indirect, fragmented, and poorly coordinated. Spain began to shift toward service development and strategic planning, albeit with high territorial variation. Italy consolidated its cash-based compensatory model, reinforcing private caregiving without integrating social and health services. Portugal remained the most underdeveloped, relying extensively on civil society and religious institutions, with only tentative state involvement.

Converging starting points and divergent reform logics would deeply influence the structure and performance of LTC systems in the following decades. Understanding these historical foundations is essential to interpret both convergence and divergence in the trajectories of Southern European long-term care policy.

Chapter 4. The Politics of LTC: In Search for a Theoretical Framework

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1. Introduction

In the field of political science, academic research on LTC remains relatively limited and fragmented. Some studies have examined policy change using qualitative methodologies, often focusing on specific measures within individual country cases (e.g., Morel, 2007). Others have adopted a more comparative approach, employing quantitative methods to analyze multiple LTC systems, though typically emphasizing levels of public expenditure rather than institutional characteristics (e.g., Hieda, 2012). While considerable efforts have been made to reconstruct the historical development of LTC systems (e.g., Ranci & Pavolini, 2013; Greve, 2017; 2022), interpretative frameworks rooted in political science theory that can account for the adoption and evolution of LTC policies in Europe remain underdeveloped. Existing research has predominantly been concentrated in the field of sociology, with

a focus on the institutional evolution of healthcare, pension, and social protection systems, rather than on the role of political and social actors in shaping LTC policy trajectories.

This research gap raises several important analytical questions: Why do some states adopt universalistic LTC systems, while others remain entrenched in residual models? What factors explain the substantive content and formulation of LTC policies? From the analysis presented in this chapter, at least three defining features of the LTC policy domain emerge, which are analytically useful for the theoretical frameworks that follow.

First, LTC should be understood as a “new social risk.” This categorization does not stem from the novelty of the condition itself but from its reflection of the intersection of multiple risks—both social (e.g., social isolation, and the declining availability of informal female caregivers) and health-related (e.g., increased longevity, chronic illness, and reduced quality of life). The care of frail older adults has become an urgent social challenge, particularly in terms of the sustainability of welfare states, given that this demographic group is largely outside the labor market. This group is also typically perceived as politically weak, with limited voting power or mobilization capacity. In familistic welfare regimes, especially in Southern Europe, LTC has historically been regarded as a private, family-based responsibility. Families, and especially women, have long shouldered the burden of care, which has subsequently justified the limited involvement of the public sector in this domain. As a result, efforts to shift responsibility from families to the public sector often encounter strong socio-cultural resistance. Consequently, LTC policies have generally been supported through institutions initially designed to address permanent or temporary disability, remaining politically marginal and resulting in small, fragmented constituencies primarily focused on protecting established entitlements. However, despite their numerical underrepresentation, these beneficiary groups are often supported by stable and well-organized interest organizations, which actively engage with government institutions and seek to influence policy decisions.

Second, the preferences of organized collective groups interact with political parties’ ones. Depending on the political institutional context, these parties seek to maintain or expand electoral support while avoiding reputational damage. This contribution supports the argument that partisan ideology still matters but in constrained environments: Including coalition dynamics, fiscal limitations, institutional legacies, and the evolving structure of the electorate. Against the backdrop of the longstanding familism *versus* commodification debate, political parties adopt differentiated strategic positions, responding to both electoral incentives and systemic constraints.

Third, this strategic interaction is particularly salient in the realm of LTC: Political competition rarely centers on whether to implement LTC policies, but rather on how these policies are formulated and structured. This reflects the persistence of traditional political cleavages, while simultaneously highlighting the emergence of new political cleavages related to gender roles, family transformations, and the political economy of care. Also, the diffusion of European Union-level ideas, particularly around the “Social Europe” agenda and the social investment paradigm, has been selectively embraced by

certain member states and integrated into policy design, facilitating dialogue among political and social actors.

As a result, LTC policy reform has gained *momentum* primarily within specific political and institutional configurations, allowing for a more nuanced understanding of the interplay between functional pressures, institutional constraints, and actor dynamics. This process of transformation requires a dual-level interpretation—both structural and agency-based—considering how political and institutional actors facilitate, hinder, or obstruct systemic change.

This chapter is organized as follow. Section 2 engages with structural theories, particularly functionalism and neo-institutionalism, to highlight the broader systemic factors at play. Section 3 shifts focus on actor-centered theories, analyzing the role of political and social actors, their preferences, and the strategic interactions that shape LTC policymaking. The Section 4 section presents the argument, outlining the interaction between the demand and supply sides of the policy domain. Section 5 concludes, defining the main argument of the thesis.

2. Structural-level Theories: Functionalism and Historical Institutionalism

This section focuses on presenting structural-level theories aimed at interpreting the adoption and content reform of long-term care policies. The analysis explores two key approaches: Functionalism (Section 2.1.) and historical neo-institutionalism (Section 2.3.), each of which is examined through its specific application to the long-term care sector (Sections 2.2. and 2.4.).

2.1. Functional Theories

Early studies on the welfare state identified its primary causes of emergence and evolution within socio-economic factors, adopting a predominantly functionalist perspective. According to this framework, social protection systems emerged in response to a series of needs generated by global dynamics (Myles & Quadagno, 2002). Specifically, these early works focused on theories of industrialism, which argue that industrialization generates new demands for public expenditure and social support. These demands arose as a consequence of the erosion of traditional protective structures, such as family-based support systems, which were typical in agrarian societies (Kerr et al., 1960). Simultaneously, the increasing dependence of individuals on wages for subsistence created or amplified new risks, particularly those associated with the inability to work due to unemployment or illness, necessitating formal mechanisms of protection (Pampel & Tanaka, 1986).

Within this early “functionalist” strand of welfare state studies, the work of Wilensky (1974) stands out. In this view, the expansion of the welfare state is interpreted as a necessary and, in a sense, automatic consequence of capitalist industrialization. The transition from an agricultural to an industrial economy generated several social distortions, often referred to as the “externalities” of the market. The market itself was not able to provide social safety nets for the entire population, as had been done by the church and the family, which prompted the state to step in. Economic growth, with its social (including

demographic) and bureaucratic outcomes, is thus functionally presented as the root cause of the growing social expenditure observed during the welfare state's "golden age" (*ibidem*).

Functionalist theories of the 1960s and 1970s were not mistaken in attributing the origins of welfare state policies to social and economic changes. This is evident in the transition from industrial to post-industrial society, which has historically driven subsequent developments in welfare systems (Busemeyer et al., 2022). While these functional pressures were particularly relevant in the context of traditional Bismarckian welfare models, which were prevalent in continental Europe and were designed to address risks associated with stable, long-term male employment (Armingeon & Bonoli, 2006), the emergence of post-industrial societies disrupted this economic and social model, revealing the inadequacies of welfare systems designed for a Fordist labor market (Bonoli, 2007).

The decline of the Fordist industrial model in the 1970s, driven by economic globalization, oil crises, and the rise of information and communication technologies, gave rise to what Taylor-Gooby (2004) and Bonoli (2007) identified as "new social risks" (Taylor-Gooby, 2004; Bonoli, 2007). Adopting a functionalist perspective assumes that welfare state changes do not originate from within the political system but are instead exogenous. According to this view, countries with similar economic and socio-demographic contexts are expected to develop similar welfare institutions (Quadagno, 1987). Political preferences, institutional features, and historical or cultural heritages are not considered significant in explaining welfare state changes in a functionalist framework.

Therefore, critics of this approach argue that it can only account for the quantitative expansion of the welfare state (i.e., increases in public expenditure) but fails to explain qualitative aspects, such as differences in policy content and the variety of welfare state models (Graziano & Jessoula, 2018). Furthermore, while the mere presence of social risks is necessary to trigger policy responses, functionalism falls short in providing sufficient causal explanations (Natili, 2019). Indeed, the emergence of new and uncovered risks certainly creates pressure for the "functional recalibration" of the welfare state—a call to reorient its provisions to meet new needs (Ferrera, 2000). Beyond the expectations of functionalism, the response to the new risks of the 1990s—at least in Europe—has varied considerably across countries (Armingeon & Bonoli, 2006), and functional pressures have not always led to policy recalibration or the adoption of new policies (Saraceno, 2008; Hemerijck, 2012).

2.1.1. A Functional Explanation of LTC Policies: Ageing Population as a Problem Pressure

The functionalist approach provides a valuable lens for analyzing the pressures driving the evolution of LTC systems. Before the 1900s, most individuals did not live long enough to concern themselves with retirement. The small percentage of the population that reached old age typically relied on their family or public charity for survival. It was only when aggregate life expectancy rates began to rise that retirement from the workforce became a more common phenomenon. Demographic aging has been a particularly significant force, with growing older populations requiring more formal care services due

to the declining viability of traditional family-based caregiving (Saraceno, 2008). For example, the shift from unpaid, informal care—predominantly provided by women in the post-war period—to formal LTC services reflects the systemic response to changing labor market dynamics and demographic structures (Bonoli, 2007). Functionalist theories emphasize that these pressures create a demand for institutional change, but they often assume that similar pressures will lead to convergent policy trajectories. By the 1920s and 1930s, industrial pensions for workers were widely available, and by the 1940s, the post-war surge in pension concerns had made social security safety nets a government responsibility in most developed and developing countries (Clark & Spengler, 1980; Esping-Andersen, 2002).

Previous research on the relationship between the growing older population and welfare state development has predominantly relied on demographic-functionalist theories, which suggest that as technology and the economy improve, the population ages, and thus the state expands its services to meet the needs of the older persons. The demographic-functionalist explanations first emerged in the 1930s and 1940s, resurfacing in the 1970s and 1980s. The UN commissioned numerous reports on the aging population in Western countries to assess whether this demographic shift was increasing society's burden to provide welfare services for the older persons (Easterlin, 1978; Esping-Andersen, 1990; Duval, 2003; Galasso, 2006). The central debate was whether this would inevitably lead to a resource scarcity problem, where services for the older people would limit those for the younger population, causing tensions between workers and the older persons (Easterlin, 1978; Clark & Spengler, 1980). These political debates demonstrate how the aging population spurred the development of programs and services for the older persons. The conventional wisdom in aging societies' literature is derived from these demographic-functionalist theories, which argue that an aging population creates a need for more welfare protections for the older, and this need is met by the government's expansion of old-age benefits (Esping-Andersen, 1990; Lynch, 2006). Simply put, the argument is that as the state expands with economic advances, this automatically includes a response to the aging population through greater welfare protections for the older (Segura-Ubiergo, 2007). As Alex Segura-Ubiergo (2007: 8) suggests, in demographic-functionalist theories, "the state expands because of exogenous technological and industrial pressures and responds (almost automatically) to the economic and demographic needs of the population."

On one hand, these demographic and social transformations exert specific pressures on established welfare state institutions, particularly in the areas of healthcare and pensions, which are closely tied to the challenges posed by an aging population. On the other hand, changes in family structures and labor markets place additional stress on the social care system, which has historically been viewed as a residual component of welfare provision. The dysfunctionality of care regimes further exacerbates these pressures, as an increasing number of individuals face the risk of long-term dependency, while the availability of potential caregivers—primarily women—continues to decline. This imbalance underscores the core argument of functionalism, which posits that governments will act to restore equilibrium within malfunctioning care regimes in response to rising costs, diminishing welfare protections, and evolving demographic conditions. As such, the emergence of new social risks creates functional pressures, compelling state intervention through targeted public policies. Within this framework, the adoption of

comprehensive long-term care policies serves to better align mature welfare systems (i.e., healthcare and pensions) with those that have traditionally been residual (i.e., social care).

However, as discussed, this perspective has significant limitations, as it fails to account for the role of institutional structures, political agency, and broader contextual factors in shaping divergent policy trajectories. While functional pressures certainly serve as a necessary condition for welfare state change, they are insufficient to explain why similar pressures result in different policy responses across various national contexts. In fact, demographic-functionalist theories provide inadequate answers as to why a larger older population is associated with greater welfare efforts. The causal mechanisms in these arguments are not sufficiently specified. Therefore, the link between the economic needs of the population, the needs of the older people, and the degree or type of welfare expansion remains unclear (Segura-Ubiergo, 2007). This expansion may stem from an altruistic response from the government, a response to governmental pressures, or a reaction to the industrial needs of society (i.e., enabling retirement to create room for younger workers), among other factors.

An empirical comparison of population aging, life expectancy at 65, female employment rates, and GDP per capita for Portugal, Spain, and Italy in 1990, 2004, and 2022 highlights the pressures faced by traditional care systems, particularly in the realm of LTC (Table 4.1.). The first three indicators reflect the major pressures from medical advancements, demographic aging, and the shrinking pool of potential informal caregivers. The fourth indicator, GDP per capita, serves as a proxy for economic development and the financial capacity of each country to undertake large-scale reforms in the social and healthcare sectors.

In all three countries, demographic pressure from an aging population has been accompanied by rising life expectancy and increasing female labor market participation. These phenomena are particularly relevant for LTC policies, as they affect both the demand for care services and the availability of informal caregiving within families. Among these countries, Italy has experienced the greatest demographic pressure, with 31.6% of its population aged 65 and over by 2004, compared to 24.3% in 1990, continuing to rise to 41% by 2022 (OECD dataset). A similar trajectory is observed in Portugal, where the aging population increased from 23.9% in 1990 to 27.6% in 2004, reaching 39% in 2022. Spain followed a similar pattern, with the proportion of older people increasing from 23.1% in 1990 to 26.5% in 2004, and further rising to 33.4% in 2022 (OECD dataset).

In contrast, female employment rates exhibited a marked upward trend, reflecting broader shifts in labor market structures and gender norms. Between 1990 and 2004, all three countries saw an increase in women's employment, though Portugal consistently maintained higher levels than Spain and Italy. By 2004, female employment in Portugal reached 61.5%, up from 59.5% in 1990, and rose to 70.2% in 2022. Spain demonstrated the most significant increase, climbing from 38.5% in 1990 to 48.8% in 2004, and reaching 60.7% in 2022. Italy followed a similar trajectory, with female employment rising from 38.3% in 1990 to 45.5% in 2004, before reaching 52.5% in 2022 (OECD dataset). When considering the economic dimension, as measured by GDP per capita, Italy initially had a comparative advantage. However, its

slower economic growth rate compared to Portugal and Spain appears to have influenced its long-term policy trajectory. Weaker growth projections may have constrained the state's fiscal capacity and political willingness to engage in ambitious welfare and LTC reforms.

Table 4.1. Aging Population, Life Expectancy at 65 and Female Employment: Descriptive Statistics in Spain, Italy and Portugal.

	Spain			Italy			Portugal		
	1990	2004	2022	1990	2004	2022	1990	2004	2022
Aging Population	23.1	26.5	33.4	24.3	31.6	41	23.9	27.6	39
Life Expectancy at 65	17.4	19.2	21.4	17.1	19.3	20.5	15.6	18.2	20.2
Female Employment	38.5	48.8	60.7	38.3	45.5	52.5	59.5	61.5	70.2

Source: Author's elaboration on OECD dataset.

The imbalance in traditional care systems had been a topic of debate in all three countries under examination since the early 1990s. However, this imbalance led to divergent outcomes, which is the topic of Chapters 5, 6 and 7. Thus, while this analytical framework helps to identify the pressures that have shaped these systems for over three decades and underscores the need for structural reform, it does not sufficiently address the *why* question—neither in terms of the adoption nor the formulation of long-term care policies.

However, it is worth noting, under the family of explanations based on political pressures the growing older population increased the aged population's ability to pressure the government for more welfare provisions that were beneficial for them. These aged population political pressure theories assume that the older population prefers the expansion of welfare provisions and pressures the government to represent their interests (Lynch, 2006). Literature on advanced industrialized countries has established that, at least empirically, a larger and more well-organized older population is associated with a larger total welfare effort (Wilensky, 1974; Easterlin, 1978; Guillebaud, 1980; Myles, 1984; Pampel & Williamson, 1985; Pampel & Williamson, 1989; Esping-Andersen, 1990; Phillipson, 1990; Phillipson, 2000; Duval, 2003; Galasso, 2006). An interesting insight emerges from the fact that growing pressures and the development of new social risks give rise to new political demands, affecting various groups such as the older people, the aged, the unemployed, and dependents. That means, in the latter case, they provide causal mechanisms that are often lacking in demographic functionalist explanations. Specifically, they suggest that welfare programs disproportionately benefit the older over younger generations, and, as a result, aging populations across different countries tend to support a broad range of welfare provisions (Lynch, 2006).

2.2. Historical Institutionalism and Beyond

While functionalism focuses on the explanatory power of socio-economic conditions, neo-institutionalism, as the label suggests, emphasizes the causal role of institutions. Emerging in the 1980s (March & Olsen, 1984), neo-institutionalism developed as a theoretical framework to analyze the constraining and enabling roles of institutions in shaping the policymaking process. Institutional settings, in this perspective, affect actors' cognitive and normative positions, structuring the ways in which these positions are expressed and acted upon (Hall & Taylor, 1996). Neo-institutionalism encompasses several sub-approaches, including rational choice institutionalism (Immergut, 1998), sociological institutionalism (*ibidem*), and discursive institutionalism (Schmidt, 2006). Among these, historical institutionalism has become a particularly prominent variant for studying social policies.

Neo-institutionalism challenges the pluralist view, which posits that social class interests are effectively communicated to political elites through interest groups and political parties. Instead, neo-institutional scholars focus on the role of political institutions in structuring the policymaking process. These institutions shape political outcomes by providing strategically valuable information, influencing actors' identities and preferences, and constraining the range of policy choices available (Hall & Taylor, 1996; Immergut, 1998). As a result, neo-institutionalism places institutions at the center of analysis, emphasizing their differential capacity to shape public policy and drive institutional change across political systems.

The central argument of historical institutionalism is that political developments must be understood as processes unfolding over time (Pierson, 2004). At its core, historical institutionalism presents public policies as institutionalized entities (Pierson & Weaver, 1993), using path dependence as a core concept to explain their evolution. In its purest form, path dependence suggests that previous policy decisions induce future developments along the same trajectory (Pierson, 2000). This concept is drawn from economic studies, specifically the idea of increasing returns, or positive feedback, where each policy step in a particular direction raises the likelihood that subsequent steps will follow the same path. Path dependence arises from the high fixed costs associated with reversing initial policy choices, which lead political actors to adhere to their original decisions (Myles & Pierson, 2001).

According to this view, past policy decisions shape future developments by influencing how social forces organize, how identities are constructed, and how specific policy interests emerge and consolidate. Social policies, due to the high fixed costs associated with establishing new institutions and mobilizing interest groups that defend these institutions, tend to generate strong path dependencies. These groups include not only current beneficiaries but also future recipients who expect to receive the same benefits as past generations. As a result, the initial configuration of the welfare state—shaped by historical struggles and power relations at particular moments—has long-term inertial effects on the policymaking process. This institutional framework determines which actors gain access to decision-making and facilitates the creation of strong constituencies that advocate for policy continuity.

The so-called “new politics” of the welfare state is not simply a direct consequence of partisan competition but is instead a structurally determined process, heavily influenced by past policy choices made during the formative and expansionary stages of welfare state development (Pierson, 1994). The explanatory power of policy legacies is crucial in this context. According to this perspective, institutional structures serve as the primary determinants of policy inertia, shaping both the constraints and opportunities for reform (Pierson, 2001). Welfare institutions generate entrenched constituencies that actively defend the *status quo*. Consequently, policy change is predominantly path-dependent, typically manifesting as incremental adaptations rather than comprehensive reforms, constrained by pre-existing institutional arrangements and vested interests (Green-Pedersen & Haverland, 2002; van Kersbergen, 2002).

Change, in this framework, is conceived as a punctuated equilibrium (Krasner, 1984; Häusermann, 2010; Bonoli & Natali, 2012), within a path departure hypothesis: Institutional change primarily occurs during critical junctures triggered by exogenous shocks. Events such as economic crises or demographic shifts weaken structural constraints temporarily, allowing political actors to pursue new policy directions (Capoccia, 2016). However, these shifts often become self-reinforcing through feedback loops, stabilizing the new arrangements (Pierson, 2000). These dynamics underscore the varying degrees of resistance within institutions and introduces the concept of “institutional gates,” which represent moments of opportunity for significant policy departures (Jessoula, 2004; 2009; Streeck & Thelen, 2005).

Path departure, as a result, encompasses a range of processes and forms, often involving simultaneous mechanisms (Streeck & Thelen, 2005). Three key processes illustrate this phenomenon: First, gradual, long-term changes can accumulate over time, resulting in significant reorientations of institutional frameworks (Pierson, 2000); second, functional conversion describes transformations in which existing institutions are repurposed to serve functions different from those originally intended (Thelen, 2003); and third, institutional layering involves the addition of new institutional arrangements that introduce divergent orientations alongside established structures (*ibidem*).

Challenging this dominant perspective on institutional persistence, a growing body of empirical research has demonstrated that welfare states are undergoing significant transformations, and not solely due to external pressures promoting retrenchment (Häusermann, 2010; Palier, 2010; Bonoli & Natali, 2012; Hemerijck, 2012). Beyond the assertions of punctuated *equilibrium*, incremental transformative policy change was identified by more recent studies as a fundamental mechanism for endogenous institutional change in a historical institutionalist perspective (Streeck & Thelen, 2005; Mahoney & Thelen, 2009). In this view, incrementalism is still gradual, but it can lead to a change of considerable magnitude, produced by the behaviour that institutions themselves generate within a policy subsystem. An important takeaway from transformative incrementalism is that, when institutions are less resistant to change, an institutional “gate” can open for socio-political actors to drive policy change (Jessoula, 2004; 2009). Therefore, away from the original conception of institutions as constraints, this new branch of historical institutionalism has started to frame them also as opportunity structures.

Consequently, the attention of historical institutionalists has more recently shifted towards the relationship between agency and structure, hence to how socio-political actors' behavior and preferences play out within the range of possibilities offered to them by the structures they operate in (Mahoney & Thelen, 2009). In fact, this theoretical perspective has its limitations. In particular, it tends to underplay the role of agency and political strategy, leaning too heavily on structural explanations. As Hay and Wincott (1998) note, the strong emphasis on institutional continuity often overlooks how political actors actively shape policy trajectories. Carstensen (2025) further critiques this approach, arguing that while historical institutionalism excels at explaining policy stability, it struggles to capture moments of significant institutional transformation driven by political agency and strategic framing. Carstensen (2025) and Moschella (2025) highlight the importance of such moments, arguing that external crises or shifts in political power allow political actors to push for reforms that break away from established institutional paths, even in highly fragmented political systems. This is particularly true when there is a shift in ideational frameworks, allowing for changes that would not typically occur within the context of path-dependent models.

2.2.1. A Neo-Institutionalist Perspective of LTC Reforms

A few scholars have emphasized that LTC systems are deeply shaped by the specific characteristics of national welfare regimes (see Ranci & Pavolini, 2013; 2015). Southern European countries are typically classified within the Southern European welfare model (Ferrera, 1996; Ferrera & Gualmini, 2004). As Ferrera (1993; 1996) points out, these welfare states are characterized by a high reliance on cash transfers, the overprotection of old-age risks and of the older people as a social group—most notably through generous pension schemes—and the underdevelopment of family benefits and care services.

Functional equivalents to LTC. Despite the centrality of old-age protection in welfare systems, LTC policies have remained largely residual across Spain, Italy and Portugal (see Chapter 3). As Ranci and Pavolini (2015, p. 274) emphasize, institutional change in the LTC sector must be examined in conjunction with broader reforms in traditional and financially demanding social policy areas—most notably healthcare and pensions. The configuration of these more established policy domains can either intensify or mitigate pressures for LTC reform.

By the late 1980s, all three countries had established universal NHS—Italy in 1978, Portugal in 1979, and Spain in 1986—which progressively incorporated provisions targeting frail older adults. In the broader social policy field, these healthcare reforms were complemented by the introduction of universal, non-contributory pensions—i.e., benefits not subject to means-testing—aimed at alleviating the socio-economic vulnerabilities that emerged in the aftermath of the 1970s oil crisis. The expansion of non-contributory social benefits (such as Italy's *Indennità di accompagnamento*, introduced in 1980, and analogous Spanish provisions in the early 1990s) contributed to the establishment of an initial framework of support for dependent older people.

These policy developments have been deeply intertwined with the evolution of healthcare and pension systems, progressively extending into the social policy arena. Traditionally entrusted to families, the provision of social care has gradually been formalized through public networks of services designed to support families facing various vulnerabilities, including those associated with LTC needs. Nevertheless, when compared to healthcare and pensions, LTC policies have remained “residual” or “marginal” due to their relatively recent institutionalization and the existence of functional equivalents in more established sectors. These equivalents—such as cash transfers or home-based health services—often fulfill similar needs, thus reducing the perceived necessity for comprehensive LTC reform.

As a result, the legal and policy frameworks governing healthcare, non-contributory benefits, and social care have likely exerted differing levels of influence on LTC reform trajectories since the early 2000s. Moreover, the layering of policies across different sectors—and the specific constituencies they engage—has contributed to the emergence of path-dependent dynamics and sector-specific interest groups with particularistic aims. Overall, the presence of functional equivalents in adjacent policy domains may have diminished the visibility and political urgency of structural LTC reforms, leading policymakers to favor more familiar, incremental, or politically feasible interventions over systemic change.

The dominant cognitive frames: Invalidity, family and market. In the aftermath of World War II, countries such as Italy witnessed a significant increase in the number of war invalids and disabled veterans, prompting state intervention through the establishment of institutionalized—albeit often residual—public assistance schemes. These measures, whether conceived as temporary or permanent, were intended to provide care and support for individuals with war-related disabilities, thereby laying an institutional foundation for the subsequent development of LTC policies. In this context, the early expansion of universal, non-contributory measures targeting vulnerable populations, alongside the emergence of specific interest groups (e.g., ANMIC—Associazione Nazionale Mutilati e Invalidi Civili, founded in 1956), can be understood as products of broader historical and institutional dynamics. The central role of families in the provision of social care, reinforced by strong intergenerational solidarity, continues to shape both the demand for and the organization of LTC systems (Fischer et al., 2022). Cultural expectations regarding caregiving responsibilities—whether they are to be borne by the state, the market, or the family—have a profound influence on institutional configurations, policy design, and everyday caregiving practices. These dynamics are further shaped by evolving gender norms, particularly the changing role of women within households and the labor market, which continues to affect how care responsibilities are distributed, experienced, and perceived. This socio-cultural backdrop is essential to understanding the growing role of market-oriented and neoliberal ideologies in the governance of social and healthcare services. Market institutions have significantly reshaped the LTC landscape through mechanisms such as outsourcing and accreditation systems based on public-private partnerships. These processes have progressively redrawn the boundaries between state and market responsibilities, leading to a reconfiguration of care governance.

Central to this shift is a broader normative transformation in LTC: From a model that treats care as a social right to one that increasingly conceives care as a commodified service, accessible according to

individuals' financial means (Mercille, 2024). As previously discussed, the policy trajectories of Italy, Spain, and Portugal have increasingly relied on market actors—both for-profit and non-profit—to address persistent shortcomings in public welfare provision. Despite these formal developments, informal caregivers—particularly family members and migrant care workers—continue to occupy a central, albeit frequently undervalued, role in LTC provision. While the sector has undergone a gradual process of professionalization, informal care has not been displaced. Rather, formal and informal systems coexist in hybrid configurations that reflect both institutional inertia and the persistent influence of familialistic cultural norms. Table 4.2. summarizes the cognitive frames emerging from the literature in the field, as well as—where applicable—from the analysis of policy trajectories presented in the preceding chapters.

Table 4.2. Cognitive Frames in the LTC Policy.

Cognitive Frame	Underlying Assumption	Preferred choice in LTC
Invalidity/Disability	Frailty is a compensable form of disability	Residual and monetary-based support
Family-oriented	The family is the primary site of care	Predominance of informal care
Market-oriented	Care is a purchasable good	Hybridization of care; unequal access

Source: Author's elaboration.

Stratified Institutions and multi-layered policy responsibilities. The multi-level governance of care provision, combined with the absence of a coherent national legislative framework, has led to the delegation of primary responsibility for service delivery, particularly in the area of social care, to regional authorities. As previously noted, efforts to introduce structural LTC reforms—such as Spain's 2006 Dependency Law—have often encountered resistance from regional governments, which feared the erosion of their autonomy and policymaking powers over a domain they considered to be within their exclusive jurisdiction. In institutional terms, the political “rules of the game” in Spain enable regional governments to act as veto players. While the Dependency Law was passed at the national level, its implementation was subject to extensive negotiation with regional authorities. Some CC.AA. responded with active or passive resistance, delaying or reshaping the policy's rollout in order to maintain control over their existing welfare systems (see Chapter 5). Similarly, in Italy, regions enjoy significant legislative and administrative autonomy, particularly in the areas of healthcare and social assistance, which are defined as matters of concurrent or even exclusive regional competence. Consequently, Italian regions have the capacity to delay or significantly alter national reforms, particularly when they perceive these reforms as encroachments on their authority.

A notable example of this is the implementation of the National Long-Term Care Plan (*Piano per le Non Autosufficienze*, see Chapter 6), which requires consensus within the State-Regions Conference. In this setting, regional governments can effectively exercise veto power, slowing down or renegotiating measures to align with their preferences. In contrast, Portugal remains the most centralized of the three countries. Its regions (with the exception of the autonomous regions of the Azores and Madeira) do not hold constitutional status as autonomous political entities. Nonetheless, local authorities such

as municipalities play an important role in the delivery of social services (see Chapter 8). While they do not function as formal veto players, local actors can still influence policy implementation, particularly in contexts where central coordination is weak or fragmented. Additionally, horizontally, the shared responsibility between multiple ministries, as discussed in Chapter 3, has involved the participation of various political actors in framing long-term care policy, thereby generating potential veto points that can hinder change.

A widely shared hypothesis in the literature on policy change is that it tends to occur incrementally, shaped by pre-existing institutional legacies and entrenched interest structures. Substantial transformation is usually seen as contingent on major reforms or external shocks—such as economic crises or demographic transitions—that open a window of opportunity for deeper institutional change. Within this framework, the development of social policies in Southern European countries is generally expected to follow a gradual and reactive pattern, constrained by historically rooted welfare models. Indeed, the historical trajectory of Southern European welfare regimes has produced a model in which support for vulnerable populations remains largely residual. Assistance is predominantly channeled through cash transfers, while the family continues to serve as the main provider of care. In these highly path-dependent contexts, opportunities for significant policy innovation are limited—unless disrupted by strong external pressures such as fiscal crises.

However, the Spanish case presents a clear departure from this general pattern. The 2006 Dependency Law marked a significant turning point in Spain's social policy, by introducing the formalization of care services, the provision of benefits explicitly tied to service use, and the recognition of professional caregiving roles. Most importantly, it addressed Spain's long-standing issue of regional fragmentation by creating a unified national legislative and institutional framework. In doing so, the reform overcame one of the major barriers to structural change in a system characterized by multi-level governance.

3. Actor-Based Theories

Building upon earlier structural and institutionalist analyses, this section advances an actor-based theoretical framework to explain changes in LTC policies. The primary objective is to supplement macro-level explanations by demonstrating how the agency of various actors can either enable or constrain the process of policy change within existing welfare state institutions.

Section 3.1 delves into the significant role of ideas as a catalyst for policy innovation and reform. Following this, Section 3.2 investigates the strategic interplay among political and non-political actors, moving beyond purely partisan explanations, as a mechanism for achieving policy transformation.

3.1. Puzzling: Ideational Drivers as Instrumental to Policy Change

Ideational approaches to welfare state transformation primarily emphasize the evolution of policy ideas over institutional continuity, focusing on how political actors discursively construct policy problems and articulate potential solutions (Schmidt, 2008). These approaches argue that actors are motivated not only by strategic interests or power maximization but also by “puzzling”—a cognitive and normative process through which social reality is interpreted, and policy alternatives are framed (Heclo, 1974; Hall, 1993). From this perspective, policy change is largely driven by policy learning, an endogenous process of knowledge construction that occurs particularly under conditions of uncertainty, often triggered by crises or anomalies in prevailing policy frameworks (Hall, 1993; Blyth, 2002).

Policy learning can be actively shaped by political entrepreneurs—actors who invest resources to promote and diffuse particular ideas within the policy arena, facilitating their endorsement by broader coalitions (Kingdon, 2014). An important variation within this framework is the notion of “international benchmarking,” where policymakers emulate successful policy models from other countries (Hemerijck, 2008). In this logic, policy diffusion occurs through mechanisms such as emulation or normative pressure, particularly from international or supranational institutions (Arriba & Moreno, 2005). The European Union, in this context, plays a central role as an ideational catalyst through “Europeanization,” using soft governance instruments like the Open Method of Coordination to promote alignment with common priorities in employment and social policy (Graziano, 2004; Moreno & Palier, 2005; Jessoula & Madama, 2018).

However, ideational approaches, while emphasizing cognitive and discursive dynamics, do not neglect the role of power relations. Ideas are understood to both shape and be shaped by power structures within the policymaking process (Schmidt, 2008; Carstensen & Schmidt, 2016). Particularly, polysemic or ambiguous ideas—those that can support multiple interpretations—serve as “coalition magnets,” enabling diverse actors to unite around shared but flexible discourses (Palier, 2005; Béland & Cox, 2016). This facilitates the formation of “advocacy coalitions” across institutional and ideological divides (Sabatier & Jenkins-Smith, 1993).

In the LTC sector, these ideational mechanisms are especially visible, where the Europeanization process has promoted new normative and cognitive frameworks that prioritize concepts such as “aging with dignity,” “universal access,” and “sustainability.” Through discourses and soft policy instruments, the EU has fostered convergence around care systems that emphasize user choice, efficiency, and multi-stakeholder governance (Maino & Razetti, 2019). However, as Béland (2025) argues in his exploration of ideational dynamics, such transformations in policy ideologies are not unidirectional. Domestic actors often strategically engage in the “upload” and “download” of European ideas to serve national agendas, selectively appropriating these frameworks based on local political needs and institutional arrangements (Börzel & Risse, 2012).

The social investment paradigm, formalized at the EU level through the Social Investment Package (2013), has become particularly relevant in this context. This paradigm reconceptualizes social policy

as an economic asset, emphasizing human capital formation, labor market activation, and gender equality (Esping-Andersen et al., 2002; Bonoli, 2007; Hemerijck, 2017). In the LTC sector, this has translated into policies that frame care services not only as responses to demographic aging but also as opportunities for job creation, particularly in the “white jobs” sector (Simonazzi, 2009; Bouget et al., 2015). The EU strategies, such as the Employment Package (2013) and the European Care Strategy (2022), reflect this dual rationale: Expanding formal care services both to support caregivers’ labor market participation and to foster employment in low-productivity sectors.

However, this framing introduces a deep contradiction. While the social investment logic values care primarily for its economic returns—especially by enabling (female) caregivers to rejoin the workforce—LTC mainly serves populations (e.g., frail older individuals) who are structurally disconnected from labor markets (Ciarini, 2016; Saraceno, 2023). As a result, LTC remains marginal in core social investment discourses, which tend to prioritize childcare and labor market activation over care for dependency. The EU’s Work-Life Balance Directive (2019), for example, targets the labor force participation of informal caregivers rather than the rights of dependent older people themselves.

Moreover, the prevailing focus on outcomes—such as labor market participation—tends to obscure the processes and conditions of care provision. The quality of LTC jobs, persistently characterized by low pay, low skill, and precariousness, receives little attention in social investment strategies (Simonazzi, 2009; van Hooren, 2021). Market-oriented reforms, promoted in the name of efficiency and consumer choice, have further intensified the commodification of care, exacerbating inequalities and undermining care quality and sustainability (Brennan et al., 2012; Ledoux et al., 2021). Competing ideational frames thus coexist in the LTC sector. The social investment frame, aligned with neoliberal market logics, favors outsourcing and privatization, while a rights-based or care-oriented frame emphasizes care as a fundamental human right and a cornerstone of social citizenship, advocating for publicly funded, universally accessible services rooted in solidarity and gender equity (Tronto, 1993; Daly & Lewis, 2000; Lister, 2003). These conflicting ideational narratives shape not only policy design but also the coalitional alignments that support or resist LTC reforms.

Despite its analytical appeal, the ideational framework—particularly its emphasis on “puzzling” and policy learning—has come under increasing scrutiny. As Dunlop et al. (2024) argue, the conceptual dichotomy between puzzling (cognitive reflection) and powering (strategic action) risks oversimplifying the complexity of policymaking. In practice, learning is not a neutral or purely cognitive process, but is deeply embedded in political dynamics. The ability to define policy problems, select and interpret evidence, and shape learning agendas is conditioned by institutional power, asymmetries in resources, and actors’ strategic positioning.

Building on this critique, Carstensen (2025) emphasizes that policy learning unfolds within a field of power, where dominant actors actively shape the boundaries of legitimate knowledge and steer debates toward pre-existing goals rather than genuine deliberation. The authority of certain “teachers”—such as supranational institutions or epistemic communities—further illustrates how learning opportunities

are unequally distributed and how knowledge is filtered, reframed, or instrumentalized to support political objectives. In a similar vein, Ferrera (2025) contributes to this debate by exploring the role of political ideologies as ideational drivers of institutional change. Engaging with recent developments in historical and discursive institutionalism, he argues that ideologies—conceived as configurations of normative (ideas-as-imagination) and descriptive (ideas-as-representation) elements—possess a distinctive capacity to mobilize collective political action, shape actor preferences, and enable coalition building. Unlike other ideational constructs, such as frames or paradigms, ideologies are explicitly transformative: They aim to change the world, not merely to interpret it. Ferrera also introduces the concept of meta-ideas and boundary symbols (e.g., “Just Transition”, “European Social Union”) as powerful tools for political alignment and institutional innovation, particularly in the context of the EU’s post-2015 “social turn.”

Empirical evidence further questions the actual influence of deliberative puzzling on policy outcomes. As shown by Natili and Fabris (2024) in their analysis of minimum income policy debates in Italy, policy change was driven less by evidence-based deliberation and more by politicized party competition. Reforms were shaped by electoral incentives rather than shared cognitive frameworks and were often characterized by incoherence and discontinuity. This “powering without puzzling” dynamic exposes the limitations of ideational explanations that focus primarily on discursive consensus, underestimating the impact of political conflict, strategic manipulation, and institutional inertia.

In the field of LTC, similar dynamics are observable. While EU-level discourses promote convergence around care-related objectives, the voluntary and non-binding nature of EU instruments often leads to fragmented and uneven implementation across member states. As Madama and Jessoula (2014) show, national responses are filtered through domestic political configurations, fiscal constraints, and welfare legacies—often resulting in the selective appropriation of EU ideas. In some cases, the language of Europeanization has been strategically used to legitimize austerity-driven or market-oriented reforms, rather than to foster a rights-based expansion of LTC systems.

In sum, while ideational approaches remain valuable for understanding how policy issues are framed and how ideas travel, their explanatory power is limited if detached from the political processes in which they are embedded. A more robust analysis of policy change requires integrating ideational dynamics with a nuanced understanding of conflict, institutional constraints, and strategic action—that is, puzzling must be complemented by powering.

3.2. Power Resources Theory and Beyond

The role of political and partisan agency in shaping the expansion and transformation of welfare states has been extensively explored in comparative politics and welfare state research, particularly since the 1970s and 1980s with the emergence of Power Resources Theory (PRT). This approach emphasizes the centrality of political agency and partisanship in determining welfare policy outcomes (Korpi, 1983;

Esping-Andersen 1985; Myles & Quadagno 2002). The class cleavage was the first social divide to be extensively analyzed in welfare state literature, most notably through Korpi's (1983; 2006) PRT, which posits that the presence of a leftist government, supported by strong trade unions, serves as the primary driver of welfare state expansion. At the core of this theory is the assumption that political party preferences are shaped by class mobilization, which introduces—or politicizes—the fundamental cleavage between labor and capital within the political arena. PRT draws on distributional theories of capitalist democracies, which argue that for individuals of modest means (*i.e.*, workers), collective organization through unions and left-wing parties is the only viable mechanism for counterbalancing structural inequalities of power (Myles & Quadagno, 2002: 37).

Through the political representation of labor interests by left-wing parties and trade unions, distributive struggles between capital and labor are transferred into the political sphere, thereby enabling economically disadvantaged groups to challenge existing inequalities in power and resource allocation. From a social policy perspective, this implies that the expansion of welfare states is more likely when left-wing parties hold power, thereby reinforcing the argument that government ideology—or “government color”—matters in shaping welfare outcomes. This dynamic assumes that individuals occupying similar socio-economic positions within the labor market share common opportunities and constraints, shaping what Korpi (2006) terms the “logic of the situation.” In industrial economies, this logic fostered cohesive class-based coalitions, as the industrial working class—relatively homogeneous in socio-economic conditions and numerically significant—formed a stable constituency for social democratic parties. Labor unions played a central role in mobilizing and channeling these demands, benefiting from the physical concentration of workers in factories and the economic prominence of the manufacturing sector (Gingrich & Häusermann 2015; Visser et al., 2019).

However, this alignment began to weaken with the transition to a post-industrial economy, as the fragmentation of the working class disrupted traditional class-based political coalitions. The shift towards a service-based economy introduced increasing differentiation between industrial workers and those in higher-skilled service occupations (Häusermann et al. 2013; Gingrich & Häusermann 2015). These economic transformations led to diverging interests between different segments of the workforce, a division further exacerbated by the growing divide between labor market insiders—workers with stable contracts and job security—and outsiders, who experience precarious employment, temporary contracts, or part-time work (Rueda, 2007; Marx & Picot, 2020). This fragmentation not only weakened the numerical and political coherence of the working class but also created strategic dilemmas for social democratic parties, which increasingly struggled to reconcile the competing demands of their traditional blue-collar base and the emerging middle-class constituencies (Emmenegger et al. 2012; Lindvall & Rueda 2014).

Over time, internal critiques have led to several refinements of PRT. First, scholars have acknowledged that working-class mobilization alone is insufficient to counteract the economic power of capital; thus, the capacity to build cross-class alliances must also be considered (Oliver & Zarb 1989; van Kersbergen, 2003). Moreover, in many cases, the primary political force behind welfare state expansion has not

been social-democratic parties or trade unions but rather Christian-democratic parties and, more broadly, center-right conservative actors. This perspective underscores the importance of partisan dynamics in welfare state development while challenging the assumption that “the power of labor equals the power of social democracy” (Kalyvas & van Kersbergen, 2010: 197).

3.2.1. From Class Mobilization to Strategic Interaction: Powering in the LTC

In the context of LTC, PRT provides a useful framework for analyzing the development of structural reforms at the national level. As previously discussed, PRT posits that the evolution of welfare states is driven by the balance of power between social classes—particularly between organized labor and capital—with social policies reflecting the relative strength of these actors. From this perspective, the expansion of LTC policies can be attributed to the political influence of trade unions and left-wing parties, which have traditionally advocated for stronger social protection and increased public investment in welfare services.

However, the unique characteristics of the LTC sector necessitate a reconsideration of the assumptions underlying PRT. Assuming the original actor configuration outlined by the theory, trade unions—as formal political actors—encounter significant limitations in representing the interests of older adults with LTC needs. Historically, union advocacy has prioritized the concerns of the average worker, especially those related to employment, income security, and workplace protections, rather than the specific needs of retired, non-working, or care-dependent individuals (Humphrey, 2000).

Furthermore, consistent with findings in the field of disability rights, individuals experiencing non-self-sufficiency often face systemic barriers that hinder their ability to exercise political rights. These include limited access to information, social isolation, lower levels of educational attainment, confinement in institutional settings, and the enduring effects of stigma and negative stereotypes. As a result, people with LTC needs are significantly less likely to participate in electoral processes or engage in formal political activity compared to the general population (Schur et al., 2017; Teglbjærg et al., 2021).

The medical categorization and institutional fragmentation of individuals with chronic conditions or care needs—entrenched within health and welfare systems—further inhibit the formation of a coherent political identity among care-dependent populations. This dynamic reflects a broader “divide-and-conquer” logic that undermines collective mobilization and presents structural obstacles to both class-based and constituency-based political organization (Oliver & Zarb, 198, p. 222). Consequently, the political underrepresentation of LTC-dependent individuals is not only a question of formal access but also the result of deeper structural and institutional exclusions that limit their ability to act as a visible and organized political constituency.

Unlike poverty, which primarily affects specific socio-economic strata, non-self-sufficiency cuts across class boundaries, affecting individuals from diverse backgrounds. The specific needs of people experiencing dependency are largely shaped by health trajectories and medical histories. While some require lifelong support, others may develop care needs only in old age. As a result, from both a political and public opinion standpoint, non-self-sufficiency is generally not perceived as a politically salient or electorally advantageous issue.

Beyond the issue of representation, non-self-sufficiency is frequently regarded—at the political level—as an “uncontrollable” risk, one that is more closely linked to medical-demographic trends than to economic conditions. This perception generates a degree of uncertainty regarding the design of targeted policies that could simultaneously support both care recipients and caregivers. Moreover, older adults experiencing non-self-sufficiency are generally outside the labor market and therefore possess limited political leverage in influencing policy agendas (León & Pavolini, 2014).

In familialist welfare regimes, where caregiving responsibilities are primarily delegated to households, policies addressing non-self-sufficiency—as well as broader family policies—have historically been neglected (Saraceno & Keck, 2010). This political marginalization is further exacerbated by the weak representation of care workers, many of whom are employed in informal or precarious labor arrangements, thereby limiting their collective bargaining capacity relative to other labor sectors (Molina & Rhodes, 2002; Williams, 2012; Da Roit & Weicht, 2013).

In her comparative study of LTC in France and Germany, Morel (2007) argues that the power resources approach helps explain the conservative and weakly decommodifying nature of LTC policies—particularly their reliance on informal caregiving—given that both *Pflegeversicherung* and Personal Social Services were introduced by right-wing governments. However, this approach does not fully explain the initial adoption of these policies, as they did not emerge from traditional class mobilization nor from advocacy by newly mobilized social groups, including those directly affected by non-self-sufficiency. Even trade unions—typically central to group-based mobilization—played only a marginal role in both cases, in part due to the prevailing notion that non-self-sufficiency does not constitute a work-related risk.

Indeed, a comparison of Southern European cases suggests that policy change in the LTC field cannot be fully interpreted through a purely ideological or partisan lens. Although left-wing governments appear more receptive to social concerns—and have, in some cases such as Spain and Portugal, included LTC in their policy programs—the trajectory of individual reforms has ultimately been shaped by more complex dynamics, including coalition strategies and institutional constraints, which reflect the analytical limitations outlined above.

This leads to a crucial question: *In the absence of clear electoral or programmatic incentives, what compels governments to undertake costly and politically complex LTC reforms?* Without substantial pressure from influential actors—such as trade unions, organized electoral constituencies, or dominant governing coalitions—political will to pursue significant LTC reform remains weak. If, as this argument

suggests, LTC has not been prioritized by major political parties due to electoral incentives favoring the working-age population, and if trade unions struggle to represent the interests of both non-self-sufficient individuals and precarious care workers, then the political neglect of LTC should be understood as a structural feature of welfare politics rather than a temporary policy oversight.

Within this context—marked by increasing demographic pressure and growing concerns about the long-term economic and fiscal sustainability of care systems—it is essential to explore how institutional opportunity structures (so-called “gates”) interact with actor-based explanations in shaping governmental incentives for reform. Analyzing these dynamics requires distinguishing between demand-driven reforms, initiated in response to social needs and bottom-up mobilization by affected groups, and supply-driven reforms, pursued by governments as a result of macroeconomic constraints, policy learning, or strategic recalibration.

4. Understanding the Political Exchange in the LTC Sector

This first part of this Chapter has shown that, by drawing on a range of theoretical approaches, multiple mechanisms can be identified to explain both the adoption and the formulation of LTC policies. Table 4.3. provides a summary of the mechanisms discussed. The chapter offers a critical examination of prevailing welfare theories in the literature on policy change, with specific reference to their application in the field of long-term care.

Table 4.3. Classical Theoretical Approaches: Explanans and Mechanisms.

Theoretical Approach	Explanans	Mechanism	Applied to LTC Sector	Limitation
Structural-level theories: Functionalism	Socio-economic factors	Problem pressure from social risks	Demographic ageing, increasing female labor market participation, and rising longevity generate functional pressures on care systems, prompting the need for institutional responses.	Insufficient explanation
Structural-level theories: Historical Institutionalism	Institutions	Path dependence on past policy choices	Existing institutional arrangements in healthcare, social care, and non-contributory pension schemes create path-dependent trajectories that constrain or enable LTC reform.	Insufficient explanation
Actor-centred theories: Ideas	Actors' discourses	Policy learning; coalition magnets	Novel policy paradigms, i.e. the Social Investment approach and the European Care Strategy, have shaped domestic discourse and legitimized LTC as a policy domain through ideational diffusion.	Spurious explanation
Actor-centred theories: Interests	Actors' power resources	Strategic interaction	Strategic interactions between governments, trade unions, care providers, and other organized interests influence LTC policy design, particularly in contexts of political fragmentation or low salience.	Spurious explanation

Source: Author's elaboration.

While traditional welfare state theories—most notably PRT—have emphasized class-based conflict as the principal driver of social policy development, more recent scholarship suggests that contemporary welfare politics are shaped by multidimensional cleavages and strategic interactions among a wider array of political and societal actors (Häusermann, 2010; Bonoli & Natali, 2012).

Moving beyond class-centric frameworks, this approach adopts a political exchange perspective, in which policy reforms emerge from dynamic and often non-linear interactions between political institutions (supply-side) and organized social interests (demand-side) (Stoppino, 2001; Ferrera, 2005; Natili, 2019). Political parties and governments, seeking to achieve both electoral and policy objectives, act strategically in shaping the policy agenda. At the same time, societal groups—including trade unions, third-sector organizations, and advocacy networks—attempt to influence policy by leveraging their organizational resources, institutional access, and capacity to articulate social demand. Policy outcomes are thus not simple reflections of ideological alignment or class dominance, but the result of negotiated compromises among actors with varying preferences, resources, and motivations.

Critically, political exchange does not require ideological consensus. Policy alliances can be formed among actors with divergent goals, provided there is convergence on specific policy instruments or objectives. For example, a government may prioritize fiscal sustainability, while an interest group advocates for service expansion—yet both may support the same reform if it serves their respective interests (Häusermann & Kübler, 2010). These ambiguous coalitions enable policy change by aligning heterogeneous preferences through compromise and pragmatic bargaining. Especially in low-salience and high-complexity fields such as LTC, this mode of interaction becomes essential for overcoming inertia and enabling reform.

From this perspective, the policy-making process is shaped by the interaction of two sides:

- **The demand side** includes organized societal actors that seek to influence public policy to advance their interests. These actors are not necessarily partisan but may engage in targeted forms of political participation, including lobbying, mobilization, and negotiation. Their effectiveness depends on their organizational strength, access to policymakers, and capacity to articulate credible and legitimate claims.
- **The supply side** is composed of political parties and executive institutions that formulate and implement policy. Their behavior is conditioned by institutional constraints (e.g., veto players, electoral rules), electoral incentives, and reputational considerations. Governments are often risk-averse, particularly in fields characterized by low public visibility and unclear political rewards.

The interaction between these actors unfolds through various mechanisms of interest intermediation. Building on industrial relations literature, three principal modes can be identified (Molina & Rhodes, 2002; Streeck & Hassel, 2004). The first one is concertation: A formalized process of consensus-building in which governments negotiate directly with major interest groups to co-produce policy decisions. Typical of neo-corporatist systems, concertation relies on mutual recognition and institutionalized dialogue. The second one is lobbying, a pluralist mechanism whereby interest groups seek to influence decision-makers by providing policy-relevant information, framing issues strategically, or building public support. This form is more prominent in liberal or fragmented systems. The third, and final one, is the strategic political exchange, a hybrid mechanism in which political and societal actors align

temporarily around shared objectives, despite lacking long-term institutionalized cooperation. This form is particularly relevant in contexts where formal corporatist structures are weak or absent, yet mutual incentives for cooperation emerge (Pizzorno, 1977; Gumbrell-McCormick & Hyman, 2013; Natili, 2019).

The LTC field is particularly well-suited to be analyzed through the framework of strategic political interaction due to several distinctive features. First, LTC is typically characterized by low political salience: It does not rank high on the public or electoral agenda, as its beneficiaries—older adults with care needs—have limited political mobilization capacity. Second, the field involves high complexity, spanning multiple policy domains (health, social care, family policy) and levels of governance. Third, demand-side actors are fragmented, often lacking unified platforms or stable coalitions, which limits their visibility and bargaining power.

Political exchange emerges from a strategic interaction between puzzling and powering. The development and articulation of ideas is not purely deliberative but strategically instrumental to the pursuit of specific political objectives. These ideational processes interact with dynamics of powering—namely coalition-building, resource mobilisation, and positional bargaining—within pre-existing institutional rules that structure the political arena. In this context, partisan competition is shaped and guided by ideas insofar as they serve to legitimise and advance a particular reform objective. The interaction between puzzling and powering shapes both the temporary opening of institutional opportunities for reform and the specific policy outcome that emerges. In other words, reform becomes possible when shared problem definitions and viable policy solutions align with favourable power configurations, allowing political actors to sustain a window of opportunity and translate it into concrete institutional change.

Importantly, this approach does not dismiss the relevance of partisanship or institutional configurations. Instead, it reframes them as conditions that shape the scope and nature of political exchange. Center-left governments may be more receptive to pro-welfare reforms, but such reforms only materialize when supported by credible societal demand. Similarly, institutional features—such as the level of pluralism, the number of veto players, and the structure of interest representation—mediate the likelihood of successful policy exchange. For example, fragmented party systems or overlapping social cleavages may hinder the formation of stable coalitions for reform, even in the presence of strong demand-side pressure.

The political exchange framework provides a more flexible and empirically grounded approach for analyzing policy change in the domain of LTC. By emphasizing the strategic interactions between supply-side and demand-side actors, it shifts the analytical focus away from ideological alignment and class-based mobilization, and toward the processes of negotiation, alignment, and mutual accommodation that underpin real-world policymaking. The following chapter applies this framework

to examine how political exchange mechanisms have shaped LTC reform trajectories across different national contexts.

Specifically, Section 4.1. explores the structure and evolution of social demand, identifying the actors involved, the forms of mobilization employed, and the types of claims articulated in the public arena. Section 4.2. shifts the focus to the political supply side, analyzing how governments and political parties have responded to—or strategically interacted with—those demands. Finally, Sections 4.3. and 4.4. present the core argument of this thesis, developing a set of hypotheses and interpretive mechanisms to explain when, how, and under what conditions policy exchanges in LTC become politically viable.

4.1. The Demand Side: The Role of Interest Groups

On the demand side of the political arena, group leaders and lobbyists do not directly pursue political power or government positions. Instead, their primary interest centers on influencing the political process and the substance of specific policy decisions. This is because policy outcomes can either offer them significant advantages or expose them to substantial risks. This strategic engagement often leads interest groups to support particular political parties over others, anticipating favorable policy outcomes—a phenomenon commonly referred to as pressure. Unlike political actors who seek direct governing authority, interest groups participate in politics primarily to shape policy content rather than to acquire power itself (Stoppino, 2001). Section 4.1.1. introduces the role of trade unions and employer associations. Following this, Section 4.1.2. examines the influence of other intermediary bodies in the decision-making process.

4.1.1. Social Partners: Trade Unions and Employers' Associations

Trade Unions: Workers and Retired

In the post-World War II era, trade unions played a central role in shaping welfare state policies, particularly in the development of old-age income security systems. Their influence has remained significant in the “new politics” of welfare reform, where unions continue to negotiate and shape social protection measures. Historically, unions have collaborated with states and employers in social governance, extending their role beyond wage bargaining to include advocacy for broader social rights—protecting workers and their families from risks such as unemployment, illness, and old age (Esping-Andersen, 1992; Streeck & Hassel, 2004). Early union-led initiatives, such as mutual aid funds, emerged prior to formal wage bargaining and sought to mitigate worker insecurity (Baldwin, 1990; Brugiavini et al., 2001).

In recent decades, however, unions have faced mounting challenges due to austerity, welfare retrenchment, and efforts by governments and employers to restructure governance frameworks, often at the expense of union influence. While unions have attempted to negotiate policy adaptations and

assume regulatory roles, their room for maneuver has narrowed under fiscal constraints and shifting power dynamics.

Comparative political economy literature portrays trade unions ambivalently. On one hand, dualization theories argue that unions tend to protect core, male, industrial workers, resisting welfare recalibration and neglecting emerging needs such as childcare and long-term care (Rueda, 2007; Palier & Thelen, 2010). On the other hand, empirical research highlights unions' potential as "swords of justice," capable of adapting their strategies and expanding solidarity-based welfare goals²⁵ (Scharpf, 1997; Gumbrell-McCormick & Hyman, 2013). Two key concepts—encompassingness and centralization—are useful for analyzing union influence on welfare reform. Encompassing unions that represent broad constituencies are more likely to promote egalitarian policies (Thelen, 2014; Rathgeb, 2018). Centralized unions, particularly national confederations, have greater capacity to influence strategic policymaking through tripartite negotiations. In contrast, decentralized unions, focused on sectoral concerns, are less equipped to shape systemic welfare policies, including LTC.

In the "old politics" era, unions were instrumental in expanding public pension systems. In the "new politics" era of austerity and demographic pressure, their strategies have shifted toward defending existing benefits and promoting occupational pensions. Retirees have become increasingly influential within unions, reshaping their policy agendas to address retirement-related concerns (Kohli et al., 1997; Ebbinghaus, 2011). The evolution of trade unions in Southern Europe can be understood through the Varieties of Capitalism (VoC) and Growth Models frameworks. In the VoC perspective, Southern European economies (e.g., Italy, Spain) are classified as Mediterranean Market Economies with fragmented industrial relations and strong public pension systems shaped by corporatist negotiations (Molina & Rhodes, 2007). The Growth Models literature adds that these pension systems supported domestic consumption and macroeconomic stability, especially in contexts with limited private savings (Baccaro & Pontusson, 2016). Following the 2008 crisis, austerity and EU-led reforms reduced public pension generosity, prompting unions to resist retrenchment but with limited success (Meardi, 2018).

As union power declined and their constituency changed, trade unions were compelled to reassess their role in broader welfare reform, including long-term care. The LTC sector poses specific challenges, as its direct beneficiaries—older individuals—do not belong to unions' traditional core constituencies. However, the aging of union members and the growing presence of retirees within unions have pushed these organizations to engage more actively in LTC policy debates.

A constituency-based distinction helps explain union positions on LTC. Worker-oriented unions, focused on employment and labor standards, tend to support the professionalization and formalization of LTC services. Their goal is to improve job quality in the care sector, reduce informality, and expand public

²⁵ Cigna (2024) highlights that, while unions have historically focused on wage negotiations and worker protections, they are increasingly recognizing work-life balance as a fundamental labor right. This shift is largely driven by labor market feminization and the need to support dual-earner households.

services. Pensioner-oriented unions, by contrast, prioritize financial security for retirees and are more inclined to support cash transfers for LTC, viewing service expansion skeptically if it threatens pension adequacy.

From a VoC perspective, pensioner unions in Southern Europe are likely to defend redistributive, earnings-related monetary benefits. This aligns with dualization theory, which suggests unions protect core constituencies (retirees) over precarious groups (e.g., informal caregivers or non-standard workers). Pensioner unions may favor cash transfers as a means of preserving autonomy and resisting market-driven service reforms that could increase inequality (Palier & Thelen, 2010).

Employers' Associations (Providers)

In Southern European countries, limited public investment in formal LTC infrastructure, combined with weak regulatory oversight, has created a governance vacuum. This has enabled both for-profit and non-profit actors to operate with minimal accountability, contributing to significant regional disparities in service quality and access (Brennan et al., 2012; Ranci & Pavolini, 2013). In this context, non-profit organizations have emerged as key actors in filling the gaps left by underdeveloped or decentralized public systems (Da Roit et al., 2007).

According to Ranci & Pavolini (2015), the marketization of LTC across Europe has been driven by three main pressures. First, demographic aging has increased the demand for LTC services. Second, fiscal constraints—especially under conditions of “permanent austerity” (Pierson, 2001)—have undermined the sustainability of traditional care systems. These pressures intensified following the 2008-2009 financial and sovereign debt crises (Meardi, 2014; Pavolini & Guillén, 2015), leading many Southern European governments to outsource care services to both expand and maintain provision (Bordogna & Neri, 2014; Dorigatti et al. 2020). Third, cultural shifts have fostered a preference for care systems emphasizing efficiency, flexibility, and user autonomy. In labor-intensive sectors such as social and educational services—where labor costs are dominant—outsourcing often functions as a cost-reduction strategy, exploiting regulatory differences between public and private employment contracts (Da Roit & Sabatinelli, 2005). Additionally, lobbying by various interest groups has shaped the trajectory of market-oriented reforms in each national context. In this landscape, indicators such as changes in service coverage, public spending, and the degree of defamilialization are essential for assessing the evolving interplay between formal and informal care provision (Ranci & Pavolini, 2013).

Non-Profit Health and Social Care Providers

Non-profit organizations—including charitable, religious, and cooperative entities—play a vital role in the provision of LTC services (Fischer et al., 2022). They distinguish themselves from for-profit actors by prioritizing care quality over financial returns and often justify increased public funding on the basis of their patient-centered approach (Polivka & Luo, 2019). In response to the expanding privatization of

LTC, non-profits frequently oppose profit-driven models, which they argue contribute to declining care standards due to cost-cutting practices (Corlet Walker et al., 2022).

Non-profits rely heavily on government subsidies and therefore advocate for stable and predictable public funding. Beyond financial sustainability, they also address structural challenges in the LTC workforce—such as low wages and precarious contracts—which contribute to labor shortages and burnout. As such, they promote policies that support professionalization, fair pay, and workforce development (Brinkerhoff, 2002; MacIndoe & Whalen, 2013). Non-profits often push to expand care access to underserved populations, including rural residents and low-income individuals, warning that for-profit actors tend to neglect these less profitable groups (Estes & Linkins, 1997; Cloutier-Fisher & Skinner, 2006).

A central feature of non-profit advocacy is support for strong regulation, including higher staffing standards, improved oversight, and transparency in care outcomes (Ikegami & Campbell, 2002). Many non-profits also champion a shift toward decentralized, community-based models of care, which they argue enhance outcomes and reduce long-term costs (Tsukamoto & Nishimura, 2008; Wysocki et al., 2012). However, their influence is shaped by local political and economic contexts. In Southern Europe, where elder care is traditionally family-based and public funding remains limited, non-profits often struggle to compete with both informal care networks and expanding private-sector providers (Ranci & Pavolini, 2013).

For example, in Italy, intensified competition from for-profit actors has eroded the policy influence of non-profits (Bönker et al., 2010). By contrast, in countries with social insurance systems—such as Germany—non-profits have achieved greater policy success through sustained lobbying and stable funding mechanisms. Nonetheless, non-profits also face risks of co-optation, where financial dependence on public authorities limits their willingness to challenge the status quo (Kitchener & Harrington, 2004). In heavily privatized LTC systems, they are often unable to counterbalance the economic and political power of large corporate providers (Osterle, 2010). Moreover, smaller non-profits are disproportionately affected by overregulation and bureaucratic constraints, which hinder innovation and reduce operational efficiency (Mercille & O'Neill, 2020). Internal divisions—such as conflicting priorities between advocates of home care and institutional care—further weaken their collective lobbying capacity (Longo & Notarnicola, 2018).

For-Profit Health and Social Care Providers

For-profit providers have gained substantial influence in LTC systems, particularly where public funding is limited, poorly regulated, or means-tested—as seen in the United States (Brennan et al., 2012; Fischer et al., 2022). These actors use coordinated lobbying to shape funding rules, weaken labor protections, and promote privatization. In quasi-market systems, they have expanded rapidly, particularly in institutional care such as nursing homes and assisted living. Their business models often rely on dual revenue streams: Fees from residents and financial returns from real estate holdings. As private equity

firms, hedge funds, and real estate investment trusts increasingly invest in elder care, financialization has turned care facilities into speculative assets.

For-profit providers often lobby for public reimbursement schemes that favor institutional over home-based care, despite evidence that the latter is more cost-effective and beneficial for patients (Hawes, 1987). This dynamic reinforces their market dominance while displacing public and non-profit alternatives (*ibidem*). Simultaneously, they advocate for deregulation—opposing staffing mandates, oversight inspections, and liability mechanisms—on the grounds that regulation impedes operational efficiency (Svallfors & Tyllström, 2017). In Southern Europe, for-profit chains have leveraged EU-driven privatization agendas to expand their role, especially in Portugal, Spain, and Italy, often benefiting from cash-for-care allowances (e.g., PECEF in Spain, IdA in Italy). These firms frequently cut costs by reducing staff, outsourcing services, and extracting profits through high management fees, often without reinvesting in care quality (Kingsley, 2018).

Family as Providers

Families, often acting as employers of care workers, have also emerged as key stakeholders in LTC policymaking. They advocate for direct subsidies, tax credits, and flexible employment rules that make home care more accessible (Kane et al., 1998). Family caregivers frequently resist standardized labor protections—such as formal contracts and higher wages—arguing that such regulations would make care unaffordable (Hertel-Fernandez, 2018). They also promote home-based care as both a cost-saving and quality-enhancing alternative to institutionalization (Murphy & O’Sullivan, 2021).

In Southern Europe, however, the family’s role differs. Rather than directly hiring caregivers, families in countries like Italy, Spain, and Portugal often lobby for allowances and formal recognition of unpaid caregiving roles (Costa-Font, 2010; Osterle, 2010). This has led to widespread use of cash-for-care schemes (e.g., PEAP in Spain), which offer financial compensation for either hiring care workers or remunerating family members. While these schemes ease financial burdens, they often reinforce traditional gender roles and perpetuate reliance on undocumented migrant labor (Ilinca et al., 2022).

Despite their growing influence, family-led advocacy is often critiqued for prioritizing cost-saving over systemic reform. Critics argue that it contributes to a fragmented LTC system where worker protections and care standards are secondary (Williams, 2010; Naiditch et al., 2013). Although families play a crucial role in providing accessible, person-centered care, their resistance to formal labor standards has exacerbated issues such as low pay, job insecurity, and the marginalization of home care workers (Kluzer et al., 2010; Morgan, 2013).

4.1.2. Other Intermediate Bodies

Church and Faith-Based Organizations

Despite increasing convergence in LTC systems across industrialized countries, faith-based organizations (FBOs) continue to assert their religious identity and maintain a prominent role in care provision. This is particularly evident in countries like Germany and Italy, where religious institutions have historically shaped the organization and delivery of eldercare services.

In Germany, this phenomenon is encapsulated by the so-called “*confessional paradox*”—the coexistence of declining religious affiliation with the enduring and even expanding influence of church-affiliated welfare providers in LTC (Neri & Abramowski, 2024). In Italy, Church-affiliated providers similarly emphasize values such as equity, solidarity, and compassion, which remain embedded in their care models. Nonetheless, these providers are under growing pressure to professionalize and conform to secular regulatory frameworks.

The historical configuration of church-state relations has played a crucial role in shaping LTC systems across Europe. In Protestant-majority countries such as those in Scandinavia and the Anglosphere, early collaboration between church and state facilitated the emergence of universal, publicly funded LTC systems, with the state assuming a central redistributive role. By contrast, in Catholic-majority countries—such as Italy, Spain, and Portugal—prolonged tensions between Church and state delayed the development of public LTC systems. In these contexts, caregiving remained a responsibility largely managed by religious and familial networks, with parish-based charities providing care well into the post-war period (van Kersbergen & Manow, 2009).

Catholic social doctrine, particularly the principle of subsidiarity, has profoundly shaped Southern European care regimes. Subsidiarity promotes the delegation of social responsibilities to families, local communities, and religious institutions, limiting state intervention to cases of absolute necessity. This moral framework has constrained the development of public LTC systems and reinforced informal, family-based care models (Kahl, 2009). In contrast, Lutheran and secular traditions tend to frame care as a universal right, thereby legitimizing extensive public responsibility in LTC provision. As a result, Catholic-majority countries tend to maintain fragmented LTC systems marked by limited state involvement, strong ecclesiastical influence, and persistent reliance on informal care.

Amid increasing privatization and outsourcing of care services, FBOs have shown considerable institutional resilience. They continue to be central actors in LTC, often running nursing homes, home care programs, and hospice services through public-private partnerships (Bahle, 2003). This expansion reflects both pragmatic responses by states to growing care demands and the historical embeddedness of religious institutions in national welfare architectures. However, the growing reliance on FBOs raises concerns about access, inclusivity, and accountability. Some religious providers may impose doctrinal

constraints on service delivery, potentially clashing with secular policy objectives—particularly in areas like end-of-life care and LGBTQ+ inclusion.

FBOs are not merely passive providers; they are active participants in LTC governance. Leveraging their institutional networks and political ties, they negotiate public funding, regulatory exemptions, and favorable contracts (Grzymala-Busse, 2012). In democratic settings, they engage in advocacy through coalitions with political parties, public institutions, and civil society organizations (*ibidem*). Their lobbying strategies combine ideological commitments to religious ethics with pragmatic concerns over funding and autonomy. While highlighting their ethical mission and contribution to social cohesion, FBOs frequently resist regulatory secularization that could challenge their institutional identity.

Associations of Older People and Caregivers

Associations of older people and (family) caregivers operate as interest intermediaries that transform dispersed experiences into organized claims over recognition, resources, and rights in LTC. Their power resources combine distributive and organizational elements—structural bargaining capacity rooted in welfare politics, partisan linkages, and associational density (Huber & Stephens, 2001)—with electoral voice grounded in older cohorts’ high turnout and demographic weight (Goerres, 2009). Organizationally, umbrella bodies, federations, and professionalized secretariats enhance agenda-setting, knowledge production, and insider access (Ranci & Pavolini, 2013). They also mobilize normative and epistemic resources—rights-based frames, patient/user evidence, and monitoring—to legitimate proposals on affordability, quality standards, and home- and community-based services (Baggott & Jones, 2014). In multi-level governance, these actors exploit consultative venues and policy windows to press for carers’ leave, respite, income support, and integrated care—an influence visible in reform cycles and EU-level initiatives such as the debates surrounding the European Care Strategy (Daly, 2025).

Mechanistically, influence travels through agenda-setting and framing (Korpi, 1983; Huber & Stephens, 2001), insider strategies—participation in working groups, standard-setting, and co-regulation—tempered by resource dependence and risks to advocacy autonomy (Van de Bovenkamp & Trappenburg, 2011; Larkin & Milne, 2014), and outsider strategies—coalitions with unions, professional bodies, and patient organizations; media campaigns; and venue shopping across municipal, national, and EU arenas (Ranci & Pavolini, 2013; Baggott & Jones, 2014; Albareda et al., 2023). At the implementation stage, user-participation and co-production instruments provide levers for monitoring access and service quality, though effects are uneven and context-dependent (Christensen & Pilling, 2019). Substantively, their preferences converge on reducing unmet need, expanding home-based and respite services, improving workforce conditions as a proxy for quality, and combating ageism—priorities that align with power-resource expectations linking organized constituencies to distributive outcomes, while acknowledging collective-action hurdles (time poverty among carers, heterogeneous memberships) and

asymmetric resources vis-à-vis provider and employer lobbies (Goerres, 2009; Larkin & Milne, 2014; Ranci & Pavolini, 2015; Daly, 2025).

Healthcare and Social Care Professional Orders

Healthcare professional orders—such as those representing physicians, nurses, and allied health workers—typically advocate for the medicalization and professionalization of LTC. Their policy goals include increased public investment in clinical infrastructure and staffing; better wages and working conditions; the expansion of clinical roles for nurses and allied professionals; and the enforcement of high regulatory standards, including certification and continuing education (Hall & Deardorff, 2006; Leiber et al., 2019). These actors tend to favor institutional care models, emphasizing clinical oversight and specialized training as essential for ensuring patient safety and care quality. However, their demands often conflict with state cost-containment strategies and provider preferences for low-cost, flexible labor. In Southern Europe, where funding is limited and informal caregiving remains dominant, healthcare orders have struggled to gain traction, facing institutional and cultural resistance.

Social care professional orders, by contrast, represent frontline care workers such as social workers, home aides, and personal support staff. Their advocacy focuses on improving labor conditions (e.g., wages, job security, formal contracts), expanding access to community-based LTC, and securing formal recognition for care work—particularly that performed by women and migrant workers (Hertel-Fernandez, 2018; Murphy & O’Sullivan, 2021). Unlike medical professionals, social care actors often support flexible, family-oriented care models, including cash-for-care programs that allow families to directly employ caregivers. However, such flexibility can come at the expense of workforce standardization and labor protections.

In Southern Europe, social care organizations have effectively lobbied for expanded family allowances and greater support for informal care, reinforcing a preference for low-cost, home-based models. Despite some shared goals—such as expanding LTC coverage—health and social care professions diverge in their governance preferences. Healthcare orders prioritize formal hierarchies, regulation, and clinical authority, often opposing the delegation of responsibilities to less-qualified personnel. Social care orders, on the other hand, promote accessibility, labor equity, and decentralized service delivery, and resist over-medicalization and administrative barriers (Weissert et al. 1998). These conflicting visions contribute to fragmentation in LTC policymaking, especially in countries with uneven public investment and contested responsibilities between families, markets, and professionals.

Scientific associations

Scientific associations—comprising experts from health, social policy, and welfare disciplines—are increasingly influential actors in LTC governance. Operating at both national and international levels, these organizations include professional societies, research networks, and multidisciplinary think tanks. Unlike interest-based lobbies, their influence derives from epistemic authority grounded in peer-reviewed research, empirical analysis, and technical expertise (Counts & Ilakkuvan, 2023).

These associations advocate for evidence-based LTC policy, emphasizing public investment, regulatory standards, workforce development, and protection against excessive marketization. They consistently argue for long-term, stable funding in healthcare and social services to meet rising demographic needs. In several countries—including Japan, Germany, and South Korea—scientific lobbying played a pivotal role in the development of national LTC insurance systems, grounded in empirical policy modeling (Rothgang, 2010).

Another major focus is the promotion of integrated care models that link medical and social services to address the multidimensional needs of aging populations. Scientific organizations support person-centered approaches that recognize physical, emotional, cognitive, and social aspects of elder care. These efforts have helped shift policy toward home- and community-based care, widely recognized as more cost-effective and responsive than institutional models (Cloutier-Fisher & Skinner, 2006).

Scientific associations also draw attention to systemic workforce challenges, such as staffing shortages, burnout, and inadequate job quality. They lobby for stronger staffing ratios, higher pay, improved career pathways for geriatric specialists, and continuous professional development. In several European countries—especially Germany, Sweden, and the Netherlands—their efforts have informed reforms to improve employment conditions and professional recognition for LTC workers (Gotze & Rothgang, 2014).

Scientific associations often find themselves in conflict with for-profit providers and industry groups over regulatory and care models. While empirical evidence highlights the negative consequences of profit-driven care (e.g., understaffing, inequity), corporate actors tend to resist regulatory interventions, citing concerns about innovation and cost efficiency. In response, scientific organizations advocate for stricter oversight, mandatory accreditation, financial penalties for non-compliance, and the prioritization of public or non-profit provision (Morgan & Campbell, 2011).

Their influence, however, varies by national context. In Northern Europe, where welfare governance is institutionalized and evidence-based policymaking is more common, scientific associations play a prominent role in shaping LTC reform. In contrast, their impact is more limited in Southern Europe, where care regimes are shaped by familialism, fragmented governance, and fiscal conservatism. Recognizing the limits of technocratic advocacy, scientific associations are increasingly building coalitions with non-profits, unions, and patient rights groups to enhance the legitimacy and political

weight of their policy proposals. These alliances aim to strengthen evidence-based policymaking in contested areas such as LTC financing, labor regulation, and equitable access to care.

Insurance and Mutual Funds in the LTC

Private-sector finance shapes LTC through three channels: (i) risk pooling via commercial insurance, (ii) solidaristic pooling via mutual societies, and (iii) capital allocation and corporate governance by institutional investors (notably mutual funds and real-estate vehicles). Classic information frictions (multidimensional private information, selection) and public “crowd-out” help explain the small size and specific design of private LTC insurance markets—high loads, restrictive underwriting, and limited take-up—even in ageing societies (Finkelstein & McGarry, 2006; Brown & Finkelstein, 2007, 2008). Reform debates contrast social-insurance or mandatory schemes with incentivized voluntary coverage, emphasizing equity, transparency, and fiscal sustainability (Barr, 2010; Costa-Font & Courbage, 2012; Karagiannidou, 2022). On the supply side, product innovation (e.g., life-care annuities bundling longevity and dependency risks) and balance-sheet regulation shape insurers’ willingness to underwrite long-dated liabilities, with sensitivity to interest rates and capital requirements (Brown & Warshawsky, 2013; Koijen & Yogo, 2016).

Mutual societies—member-owned, nonprofit insurers governed by one-member-one-vote—pool risks on solidaristic terms (community rating, limited risk selection), differentiating them from stock insurers and giving them distinctive associational and normative power resources (legitimacy, dense membership networks, insider access in corporatist venues) (Hansmann, 1985; Mossialos & Thomson, 2002; European Parliament, 2011; Sagan & Mossialos, 2016; Pereira, 2023). In practice, European mutuals often act as complementary payers, adding LTC measures (cash allowances, respite vouchers, service packages) to occupational or community contracts; nonetheless, persistent under-insurance reflects structural crowd-out and preference heterogeneity (Mossialos & Thomson, 2002; Fontaine, Plisson, & Zerrar, 2014; Benoît, 2019; Bailo et al., 2024).

On the investment side, large mutual funds—especially passive index funds—exercise governance influence over listed care chains and healthcare real-estate through voting power and board-level engagement, a form of structural power that can diffuse across sectors (Appel et al., 2016). Ownership structures matter for provision: Real-estate investment trusts and private-equity acquisitions can alter staffing mixes, liquidity, and cost structures, prompting concerns about quality and calls for ownership transparency and rate-setting reform (Braun et al., 2023; Gupta et al., 2024). Insurers seek predictable public co-financing, stable solvency rules, and tax incentives; mutuals seek recognition as solidarity-based complements and supportive co-regulation; asset owners prioritize stable reimbursement and permissive property/leasing regimes—while governments and user groups push for enforceable quality standards and risk-sharing. The balance struck among these interests conditions the eventual mix of public insurance, private top-ups (commercial or mutual), and financialized provision.

4.2. The Supply Side: Political Parties Between Conflict Lines and Constrained Choices

LTC policies represent a paradigmatic example of welfare provision characterized by low salience and high complexity. Unlike more universally visible programs such as pensions or healthcare, LTC typically remains outside the electoral spotlight, despite its significant redistributive and gendered implications. As Pierson (2001) argues, in such policy domains, political actors face substantial constraints and weak incentives to pursue reform unless they are able to engage in “credit-claiming” rather than “blame avoidance.”

Following the insights of Gingrich & Ansell (2012) and Palier (2013) on the politics of welfare state reforms, the supply side of LTC policy can be understood not only in terms of “who provides” care (whether it be the state, market, or family) but also “how” it is provided—through cash transfers, public services, or market subsidies. Political parties play a crucial role in shaping these decisions, with their preferences shaped by historical institutional configurations (Pierson, 2001), partisan incentives, and the strategic use of ideas (Carstensen & Schmidt, 2016). Therefore, LTC policymaking must be understood as an arena of constrained agency, in which ideological preferences interact with structural pressures and electoral dynamics to produce policy outcomes that are deeply context-dependent.

4.2.1. Political Conflict Lines and Governmental Strategies

Political cleavages represent enduring lines of division within societies that structure political behavior, inform party competition, and shape welfare state trajectories. As conceptualized by Lipset and Rokkan (1967), cleavages emerge from critical historical turning points—such as the reformation, state-building, and industrialization—and become institutionalized through party systems, electoral alignments, and state-society relations, providing the scaffolding on which modern welfare regimes were constructed. In their classical formulation, four primary cleavages—center-periphery, church-state, rural-urban, and capital-labor—organized political conflict across Western Europe.

In social policy, the capital-labor divide aligned working-class interests with parties of the left and generated demands for redistribution and universal services; the church-state cleavage, especially salient in Catholic contexts, empowered Christian Democratic parties to defend the family and faith-based provision, yielding familialist, low-decommodification arrangements (Van Kersbergen, 1995). Deindustrialization, educational expansion, labor-market dualization, and globalization have since attenuated class-based structuring and elevated a value-based axis—variously labeled libertarian-authoritarian or universalism-traditionalism—that crosscut left-right and increasingly organizes conflicts over immigration, gender, family norms, and social rights (Kriesi et al., 2008; Beramendi et al., 2015; Langsæther & Stubager, 2019).

Within LTC, four cleavages are especially diagnostic for party positioning and instrument choice (Table 4.4.). Along family-state, parties on the family pole—typically Christian Democrats, liberal-

conservatives, and parts of the radical right—emphasize subsidiarity and household responsibility, preferring cash allowances, tax relief, service vouchers, and caregiver recognition over enforceable service entitlements; parties on the state pole—social democrats, greens, and social-liberal centrists—advocate defamilization via universal rights, public investment in home- and community-based services, professionalization, and paid care leave (Daly & Lewis, 2000; Leitner, 2003; Saraceno & Keck, 2010; Hemerijck, 2017). Along church-state, Christian Democratic and communitarian actors defend plural provision and subsidiarity, favoring public funding of non-state/faith-based providers under light-touch central rights, whereas secular left, and green parties prioritize state-guaranteed, religion-neutral entitlements, tight accreditation, and rights-based regulation. Along state-market, social democrats and the radical left push direct public provision or strongly regulated commissioning, single access points, and standardized multidimensional assessment; market-liberal and conservative parties instead prefer outsourcing, competitive accreditation, vouchers, and complementary private/mutual insurance, aiming to expand choice while limiting universal fiscal commitments (Gingrich, 2011). Finally, the urban-rural cleavage tilts instrument design through territorial capacity: Urban-anchored parties (left, greens, liberal-centrists) back uniform national service packages and workforce expansion, while rural/agrarian-conservative actors prefer flexible cash-plus-service budgets, decentralization to municipalities, and support for informal care given thin provider markets (Saraceno & Keck, 2010; Rodden, 2019).

Table 4.4. Cleavages, Preferred Instruments and Expected Positioning of Political Parties.

Cleavage	Expected preferred instruments (when first pole dominates)	Expected preferred instruments (when second pole dominates)	Political parties' positioning (expected)
Family - State	Non-means-tested cash allowances, tax credits, service vouchers, recognition of informal carers; minimal conditionality.	Universal, enforceable service entitlements; professionalization; paid care leave as a social right.	Family pole: Christian Democrats, liberal-conservatives, radical right. State pole: Social democrats, greens, social-liberal centrists.
Church - State	Subsidiarity, public funding of faith-based/community providers, plural provision with lighter central rights.	Secular universalism, strong accreditation and rights-based regulation of providers.	Church pole: Christian Democrats, communitarian conservatives. State pole: Social democrats, greens, secular liberals/left.
Market - State	Outsourcing, competitive accreditation, vouchers/choice, complementary private or mutual insurance; tighter fiscal caps.	Direct public provision or tightly regulated commissioning; single access points; standardized needs assessment; price/quality regulation.	State pole: Social democrats, radical left, greens. Market pole: Liberals, conservative-liberals, parts of Christian Democracy.
Urban - Rural	Uniform national service packages, workforce expansion, professionalized infrastructures in dense areas	Flexible cash-plus-service budgets, decentralization to municipalities; travel/distance adjustments; support for informal care.	Urban pole: Left, greens, liberal centrists. Rural pole: Agrarian/regional parties, conservatives, Christian Democrats

Source: Author's elaboration

4.2.2. Political Interests and Constrained Choices

While partisan ideology remains a significant factor in shaping LTC preferences, political actors do not operate in isolation. Their positions are shaped—and often constrained—by institutional legacies, electoral competition, and the shifting strategic environment in which care needs are framed and negotiated. As a result, LTC policy choices emerge not solely from ideological conviction but through a complex interplay of interests, institutional constraints, and strategic considerations.

From a historical institutionalist perspective, parties are often “bound by history.” Past policy decisions generate feedback effects and vested interests that shape current reform options (Pierson, 2001). For example, in countries where familialist policies—such as cash-for-care allowances or caregiver leave—were institutionalized early (e.g., Germany, Austria, Italy), conservative parties are more likely to defend and perpetuate these arrangements, especially when they align with cultural norms and electoral preferences (Leitner, 2003; Saraceno & Keck, 2010). In contrast, in countries with well-established service-based models (e.g., Sweden, Denmark), even conservative parties may accommodate defamilializing strategies due to institutional inertia and public feedback.

These institutional structures are further reinforced by distributional effects. Welfare policies create constituencies—such as caregivers, older adults, and care workers—who develop expectations and exert pressure on policymakers. As Jensen (2014) notes, simplistic assumptions that “the left wants more state, the right wants less” fail to capture the strategic adaptations parties must make in the face of these legacies. For example, when left-wing governments implement cash benefits as second-best solutions due to fiscal or political constraints, future conservative governments may adopt them for electoral gain—even if these measures contradict decommodifying goals.

Additionally, LTC policymaking is influenced by intra-party dynamics and electoral competition. Within parties, conflicts may arise between traditionalist and modernizing factions. As Schwander (2018) highlights, conservative parties often contain both communitarian actors who favor familialism and pro-market liberals who endorse privatization. Similarly, center-left parties may experience tensions between traditional working-class supporters—who tend to favor status-preserving transfers—and middle-class professionals who prefer public services or gender-equal care arrangements (Häusermann et al., 2013).

Inter-party competition further exacerbates strategic repositioning. When left-wing parties compete with New Left or feminist-oriented parties, they may adopt more ambitious defamilializing reforms to appeal to working women and younger voters. Conversely, conservative parties may embrace selective pro-care measures—such as conditional cash transfers or service vouchers—to capture centrist voters without fundamentally challenging familialism. These dynamics blur traditional ideological lines, leading to what Ferrera et al. (2000) describe as “recalibration” rather than paradigm shifts.

These dynamics are also shaped by the low political salience of LTC. Unlike pensions or unemployment benefits, LTC does not feature prominently in electoral campaigns, providing governments with more

flexibility to pursue incremental or path-dependent reforms. However, salience may increase when political actors successfully reframe LTC as an economic, gender, or demographic challenge. As shown by Carstensen & Schmidt (2016) in their theory of ideational power, strategic reframing allows actors to reshape the political feasibility of care reforms by linking them to labor productivity, population aging, or women's employment. For example, portraying LTC investments as a means to increase female labor participation can garner cross-ideological support, even in otherwise fiscally conservative environments. Also, international and supranational influences also constrain domestic LTC politics. As Moschella (2025) notes, Europeanization and fiscal surveillance mechanisms—such as the European Semester—can shape national agendas and pressure governments to adopt care strategies that align with social investment narratives or fiscal discipline imperatives. This influence has been particularly noticeable in Southern Europe, where EU discourse has pushed governments to formalize care markets and reduce reliance on informal care, thus reconfiguring the trade-offs between commodification and defamilialization.

Thus, to build a bridge with the previous discussion, organised social demand and political parties can be understood as holders of resources, power, ideas, and divergent interests. These interests depend on the configuration of political opportunities at a given historical moment and are, moreover, strongly shaped by institutional arrangements that predate the emergence of the policy problem. The capacity of these actors to interact and negotiate constitutes a central premise of this dissertation. Rather than operating as ideologically driven agents, political parties engage in processes of strategic adaptation, adjusting their positions on LTC according to the political feasibility of policy options, the institutional context, and the evolution of governing coalitions. Consequently, LTC reform should not be interpreted as a binary partisan conflict, but rather as a contested policy arena in which political actors negotiate their positions within the constraints imposed by historical legacies, institutional structures, and prevailing ideas.

4.3. Outline of the Argument: Expected Causal Mechanisms and Interpretative Drivers

In the field of LTC, the political arena is often characterized by low salience and overall agreement in introducing long-term care policies, between left- and right-wing parties. LTC does not generally represent a high-intensity media topic, except in moments of crisis (e.g., pandemics). This makes it an area of “low salience politics” (Bonoli, 2007), where decision-making dynamics are often expert-driven sectoral, and oriented towards compromise rather than polarization. In this context, reforms emerge not as a direct response to electoral pressures but through negotiated interactions among organized actors who possess policy resources, legitimacy, and know-how.

Also, historical institutionalism reminds us that social policies are subject to path dependence: Welfare regimes consolidate on historical and cultural bases that make changes costly (Thelen, 1999; Pierson, 2004). In Southern Europe, familism as the infrastructure of welfare has constituted a self-reinforcing institutional path: The expansion of private services, the centrality of the family as a caregiver, and

administrative fragmentation have produced a resilient, but non-expansive, model (Leitner, 2003). LTC reforms must therefore contend with structural constraints and established social expectations.

Within these constraints, policy change in the LTC sector does not occur solely in response to functional pressures—such as population aging or fiscal constraints—but rather through the strategic mobilization and negotiation among collective actors. The direction and content of reform in this context depend on which coalition dominates the political arena and whose interests prevail in the process of political bargaining.

From the perspective of the policy change literature, and beyond dynamics such as path dependency and institutional inertia, policies may also evolve through mechanisms of retrenchment or reversal. As theorized by Pierson (1994), *retrenchment* refers to the deliberate rollback of welfare provisions, typically implemented through measures such as reductions in public expenditure, tighter eligibility criteria, or the privatization of services. These reforms are often politically contentious, as they challenge entrenched interests and the institutional resilience of welfare entitlements. In contrast, *reversal* (Natili, 2019) entails a return to a previous policy paradigm or institutional configuration. This form of change is generally ideologically motivated, involving the deliberate dismantling of recent reforms, often driven by shifts in political coalitions or by changing ideational frameworks that legitimize more traditional, restrictive, or exclusionary models of welfare provision.

Within this framework, reform strategies can be understood as the specific policy orientations adopted by governments at a given point in time. These strategies provide analytical insight not only into the immediate logic of governmental action—for instance, whether policies are oriented toward expansion or retrenchment, emphasize service provision or cash benefits, or prioritize universalism over selectivity—but also into the longer-term trajectories of welfare state development they initiate or consolidate. In this sense, reform strategies operate as intermediate analytical categories, capturing the short-term political and institutional choices of governments while remaining conceptually linked to broader, long-term processes of institutional continuity, transformation, and layering within welfare regimes.

We can identify at least three competing policy logics, each corresponding to a potential coalition of actors.

- First, coalitions dominated by actors advocating the expansion of the public sector may include public-sector unions, progressive political parties, and third-sector organisations. The likely outcome of such a coalition would be policies oriented toward de-familization and de-commodification, with reforms centred on the expansion of publicly provided services and monetary transfers, grounded in the recognition of LTC a universal social right.
- Second, coalitions promoting the expansion of the private sector would typically involve for-profit providers, business associations, and sectoral lobbying organisations. In this case, the expected policy orientation would be one of regulated commodification, relying on instruments such as

vouchers, accreditation systems, outsourcing arrangements, and co-financing mechanisms aimed at expanding care markets while maintaining a degree of public regulation and oversight.

- Third, coalitions seeking to preserve a familistic and conservative care regime would likely include pensioners' organisations, caregiver associations, and conservative political actors. The resulting policy model would be one of supported familization, characterised by tied cash benefits, caregiver allowances, and other financial measures designed to sustain informal family care rather than replace it with public services.

We therefore hypothesise that the convergence of ideas and interests across these coalitions may lead to three possible reform outcomes: inertia, path departure, or selective expansion. The first refers to a situation of policy stasis, in which existing arrangements remain largely unchanged. The second denotes a departure from the existing policy model, involving a substantial reorientation of the institutional or policy framework. The third describes a scenario in which the prevailing coalition succeeds in expanding a specific policy instrument or area of intervention or, in some cases, in achieving targeted retrenchment. These outcomes reflect the balance of power and the degree of convergence among competing coalitions (Table 4.5.).

Table 4.5. Hypothesis of Inertia or Reversal, Path Departure and Targeted Retrenchment or Selective Expansion.

Hypothesized Policy Trajectory	Dominant Mechanism in Political Exchange	Facilitating Conditions	Expected Outcome
H1: Inertia	Government grants stability to families and conservative groups in exchange for <i>consensus</i>	Absence of shocks, fragmented or divided coalitions	Maintenance of the status quo, familism with partial support
H2: Path Departure	Government grants universalistic reforms to reformist coalitions in exchange for political support and legitimacy	Window of opportunity (crisis, EU funds, reputational shocks) + coordinated action by actors	<i>Break with the past:</i> new rights, public services, formalization of care
H3: Targeted Retrenchment or Selective Expansion	Government grants pro-market demands while maintaining <i>symbolic</i> public oversight	Budget constraints; influence of market-oriented actors; limited political resistance	Expansion of private provision; regulated commodification of care services

Source: Author's elaboration.

According to the process-tracing methodology (Beach and Pedersen, 2019), the main hypotheses concerning policy inertia, path departure, and processes of targeted retrenchment or selective expansion are reconstructed and empirically assessed below.

Hypothesis 1: Inertia

When political elites rely on interest coalitions that prioritize the preservation of familial role in caregiving—such as religious organizations, pensioners' unions, or subnational governments—and these actors offer electoral support in exchange for the maintenance of informal care arrangements (*major premise*), and when LTC lacks political salience and does not generate strong incentives for reform,

i.e. credit-claiming returns (*minor premise*), then inertia is likely to prevail. This results in the preservation of existing arrangements, with limited public intervention (e.g., means-tested monetary transfers) and no significant expansion of universal service provision (*expected outcome*).

In this scenario, political exchange operates defensively. Governments, constrained by fiscal pressures and electorally influential constituencies, opt for stability rather than structural reform. The result is not full institutional *stasis*, but either *stasis* or incremental adjustments that maintain the underlying architecture of familism.

These defensive coalitions—what Mahoney and Thelen (2010) describe as “veto players”—effectively block transformative change by promoting a moralized and privatized vision of care, where responsibility rests primarily with families. This mechanism is especially effective in Southern European contexts, where familism aligns with cultural norms and administrative fragmentation. Political parties in government tend to engage in blame avoidance (Weaver, 1986), especially in sectors like LTC, where beneficiaries are diffuse and electoral returns are uncertain. Instead of pursuing reform to claim credit, policymakers avoid conflict by deploying low-cost, low-conflict policy instruments (e.g., cash allowances) that leave the informal care system intact.

Hypothesis 2: Path Departure

If a broad and cohesive reformist coalition—including progressive parties, unions, social enterprises, and civil society actors—successfully seizes a critical juncture (e.g., economic crisis, EU investment cycles, public scandal), and articulates a shared vision based on formalization and redistribution (*major premise*), and if the coalition is dominated by actors who stand to gain materially or normatively from the expansion of public services (e.g., care workers, female labor market participants, rights-based NGOs) (*minor premise*), then the result is a path departure, characterized by de-familization and/or de-commodification and the establishment of new social rights (*expected outcome*).

In this case, the coalition’s strength lies in its ability to redefine LTC not as a private burden but as a public responsibility. Unions may push for the professionalization of care jobs; NGOs may advocate for the rights of dependent individuals; and governments may frame investments as tools to boost female employment and long-term fiscal stability. EU mechanisms—such as the Recovery and Resilience Facility—can serve as enablers, especially when reforms align with broader social investment logics.

In this framework, institutions are understood less as veto points and more as opportunity structures that enable change through mechanisms such as institutional layering. While layering is often associated with gradual, incremental adaptation, it can also facilitate abrupt transformations, thereby challenging the conventional assumption that institutional change in mature welfare systems is necessarily slow or path-dependent.

Hypothesis 3: Targeted Retrenchment or Selective Expansion

When pro-market coalitions—including private care providers, residential care enterprises, social cooperatives, and market-oriented political actors—mobilize to promote the expansion of LTC through market-based instruments (*major premise*), and when governments face fiscal constraints or legitimacy pressures that discourage the direct expansion of public services while incentivizing efficiency-oriented innovation (*minor premise*), then a (targeted) retrenchment or selective expansion is likely to emerge (*expected outcome*).

This strategy entails a regulated commodification of care provision, in which governments delegate service delivery to private or third-sector actors while retaining oversight through accreditation, co-financing mechanisms, and quality control tools.

In this scenario, political exchange follows an instrumental logic: governments seek to reconcile budgetary discipline with the symbolic imperative of reform by outsourcing care delivery to non-state actors. Rather than pursuing universal public services, policymakers adopt selective and market-mediated interventions—such as vouchers, tax credits, outsourcing, or public-private partnerships—that allow for controlled service expansion while limiting public expenditure.

This mechanism aligns with what Starke (2007) terms “contained retrenchment”, as well as with strategies of delegated blame avoidance (Weaver, 1986) where responsibility for policy shortcomings is dispersed across a fragmented governance structure. Reform is reframed not as a state-driven project, but as a process of modernization, innovation, and user empowerment—discursively legitimized through references to efficiency, freedom of choice, and cost-effectiveness.

Such a trajectory is particularly likely in contexts where:

- Private and third-sector actors are institutionally embedded and politically influential.
- Governments are incentivized by EU-level funding frameworks emphasizing performance, innovation, and public-private collaboration.
- Political elites face reputational pressures to deliver “visible” reforms without expanding the public sector.

Building on these three hypotheses, this dissertation examines whether—and how—the interaction between puzzling and powering can explain reform outcomes in the three countries under analysis. Following a Most Similar Systems Design, the three cases are assumed to share a number of independent variables, with the exception of one dimension that maximises variation, while the dependent variable (the *explanandum*) is expected to differ across cases. Contextual and institutional factors specific to the LTC sector, as well as the opening of an institutional window of opportunity, account for the common background conditions across countries. The independent variable that is expected to provide the greatest explanatory leverage is therefore located in the political exchange mechanism, namely the strategic interaction between the formation of organised social demand and political parties.

The development of shared policy solutions is instrumental to political competition. At the same time, powering is hypothesised to shape the process of policy formulation by influencing the selection and construction of specific problem frames, which are strategically aligned with the reform outcomes that political actors seek to achieve.

As anticipated, Table 4.6 presents the mechanisms examined under the MSSD approach.

Table 4.6. Causal mechanisms examined within the Most Similar Systems Design framework.

Theories applied	Mechanisms	Spain	Italy	Portugal
Mechanism 1: Functionalism	Problem pressure	Similar	Similar	Similar
Mechanism 2: Historical Neo-Institutionalism	Institutions & policy legacy	Similar	Similar	Similar
	Opening of an Institutional Gate	Similar	Similar	Similar
Mechanism 3: Strategic interaction and political exchange	<i>Puzzling</i> - Formulation and Elaboration of Ideas	Divergence in explanatory factors to maximize variation: Core explanatory mechanism		
	<i>Powering</i> - Political Competition			
	Dominant coalition formation & strategic political exchange			
<i>Explanandum</i>	Reform outcome	Expected divergence In <i>explananda</i>		

Source: Author's elaboration.

5. Conclusion

This chapter has developed a tentative theoretical framework for analyzing LTC policy reform by foregrounding political exchange as the key mechanism linking structural constraints, institutional legacies, and actor preferences. In contrast to traditional explanations based on functional imperatives or path-dependent institutionalism, the proposed approach emphasizes the contingent and negotiated nature of policy change—particularly in low-salience, high-complexity policy areas such as LTC. Challenging classical historical institutionalist theories, this framework re-centers the role of strategic political actors, who engage in negotiated exchanges that—depending on the nature of demand and the strategic incentives on the supply side—lead to specific welfare reforms and shape long-term policy trajectories. As such, the argument supports a more balanced perspective that integrates both institutional structures and actor-driven agency.

While demographic ageing, declining informal caregiving capacity, and fiscal pressures undoubtedly generate structural incentives for policy adaptation, they do not, in themselves, determine reform outcomes. Similarly, while institutional legacies shape the *repertoire* of available policy tools and delimit the space of political possibility, they do not preclude the emergence of agency-driven transformations. Instead, reform trajectories in LTC are shaped by how political and societal actors strategically interact within existing constraints—mobilizing interests, framing problems, and seizing windows of opportunity to advance their preferred solutions.

This chapter has developed three hypotheses consistent with the *explananda* examined in the following chapters: inertia, path departure, and (targeted) retrenchment or selective expansion. Each hypothesis is grounded in a distinct configuration of actor coalitions, strategic incentives, and institutional conditions.

These hypotheses underscore a broader argument: LTC reform is not primarily shaped by ideological divides or linear institutional evolution, but by the capacity of coalitions to mobilize, align, and negotiate within specific opportunity structures. The politics of LTC is thus characterized by asymmetries in mobilization, uneven distribution of veto power, and a highly contingent logic of reform. Crucially, change occurs not simply in response to functional pressure or ideational innovation, but when actors are able to strategically transform crises into opportunities—crafting solutions that resonate with prevailing legacies while realigning coalitional dynamics.

Political exchange, in this context, serves as the analytical bridge between micro-level actor strategies and macro-level institutional outcomes. It reveals how reforms in long-term care are constructed, resisted, or reshaped through dynamic interactions between governments and organized interests. Understanding these interactions—who participates, under what conditions, and with what strategic objectives—is essential for explaining why some systems undergo structural change, while others remain anchored in continuity or pursue selective forms of commodification.

The analytical framework proposed here will serve as the basis for the empirical analysis in the following chapters, which examine how these mechanisms have operated in concrete national contexts. By tracing the conditions under which inertia, path departure, or selective expansion emerge, the study aims to offer a theory-driven yet empirically grounded explanation of LTC reform across Southern Europe.

Chapter 5. The Politics of Ley 39/2006 in Spain (2000-2006)

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1. Introduction

As outlined in Chapter 3, by the early 2000s, Spain's LTC landscape was emblematic of the Southern European model: Residual, highly decentralized, and deeply reliant on family provision. While demographic aging, rising female labor force participation, and public scandals underscored the inadequacies of this arrangement, sustained policy inaction persisted for over a decade. This inertia

was not the result of mere neglect but stemmed from a constellation of mutually reinforcing legacies—fiscal orthodoxy, the primacy of pension system sustainability, and the piecemeal emergence of private insurance mechanisms. These forces effectively narrowed the policy agenda and left the CC.AA. to navigate LTC needs in a context of resource scarcity and institutional fragmentation.

However, the roots of reform were planted well before the law’s enactment. Spain’s broader “social transition,” initiated in the 1990s and spearheaded by the PSOE, gradually redefined the welfare state, prioritizing the development of non-contributory and social policy pillars alongside the strengthening of socio-healthcare infrastructures. This trajectory unfolded within an institutional culture deeply shaped by Spain’s democratization: A negotiated, pragmatic, and consensus-seeking transformation. The political transition after Franco’s death was marked by a series of foundational pacts—most notably, the Moncloa Pacts of 1977 and the 1978 Constitution—which privileged incremental reform and compromise over rupture. Moderation and centripetal dynamics became hallmarks of the Spanish party system, as both left- and right-wing forces converged towards the democratic center, relegating radical alternatives to the margins. Table 5.1 summarizes the main political phases that shaped Spain between 1978 and 2011, covering the period preceding and immediately following the reform. The subsequent phases will be addressed, briefly, in the Conclusions of this thesis.

Table 5.1. Political Phases in Spain, from 1975 to 2011.

Period	Political Configuration	Main Parties	Key Features
1975-1982	Democratic transition; negotiated reform; emergence of moderate pluralism	UCD, PSOE, PCE, AP, PNV, CiU	Reforma pactada; Moncloa Pacts; limited fragmentation; foundational consensus
1982-1992	PSOE hegemony; consolidation of moderate pluralism and party system	PSOE, AP (becoming PP), IU, PNV, CiU	Stable majorities; centre-left governance; institutional consolidation; moderate ideological space
1993-2011	Bipolar alternation between PSOE and PP; regionalist alliances	PSOE, PP, IU, UPyD, PNV, CiU, BNG	Power alternation; low fragmentation; reliance on regionalist support; centrist governance

Source: Author’s elaboration.

This *ethos* of compromise and consensus shaped not only Spain’s democratization but also the trajectory of social policy and interest intermediation. Unlike the robust and institutionalized corporatism characteristic of Northern Europe, Spanish social dialogue has been cyclical and contingent—alternating between phases of inclusive institutional expansion and periods of unilateral state action (Molina & Rhodes, 2002). Over time, the main trade unions (CC.OO, UGT) and employer organizations (Confederación Española de Organizaciones Empresariales, CEOE) converged on more centralized and formalized engagement with the State, but their cooperation was grounded less in entrenched partnership than in episodic pacts aimed at securing regulatory legitimacy and predictability. The effectiveness of this “strategic corporatism” has thus proved highly dependent on the political and macroeconomic context.

NGOs, particularly those representing people with disabilities and individuals in situations of dependency, underwent parallel processes of formalization and ambivalence. While the transition to democracy facilitated a proliferation of advocacy groups and consultative bodies, substantive influence over agenda-setting and policy design remained uneven and often subordinate to governmental priorities. The 1980s saw the institutional consolidation of key actors such as *Confederación Española de Personas con Discapacidad Física y Orgánica* (COCEMFE) and *Comité Español de Representantes de Personas con Discapacidad* (CERMI), the latter evolving into a major umbrella organization and interlocutor in the policy field. CERMI and similar federations participate in statutory consultative arenas—including the *Consejo Nacional de la Discapacidad* and regional disability councils—but the substantive impact of their involvement has been circumscribed.

All in all, the evolution of Spanish LTC policy at the turn of the century reflected a complex balance of institutional inertia, fragmented governance, and interest-based negotiation. Policy innovation was constrained by a high density of veto players, fiscal limits, and the persistence of established policy legacies, yet change remained possible at key junctures—facilitated by demographic pressure, media scandals, and the discursive power of rights-based arguments. The design and passage of the *Ley de Dependencia* thus resulted not from a simple consensus but from complex processes of political exchange, coalition-building *vis-à-vis* deep territorial and ideological cleavages.

The chapter proceeds as follows. After the Introduction, Section 2 maps the contextual and political dynamics of Spain's LTC field between 2000 and 2006. Section 3 analyses coalition formation in support of reform during the years of government alternation (2000-2005). Section 4 reconstructs the political debate and the content of the 2006 *Ley de Dependencia*. Section 5 concludes by asking whether the 2006 reform amounted to a “quiet” consensus and distills the dynamics of political exchange that underpinned change in the LTC sector.

2. Contextual Factors and Political Dynamics in the LTC Sector (2000-2006)

This section sets out the contextual (functional) pressures and political dynamics underpinning the 2006 reform. Section 2.1 reviews the drivers behind the recognition of long-term care as a new social risk. Section 2.2 examines the Partido Popular's evolution from minority government (1996-1999) to parliamentary majority (2000-2004), with particular attention to the divergent policy orientations of the PP and the PSOE regarding long-term care.

2.1. The Contextual Factors: Emerging Social Pressures in the LTC System

At the outset of the reform, Spain's long-term care system had already undergone notable development, particularly at the regional and municipal levels. Yet in the absence of a comprehensive national framework, the sector remained highly fragmented and residual, comprising a patchwork of discrete provisions—including both cash benefits and services. Resources in the social and healthcare domains

nonetheless fell well short of the targets established in the *Plan Gerontológico* (see Chapter 3) for meeting the needs of dependent older adults. Section 2.1.1 details the residual character of long-term care in the face of emerging social risks—most notably population ageing—while Section 2.1.2 examines the fragmentation of existing long-term care services at the outset of the reform process.

2.1.1. LTC at the Turn of the Century: A Residual System

At the turn of the century, LTC began to ascend the Spanish policy agenda, propelled by a confluence of contextual pressures. Several interviewees underscore those demographic changes—particularly population ageing—and the ineffectiveness of an inherited, fragmented system based on residual social assistance became increasingly untenable. As Interview ES9—Academic Expert and LTC Consultant, University of Alcalá—reflected, *“the existing model was clearly insufficient for addressing the emerging needs of an ageing society.”* This period also witnessed a profound transformation in gender and labor market dynamics, as the massive entry of women into paid employment exposed the contradictions between caregiving needs and family structures. As Interview ES5—Academic Expert and Former Regional Legislator—stated, *“work-life reconciliation became central, as women’s increasing labor force participation highlighted the gap in public support for care responsibilities.”* In addition, the growing privatization of the care sector exacerbated existing inequalities, pushing the most vulnerable even further to the margins (Interview ES5).

Beyond domestic factors, Europeanization exerted a significant ideational influence on Spanish LTC reform. Multiple interviewees (i.e., Interviews ES5 and ES9) identified the Maastricht Treaty and the Lisbon Strategy as pivotal reference points, noting that *“the European Social Model and the experience of Nordic countries served as explicit benchmarks for Spanish policymakers and experts seeking legitimacy for reform.”* Another crucial catalyst was the heightened media attention to increased mortality rates in residential care settings, which generated public indignation and political urgency. As Interview ES7—Union Representative, CC.OO.—observed, *“the surge in deaths within care homes, widely reported by the media, shocked public opinion and mobilized support for systemic change.”*

Collectively, these dynamics—demographic transformation, the feminization of employment, increasing inequalities driven by privatization, normative pressures from the European level, and episodic media scandals—converged to unsettle Spain’s traditional care regime and opened a window of opportunity for reform. As is the case with all windows of opportunity (Kingdon, 1984) or instances of institutional gate-opening (Jessoula, 2009), this opening could have closed again. The departure from the existing system, however, was ultimately the result of deliberate political will and the strategic engagement of social actors, who pursued a negotiated exchange within the care sector. The subsequent section documents the structural characteristics and limitations of the pre-reform system, providing quantitative evidence of the scope of this rupture.

Between 1991 and 2006, Spain witnessed a substantial demographic shift among its oldest age cohort. During this period, the population aged 80 and above rose from 1,189,798 in 1991 to an estimated 2,016,934 by 2006, representing an increase of nearly 70% over 15 years. This expansion within Spain's oldest age brackets underscored a marked shift in the age structure of the population. In 1991, those aged 80 and above made up 3.1% of the total population, a figure that rose to 4.6% by 2006, reflecting a growing share of the population reaching advanced ages. Within the older population (65 and older), the proportion of those aged 80+ increased from 21.6% in 1991 to an anticipated 27.2% in 2006, indicating that a larger segment of Spain's older people was entering very advanced ages (Table 5.2.).

Table 5.2. Demographic Trends of the Population Aged 80 and above in Spain (1991-2006).

Year	80 years +	% over total population	% over 65+
1991	1,189,798	3.1	21.6
1996	1,364,820	3.5	21.9
2001	1,615,867	3.9	23.2
2006	2,016,934	4.6	27.2

Source: Adapted from Libro Blanco (2005: 28).

Parallel to these demographic changes, data from the *Encuesta sobre Discapacidades, Deficiencias y Estado de Salud de 1999* (INE, 1999) highlighted the correlation between age and disability prevalence. In 1999, an estimated 3,528,221 individuals in Spain had some form of disability or limitations that had caused or could potentially lead to disability, equating to approximately 9% of the Spanish population. The survey findings showed a clear relationship between disability prevalence and age: Over 32% of individuals aged 65 and above experienced some form of disability, while the proportion was under 5% among those under 65. Notably, while the prevalence of disability increased progressively with age, this rise became markedly steeper from the age of 50 onward.

During the same period, public expenditure on LTC, which included both cash benefits and services, demonstrated a growth. Between 1995 and 2003, spending on dependency services increased from 1,014.6 million euros to 2,357 million euros. This rise was primarily driven by heightened investment in social services, particularly after 1999, reflecting an enhanced commitment to addressing dependency needs. As a share of GDP, expenditure on dependency services grew from 0.23% in 1995 to 0.40% in 2003. Furthermore, dependency-related spending within total social protection expenditure also rose, increasing from 1.1% in 1995 to 1.57% in 2003 (Table 5.3.).

Table 5.3. Public Expenditure for LTC, by Functions, 2005 and 1995 Prices, 1995-2003.

Year	Monetary Benefits (2005 prices)	Monetary Benefits (1995 prices)	Social Services (2005 prices)	Social Services (1995 prices)	Total Spending on Dependency (2005 prices)	Total Spending on Dependency (1995 prices)	% GDP	% Social Protection Spending
1995	232	232	782,6	782,6	1014,6	1014,6	0.23	1.1
1996	247	239,8	879,1	850,8	1125,3	1089	0.24	1.08
1997	269,8	242,9	994,8	921,4	1264,6	1164,3	0.27	1.16
1998	284,9	238,4	1046,3	1005,4	1331,2	1248,7	0.27	1.15
1999	296,1	232,1	1082,5	1019,3	1378,6	1251,4	0.27	1.14
2000	269,1	236,1	1399,9	1188,8	1669,1	1453,9	0.33	1.32
2001	322,1	247,6	1572,6	1291,7	1894,7	1539,3	0.36	1.43
2002	354,8	274,5	1806,3	1492,7	2161,1	1767,2	0.39	1.49
2003	372,5	286,6	1984,4	1526,6	2357	1813,2	0.4	1.57

Source: Adapted from Libro Blanco (IMSERSO, 2005b: 548).

As for monetary transfers, since the enactment of Law 26/1990, the number of recipients of the *Subsidio de Ayuda a Tercera Persona* has steadily declined. This change effectively reduced access to these economic benefits, particularly impacting those over the age of 65 who did not have access to an invalidity pension from the Social Security System, leading to a drop in beneficiaries from 89,944 in 1990 to 46,370 by 2005 (IMSERSO, 2005b).

As for in-kind services, regulatory developments beginning in the 1980s (see Chapter 3) led to a notable expansion in the coverage of home care services across Spain, although this growth did not meet projected targets. The *Plan Gerontológico* (IMSERSO, 2005a) set a goal of reaching an 8% service coverage ratio over the following decade, but progress was slower than anticipated. From 1988 to 2004, the aging Spanish population (65 years and over) saw increased demand for home care services, with utilization rates rising from 0.13% in 1988 to 3.20% in 2004. As of January 2004, the number of SAD users totaled 228,812, equating to just over 3% of the population aged 65 and older. While coverage had nearly doubled over the past five years, with an addition of 116,015 users (averaging 23,203 new users per year), this increase was tempered by a concurrent growth in the older population. Between 1999 and 2004, the population aged 65 and increased by 537,062 individuals, which resulted in only a modest increase in the coverage rate. Service intensity also varied widely by Region: Galicia and the Basque Country averaged 29 and 25 hours of care per user per month, respectively, whereas Andalucía, Aragón, Canarias, and Navarra provided around 10 hours monthly. The national average in 2004 stood at 16.43 hours per month, equivalent to just over four hours per week.

In the meanwhile, since 1999 the growth of teleassistance²⁶ had been exponential, with 148,905 users recorded as of January 2004. This corresponds to a coverage rate of 2.05% among those over 65 and 11% of the total number of older people living alone, a population that was prioritized according to the proposal outlined in the *Plan Gerontológico*. Similar to the home-based services, the majority of teleassistance users are over 80 years old (51%), a percentage that has increased significantly since 1995, when only 31.4% of users were over this age.

In the field of institutional care (*i.e.*, nursing homes), in 1975 the population aged 65 and above stood at approximately 3.76 million, with only 55 residential home beds available, resulting in a negligible ratio of 1.46 beds per 1,000 older individuals. Over the years, the older population grew steadily, reaching 6.74 million by the year 2000. Concurrently, the number of beds in residential homes increased, from 55 in 1975 to over 213,000 in 2000. The ratio of beds to the older population also rose during this period, reaching a peak of 3.20 in 1998 (Table 5.4.).

Table 5.4. Development of Population over 65 Years Old, Beds in Residential Homes and Ratio in Spain, Selected Years (1975-2000).

Year	Population ≥ 65 years	Beds in Residential Homes	Ratio (Beds over population ≥ 65 years)
1975	3,757,754	55	1.46
1988	4,961,456	106,488	2.15
1994	5,761,767	163,338	2.83
1998	6,196,300	198,352	3.20
2000	6,739,559	213,398	3.17
2002	6,980,549	239,761	3.43
2004	7,146,678	266,392	3.72

Source: Author's elaboration, adapted on Sancho Castiello, 2002: 34.

Over time, residential care places allocated to assisted living increased significantly, reflecting the rising demand for specialized care in older residential services. In 1988, only 5.1% of residential care places were designated for assisted individuals, illustrating limited support for those requiring higher levels of care. By 1994, however, this percentage had surged to 29.5%, marking a substantial expansion in assisted living capacity within residential facilities. This trend persisted, reaching 49.3% by 1999 and surpassing the 50% threshold in 2001, with 51.5% of places dedicated to assisted care. Growth in this area accelerated in the early 2000s, peaking at 64.9% in 2003, before slightly reducing to 60% in 2004 (IMSERSO, 2005b). In the context of day centers, coverage for individuals aged 65 and older in Spain showed a gradual but notable increase in usage between 1999 and 2004. Initially, coverage remained

²⁶ Teleassistance was introduced by the Red Cross in the early 1990s. Subsidized by the *Instituto de Mayores y Servicios Sociales* since 1993, teleassistance quickly became integrated into the social services of municipalities and provincial councils. This service was organized locally and provided by private contractors, with the exception of Andalusia, where it was offered by a public provider (Leal et al., 2012).

stable from 1999 to 2001, reflecting limited progress in expanding care services. However, from 2002 onwards, a steady rise occurred, culminating in a sharp increase by 2004.

These developments reflected Spain's progressive adaptation of long-term care policies at the national level to address an aging population's needs vis-à-vis family changes. This national framework set the groundwork for a more decentralized approach, where CC.AA. assumed a crucial role in tailoring and expanding long-term care services to meet local demands, further enhancing coverage and service delivery across Spain.

2.1.2. A Fragmented System: Regional Disparities in the LTC Sector

Since the 1980s, the evolution of LTC policy in Spain has mirrored the development of the "State of Autonomies." The result was a system marked by profound decentralization, in which each CC.AA. had developed its own set of eligibility criteria, service standards, and pricing mechanisms. Numerous interviewees—including regional policymakers and national officials—consistently emphasize how this institutional architecture has led to persistent fragmentation and pronounced territorial inequalities, both in the quality and in the affordability of care.

Key informants from both the administrative and expert communities underscore that decentralization was not only a response to Spain's historical and political context but has since become self-reinforcing. Interview ES16—Public Official, Agency for Social Services and Dependency, Regional Government of Andalusia—and Interview ES19—Public Official, Directorate General for Social Rights, Regional Government of Asturias—describe regional governments as having jealously guarded their prerogatives, often viewing any attempt at harmonization or national standard-setting as an encroachment on their exclusive competences. As Interview ES4—Academic Expert, Institute for Labour Studies, Universitat Autònoma de Barcelona—notes, this has produced a patchwork of LTC models across Spain: Some regions—particularly those with stronger fiscal resources and established welfare traditions, such as the Basque Country and Navarra—have built more generous and integrated systems, while others lag behind, generating significant disparities in both access and outcomes.

Overall, the enduring decentralization of LTC in Spain has produced a landscape of variability and persistent inequality, reinforcing the view—widely shared among both practitioners and scholars—that effective policy innovation was contended with a complex mosaic of regional interests, institutional legacies, and competing models of governance. By 2004, public ownership accounted for 75.4% of residential care, a shift from initial private-sector dominance, indicating a policy-driven increase in state-managed care. Despite this foundation, funding inequalities across municipalities and CC.AA. led to regional disparities in service availability, particularly for high-intensity care. The *Plan Concertado* also aligned with the *Plan Gerontológico* of the early 1990s, which aimed to increase home and residential care coverage for the older people and was adopted by many regions as a guide for local adaptation.

In terms of development of the LTC system, a comparative analysis of regional social care expenditures across Spain's CC.AA. reveals notable disparities (Table 5.5.). In 2005, the País Vasco led in expenditure per user (€9,702) and per person aged 65 or older (€756.56), with its investment accounting for 0.60% of GDP and comprising 14.7% of total regional expenditure—the highest proportion in all categories. Navarra and Castilla y León also demonstrated significant investment, particularly in expenditure per user and as a percentage of GDP, with Navarra dedicating 0.69% of its GDP to social care, the highest percentage among all regions.

In contrast, regions such as Murcia, Ceuta, and Melilla showed lower expenditure levels across all categories. Murcia recorded the lowest expenditure per person aged 65 or over (€98.61), while Ceuta and Melilla report modest figures for expenditure per user (€2,027 and €1,857, respectively) and as a percentage of GDP (0.17% and 0.16%). At the national level, stark disparities emerge. For instance, while Madrid and Cataluña had high total expenditures per community (11.0% and 9.3%, respectively), their allocations *per user* and *per older person* were comparatively lower than in regions such as País Vasco and Castilla y León, highlighting distinct regional approaches and priorities in resource allocation. These differences underscored the uneven landscape of social care funding across Spain, reflecting diverse regional priorities and economic capacities.

Table 5.5. Regional Public Expenditures for the LTC sector, per CC.AA., as of 2005.

CC.AA.	Expenditure per user (euros)	Expenditure per person aged 65 or over (euros)	Expenditure as a % of GDP	Percentage of total expenditure per community
Melilla	1,857	204.41	0.16	0.2
Ceuta	2,027	208.33	0.17	0.2
Andalucía	2,047	143.18	0.14	6.5
Murcia	2,227	98.61	0.13	2.0
Aragón	2,439	260.43	0.25	2.6
Asturias	3,266	240.83	0.32	2.5
Castilla - La Mancha	3,344	376.69	0.29	3.1
Extremadura	3,441	363.87	0.50	3.5
Madrid	3,697	237.16	0.15	11.0
Cataluña	4,092	243.79	0.17	9.3
Balears	4,268	323.87	0.24	1.3
Rioja	4,359	376.05	0.36	1.2
Galicia	4,891	191.92	0.27	4.5
C. Valenciana	5,199	224.35	0.15	6.5
Canarias	5,966	258.91	0.18	2.1
Cantabria	5,98	330.76	0.26	1.2

Castilla y León	6,623	462.76	0.49	6.1
Navarra	6,946	332.96	0.69	1.8
País Vasco	9,702	756.56	0.60	14.7

Source: Author's elaboration on Informe del IMSERSO (2005a).

Table 5.6. presents a comparative overview of the provision of social care services across various regions of Spain, focusing on five key service types: Home care, telecare, day centers, public residential homes, and private residential homes. Notably, the País Vasco showed the highest figures for both home care (4.22) and telecare (2.35), while La Rioja and Navarra also demonstrated relatively high availability of public and private residential homes, with private homes being most prominent in Navarra (3.48). In contrast, regions like Baleares and Murcia exhibited lower levels of home care (1.48 and 1.53 respectively) and day centers (0.01 each), indicating less developed infrastructure in those services. Madrid stood out with higher-than-average home care (3.05) and telecare (1.35), suggesting a more robust social care system.

Table 5.6. Regional Development of the LTC Services, by Type of Service, as of 2004.

CC.AA.	Home Care	Tele Care	Day Centers	Public Residential Homes	Private Residential Homes
Andalucía	2.04	1.55	0.02	2.20	1.44
Aragón	2.44	2.07	0.02	2.10	3.28
Asturias	3.19	1.29	0.12	1.16	2.23
Baleares	1.48	1.17	0.01	0.38	2.10
Canarias	2.23	1.18	0.03	2.44	2.17
Cantabria	2.25	1.02	0.08	1.34	3.37
C. León	2.55	1.06	0.03	1.35	2.23
C. Mancha	2.23	1.17	0.01	1.24	1.19
Cataluña	2.10	0.57	0.12	1.25	2.45
C. Valenciana	2.36	1.48	0.04	1.02	2.06
Extremadura	1.45	1.01	0.01	1.35	1.53
Galicia	2.29	0.46	0.05	1.42	1.28
Madrid	3.05	1.35	0.05	2.08	2.34
Murcia	1.53	1.05	0.01	1.11	1.00
Navarra	2.08	1.56	0.03	2.17	3.48
País Vasco	4.22	2.35	0.13	3.30	2.56
La Rioja	2.11	1.43	0.16	1.34	3.44
Ceuta	1.44	1.04	0.10	1.19	2.19
Melilla	1.44	1.03	0.10	1.34	2.19
España	2.07	1.07	0.13	1.33	2.26

Source: Author's elaboration on Libro Blanco (IMSERSO, 2005b: 356).

In conclusion, the decentralized development of Spain's long-term care system reflected a complex landscape shaped by regional priorities and economic capacities. While frameworks like the Plan Concertado and regional social service laws aimed at creating universal access, significant disparities remain in funding and service provision across CC.AA.

2.2. The *Partido Popular* in Government after A Decade of PSOE's "Social Transition"

To better understand the political dynamics that ultimately led to the 2006 reform, it is essential to highlight the transition from more than three decades of Socialist governance to the rise of the PP. Indeed, between 1982 and 1992, Spain's party system was characterised by the electoral hegemony of the PSOE, which governed with successive absolute majorities and established itself as the central force in the democratic consolidation of the post-Franco era. However, the early 1990s initiated a new phase in Spanish politics, characterised by increasing electoral volatility, the erosion of single-party majorities, and the progressive establishment of a moderately bipolar party system. This emerging configuration was defined by alternation between two dominant statewide catch-all parties: The PSOE on the centre-left, and the reconstituted conservative Partido Popular on the centre-right²⁷.

Under the leadership of José María Aznar—a younger figure with technocratic credentials as former president of Castile and León—the PP implemented significant discursive and organisational reforms. Internally, the party underwent centralisation; externally, it sought continuity with Spain's democratic consensus by positioning itself as heir to the centrist Union of the Democratic Centre (UCD). Aznar's 1991 programmatic discourse articulated the PP's identity as a modern, democratic, and reformist force committed to economic modernisation, employment, and social rights (Balfour, 2005). This repositioning bore fruit electorally. In the 1993 general election, amid economic recession and increasing public discontent with corruption (notably the *GAL affair*), the PSOE lost its parliamentary majority. Although it continued to govern with ad hoc support, the electoral gap with the PP had narrowed significantly, and centrist competitors such as the Democratic and Social Centre (CDS) were eliminated from parliament.

In the 1996 general election, the PP surpassed the PSOE for the first time, securing 38.8% of the national vote and 156 seats in the Congress of Deputies, compared to the PSOE's 37.6% and 141 seats. Lacking an absolute majority (176 seats), Aznar formed a minority government through a parliamentary agreement with moderate regionalist parties—*Convergència i Unió*, the *Partido Nacionalista Vasco*, and

²⁷ A decisive element in this transformation was the strategic reorganisation of the Spanish centre-right. Throughout the 1980s, the People's Alliance struggled to surpass the 25% vote threshold, largely due to its associations with the Francoist past. Recognising the need for renewal, AP was refounded in January 1989 as the PP, embracing a new ideological identity rooted in liberal conservatism and Christian democracy. This rebranding entailed a deliberate move toward the political centre, a formal endorsement of ideological pluralism, and a symbolic distancing from authoritarian legacies.

Coalición Canaria. These agreements, built on fiscal decentralisation and recognition of regional autonomy, marked a strategic convergence between centre-right and nationalist forces and enabled the PP to demonstrate responsible governance within Spain’s consensus-oriented parliamentary system (Chari, 2004).

During its first term (1996-2000), the Aznar government pursued a centrist and pragmatic governing style. It prioritised fiscal consolidation, debt reduction, and eurozone accession while maintaining social dialogue and avoiding confrontation with peripheral nationalisms (Natili, 2019). Many analysts compared this approach to the “Third Way” politics adopted by leaders like Tony Blair and Gerhard Schröder (Balfour, 2005). The PP’s integration into mainstream democratic politics was thus consolidated, and its government was perceived as a continuation, rather than a rupture, with the institutional reforms of the previous decade.

Buoyed by strong economic performance and growing public confidence, the PP achieved an absolute majority with 44.5% of the vote and 183 seats, while the PSOE fell to 34.2% and 125 seats. For the first time since the democratic transition, a centre-right party governed without coalition support. This shift in parliamentary arithmetic catalysed a transformation in governing style. Freed from the need for legislative alliances, the PP adopted a more assertive, ideologically driven posture, particularly regarding national unity, Church-State relations, and executive power (Morlino & Montero, 1994; Montero, 1998; Gunther et al., 2000; Gunther & Montero, 2006; Ramiro & Salvador, 2024). Table 5.7. presents election results in 2000 in comparison to 1996.

Table 5.7. Election Results in the 2000 General Election in Spain.

Party	Vote Share (%) 1996	Seats 1996	Vote Share (%) 2000	Seats 2000	Government 1996	Government 2000
Partido Popular	38.8%	156	44.5%	183	Governing party (minority); supported by CiU, PNV, CC	Governing party (absolute majority); no coalition
Partido Socialista Obrero Español	37.6%	141	34.2%	125	Main opposition	Main opposition
Izquierda Unida	10.5%	21	5.4%	8	Opposition	Opposition
Convergència i Unió	4.6%	16	4.2%	15	Parliamentary support to PP	Opposition
Partido Nacionalista Vasco	1.2%	5	1.6%	7	Parliamentary support to PP	Opposition
Coalición Canaria	1.3%	4	1.6%	4	Parliamentary support to PP	Opposition

Source: Author’s elaboration.

2.2.1 The 2000 General Elections (and a comparison with 1996): The Programmatic Priorities of the PSOE and the *Partido Popular* on LTC

In 1996, the *Partido Popular* won the Spanish general elections with a relative majority, consolidating its success in 2000 with an absolute majority. This period in the late 1990s was marked by what scholars

have described as a “liberal turn” in Spanish social policy (Guillén & Matsaganis, 2000). The prevailing ethos combined an ethic of individual responsibility with new forms of solidarity, notably through the mobilization of public-private partnerships and voluntary sector resources. The PP’s approach entailed a retreat from direct public provision, with the expectation that the non-profit sector would be strengthened and the for-profit sector would expand its role, partially substituting for public services. Within this framework, the family was reaffirmed as the cornerstone of social solidarity. Economic growth was conceptualized as the precondition for advancing social protection, which, in turn, was increasingly equated with expanding employment opportunities.

Against this backdrop, the electoral cycles of 1996 and 2000 saw the PSOE and the PP articulate sharply contrasting approaches to the issue of long-term care (or in Spanish, *dependencia*). These differences were expressed both explicitly—in party manifestos—and implicitly, through the broader ideological framing of social protection. The PSOE placed dependency at the heart of a universalist welfare vision, emphasizing public responsibility and gender equality. By contrast, at least in a preliminary phase, the PP treated dependency as a peripheral concern, subordinate to fiscal sustainability, subsidiarity, and the strengthening of family-based care.

The PSOE’s 1996 electoral programme cast dependency as a public social challenge, necessitating robust institutional intervention. Although the term *dependencia* was not consistently used, the program referred directly to care for older and disabled people unable to live autonomously. The PSOE proposed expanding home help and establishing more day and night centers for dependent older people (PSOE, 1996: 77). This commitment reflected a broader social democratic perspective, in which public services serve not only as compensatory mechanisms to promote equality, but also as tools to relieve private households—especially women—of unpaid caregiving obligations. As the program stated, “*We are committed to a new model of care for older people, one that guarantees personal autonomy, social integration, and the ability to remain in one’s own environment*” (PSOE, 1996: 76). This language was explicitly de-familialist, as the party connects dependency care to gender equality, vowing to “*liberate women from the traditional caregiver role through the development of public services*” (*ibidem*: 64). The PSOE also advocated for enhanced intergovernmental coordination to guarantee universal access to social services, anticipating many of the principles later codified in the 2006 Dependency Law. These early proposals laid a normative foundation for future reforms by framing dependency as a new social risk requiring institutional, not merely familial, responses.

In stark contrast, the PP’s 1996 programme adopted a markedly different stance. The document contained no direct reference to dependency or non-self-sufficiency as structured social problems. Instead, support for vulnerable groups was addressed indirectly, through repeated references to the family as the primary locus of care. The PP pledged to “*strengthen the family institution as the basic nucleus of intergenerational solidarity*” (PP, 1996: 27), reflecting a subsidiarity-based approach in which the state’s welfare role is residual—supplementing, but not supplanting, informal care. While the PP did mention support for older people, its emphasis lay in fostering home-based care, using fiscal incentives and social measures to facilitate caregiving by families: “*We will promote fiscal and social*

measures to facilitate care for older people and people with disabilities by their own families” (PP, 1996: 32).

Analysts such as Chari (2004) and Field (2009) have described the PP’s first term (1996-2000) as oriented towards fiscal consolidation and European convergence, with social policy—particularly LTC—subordinated to economic priorities. Indeed, the party’s 1996 platform made strong commitments to austerity and deficit reduction, promising to *“control the growth of public social expenditure”* (PP, 1996: 8). This fiscal stance explains the lack of substantive proposals for expanding public care services and aligns with the PP’s broader ideological repositioning under Aznar, which married liberal economic principles with conservative social values (Balfour, 2005).

By the 2000 election, however, both major parties had begun to adapt their positions in response to demographic change and growing public recognition of LTC needs. The PSOE, in opposition, intensified its critique of the PP’s inaction and reaffirmed its commitment to extending social services for dependent persons. Meanwhile, the PP, now governing with an absolute majority, for the first time acknowledged the issue of dependency in its electoral platform: *“We will pay special attention to situations of dependency arising from ageing and disability, supporting home care and assistance for caregiving families”* (PP, 2000: 90). Yet, the proposed mechanisms remained mostly fiscal and voluntary—such as tax incentives, collaboration with NGOs, and home care promotion—rather than direct public provision. The PP’s programme reaffirmed “family solidarity” and advocated for public-private collaboration, reinforcing a neoliberal-familialist orientation (PP, 2000: 89-90).

This ideological polarization was already evident during the 2005-2006 legislative process, when the Ley de Dependencia was drafted and debated (see below). Multiple interviewees confirmed that parliamentary negotiations became a key arena for these opposing visions. As Interview ES5—Academic Expert and Former Regional Legislator, Parliament of Catalonia—recalled, *“the PSOE consistently framed dependency as a new social right—an entitlement the state should guarantee as part of the European welfare model—while the PP argued that care responsibilities belonged primarily to the family, and that excessive state intervention would undermine traditional values and self-reliance.”* Interview ES9—Academic Expert and LTC Consultant, University of Alcalá—similarly described the process as *“a clash between those who viewed care as a collective responsibility, and those for whom it remained essentially a private issue.”*

These tensions were also reflected among stakeholders from trade unions and employer associations. Union representatives noted that the very architecture of the law embodied these ideological divides: As Interviews ES7 and ES8—Union Representatives, Public Policy Department, Workers’ Commissions—explained, *“the left pushed for a universal right and a strong public system, while the right insisted on limiting the law’s scope, prioritizing cash benefits and user choice to preserve family autonomy.”* Similarly, Interview ES12—Union Representative, UGT—recalled the intense negotiations, in which *“Christian Democratic and conservative MPs demanded the inclusion of family care allowances and*

minimal state obligations,” culminating in a balanced compromise. Table 5.8. retraces the main visions of LTC for PSOE and PP.

Table 5.8. Vision of LTC and its Components, Partido Popular and PSOE.

Dimension	Partido Popular	Partido Socialista Obrero Español
Main vision of LTC	Promotes home-based care through tax relief and voluntary sector involvement; frames care as a familial responsibility rather than a public duty.	Frames dependency as a collective challenge requiring robust public intervention; proposes expanding residential and community-based public care services.
Primary policy objective	Containment of public social spending, reinforcement of individual and family responsibility, and fiscal sustainability.	Promotion of individual autonomy, social inclusion, and reduction of the unpaid care burden, particularly for women.
Preference: In-kind vs. in-cash benefits	In-cash benefits prioritized. Preference for fiscal incentives and monetary transfers to support informal (primarily family-based) caregiving.	In-kind benefits emphasized. Commitment to expanding public services and care infrastructure as primary tools for addressing social needs.
Role of the state	Subsidiary and limited. The state plays a supporting role, complementing but not replacing informal family care networks.	Central and proactive. The state is seen as the main provider and coordinator of services ensuring universal access and equality.
Preferred policy instruments	Fiscal measures, cash allowances, public-private partnerships, and support for caregiving families through financial means.	Expansion of public services, intergovernmental coordination, and rights-based access to care as institutional responsibilities.

Source: Author’s elaboration.

From the administrative and political perspective, the salience of the issue in electoral competition—though lower than topics such as the labor market—was nevertheless recognized. As Interview ES15—Former Director, IMSERSO—observed, *“from the very beginning, the law was seen as a flagship policy of the left—something the PSOE wanted to be remembered for—while the right agreed only reluctantly and sought to restrict the state’s role to financing a minimum floor of benefits, leaving as much discretion as possible to families and regions.”* Interview ES17—Former PSOE Minister—corroborates this interpretation, emphasizing that electoral incentives and the logic of coalition-building required each side to accept an outcome that was perceived as imperfect but *“politically viable.”* The subsequent paragraphs develop this point.

2.2.2. Early Proposals of Reform of LTC Policy: Pro-privatization Issues vis-à-vis Public Orientation

At the turn of the century, the IMSERSO published *La protección social de la dependencia* (Rodríguez Cabrero, 1999), followed by a Senate report in 1999 that underscored the aging population as a growing pressure on Spain’s social systems. These publications laid essential groundwork, providing foundational data that sparked early proposals on long-term care. By the dawn of the twenty-first century, the issue of long-term care had decisively entered the core of Spain’s political agenda. Both major parties—albeit with contrasting visions—recognized dependency as a pressing social challenge, and the proliferation of institutional reports and policy documents signaled an unprecedented degree of political salience. Crucially, the debate over the future architecture of LTC policy unfolded along the fault line separating contributory and non-contributory models: Whether to integrate dependency protection within the

Social Security system, as a new contributory pillar, or to pursue a universalistic, tax-financed approach, more in line with the principles of social citizenship.

In this novel context, mounting pressures toward privatization—particularly from the private insurance sector—became increasingly influential in shaping government decisions. This trend was notably reflected in the Partido Popular’s 2001 announcement of a planned reform targeting the private long-term care sector, which was widely covered in the press. As reported by *El País* (2001), the government explicitly advocated for expanding the role of private insurers in the management of long-term care benefits, prompting public debate on the future governance of the sector. Additional articles from the period, documented how these developments intensified lobbying activity and sparked controversy among trade unions and advocacy organizations, who raised concerns about the risks of privatization and the possible weakening of public guarantees (*El País*, 2001).

This cleavage did not merely reflect technical or fiscal considerations but was tightly intertwined with broader party-political strategies. For the PSOE—still striving to regain public trust after corruption scandals and to reaffirm its progressive credentials—the LTC agenda offered a timely opportunity to reposition itself on the left of the political spectrum (Interview ES17—Former PSOE Minister). Endorsing a universal, rights-based, and redistributive model of long-term care thus became both a programmatic priority and a vehicle for political renewal. In this context, the framing of dependency policy was not only a response to evolving demographic and social needs but also an expression of the PSOE’s effort to reclaim a leading role in Spain’s ongoing welfare-state transformation. This is evident in the emphasis placed by social actors and the government on the need to construct a new legal and institutional framework for dependency—highlighted in official statements and in the revival of a draft dependency law—with explicit attention to intergovernmental coordination and funding mechanisms (*Europa Press*, 2000).

From 2000 onward, a wave of documents—including analyses, position papers, and reports—advocated comprehensive structural reform of the sector. The scale of the demographic challenge became increasingly salient in public debate, with projections showing a sharp rise in dependent older adults and estimates indicating that Spain would need to double its LTC spending to meet these needs (ABC, 2001b). Although LTC was gaining traction in political discourse, pro-privatization pressures—driven largely by private insurance companies—arose within a residual and selective LTC system. Under the Partido Popular’s governance, this environment often served to stall public policy initiatives in LTC, creating favorable conditions for the advancement of privatization strategies (ABC, 2001a; 2001b).

The privatizing approach, supported by private insurers, found institutional backing in the 2000 state budget (Law 55/1999), which included a government commitment to submit a report to Parliament on dependency insurance. As previously discussed, the report conducted by the Directorate General of Insurance (DGSFP, 2000: 45), under the Ministry of Economy, acknowledged that a purely private insurance model enjoys limited public acceptance—even in countries characterized by residual or liberal welfare regimes, such as the United States. Nevertheless, the report also argued that a universal

public insurance scheme would be financially unsustainable within a broader context marked by constraints on public spending. The preferred model outlined in the report envisioned a hybrid approach, combining public assistance insurance for those lacking financial resources, fiscal support for families providing care, tax-incentivized private supplementary insurance, and support for the private management of LTC services. This proposed framework aligned closely with the interests of private insurance actors (ABC, 2001a).

At the same time, following the Partido Popular's announcement of its intention to pursue reform, the divergent positions of political and social actors became increasingly apparent. During this period, a clear division emerged among key government actors regarding the future of long-term care. Through the media, the Ministry of Economy—under the leadership of Rodrigo Rato—explicitly endorsed the development of private insurance and pension schemes as the preferred strategy. This position favored tax incentives to encourage citizens to purchase dependency insurance, closely aligning with the interests of the private insurance industry (ABC, 2001a). In contrast, the Ministry of Labor, led by Minister Juan Carlos Aparicio, advocated for a more universalistic model grounded in collective funding, social rights, and public solidarity. Aparicio cautioned that prioritizing private insurance risked excluding lower-income groups and jeopardizing the equity principle (ABC, 2001a). Trade unions echoed these concerns, warning that market-based solutions would exacerbate social inequalities, and instead called for a public, rights-based framework (ABC, 2001a). Meanwhile, representatives of the private sector, particularly from the insurance industry, pressed for clearer governmental commitments, expressing support for fiscal incentives but voicing frustration over the absence of concrete assurances regarding public co-funding (ABC, 2001a). Amidst this fragmented debate, a parliamentary motion spearheaded by Carles Campuzano (CiU) garnered cross-party support for a hybrid model, proposing a public-private partnership anchored in basic social rights and urging the government to establish a formal catalogue of entitlements for dependent persons (ABC, 2001a).

In parallel with inter-ministerial negotiations and the reactions of both ruling and opposition parties, proposals advocating for a social insurance-based LTC model proliferated. As Rodríguez Cabrero and Marbán Gallego (2013) note, the *Defensor del Pueblo* (Ombudsman) explicitly identified social insurance as a normative reference for the future institutional development of LTC in Spain. In 2001, the Ombudsman released the report *La atención sociosanitaria en España: perspectiva gerontológica y otros aspectos conexos*, which offered a comprehensive overview of the socio-healthcare landscape, with a particular emphasis on the needs of older adults and dependent individuals. The report called for an expansion of social services—particularly home care, institutional support, and assistance to family caregivers—while also highlighting deficiencies in the healthcare system. In particular, it underscored the need to strengthen geriatric care pathways in primary healthcare, improve home-based medical services, and eliminate age-based discrimination in access to specialized care (ABC, 2001b; Europa Press, 2001).

Crucially, the Ombudsman proposed a mixed funding strategy aimed at balancing universality and sustainability. Two primary financing options were identified. The first model, grounded in social

insurance, envisioned integrating dependency protection into the Social Security system through contributory financing for formally employed individuals, supplemented by non-contributory benefits funded through general taxation. This dual-pillar model sought to promote equity while ensuring broad coverage. The second model proposed financing LTC services entirely through general taxation, mirroring the mechanisms used for non-contributory pensions. As reflected in media coverage at the time (ABC, 2001a; Europa Press, 2001), this generated an increasingly polarized political and technical debate over the future architecture of the LTC system—one that juxtaposed market-based and insurance-oriented approaches with universalistic, rights-based visions of care. These discussions touched on core issues such as cost-sharing, public-private partnerships, and the definition of a guaranteed catalogue of rights and services for dependent persons.

Ultimately, the public-private divide—alongside the parallel debate on the respective roles of family and state in the provision of care—functioned as a driving force behind the eventual passage of a structural LTC law. These cleavages compelled political parties, trade unions, and employer associations to strategically position themselves on the issue, recognizing the political and representational incentives at stake. As new social risks gained visibility in public discourse, long-term care became not only a policy necessity but also a valuable terrain for actors seeking renewed legitimacy and electoral consensus in a period of systemic transformation.

3. Coalition Formation during Government Alternation (2000-2005)

The need to recognize dependency as an emerging social risk requiring integration into Spain's protective systems had already been explored in depth by prominent field experts (Rodríguez and Sancho, 1995; Rodríguez Rodríguez, 1998, 2002a; 2002b, 2004; Rodríguez Cabrero, 1999, 2004a, 2004b; 2004d Vilá, 1999a; Casado & López Casanovas, 2001; Abellán and Puga, 2002; Sarasa, 2003; Casado, 2004; Casado & Fantova, 2007), alongside several key Spanish institutions that held significant scientific, political, or representative influence (CC.OO, 2000; Defensor del Pueblo, 2000; SEGG, 2000; Consejo Estatal de Personas Mayores, 2001; CERMI, 2004; 2005a; 2005b). Together, these entities generated a series of well-considered proposals, urging public administrations to develop policies that would address the needs of Spain's increasingly dependent populations. By 2005, these efforts culminated in the release of the *White Paper on Dependency (Libro Blanco por la Dependencia)*, developed by the Ministry of Labour and Social Affairs in collaboration with IMSERSO.

Section 3.1 traces the agenda-setting phase and the first stage of coalition formation. Section 3.2 illustrates the policy-formulation phase and the second stage of coalition formation.

3.1. Agenda Setting and the First Phase of Coalition Formation (2000-2003)

Recognizing the centrality of the issue for stakeholders, and in the pursuit of “renewed” consensus, both left- and right-wing parties began to move toward establishing a process of social dialogue. Broad-based electoral support was also essential for both social partners and employer organizations, which included the expanding cohort of new enterprises and investment funds that had come to dominate the sector. Section 3.1.1. highlights two pivotal moments for social dialogue: The *II Congreso Estatal de Personas Mayores* (2001) and the *Pacto de Toledo* (2003, see Devesa & Dominguez, 2005). Section 3.1.2. examines the return of the PSOE to power and, in 2005, the signing of an agreement between the PSOE, social partners, and employer associations, which laid the foundations for the *Ley de Dependencia* (3.1.3.).

3.1.1. From the *II Congreso Estatal de Personas Mayores* (2001) to the *Pacto de Toledo* (2003)

In Spain’s evolving debate over ageing and social protection, the Consejo Estatal de las Personas Mayores played a catalytic role in shaping the agenda around long-term care in the early 2000s. At the *II Congreso Estatal de Personas Mayores*, held in Madrid in 2001, the Consejo presented a series of recommendations that reflected both the demographic urgency and the normative ambition to reframe care for dependency as a universal social right. The Council explicitly described older persons in situations of dependency as “*an increasingly large constituency that requires continuing, comprehensive care*” (Consejo Estatal, 2001d: 4), and advocated for legally guaranteed access to long-term care services within the national social security system. These recommendations included the integration of health and social services, the development of proximity-based care models to prevent unnecessary institutionalization, and the establishment of a comprehensive right to long-term care (*derecho subjetivo*), supported by adequate funding and legal recognition. Moreover, the *Consejo* criticized the limited coordination between social and health sectors and called for structural measures to ensure continuity of care and greater involvement of public authorities at all territorial levels.

Between 2001 and 2002, the debate over the future of long-term care in Spain became increasingly polarized, with significant divergences between political parties and social actors regarding the very architecture and direction of reform. The governing Partido Popular publicly committed to passing a dependency law during the 2000-2004 legislature, emphasizing a mixed system where the state would guarantee basic benefits, but with explicit incentives for private sector involvement and individual responsibility (Diario Médico, 2002a). However, delays and repeated postponements—justified alternately by the need for further technical work and the search for consensus—prompted frustration and skepticism among opposition parties and civil society organizations (Gaceta de los Negocios, 2002; Diario Médico, 2002b).

Notably, PP spokespersons such as Tomás Burgos stressed that “*the State must act as a guarantor of basic provisions, coordinating different actors, while also encouraging complementary private solutions,*” and insisted that “*neither a fully public nor a purely private system could guarantee sustainable and equitable coverage*” (Diario Médico, 2002a). However, representatives of the PSOE,

including Consuelo Rumí, denounced these approaches as insufficient and overly focused on shifting responsibilities to families and the market, labelling government proposals as “pyrotechnics” and criticizing both underfunding and repeated delays: *“We are still waiting for the report on dependency promised in 1999”* (El País, 2002). PSOE and *Izquierda Unida* both called for a universal, publicly funded system, with the PSOE opposing measures such as paying housewives for family care—which, they argued, would *“condemn women to remain as informal caregivers,”* instead demanding investment in formal care services and promotion of female employment (El País, 2002).

Civil society and professional associations like the *Sociedad Española de Geriatria y Gerontología* (SEGG) also intervened, urging rapid adoption of a comprehensive law, but warning against neglecting prevention, adequate funding, and the need to avoid perpetuating regional disparities and insufficient services (Europa Press, 2002a; Diario Médico, 2002b). SEGG President Isidoro Ruipérez called for more emphasis on preventive health and criticized delays, stating that *“political will is lacking”* and that *“neither the state nor the market can guarantee quality and coverage in isolation—coordination is essential”* (Diario Médico, 2002b). The union CC.OO, meanwhile, attributed the persistent postponements to the government’s lack of financial commitment and underlined the importance of strong coordination with autonomous regions and municipalities (Diario Médico, 2002b).

Within this contentious landscape, parliamentary dynamics further complicated progress. While a CiU motion urging the government to legislate on dependency by the end of 2002 passed unanimously (Congreso de los Diputados, 2001), the PP later confirmed that the law would be postponed until the following legislature (Gaceta de los Negocios, 2002). This reversal contributed to growing frustration among opposition and social actors, as well as to concerns that even the technical advances achieved—such as demographic analyses and new definitions of dependency levels—would be undermined by political inertia.

In 2003, these competing positions were crystallized in the debates and conclusions of the Pacto de Toledo Commission, as corroborated by El País (2003a; 2003b). Both major parties and the unions publicly recognized that the lack of a universal, public long-term care system constituted *“a major gap in Spain’s welfare state,”* with parties and CC.OO/UGT supporting the principle that public social services—not the market—should play the leading role in care provision. UGT insisted that protection *“should be configured as a new right within Social Security”* and demanded full participation in the legislative process, objecting to being excluded from debates due to their non-signature of the 2001 pensions pact (El País, 2003a; 2003b). CC.OO, likewise, rejected the route of private insurance, demanding universal, publicly managed coverage and pointing to the employment potential of professionalized care (El País, 2003a). The PP (through Jesús Merino and Tomás Burgos) acknowledged dependency as a key challenge for the renewed Pacto de Toledo and supported a legal framework ensuring equal rights nationwide, while also suggesting a mix of fiscal, social security, and regional funding. IU (Antero Ruiz) called for LTC to be a benefit covered by Social Security, explicitly criticizing Spain’s comparatively low social spending (El País, 2003a). The CEOE (employers), on the other hand,

favoring opening participation to private companies, and recognizing a role for both private provision and insurance—albeit as supplementary, not universal, tools.

The Commission's conclusion reflected this *spectrum*: “*The protection against situations of dependency and the need for long-term care has become one of the major emerging issues within the Welfare State.*” (Pacto de Toledo, 2003: 18). The Commission advocated the establishment of a universal system intended to complement the functions already carried out by social services. At the same time, it acknowledged the potential insufficiency of public resources and recommended exploring private insurance as a complementary rather than substitutive mechanism. The proposal did not entail full privatization but instead emphasized a model of shared responsibility, with the state maintaining the primary role in guaranteeing accessibility and equity.

This *consensus* on long-term care as a structural social risk, and the need to reframe care as a citizenship right, thus emerged both from civil society advocacy and parliamentary negotiation, with the 2003 *Pacto de Toledo* revision—supported by cross-party and social partner agreement—representing a new institutional consensus, even as debates over funding, public/private balance, and regional equity persisted (El País, 2003a; 2003b).

The closing years of the Partido Popular government revealed the practical limitations of this *consensus* and the ongoing gap in long-term care. Despite increasing public and parliamentary awareness, and some incremental expansion of programs (such as the visible but socially limited increase in IMSERSO travel slots for older people), the PP failed to deliver substantive progress in formal care provision. The much-anticipated dependency law was repeatedly postponed, and existing measures—such as cash payments to housewives caring for older relatives—remained marginal and insufficiently implemented: IMSERSO data at the time showed that only a minimal share of older people in need (around 3%) received primary support from public services, with the overwhelming burden still falling on families, and especially on women (El País, 2004a).

The government did announce intentions to create a national dependency fund (similarities can be found in the Italian case, see Chapter 6) and highlighted the employment potential of expanded care services, but by the end of the PP's second term, public provision remained fragmented, regional disparities persisted, and core legislative reform was still outstanding (El País, 2004b). The absence of structural solutions—contrasted with high-profile but limited initiatives—prompted ongoing criticism from experts and civil society, and reinforced the salience of the issue at the political transition of 2004.

3.1.2. The Return of the PSOE in Power: The Zapatero I

The political landscape shifted markedly following the PP's absolute majority victory in the 2000 general elections. Unshackled from the need for parliamentary alliances, the Aznar government

adopted a more assertive and ideologically driven posture. This second term was characterized by centralization tendencies, reduced negotiation with regional elites, and a conspicuous realignment with both the Catholic Church and U.S.-led international security agendas, particularly in the context of the Iraq War (Ramiro & Salvador, 2024). The government's stance generated increasing public disaffection, particularly in response to its unilateral foreign policy decisions and its approach to identity politics.

This growing discontent was catalyzed by the government's controversial handling of the 11 March 2004 Madrid train bombings, which it initially attributed to ETA despite accumulating evidence of Islamist involvement. The perceived instrumentalization of the attacks, alongside widespread opposition to Spain's military involvement in Iraq, critically damaged the PP's credibility. In the general elections held just three days later, the PSOE, led by José Luis Rodríguez Zapatero, achieved a surprising electoral victory. Securing 42.6% of the vote and 164 seats, Zapatero formed a minority government, with the PP trailing behind with 148 seats and 37.7% of the vote. A fragmented legislature emerged, with regional and left-wing parties such as CiU (10 seats), ERC (8), IU (5), and PNV (7) playing a pivotal role in facilitating parliamentary investiture and legislative negotiation (Table 5.9.).

Despite this alternation in executive power, the 2004 election did not fundamentally alter the structural characteristics of Spain's party system. Between 1992 and 2012, the system retained key features of moderate pluralism, defined by low effective party fragmentation, limited volatility, and a persistent centripetal dynamic. The two major catch-all parties—PSOE and PP—jointly accounted for between 73.4% and 83.8% of the national vote, with seat shares consistently exceeding 84% in the *Congreso de los Diputados* (Ramiro & Salvador, 2024). This configuration preserved the dominance of a quasi-bipartisan logic, with smaller statewide parties, notably Izquierda Unida (IU), struggling to overcome the mechanical and psychological barriers imposed by the D'Hondt electoral formula, which systematically favors larger formations.

Table 5.9. Election Results in the 2004 General Election in Spain.

Party	Vote Share (%)	Seats (2004)	Government
Partido Socialista Obrero Español	42.6%	164	Formed minority government with external parliamentary support from ERC, IU, PNV, BNG
Partido Popular	37.7%	148	Opposition
Convergència i Unió	3.2%	10	Opposition
Esquerra Republicana de Catalunya	2.5%	8	Support to minority government
Izquierda Unida	4.9%	5	Support to minority government
Partido Nacionalista Vasco	1.6%	7	Support to minority government
Coalición Canaria	0.9%	3	Opposition
Bloque Nacionalista Galego	0.8%	2	Support to minority government
Eusko Alkartasuna	0.4%	1	Support to minority government
Chunta Aragonesista	0.4%	1	Support to minority government

Source: Author's elaboration.

Nonetheless, beneath this stable bipartisan superstructure persisted a territorial cleavage that had long structured Spanish politics. Regionalist forces in Catalonia, the Basque Country, and Galicia continued to exert substantial influence, particularly in moments of minority government formation. Historically, both PSOE and PP had relied on regionalist parties such as CiU, PNV, and Coalición Canaria to secure legislative majorities in the absence of outright victories. These alliances often entailed negotiated concessions in areas such as fiscal autonomy, linguistic rights, and the devolution of competences, reflecting the enduring tension between central state authority and subnational demands (Linz & Montero, 1999; Ramiro & Salvador, 2024: 221-222). As Linz & Montero (1999: 2) notably observed, Spain is best understood not as a unified national party system, but as a mosaic of interdependent regional systems.

The return of the PSOE in 2004, therefore, signified both policy change and systemic continuity. On the one hand, Zapatero's administration marked a distinct departure from PP orthodoxy by pursuing a progressive agenda of social liberalism and secularization—notably through the legalization of same-sex marriage, expansion of civil rights, and investment in historical memory legislation. On the other hand, the underlying party system remained stable, with executive alternation occurring within a consolidated competitive framework, shaped by bipartisan dominance and territorially mediated governance. The PSOE's ability to navigate minority rule by forging legislative alliances with regionalist and left-wing forces further reinforced the adaptive capacity of Spain's parliamentary democracy within a fragmented yet governable polity.

3.1.3. First Steps of the Socialist Government: Stakeholder Consultation and the Technical Proposals of the *Libro Blanco*

In April 2004, the minority government led by José Luis Rodríguez Zapatero took its first decisive step toward reshaping Spain's welfare architecture through the revival of tripartite social dialogue. This process culminated in July 2004 with the *Acuerdo sobre Competitividad, Empleo Estable y Cohesión Social* of July 2004, signed with the principal trade unions (UGT and CC.OO.) and employers' association (CEOE with Confederación Española de la Pequeña y Mediana Empresa, CEPYME). The agreement aimed not only to stabilize the labor market and improve productivity, but also to confront emerging social risks—chief among them, the challenge of long-term care for dependent individuals.

This shift in policy was pivotal in defining the government's approach to welfare reform, particularly in addressing long-term care for the older and people with disabilities. By highlighting the growing social risks and the emerging need for long-term care, the agreement signaled the recognition of care for dependent individuals as a public responsibility, ultimately paving the way for the *Ley de Dependencia* in 2006. As emphasized in the agreement, it was not only about addressing the immediate care needs of individuals but also about tackling the broader structural challenges that families faced in managing care responsibilities, which had long been considered a private matter. This was a major ideological shift that aligned with the government's progressive agenda to expand social protections and reduce reliance on family caregiving.

Between July and December 2004²⁸, the Ministry of Labour and Social Affairs—under Minister Jesús Caldera—and the IMSERSO commissioned a comprehensive analytical report on the Spanish long-term care system. The result was the *Libro Blanco sobre la atención a las personas en situación de dependencia en España*, published in 2004 and officially reintroduced in 2005 as a foundational document to inform and legitimize the forthcoming legal reform on long-term care.

The *Libro Blanco* proposed the creation of a long-term care model based on social insurance. Strongly inspired by the German system, the report advocated for a contributory scheme funded through mandatory payroll contributions by both employers and employees. As explicitly stated, “*The long-term care system should be financed primarily through a scheme of mandatory contributions—akin to the German model—whereby workers and employers are obliged to contribute to sustaining the care system*” (Libro Blanco, 2004: 18). A key component of the proposed model was the introduction of flexibility in benefit design. The report emphasized the need to allow beneficiaries to choose between in-kind services and direct monetary benefits, a shift intended to tailor care pathways to individual preferences and family contexts. However, this approach also raised important questions about equity—

²⁸ During this period, CiU also explicitly urged the Government to fulfill the promises made during the electoral campaign, thereby exerting considerable pressure on the newly formed administration (Congreso de los Diputados, 2004).

particularly the risk of reinforcing socio-economic inequalities, as lower-income individuals might be constrained to opt for cash benefits and informal care arrangements due to lack of access to services.

Moreover, the *Libro Blanco* called for a strategic partnership between the public and private sectors. It advocated expanding the role of private providers, particularly in residential and home care, to meet rising demand. While acknowledging the complementary role of private insurance, the report explicitly warned against excessive privatization: “*Private insurance may complement the public system, but regulatory mechanisms must be instituted to ensure that the care system is not privatized*” (p. 40). Despite this caution, the document leaned clearly toward a mixed-economy approach that legitimated market mechanisms, individual choice, and pluralism in service provision.

The publication of the *Libro Blanco* represented a pivotal moment: It marked the initial articulation of coalition positions among the key stakeholders—political parties (which would become more explicit during parliamentary and Senate debates), social partners, employer organizations, and civil society groups. Beyond assembling critical empirical evidence and providing international comparisons—most prominently with the German and Nordic LTC models—the *Libro Blanco* laid both the ideological and technical groundwork for the subsequent legislative agenda. This comprehensive report informed and shaped the terms of public debate, establishing common reference points for diverse actors involved in the reform process. Crucially, the *Libro Blanco* provided the analytical basis for the 2005 *Acuerdo sobre la Dependencia*, which itself constituted the final major policy milestone before the release of the draft legislation (Anteproyecto de Ley 39/2006), eventually enacted in December 2006.

3.2. The Policy Formulation and the Second Phase of Coalition Formation (2004-2005)

This second section focuses on policy formulation, which will ultimately be submitted to review by the Parliament and the Senate (see *infra*). It reconstructs the compromise reached between 2004 and 2005 between the Socialist Party and the relevant stakeholders (3.2.1.), followed by an analysis of these actors’ subsequent positioning in light of the stages previously outlined (3.2.2.).

3.2.1. La *Mesa de Dependencia* (2004-2005): The Affordable Compromise of a Socialist Minority Government in the Context of Stakeholder Coalition Formation

Between December 2004 and December 2005, social and political dialogue culminated in the approval of the *Acuerdo sobre la Acción Protectora de la Atención a las Situaciones de Dependencia*, which was presented in draft form in December 2005. Conceived as a preparatory step toward comprehensive legislative reform, the agreement emerged from several months of deliberation within the *Mesa de Dependencia*—an inter-institutional working group that included representatives from the central government, trade unions, employer associations, and subject-matter experts. The process also involved both the Senate and the Congress of Deputies (see *infra*).

The agreement articulated both the conceptual framework and institutional parameters for what would become Spain's *Sistema Nacional de Dependencia*, a publicly governed long-term care system grounded in the principle of universality. It is important to underline that, according to the unions, the transition from 2004 to 2005 and the adoption of the *Acuerdo sobre la Dependencia* marked an unprecedented driving force for their role in laying the groundwork for reform. As Interview ES7—Union Representative, Public Policy Department, Workers' Commissions (CC.OO)—explained, "*Both unions promoted, within the framework of social dialogue, the creation of the dependency system... we sought to improve the welfare state by establishing a public social service based on professional care, which we had lacked until then.*" This was particularly evident with the publication of the so-called "Fourteen Principles" approved by the unions between 2004 and 2005 (Interview ES7—Union Representative, CC.OO).

At the heart of the agreement was a shared recognition of the systemic failure of Spain's traditional reliance on family-based informal care. The text openly acknowledged that "*el apoyo informal ha entrado en crisis*" due to demographic ageing, the decline of extended family structures, and the increasing labor force participation of women. In response, the partners agreed that dependency care must be considered "*el cuarto pilar del Estado del Bienestar*," thereby elevating it to the same normative status as pensions, health care, and education. This framing was not merely rhetorical: The agreement proposed establishing a legally enforceable right to receive care services under equal conditions throughout the national territory, through a *norma básica* approved by the national parliament.

While the final content of the agreement appeared to reflect broad consensus, the negotiation process was, in fact, contentious and required the reconciliation of diverse positions. The trade unions—particularly UGT and CC.OO.—framed their involvement as part of a long-standing advocacy effort to recognize dependency as a social right. Both organizations underscored the importance of public responsibility and financing, firmly opposing models overly reliant on market-based instruments. Their endorsement of the agreement was contingent upon the inclusion of key principles such as equity, territorial cohesion, and the prioritization of home-based care. In this regard, CC.OO. explicitly asserted that "*dependency cannot be left to the vagaries of the market or to regional disparities*," calling for a robust central regulatory framework to prevent regional fragmentation. UGT echoed these concerns but placed additional emphasis on the gendered nature of dependency, arguing that a properly funded national system could help mitigate the disproportionate caregiving burden shouldered by women. The union also advocated for the integration of care policies with active labor-market strategies and social-security protections for informal carers transitioning into formal employment.

Compared to its earlier positions (see 2001, Section 3.1.3.), the employers' association CEOE adopted a more cautious and nuanced stance. While acknowledging both the demographic urgency and the ethical imperative to protect dependent individuals, CEOE's primary concern centered on the financial sustainability of the proposed system. The organization supported the establishment of a public framework but stressed that co-financing mechanisms should include not only the central government, but also regional authorities, beneficiaries, and the private sector. Additionally, CEOE advocated for

the possibility of introducing complementary private insurance schemes, “*on a voluntary basis and while respecting the public nature of the system,*” as a means to diversify funding sources and alleviate fiscal pressure on the state. Nevertheless, the employers’ federation ultimately accepted the principle that the system should be grounded in a public, rights-based logic—signaling a significant shift from the reservations it had previously expressed.

During this phase of negotiation, although not explicitly referenced in either the *Acuerdo sobre la Dependencia* (Agreement on Dependency) or the *Libro Blanco* (White Paper), the Third Sector gradually gained visibility within the decision-making process. This emergence was largely propelled by trade union advocacy and facilitated through the mediation of its principal representative body, CERMI. The inclusion of disability organizations, however, was itself a matter of internal debate. Despite being among the at-risk groups that had achieved the most progress in terms of social protection, these organizations viewed the new law as a strategic opportunity to address long-standing unmet expectations—particularly those related to national disability employment plans and the Equal Opportunities Act (Interview ES11—President of CERMI).

In the *Libro Blanco*, government materials explicitly stress the importance of building consensus not only with political and social actors, but also with the *movimiento asociativo*—a term referring specifically to platforms such as CERMI. Indeed, CERMI was formally consulted during the drafting process and was publicly presented with the document by government officials—an indication of its recognition as a key stakeholder in the policy process. CERMI’s proactive role is corroborated by its own publications. For instance, the 2005 activity report of CERMI-Aragón details its involvement in consultations on the forthcoming dependency law, emphasizing that the *Libro Blanco* served as the principal reference document for evaluating needs and proposing legal and organizational solutions. Furthermore, CERMI and related organizations played a central consultative role in fostering dialogue between civil society and political institutions. Notably, they were present in 70% of the hearings conducted by the Non-Permanent Commission of Congress for Comprehensive Disability Policies concerning the *Libro Blanco* (Interview ES11—President of CERMI).

This engagement encouraged the disability movement to, in its own words, “*board the train of the subjective universalization of this contingency,*” thereby revitalizing a capacity for mobilization and negotiation that had remained largely dormant since the late 1990s. Proposals from this sector—including those from organizations representing persons with disabilities and older adults—were frequent and substantive (Interview ES11—President of CERMI). Key actors included CERMI, the Spanish Confederation of Organizations for Persons with Intellectual Disabilities (FEAPS), the Spanish Confederation of Organizations for the Older People (CEOMA), the Independent Living Forum, the Democratic Union of Pensioners (UDP), and the Platform of Social Action NGOs.

A notable absence during this initial phase of reform was the feminist movement. Feminist organizations did not play a central role in shaping dependency policy and only entered the debate at a relatively late stage. Initially, their advocacy focused more heavily on issues related to early

childhood and work-life reconciliation. Only in recent years have elder care and broader dependency issues begun to feature more prominently on their political agenda. As observed by Interview ES4—Academic Expert, Institute for Labour Studies, Autonomous University of Barcelona: *“Feminist organizations... became involved in the issue of dependency rather late. At the time, they were much more active regarding the care of young children... Interest in the care of older people or people with dependency has been much more recent.”*

Table 5.10. summarizes the positions of the various stakeholders involved in the negotiation process. As previously mentioned, the non-profit private sector was only marginally involved. Nonetheless, the positions of these actors were clearly articulated through official documents issued by their respective organizations and—as will be further discussed—exerted ideational influence during the Congressional consultations, helping to shape the final content of the reform.

Table 5.10. Main Spanish Stakeholders' Positions between April and December 2005.

	CC.OO. & UGT	CEOE & CEPYME	CERMI, FEAPS, CEOMA, UPD
<i>Social Right, Recognition of LTC</i>	LTC was regarded as a legally guaranteed and universal subjective and social right. It was recognized as the fourth pillar at the national level and was supported by public responsibility.	They recognized the subjective right to care as positive in principle, but always conditioned it upon fiscal and institutional feasibility.	These organizations strongly supported the recognition of LTC as a fundamental and enforceable social right, anchored in equality and non-discrimination principles for persons with disabilities.
<i>Financing and Coverage</i>	They advocated for adequate and redistributive public funding for LTC. They supported a co-financed and universalistic model in which the central government played a leadership role and funding was conditional on quality improvements agreed with CC.AA.	They sought a stable, sufficient, and long-term financing framework, co-responsibly managed across government levels.	They advocated for adequate funding to guarantee real access to LTC, especially for people with severe disabilities, and for state responsibility in ensuring coverage.
<i>Eligibility Criteria</i>	They argued that access must be guaranteed to all, specifically for the most vulnerable social groups, ensuring that they were not disadvantaged—for instance, by providing free access to all users and, in particular, subsidized access for low-income groups.	They held that access must be guaranteed to all, with particular attention to ensuring that middle- and upper-income groups were not disadvantaged in accessing care.	They advocated for universal access based on dependency level, not income or territorial residence, and opposed any form of means-testing or territorial discrimination.
<i>Multilevel Governance</i>	They supported a collaborative intergovernmental structure, empowering the Consejo Territorial as a forum for consensus, where both the central state and regions agreed on the regulatory development of the system.	Their position aligned with a collaborative intergovernmental structure, especially regarding the role of private actors in contracting standards.	Their approach also aligned with collaborative intergovernmental structures, particularly regarding the role of private actors in contracting standards.
<i>Regulatory Aspects (public-private)</i>	They demanded strong regulatory oversight of private actors within the LTC sector. While they accepted private providers under strict regulation, they demonstrated a normative preference for public provision, using accreditation and administrative controls to impose quality standards on private and concerted service providers.	They strongly defended a mixed economy of care. They advocated for neutral competition, equal accreditation standards, and a single regulatory framework for all providers.	They focused on guaranteeing user rights and quality standards, regardless of the public or private nature of the provider, and demanded strong public oversight and quality assurance mechanisms.
<i>In-cash</i>	They minimized reliance on in-cash benefits, treating cash benefits for family care as exceptional and seeking to correct their overuse, which often led to low-quality, unregulated care. They imposed strict conditions and transitional use for cash benefits to ensure access to professional services.	They considered in-cash benefits as an exceptional measure to guarantee freedom of choice in choosing formal services.	They accepted cash benefits only if these ensured autonomy and choice for the dependent person, warning against over-reliance on family caregivers and unpaid care.
<i>In-kind</i>	They pursued a dual objective—public employment and gender equality—by using the formalization of care work as a strategy for creating qualified public employment, correcting structural gender inequalities in unpaid care, improving labor conditions, and recognizing care as an economic and professional domain. They sought to reduce gender inequality in care provision by prioritizing professional, formal services over family-provided solutions.	They promoted the expansion and professionalization of formal care services, emphasizing training, labor protections, and the role of care in the formal economy.	They strongly promoted professional and community-based care services, prioritized individualized care plans that respected autonomy and promoted independent living, supported respite services, freedom to choose providers, and recognition of carers' rights by social security.

Source: Author's elaboration.

3.2.2. Between Moderation and Polarization: Evolving Stakeholder Positions from the *Libro Blanco* to the *Acuerdo sobre la Dependencia*

Although released within a relatively short interval, the *Libro Blanco de la Dependencia* (December 2004) and the *Acuerdo sobre la Acción Protectora de la Atención a las Situaciones de Dependencia* (December 2005) diverged markedly in both foundational vision and policy orientation.

The *Acuerdo* framed dependency as a collective social risk to be addressed primarily through publicly funded and publicly provided services. Departing from the *Libro Blanco*, which afforded wide latitude between services and cash benefits, the *Acuerdo* established a clear “service-first” principle: “*La atención deberá ser prioritaria en el ámbito de los servicios, garantizando que las personas dependientes puedan mantener el mayor grado de autonomía posible*” (p. 15) (*care should be provided primarily through services, ensuring that dependent persons can maintain the highest possible degree of autonomy*). Monetary benefits were conceived as a last resort, to be used only where professional services were unavailable. The *Acuerdo* also emphasized intergovernmental coordination and territorial governance, promoting the creation of the *Consejo Territorial del SAAD* to ensure joint decision-making between the central state and the *Comunidades Autónomas*. It explicitly rejected a centralized, insurance-based approach in favor of financing through general taxation and shared public responsibility. While acknowledging fiscal constraints, the agreement sought to preserve equity via universal access and a reinforced state role in care provision.

The substantive divergences between the *Libro Blanco* and the *Acuerdo* reflected distinct stakeholder strategies shaped by shifting priorities across the two phases of the policy process. While maintaining overall consistency in their demands, the trade unions focused during the *Libro Blanco* phase on defending the public role in long-term care delivery, aiming to counteract any expansion of the private sector’s share in service provision. Although they did not categorically reject contributory models at that stage, their cautious stance evolved in the subsequent phase—leading to the *Acuerdo*—into explicit support for a fourth pillar of the welfare state financed through general taxation and grounded in care formalization. This approach pursued a dual objective: Expanding quality employment and alleviating the disproportionate care burden borne by women. UGT likewise championed these priorities, placing particular emphasis on gender-sensitive legislative design.

By contrast, CEOE and CEPYME advanced a public-private mix as their central advocacy position. They firmly opposed a social-insurance funding model—an approach also resisted by the CC.AA. (see *infra*)—and instead argued for a system based on equitable public-private collaboration, in contrast to the imbalanced arrangements of the early 2000s. CEOE’s principal concern was to avoid imposing additional financial burdens on firms, as might occur under a contributory scheme, while enabling both for-profit and non-profit providers to participate in service delivery. In this respect, the formalization of care emerged as a potential point of convergence between employers and unions.

These dynamics were further shaped by the proliferation of statements and positioning by regional and opposition parties (see *infra*), which—perhaps predictably—pushed both social and business actors to

adopt more distinct and, at times, more polarized stances on specific policy design questions. Table 5.11. reports Spanish stakeholders' main stances and key divergences from *Libro Blanco* in 2004 to *Acuerdo* in 2005.

Table 5.11. Spanish Stakeholders' Main Stances and Key Divergence from Libro Blanco to Acuerdo.

Stakeholders	Libro Blanco de la Dependencia (2004)	Acuerdo sobre la Dependencia (2005)	Divergent Strategies
Trade Unions (UGT, CC.OO.) and CERMI	Adopted a cautious stance: did not explicitly oppose the contributory model but expressed concerns about privatization risks and insufficient labor protections in the proposed system.	Actively supported a universal, publicly funded care model, emphasizing equity, job creation, and strong public responsibility. Explicitly rejected privatization.	2004: Limited mobilization; cautiously supported insurance-based financing.
			2005: Became more vocal in advocating for public service provision and universal access.
Employers' Associations (CEOE, CEPYME)	Advocated for a mixed model with private sector investment. Opposed compulsory contributions from businesses; favored tax incentives and public-private partnerships.	Accepted public-private collaboration in principle but resisted mechanisms implying higher employer contributions or increased regulation.	2004: Supported a flexible, market-oriented model.
			2005: Intensified resistance to compulsory, insurance-based financing mechanisms.

Source: Authors' elaboration.

4. The Ley de Dependencia in 2006

Despite these limitations, the presentation of the draft law in early 2006 catalyzed a wave of independent expert reviews (e.g., SIPOSO, SEGG), institutional opinions (e.g., CES, Council of State), and formal proposals from trade unions and civil society organizations—particularly those representing the older and persons with disabilities. Feminist organizations were initially less involved and only in the final stages of the debate did they make incisive contributions, often critical of the centrality accorded to unpaid family care work²⁹. As Marbán Gallego (2012) details, these contributions resulted in several substantive amendments to the bill, including: A clearer distinction between care and accommodation services (Article 33.3); the inclusion of gender impact assessments (Final Provision 1.4); the extension of coverage to children under three with severe disabilities (Additional Provision 13); explicit recognition of persons with intellectual disabilities and mental health conditions; and the promotion of employment for people with disabilities (Additional Provision 14).

As previously discussed, the most divisive issue during the parliamentary deliberations concerned whether the new system should be integrated into the Social Security framework—mirroring the German

²⁹ In an article authored by Begoña San José for the platform “Mujeres por la Ley de Atención a la Dependencia” (El País, 2005i), 47 associations denounced the risk of perpetuating the role of women as primary caregivers through “assistance” measures that did not correspond to genuine wages or full labor rights. Feminist activists argued that the lives of family caregivers should not be the price paid for the lives of others, instead calling for a public system of services that would universalize access to day centers, residential care, and home care services. Public controversy also erupted in response to Minister Caldera’s statement that women receiving subsidies as caregivers would be considered employed, a position seen as a distortion of the constitutional right to work (El País, 2005i).

model—or instead financed through general taxation, as in the Nordic countries. Although no official rationale was provided for ultimately excluding the law from the Social Security system (Léon, 2011), opposition from employers, regional governments, and nationalist parties prevailed. These actors feared that incorporation into Social Security would increase central government regulatory power at the expense of regional autonomy—a concern heightened by the already differentiated development of LTC services and the entrenched financial and implementation autonomy of the Autonomous Communities (Interview ES19—Public Official, Regional Government of Asturias).

Union representatives further observed that the government’s decision was also motivated by pragmatic considerations: The perceived need to expedite the rollout of a universal LTC system, and the risk that integration into Social Security would require reopening the *Pacto de Toledo* (1995; 2003), which maintained the separation of contributory and non-contributory welfare protections. Employers argued that such integration would necessitate increased contributions, while several expert voices countered that the law could have been included within the non-contributory pillar of Social Security and funded through alternative fiscal channels.

In practice, the reform was deliberately steered toward a universal, tax-financed system. This arrangement allowed the *Comunidades Autónomas* greater leeway to organize their own (co-)financing models (Interview ES19—Public Official, Regional Government of Asturias) and was predicated on the belief that a tax-based system would involve lower economic and political costs than a contributory one, which would have required renegotiating sensitive agreements such as the Toledo Pact. In this context of apparent *consensus*, the legislative process prioritized maximum flexibility—an orientation confirmed by broad, if sometimes reluctant, support, including from the Partido Popular and, with greater effort, from the regional governments. As one union representative (Interview ES7—Union Representative, CC.OO) noted, *“It is a transversal law, which compels inclusivity. But this also means it is a law that none of the parties consider perfect... there are elements that are deliberately open, flexible...”*

However, two important qualifications must be made. First, despite the rhetoric of “broad consensus,” the debate was far from harmonious. The decision to rely on general taxation and exclude the system from Social Security was driven less by budgetary necessity than by complex political considerations regarding institutional competences. While this solution enabled a negotiated agreement with the Autonomous Communities, it arguably weakened the central government’s ability to ensure uniformity and equity in service provision. As several experts observed, this fragmentation has contributed to uneven implementation across regions and limited the law’s transformative potential. Second, the legislative debate reignited longstanding political and social cleavages that have long preoccupied political scientists—notably, the state-family and public-private divides.

4.1. The Discussion in the Senate of the Draft Bill of the *Ley de Dependencia*

Parliamentary approval of the law was nevertheless contentious. Although it received broad support in public opinion³⁰, the reform discussion was highly contentious. In March 2005, during a session of the *Senate's Comisión de Trabajo y Asuntos Sociales* (Senado de España, 2005), the debate surrounding the forthcoming Dependency Law revealed a broad rhetorical consensus on the urgent need to address a long-standing social gap in care provision. However, this apparent agreement masked deep political and institutional divisions over how to define and operationalize the new right to care, how it should be financed and governed, and how to reconcile the respective roles of public and private actors in its delivery. At the center of the legislative initiative was the recognition of LTC as a universal, subjective, and legally enforceable social right—a position vigorously promoted by the governing PSOE. The Minister of Labour and Social Affairs, José Antonio Alonso Núñez, underscored this ambition by stating: *“This law is the fourth pillar of the welfare state and responds to a growing social demand”*. This framing sought not only to address the demographic and familial transformations driving demand for care, but also to advance a long-overdue ethical and institutional modernization of Spain’s welfare state—completing what many perceived as an unfinished transition in its social protection architecture.

Despite agreeing in principle, other political parties expressed strong reservations about the law’s financial underpinnings and institutional design. The Partido Popular, although abstaining rather than opposing the bill, repeatedly emphasized the fragility of its funding model. Senator José Manuel Barreiro Fernández articulated this concern by stating: *“We agree with the substance of the law, but we disagree with its form and with the government’s lack of financial commitment”*. The PP criticized what it saw as the creation of a right without sufficient guarantees or resources, raising doubts about the law’s sustainability and warning against generating *“expectativas sin contenido”* (expectations without substance). The law’s reliance on co-funding between the central government and the Autonomous Communities, without clear, binding fiscal commitments, was seen as a potential source of implementation asymmetry and future political conflict.

This concern was further echoed by nationalist and regionalist parties, such as *Convergència i Unió* and the *Partido Nacionalista Vasco*, who rejected the law for infringing upon the competencies of the Autonomous Communities. CiU’s Ramon Aleu i Bosch declared: *“It is a law that invades regional competences and does not guarantee the necessary resources for its implementation”*. Likewise, Jokin Bildarratz of the PNV criticized the lack of meaningful consultation. These interventions underscored a key territorial tension: While the law was meant to establish equal rights nationwide, its architecture—particularly the role of the central government in regulating access and quality through the *Consejo Territorial*—was perceived by some as an encroachment on regional self-rule.

The *Entesa Catalana de Progrés* (comprising PSC, ERC, and ICV) offered a position of critical support, acknowledging the law’s social ambition but raising concerns about its compatibility with Catalonia’s

³⁰ As for public opinion, according to the CIS barometer, in 2004, 76.1% of respondents considered care for dependent persons an immediate priority to relieve the burden of care on families (CIS, 2004).

institutional framework. While no single speaker was recorded as issuing a formal vote against the law, representatives expressed skepticism about implementation. A summary statement from ERC and ICV representatives read: *“We value the law’s social objectives, but its implementation may undermine Catalan self-government and lacks sufficient funding”*. This nuanced position reflected the tension between supporting progressive social policy and defending regional sovereignty.

The debate also touched—though more implicitly—on the regulatory balance between public and private actors in service delivery. PSOE’s model favored a mixed economy of care, but under unified regulatory standards, ensuring parity in quality and user protections. While no party formally opposed private sector involvement, several senators underscored the need for clear accreditation criteria and public oversight. This approach aimed to prevent fragmentation and ensure that all services—whether public or contracted—operated within a coherent rights-based framework.

A central and contested theme throughout the discussion concerned the model of service provision—specifically, the balance between in-kind services and in-cash benefits. For the PSOE and its allies, the law’s ambition was not only to recognize a right but to professionalize the provision of care. Minister Alonso articulated this vision by stating: *“The objective of this law is to promote professional care, through public or contracted services, ensuring quality and dignity for people in dependency situations”*. This emphasis on in-kind services was closely tied to a broader agenda of gender equality and labor formalization, aiming to reduce the burden on unpaid female caregivers and to generate new employment opportunities in the care economy.

In contrast, even supporting formalization of care, the PP insisted on safeguarding the beneficiary’s freedom to choose between service types, especially in contexts where public infrastructure was insufficient. Senator Barreiro maintained: *“We must ensure the beneficiary and their family’s freedom to choose, whether through professional services or financial support”*. This line of argument aligned with a more liberal interpretation of welfare provision and suggested that in-cash benefits should not be dismissed, particularly when tailored to the needs of rural or underserved communities. However, the in-cash option drew criticism from other voices, particularly within the Mixed Group, who warned against normalizing family-based and unpaid care through monetary compensation.

In conclusion, while most parties endorsed the recognition of dependency as a fundamental right, they differed significantly on the institutional mechanisms needed to implement it. The PSOE advocated for a centralized but collaborative governance model, with an emphasis on professional services and public responsibility. The PP supported the recognition of rights but stressed financial prudence and flexibility for families. Nationalist and regionalist parties criticized the law’s centralizing tendencies and perceived lack of respect for regional competencies and funding equity. Meanwhile, some members of smaller groups warned against the risk of retraditionalizing care through unchecked use of monetary transfers.

The final law thus emerged as a negotiated compromise—broad in aspiration but open to diverse interpretations and implementation pathways, laying the ground for what would later become a highly heterogeneous and contested care regime across Spain’s CC.AA.

4.2. Consultation in the Congress of Deputies: Unveiling Political Cleavages in the LTC

In June 2005, the Spanish Congress of Deputies held a session within its *Comisión No Permanente para las Políticas Integrales de la Discapacidad* (Congreso de los Diputados, 2005), focusing on the Libro Blanco. This Commission catalyzed a multi-actor debate, involving not only parliamentary groups but also key representatives of civil society and disability organizations. Among the social stakeholders, Efrén Carbonell Paret, President of the *Coordinadora de Tallers per a Minusvàlids Psíquics de Catalunya*, expressed a critical stance toward the conceptual underpinnings of the term *dependencia*: “We have unsuccessfully sought any positive connotation in the term, which denotes subordination, alienation, and emphasizes deficit.” Carbonell advocated replacing the terminology with a rights-based approach, proposing to rename the law as “*Law for Personal Autonomy and Full Social Participation*”. Similarly, Pedro Otón Hernández, representing the Spanish Federation of Down Syndrome, stressed that a universal model of dependency risks obscuring the specific needs of persons with intellectual disabilities (El País, 2005a).

From the political sphere, the Partido Popular surprisingly consolidated its role not as an obstructionist force, but rather as an institutionalized opposition—one that engaged critically with the legislative process. During the debate on the proposed law, the conservative PP focused its critique not on the law’s principles but on what it perceived as insufficient financial commitments from the government. It questioned the PSOE’s credibility in delivering on promised resources, as illustrated by its rhetorical challenge: “¿Dónde están los mil millones de euros [...] a los que se comprometió su Gobierno?” (El País, 2005c). This shift in tone and strategy marked a significant political turning point. As some scholars have argued (see Marbán Gallego, 2011; 2013), the PP at times adopted positions that were “*to the left of the left-wing parties themselves*,” particularly in demanding greater state investment. As will be discussed further, this repositioning would play a crucial role in the final stages of parliamentary negotiations leading to the law’s approval.

All in all, the debate over Spain’s *Ley de Dependencia* illuminates a complex constellation of political cleavages that have shaped both its formulation and contested implementation. Foremost among these is the urban-rural/centre-periphery cleavage, which surfaced as regionalist parties (CiU, PNV, EA, *Entesa Catalana*) and local governments challenged the PSOE’s centralized model, citing concerns over regional autonomy and the necessity for territorial flexibility. This dynamic was repeatedly corroborated in interviews: As Interview ES1—Academic Expert, University of Barcelona—remarked, “*the regions have played a pivotal role, vigorously defending local control and ultimately securing a highly decentralized architecture. This has resulted in substantial territorial disparities in the application and financing of long-term care, and in ongoing conflicts over jurisdiction with the central*

state.” Similarly, Interview ES15—Former Director of IMSERSO—explicitly notes that “*territories with special status, such as the Basque Country, Catalonia, or Navarra, have always refused any national constraint—even on basic quality standards,*” a reality confirmed by official statements from regional authorities throughout 2005–2006 (El País, 2005d).

Overlaying territorial fragmentation is a pronounced public-private cleavage. Trade unions and allied experts advocated a *service-first*, publicly funded—and largely publicly provided—model, whereas employers and private providers argued for a mixed economy of care grounded in competition, equal accreditation, and user choice. As Interview ES7—Union Representative, CC.OO—recalled, “*the goal was to build a universal, professional public service and keep cash instruments residual,*” a position reinforced by Interview ES12—Union Representative, UGT—who stressed the risks of market reliance for equity and job quality. By contrast, Interview ES3—Employer Representative, CEOE—maintained that demand-side instruments (such as the service-linked benefit and cash allowances) were essential to mobilize supply where public services were scarce, and to prevent public monopolies from crowding out private initiative. Contemporary reporting documented the structural weight of private provision—“*over 70% of residential care places are provided by private companies*”—and framed the debate around accreditation, tariff-setting, and contracting rules that would level the playing field between public and private providers (El País, 2005c). In practice, this cleavage shaped the law’s hybrid design: While rhetorically prioritizing services, the system relied on instruments that—especially in contexts of limited public capacity—channeled significant resources to private provision.

In fact, Interview ES15—Former Director of IMSERSO—adds that the prevalence of cash benefits was not simply ideological, but also a technical and political “safety valve” for managing the risk of unfulfilled entitlements: “*It was easier to offer a cash transfer than to build up services everywhere in the short term.*” He firmly rejects the narrative of a Mediterranean cultural model, instead asserting that the prevalence of family care is not a cultural trait, but a consequence of insufficient public investment in services, with Spain among the OECD’s highest for unpaid family caregiving, “*mostly by women—lost to the labor force and to their own life projects.*” This gendered dynamic is also confirmed by field research and by direct testimonies in *El País*, where feminist organizations and caregiving networks voiced concern about the risk of perpetuating women’s roles as unpaid family carers, advocating instead for a public system of universal services (El País, 2005h).

Despite nominal agreement among major parties on the professionalization of care, a family-state responsibility cleavage persists. This is evidenced by partial opposition from members of the *Grupo Mixto*, who cautioned against overreliance on cash transfers for fear of entrenching unpaid, informal caregiving (El País, 2005i). Interviews consistently reveal that such dilemmas produced compromised policy instruments: As Interview ES4—Academic Expert, Institute for Labour Studies, Universitat Autònoma de Barcelona—notes, “*The law is rather ambiguous; it acknowledges the need to address these tasks and the need for professional accreditation, but it does not provide concrete pathways, means, or criteria.*” National agreements on training, accreditation, and quality standards are often

implemented only in the regions that vote in favor, perpetuating institutional asymmetry (El País, 2005f).

Finally, a latent secular-religious cleavage can be detected in the exclusion of faith-based Third Sector organizations from institutional negotiations, despite their historic role in Spain's care landscape—a trend reported in both interviews and national press (El País, 2005a).

The documentary record, expert interviews, and contemporary reporting (El País, 2005-2006) demonstrate that, despite a formal consensus, Spain's path to care reform has been shaped by persistent territorial, ideological, and institutional cleavages. Table 5.12. summarizes the main emerging cleavages identified in the discussions.

Table 5.12. Emerging Cleavages from Spanish Congress of Deputies' Discussions.

Cleavage	Pole 1	Pole 2	Salience
State-Periphery	PSOE; central government. Favoured nationwide standards via the <i>Consejo Territorial</i> to guarantee enforceable, equal rights and coordination across CC.AA.	Regionalist parties (CiU, PNV, EA, <i>Entesa Catalana</i>), Autonomous Communities, FEMP. Defended regional competences and fiscal/organizational discretion to adapt to local contexts.	High
State-Market	Trade unions (UGT, CC.OO.) and allied experts. Prioritized publicly funded/provided services, general taxation, formalization of care work, and limits on market reliance (e.g., cash as residual).	Employers' associations (CEOE, CEPYME) and private providers. Advocated a public-private mix, co-financing (state-regions-users), optional complementary private insurance, and user choice.	High
State-Family	PSOE; unions; disability platforms (e.g., CERMI). Supported universal, rights-based, professionalized services; accreditation/quality standards; de-familialization of care burdens.	PP (Christian-democratic wing), rural constituencies. Emphasized family primacy and cash benefits/allowances as instruments of choice and subsidiarity.	High
State-Church	Central government; secular civil-society platforms (e.g., CERMI). Favoured negotiation through associative platforms and a secular, rights-based framework for service regulation.	Faith-based Third Sector (historically central in provision) sought formal inclusion/recognition in governance and funding decisions; often under-represented in negotiations.	Low (latent)

Source: Author's elaboration.

4.3. The Final Discussion before the Definitive Approval: Between Vetos and “Institutzionalized” Obstructionism

In its final stage, the Senate deliberated on the draft law on 22 November 2006. During the discussion, three motions of *veto* were introduced: By the *Grupo Mixto* (Urrutia Elorza), CiU (Casas i Bedós), and the *Basque Nationalist Senators* (Loroño Ormaechea). All three motions were decisively rejected: Approximately 230 senators voted against the vetoes, with only 12-13 in favor, underscoring the political isolation of more radical opposition groups. Importantly, none of the vetoes opposed the substantive social content of the law—no party questioned the need to address dependency—but rather focused on institutional and territorial concerns. The common denominator across the vetoes was the defense of regional autonomy and a demand for greater co-decision mechanisms between central and regional governments. Despite the rejection of these vetoes, some of the concerns they raised were

partially reflected in amendments later adopted by the Senate, signaling a tactical openness by the governing majority. The few amendments that were accepted reflected a strategy of selective accommodation aimed at (1) incorporating the Partido Popular within the consensus framework and (2) demonstrating sensitivity to regionalist demands without compromising the overall national design of the reform. Conversely, the rejection of more substantial amendments reinforced the structural tension between state-led universalism and subnational autonomy—an issue already evident in the vetoes.

The legislative process in the Senate in 2006 was characterized by broad political support, with the PSOE successfully forging a pragmatic consensus, including amendments proposed by moderate opposition groups. The Partido Popular played an active role, not opposing the law outright but attempting to shape its content through amendments—thus positioning itself as an institutional rather than obstructive opposition. At the same time, constructive dissent was voiced by nationalist parties and the Grupo Mixto, who expressed concerns about the distribution of competences and the financial sustainability of the new system.

Moreover, to satisfy the requirements of the *Corte de Cuentas*, the Socialist government included Article 14, one of the most contentious elements of the law. This provision regulated the economic participation of beneficiaries in financing services and established that contributions would be assessed based not only on income, but also on the user's assets. This approach introduced a comprehensive definition of economic capacity, aimed at ensuring redistributive fairness and fiscal sustainability. However, it provoked strong objections from several parliamentary groups, particularly the PP, CiU, and the Grupo Mixto.

While the PP did not reject the principle of co-payment, it requested corrective measures to protect older individuals with low incomes but high-value assets—especially homeowners—fearing that such criteria could distort access to services. The Grupo Mixto went further, rejecting outright the inclusion of assets in the calculation, and asserting that long-term care should remain a universal right fully funded by the state. In contrast, the government defended Article 14 as a necessary compromise to prevent abuse and ensure the financial viability of the system while preserving universal access as its normative cornerstone. The rejection of more radical amendments and the acceptance of targeted technical modifications suggest that, despite political divergence, the final formulation managed to generate broad—though not unanimous—support for a co-payment model based on the user's overall economic capacity.

The final version of the law was passed in the Congreso de los Diputados on 30 November 2006. As reported by *El País* (2006), the bill was approved despite the votes against from CiU, EA, and the PNV. In contrast to the Senate's revisions, the final text reintroduced the reference to the user's assets as a criterion for determining their contribution to the cost of services and benefits. As with the Senate vote, this opposition ultimately proved insufficient to block the adoption of the law.

4.4. Path Departure in Spain: The Ley 39/2006

On December 14, 2006, the Ley de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia (LAPAD) was approved. This law marked a decisive break from Spain's traditional, residual welfare approach, establishing for the first time a comprehensive social benefit system accessible to the entire dependent population. The LAPAD fundamentally redefined the LTC framework in Spain by recognizing dependency as a subjective right, introducing a new funding model, creating diverse modes of service provision, and revising eligibility criteria. Central to this transformation, the LAPAD established the Sistema para la Autonomía y Atención a la Dependencia (SAAD)—a new institutional structure designed to coordinate and deliver care services across the country.

The SAAD established a framework that guarantees universal and subjective rights for individuals of all ages who are unable to independently perform essential daily activities³¹. With this, the LAPAD introduced a *new* universal and subjective right and represented a significant step in the full institutionalization of the welfare state in Spain between 1996 and 2007 (Moreno & Rodríguez Cabrero, 2007). The Act enshrined the universal nature of benefits and the right to access them under equal conditions for all older or disabled individuals requiring assistance with daily tasks, signaling a model based on clearly defined national and unitary principles. This model characterizes Spain's system as a publicly managed framework with universal access, aimed at providing comprehensive, integrated care.

This section is structured according to the dimensions of variation outlined in Chapter 2 of this thesis: Financing and coverage; eligibility criteria; multilevel governance; regulatory aspects and instrumental aspects (i.e., in-cash benefits and in-kind services).

As the first dimension, concerning financing and coverage, the SAAD is funded through general taxation, so universalistic, with contributions from both central and regional governments. The right to care is secured by this minimum protection level, with equal contributions from the national government (AGE) and the CC.AA. The remaining costs are met through a combination of annual agreements between the State and the CC.AA., supplementary contributions from the CC.AA., and user co-payments.

The second dimension, regarding eligibility criteria, is access to the system determined by a national assessment scale³² (Table 5.13.). The degree of dependency is evaluated through this standardized

³¹ It is mistakenly categorized as a law specifically for the older persons, when in fact it is intended for individuals officially recognized as dependent. The aim of this law is to improve the quality of life for Spanish citizens who experience difficulties in performing basic activities of daily living, regardless of their age. Its purpose is to support autonomous living in one's usual residence through services and financial assistance (Lebrusan Murillo, 2019).

³² The Real Decreto 504/2007 established the additional incentives provided by the Spanish central government to encourage the adoption of the national assessment framework for dependency, known as the BVD, designed to ensure uniformity and equity in the implementation of the Ley de Dependencia across regions. These incentives are part of a broader strategy to address disparities in resources and capacities between local administrations and to standardize the evaluation processes nationwide. The central government allocates additional funding through

scale, which, while applied by CC.AA. evaluation bodies, is governed by common criteria established by the regulatory and oversight body of the system, the Territorial Council³³ of the SAAD (see *infra*). This scale defines the principle of universality or accessibility by distinguishing between potential demand (estimated dependent population) and actual demand (positively assessed applications). Following evaluation, an Individualized Care Plan (PIA) is developed, outlining the specific services or benefits appropriate to everyone's needs.

Table 5.13. Grid of Degrees and Levels of Dependency, as of Law 39/2006.

Grades	Level	Points
None	—	0-24
Grade I of dependence	Level 1	25-39
	Level 2	40-49
Grade II of dependence	Level 1	50-64
	Level 2	65-74
Grade III of dependence	Level 1	75-89
	Level 2	90-100

Source: Authors' elaboration on RD 727/2007.

As for the third and fourth dimensions—the multilevel governance and regulatory structure—the SAAD operated as a fundamentally decentralized system. According to Article 11 of the LAPAD, and in alignment with the Spanish Constitution, Statutes of Autonomy, and relevant legislation, the CC.AA. were entrusted with substantial responsibilities within the SAAD framework—responsibilities already embedded in their longstanding social service mandates. These included the planning, regulation, coordination, and management of the SAAD at the regional level; coordination between social and healthcare services; direct management of services and resources; registration and oversight of care centers; development of the Individual Care Plan (PIA); inspection and sanctioning powers; and overall system evaluation. Moreover, the CC.AA. were required to provide key information to the national government, though this reporting was generally limited to the implementation of financing criteria.

Rather than grounding the SAAD's authority in Article 41 of the Spanish Constitution—which would have implied a hybrid system combining contributory Social Security with non-contributory welfare models—the architects of the reform opted for a different constitutional balance. The SAAD stood at the intersection of the CC.AA.'s exclusive jurisdiction over social welfare and social services (Article

the SAAD, targeting the integration of the BVD at regional and local levels. These funds are intended to support local authorities in training personnel, acquiring the necessary technological tools, and effectively implementing the standardized evaluation criteria. Access to these resources is often conditional upon demonstrable integration of the BVD into local assessment processes, ensuring alignment with national guidelines and fostering consistency in the evaluation and provision of services. This mechanism aims to enhance fairness in access to dependency support services, irrespective of the geographical location of beneficiaries.

³³ According to Article 8 of the Law, the Territorial Council must be composed of the head of the Ministry of Labour and Social Affairs, a representative from each of the CC.AA., and several representatives from various ministerial departments. Given this composition, there will always be most representatives from the CC.AA.

148.1.20) and the State's constitutional role in ensuring fundamental conditions for equality (Article 149.1.1). In practice, the State guaranteed a minimum benefit level, providing a baseline of care consistency nationwide. This was then supplemented by two further categories of benefits: One jointly financed by the State and the regions, and another managed solely by the regions. Thus, the State did not directly guarantee a subjective right to care; instead, it set the foundational conditions under which such a right could be exercised equally across the national territory.

The authority of the CC.AA. over non-contributory benefits had clear precedent, notably in Law 26/1990, which established similar arrangements. While this approach was initially considered both viable and pragmatic, it ultimately reflected a balancing act: Safeguarding the CC.AA.'s autonomy in social services while pursuing the national goal of equal rights for citizens. To manage this balance, the SAAD was governed through a model of cooperative federalism that enabled each level of government to exercise its respective powers in a coordinated manner.

The LAPAD did not operate as a basic law in the classic sense, since the State did not claim exclusive authority over the field; rather, that authority was shared with the CC.AA. At the same time, the State was not subordinate to the regions: It invoked its constitutional power to regulate the fundamental conditions necessary to ensure equality, thereby imposing limits on regional diversity. As several interviewees summarized, *"it is a system of shared but negotiated powers, where agreements were only binding for regions that voted in favor, reinforcing the cooperative but sometimes fragile nature of Spanish welfare governance"* (Interviews ES5—Academic Expert and Former Regional Legislator, Parliament of Catalonia; ES6—Director, IMSERSO; ES12—Union Representative, UGT).

The governance of the SAAD is overseen by the *Consejo Territorial del Sistema para la Autonomía y Atención a la Dependencia* (CISAAD), an inter-administrative cooperation body tasked with coordinating the SAAD and setting the foundational conditions and general framework for the right to protection at the national level. The Council is legally empowered to adopt agreements, establish criteria, and undertake additional activities within its regulatory remit, as set out in Article 3, sections 1 and 3 of its regulations. As Cobo Gálvez (2007: 212) notes, this governance model is particularly innovative: The LAPAD *"provides for an extraordinarily formalized area of cooperation in which, in a completely novel manner, the regulatory development attributed to the State by the Law is conditioned upon a prior agreement between the State and the CC.AA. within the Territorial Council."* The procedures for reaching agreements, as stipulated in the Council's regulations, are therefore crucial—especially for decision-making.

Moreover, the LAPAD established the SAAD as a collaborative framework that encourages participation by multiple Public Administrations, including local entities such as provincial councils, island councils, municipal councils, regional councils, and associations of municipalities. This design enables the system to integrate a network of public and private centers, including facilities managed by EE.LL., as specified in Article 6, sections 1 and 2. Further underscoring local involvement, Article 12 explicitly addresses EE.LL. participation in managing services for dependent persons. Article 12(1) outlines their role in

service management in accordance with the regulations of their respective CC.AA. and within their statutory competences, while Article 12(2) allows EE.LL. to participate in CISAAD under terms and conditions established by the Council itself, thereby enhancing local representation in the governance framework.

Finally, with respect to benefits, the law regulates a comprehensive catalogue of social services (Art. 15) and three types of monetary benefits, two of which are designed to finance private social services (Arts. 17-19) (see below). Balancing services and cash benefits was a central issue in the pre-enactment debate, as stakeholders weighed the social effectiveness and employment-generating potential of service-based provision against the value of individual choice in managing monetary support. The LAPAD adopted a mixed approach, prioritizing services while designating cash benefits as exceptional. These are linked to service provision only when public services are unavailable, or are granted as compensation to non-professional caregivers under specific conditions (e.g., an individualized care plan, adequate housing conditions, and registration in the general Social Security system).

The system was designed to provide both services³⁴ and monetary benefits, and, at least in its initial structure and intent, it placed a stronger emphasis on service provision over financial assistance. The range of services covered includes various forms of support, such as: Prevention and promotion of personal autonomy (programs to delay or slow the progression of dependency); tele-assistance (remote assistance services, particularly beneficial for those living alone); home care services (support for daily tasks, including personal hygiene and household maintenance); day and night care centers (facilities offering care during designated hours); and residential care (full-time care in specialized facilities for individuals with the highest levels of dependency). Regarding home-care services, the Law established minimum standards for intensity of care to be provided to Grade II and III of dependence (Table 5.14.).

Table 5.14. Required intensity of Home-Care Services, by Monthly Hours, per Grade and Level of Dependence.

Grades of dependence	Levels of dependence	Monthly Hours
Grade II of dependence	Level 1	Between 30 and 40
	Level 2	Between 55 and 70
Grade III of dependence	Level 1	Between 55 and 70
	Level 2	Between 70 and 90

Source: Authors' elaboration on RD 7/2008.

³⁴ The SAAD did not initially include socio-healthcare benefits, as these fell under the authority of the healthcare sector, managed by the CC.AA. This exclusion, particularly relevant given the socio-healthcare nature of many dependency cases, represented what could be seen as institutional negligence. This issue was further compounded by social policy developments between 2007 and 2011, aimed at promoting autonomy and providing care for dependent individuals. The situation worsened with the removal of socio-healthcare benefits from the 2006 healthcare benefits catalog (RD 1030/2006), which contradicted earlier provisions set out in the 2003 Law on Cohesion and Quality of the Healthcare System (Ruipérez Cantera, 2006).

In addition, the LAPAD established three primary types of monetary benefits (*prestaciones económicas*): *Prestación económica vinculada al servicio* (PEVS), *Prestación económica para cuidados en el entorno familiar y apoyo a cuidadores no profesionales* (PECEF), and *Prestación económica de asistencia personal* (PEAP).

The PEVS was granted only when the services specified in the Individual Care Plan (*PIA*) could not be delivered by the public sector. In such cases, recipients had to use the allowance to purchase services from accredited professional providers (*“Esta prestación económica de carácter personal estará, en todo caso, vinculada a la adquisición de un servicio,”* Art. 17(2), Ley 39/2006). Depending on income, a co-payment could be required and deducted from the benefit amount. Interviewees (e.g., ES3—Employer Representative, CEOE; ES4—Academic Expert, Universitat Autònoma de Barcelona) noted that, in practice, PEVS often functioned as a flexible instrument to bridge persistent gaps in public provision and, in doing so, contributed to the expansion of the private care sector. As ES3—CEOE—emphasized: *“In many territories, the service-linked benefit became an indirect way of funding private provision, especially where public services were scarce or slow to develop.”*

The PECEF was intended to be exceptional, granted only when no accredited public or private resources were available to deliver the required services. Eligibility required that the beneficiary had been under the care of a non-professional caregiver for at least one year prior to application. The law specified that care should preferably be provided by a family member and, only in exceptional cases, by members of the extended family. Access conditions depended on the recognized degree and level of dependency as well as the beneficiary’s economic capacity. The caregiver was required to comply with Social Security affiliation, registration, and contribution rules; importantly, non-professional caregivers receiving this benefit had to be enrolled in the general Social Security scheme (Royal Decree 615/2007). Numerous interviewees (ES12—Union Representative, UGT; ES7-ES8—Union Representatives, CC.OO; ES6—Director, IMSERSO; ES5—Academic Expert and Former Regional Legislator, Parliament of Catalonia) stressed that the benefit was used far beyond its original exceptional intent and often reinforced gendered patterns of unpaid and informal care: *“In practice, it is still overwhelmingly women who are pushed into the caregiver role, and the majority remain in conditions of precarity or informality”* (ES4—Academic Expert, Universitat Autònoma de Barcelona; ES15—Former Director, IMSERSO).

The PEAP supported the hiring of a personal assistant for a specified number of hours, to facilitate education and employment and to promote independent living by assisting with basic activities of daily life. Targeted primarily at persons with severe dependency, this measure was widely viewed as the most innovative but least developed benefit—*“mainly concentrated in a few advanced territories (such as Gipuzkoa), and still rarely available nationwide”*—according to ES5 (Academic Expert and Former Regional Legislator) and ES15 (Former Director, IMSERSO). As ES15 observed, *“the figure of the personal assistant is a promising tool for real autonomy, but remains marginal due to limited funding and a slow process of professionalization.”* Table 5.15. reports the in-cash transfers as established in Ley 39/2006.

Table 5.15. In-Cash Transfers LTC, as of Ley 39/2006.

Benefit	Brief description	Direct recipients	Conditionalities to services	Eligibility requirements	Generosity
PEVS	<i>Service-linked benefit:</i> When it is not possible to provide the services established in the PIA through the public sector	Dependent people	Yes	Need-based	Gradual [from 585 to 780 euros]
PECEF	<i>Exceptional:</i> When no accredited public or private resources are available to provide care services	Dependent people	No	Need-based and means-tested	Gradual [from 328 to 506 euros] - based on need of dependence and income
PEAP	<i>Conditional:</i> Hiring of a professional and personal assistant for a specified number of hours	Dependent people	Yes	Need-based and means-tested	Gradual [from 686 to 780 euros] - based on need of dependence and income

Note: The means-testing criteria is calculated as follows: $CPE = IR + CM - CEB$. CPE: refers to the amount of economic benefit. IR is the cost of the monthly service as of the effective date of the benefit. CM is the amount for personal expenses of the beneficiary, referenced at 19% of the IPREM (Public Indicator of Multiple Effect Income) in the monthly amount corresponding to the year in which the right to the benefit is recognized. CEB is the individual's economic capacity divided by twelve months.

Source: Author's elaboration on Ley 39/2006.

Through Royal Decrees 727/2007 and 7/2008, the Government established maximum amounts for cash benefits, determined according to recipients' assessed grades and levels of dependency (see Table 5.16.). The expansion of coverage was implemented gradually, with cash benefits (*prestaciones económicas*) progressively extended to encompass all eligible recipients by 2011.

Table 5.16. Maximum Amount of In-Cash Benefits, per Grade and Level of Dependence, in Euros.

Grade of Dependence	Level of Dependence	PEVS	PECEF	PEAP	PEVS	PECEF	PEAP
		2007	2008	2007	2008	2007	2008
Grade I of dependence	Level 1						
	Level 2						
Grade II of dependence	Level 1						
	Level 2	-	450		328,36		
Grade III of dependence	Level 1	585	608,98	390	405,99	686	608,98
	Level 2	780	811,98	487	506,96	780	811,98

Note: All values are expressed in euros.

Source: Author's elaboration on RD 727/2007 and RD 7/2008.

5. The 2006 LTC Reform in Spain: Just a “Quiet” Consensus?

According to the typology developed in Chapter 2, an expansion of the LTC system produced a departure from its initial design. The model evolved toward a more balanced, hybrid configuration that combines elements of both de-commodification and de-familialization—marking the shift from a residual to a hybrid welfare arrangement. How and why did this transition occur?

Table 5.17. reports the steps related to the mechanisms identified for the process-tracing analysis.

Table 5.17. Steps in Process Tracing Mechanisms in Spain.

Steps in the Mechanism	Reference to Mechanism	Observable Indicators	Empirical Observations
1. Problem pressure	Mechanism 1	Convergence of external shock and opening of a reform <i>momentum</i>	Demographic ageing, rising female employment, media scandals in residential care
2. Institutional path dependence	Mechanism 2	Policy legacy and vested interests in institutions	Vertical and horizontal fragmentation; NHS universalism-imbalance; residualism of social assistance
3. Opening of an institutional gate	Mechanism 2	Political and institutional dynamics	Political context, particularly government alternation, and the Europeanization of social policy discourse, understood as the influence of the European Union.
4. Puzzling	Mechanism 3	Shared policy solutions and strategic framing	Strategic use of puzzling: - Long-term care is progressively framed as a policy instrument for reconciling employment and care responsibilities (work-care balance). Retroactive <i>puzzling</i>: from the 1990s onward, the issue is reinterpreted within the framework of social and healthcare integration policies.
5. Powering	Mechanism 3	Party competition	- Policy initiative and ownership are assumed by the Socialist Party. - Strategic use of the issue to support policy repositioning following the Partido Popular's accession to power. - Politicization was driven by alternation in government (from the PSOE to the PP) and later by the strategic deployment of policy ideas by the PSOE and trade unions. - Consequently, the strategic mobilization of social and political cleavages constrained the strategic space available to anti-reform coalitions.
6. Emergence of a dominant coalition	Mechanism 3	Coordinated action during crisis or reform window	- Two key coalitional blocs: CEOE, PP; PSOE with trade unions CC.OO. and UGT. - Formation of a broad coalition in support of an expansionary reform.
7. Strategic political exchange	Core Mechanism	Types of strategic exchanges and compensatory mechanisms implemented by social and political actors	- Service expansion addressing trade union preferences. - Expansion of conditional cash benefits reflecting employers' concerns. - Institutional guarantees preserving regional autonomy.
8. Reform outcome: path departure	<i>Explanandum</i>	Type of change	The <i>Ley de Dependencia</i> created a national LTC framework, breaking with Spain's historically fragmented, family-based model—marking a paradigmatic institutional shift

Source: Author's elaboration.

Contextual Factors and Functional Pressures

At the dawn of the 21st century, Spain's LTC system was marked by the legacies of its "State of Autonomies" constitutional architecture, introduced after 1978. This framework engendered a profound decentralization of social policy: Each CC.AA. developed its own eligibility criteria, benefit standards, and service portfolio. The result was a complex "mosaic" of LTC models characterized by persistent territorial inequalities and enduring fragmentation. This institutional diversity was further compounded by what might be termed pragmatic familism: Responsibility for care of older persons and dependent adults was primarily understood as a private family obligation—one that fell disproportionately on women—while the state provided only residual, often means-tested, support. This approach reflected not only the Catholic, familist tradition that persisted after the democratic transition, but also a political climate of fiscal restraint and fragmented governance, underpinned by a high density of institutional veto points.

By the late 1990s and early 2000s, the cumulative effects of these legacies rendered the status quo increasingly untenable. Several functional and contextual pressures converged to catalyze both elite and public recognition of the need for a more comprehensive response to the risk of dependency. First, demographic aging and increased life expectancy produced significant problem pressure for LTC reform, as the existing model—already strained by rising female labor force participation—became ever more unsustainable. Second, the Europeanization of Spanish social policy, particularly via the Lisbon Strategy and the Open Method of Coordination, provided not only a normative benchmark but also a resource for reform advocates, strengthening arguments for a universalist, rights-based approach. Third, highly publicized media scandals regarding excess mortality in residential care homes served to reframe dependency as an urgent social risk, raising its profile within the public and policy spheres.

Opening of an Institutional Gate

From an institutional standpoint, the absence of targeted LTC measures over previous decades facilitated the expansion of for-profit actors, especially in regions where public provision was limited. This environment not only created fertile ground for private interests but also opened political opportunities for trade unions and left-wing parties to regain legitimacy amid a broader crisis of confidence in traditional political actors (Interviews ES4—Academic Expert, Universitat Autònoma de Barcelona; ES5—Academic Expert and Former Regional Legislator, Parliament of Catalonia; ES9—Academic Expert, University of Alcalá). For the PSOE, long-term care reform presented an opportunity to reclaim the initiative in Spain's social transition, which had stalled during successive periods of government alternation. In practical terms, these conditions fostered two principal coalitions—one pro-public and one pro-market—that increasingly structured the debate, closely mapping onto the broader competition between the PSOE and the PP in a context of social and political flux.

At the same time, the earlier reform of the non-contributory pillar (in 1990, later consolidated by the *Pacto de Toledo* in 1994) had created a significant electoral constituency. This included women providing unpaid care—demanding greater work-life reconciliation and social-security recognition—as

well as claimants of non-contributory benefits under the public pillar (e.g., individuals out of employment due to family caregiving). These developments incentivized trade unions to broaden their agendas to include gender, the formalization of care services, and work-life balance, while business associations became increasingly active in defending private provision. The period also witnessed unprecedented mobilization by disability and advocacy organizations such as CERMI and FEAPS. As a result, political parties could no longer sidestep LTC: What had once been primarily a left-wing prerogative became a central battleground in Spanish politics.

Crucially, this evolving context underscored the pivotal role of the regions. The double-edged sword of regional power meant that Autonomous Communities could act both as reform drivers and as veto players. Initially, this was perceived as an opportunity: The repositioning of parties and unions within the CC.AA., together with parliamentary debate and coalition formation, could help anticipate and manage unpredictable electoral dynamics in an era of considerable political uncertainty. Importantly, the regions had already demonstrated policy activism; from the 1990s onward, they approved a series of *Planes Gerontológicos* that foregrounded population ageing (see Chapter 3). Thus, regional recognition of dependency as a social risk was well established, and it was expected that increased public control could serve as a powerful mechanism for credit-claiming among regional governments (Interview ES16—Public Official, Agency for Social Services and Dependency, Regional Government of Andalusia).

As historical institutionalist theory would predict (Streeck & Thelen, 2004; Jessoula, 2009), these converging contextual pressures generated a critical juncture—an institutional gate—that opened a window of opportunity for substantive reform. Key actors—especially the PSOE, major trade unions, and advocacy organizations—leveraged the emerging frame of dependency as a new social risk (Bonoli, 2007) and as a citizenship right requiring collective, public solutions. The publication of the *Libro Blanco de la Dependencia* in 2004-2005, grounded in empirical analysis and international benchmarking (notably with Germany and the Nordic countries), institutionalized LTC as a public policy issue and structured the initial positions of the main parties, social partners, and civil-society organizations. The subsequent *Acuerdo sobre la Dependencia* (2005) became the final milestone before the drafting and enactment of Law 39/2006.

Crucially, coalition dynamics during this period were not merely the passive product of institutional inertia; they were deliberately crafted as a reactive barrier against the unpredictability of Spanish politics. Major stakeholders—keenly aware of party-system volatility—anticipated the likely contours of coalition-building and strategically radicalized or moderated their demands to secure legislative passage amid expected contestations. This anticipatory coalition-building and strategic compromise were instrumental in overcoming inertia and enabling Spain's departure from its residual LTC model.

Pro-Public, Family, and Market Coalitions: Cleavage Dynamics and Strategic Compromise

Three main advocacy coalitions shaped the LTC reform's trajectory, each representing distinct ideological, territorial, and institutional interests.

The Pro-Public Coalition

This coalition brought together the PSOE, the major unions (UGT and CC.OO.), progressive advocacy groups (CERMI, FEAPS), and left-leaning regions (e.g., Andalusia, Catalonia). Its programmatic core centered on recognizing LTC as a universal, legally enforceable social right—a “fourth pillar” of the welfare state—backed by public funding, robust state regulation, and the professionalization of care work. Gender equity and the unsustainability of unpaid family care were central frames, reinforced by reference to European benchmarks (Interviews ES7—Union Representative, CC.OO.; ES11—President, CERMI; ES12—Union Representative, UGT). In progressive regions, this coalition found fertile ground to expand formal provision, strengthen user rights, and promote integration between social and health services (Interview ES16—Public Official, Regional Government of Andalusia).

The Pro-Family Coalition

Anchored in the Christian Democratic wing of the Partido Popular, conservative regional executives (Madrid, Castilla y León), and some local governments, this coalition defended the primacy of family-based care, fiscal caution, and territorial flexibility. Its stance was less strictly ideological than pragmatic, reflecting anxieties about over-centralization and the fiscal costs of universalism, as well as the need to accommodate heterogeneous regional and family arrangements (Interviews ES2—Former Cabinet Member, Ministry of Social Rights; ES5—Academic Expert and Former Regional Legislator, Parliament of Catalonia). It prioritized flexible benefit design—including generous cash-for-care allowances—and consistently resisted rigid national standards. Its influence was particularly marked in regions such as Madrid, where market-oriented solutions and family autonomy have remained central to LTC trajectories (Interview ES15—Former Director, IMSERSO).

The Pro-Market Coalition

Led by employer organizations (Interviews ES3—Employer Representative, CEOE; ES14—President, Association of Directors and Managers of Social Services), private insurers, and regions with substantial private-sector involvement (Valencia, Madrid), this coalition accepted the right to care but insisted it should be delivered through a pluralistic, competitive system. It championed regulatory harmonization, equal accreditation standards for public and private actors, and user freedom of choice. It shared common ground with the pro-family coalition on the need for flexibility but focused primarily on ensuring that private-sector interests were not crowded out by public monopolies or overregulation (Interview ES3—CEOE).

These coalitional dynamics were compounded by territorial and sectoral cleavages. Progressive and conservative regions clashed over public investment, regulatory harmonization, and the balance between services in kind and cash benefits. Disagreements over standards, financing, and the

respective roles of public and private actors persisted throughout the legislative process and remain evident in the patchwork of regional models that define post-reform Spanish LTC (Interviews ES4—Academic Expert, Universitat Autònoma de Barcelona; ES15—Former Director, IMSERSO).

The Logic of Political Exchange: Territorial and Ideological Concessions

Territorial Concession (State-Periphery)

Nationalist and regional governments secured significant discretion over the organization, financing, and delivery of LTC. The law embedded co-governance via the *Consejo Territorial*, which became the locus of intergovernmental negotiation and an instrument for safeguarding regional autonomy. The result was: National rights and minimum standards were proclaimed, but substantial variation persisted in implementation, benefit levels, and access—a direct outgrowth of Spain’s centrifugal governance model. This concession was pivotal for reform approval: The law maintained a national structure yet legitimated the regions’ broad discretion in co-financing and service delivery (Interviews ES2—Former Cabinet Member, Ministry of Social Rights; ES5—Academic Expert and Former Regional Legislator).

Ideological Concession (Family-State / Private-Public)

To accommodate diverse preferences and institutional realities, the law institutionalized a pluralistic menu of benefits, including three monetary *prestaciones* (service-linked, family care, personal assistant)—most notably the unconditional cash-for-care benefit (PECEF). Conceived initially as an exceptional, stopgap measure, this instrument quickly became central in regions lacking robust service infrastructure, especially rural areas. The compromise was necessary to meet the demands of the pro-family (e.g., Christian Democratic PP) and pro-market coalitions (e.g., CEOE), who maintained that cash benefits were essential for preserving autonomy and containing costs; for the PSOE and unions, they were the affordable agreement and a pragmatic response to implementation constraints (Interviews ES3—CEOE; ES7—CC.OO; ES12—UGT). The result was a hybrid yet ambiguous settlement, rhetorically committed to universalism and professionalization but structurally reliant on unpaid, informal care (mainly by women)—a compromise that has generated persistent tensions and criticism from feminist organizations (largely absent from negotiations) and segments of civil society, who warned that monetizing care could entrench, rather than mitigate, gendered inequalities.

It is important to note that—unlike Italy and Portugal—the Spanish debate was largely secularized: The state-church cleavage was not activated. The reform privileged large private providers and established regulatory frameworks favoring mixed provision, while marginalizing historic faith-based actors and, at times, minimizing the voice of social dialogue (Interview ES3—Employer Representative, CEOE; Marbán Gallego, 2012).

The Strategic Paradox of Trade Unions

Perhaps the most analytically salient feature of the reform process is the strategic paradox faced by UGT and CC.OO. Historically, both positioned themselves as champions of de-familialization and the formalization of care work, denouncing the “invisible,” gendered burden of unpaid family care and demanding expansion of public employment and formal training (Interview ES7—Union Representative, CC.OO.; Marbán Gallego, 2012). Yet as legislative negotiations progressed, unions accepted a compromise that legitimated extensive cash benefits and the formal recognition of informal caregivers—including provisions for their inclusion in Social Security. This acceptance was not merely a strategic retreat but reflected a dual imperative: Assembling a broad parliamentary coalition and responding pragmatically to the lack of service infrastructure in many regions (Interviews ES7—CC.OO.; ES12—UGT). As a CC.OO. representative put it, *“The inclusion of the cash benefit was never our goal; it was the price of consensus and the cost of institutional reality.”*

All in all, the gradual and incremental development of micro-measures in the long-term care sector could easily have resulted in a pattern of policy inertia or outright political inaction. Instead, an actor-centered explanation underscores the pivotal role of political agency in strategically mobilizing certain policy issues and bringing them to the forefront of the political agenda. In the Spanish case, political and social actors were able to (a) forge new alliances and, crucially, anticipate electoral outcomes by reactivating latent cleavages and adopting strategies of either moderation or polarization as circumstances demanded; and (b) signal responsiveness to public concerns by repositioning themselves around new issues—such as dependency and care—which, precisely because they were supported by a residual institutional structure, were perceived as low-risk fields open to experimentation and innovation. This process demonstrates that substantive reform in complex welfare domains is often less a matter of programmatic coherence than of creative coalition-building, strategic framing, and the capacity to exploit windows of opportunity in otherwise highly inert institutional contexts.

Chapter 6. From Neglected to Salient: Agenda Setting in the Italian LTC Sector (2018-2021)

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1. Introduction

The trajectory of the Italian political system from the establishment of the post-war Republic to the second decade of the twenty-first century reveals a pattern of profound, yet incomplete, transformations. The First Republic was defined by Sartori’s notion of polarized pluralism: A highly fragmented party system marked by sharp ideological cleavages and the structural exclusion of “anti-system” forces. Within this configuration, the Christian Democrats functioned as the pivotal governing party, securing enduring dominance by anchoring themselves in Catholic civil society. Attempts at gradual convergence—through the formation of centre-left governments in the 1960s and, later, through the “historic compromise” of the 1970s—introduced elements of ideological moderation but failed to resolve systemic *sclerosis*. Deep-seated polarization and the inability to achieve effective

alternation of power preserved the structural rigidity of the system. The collapse of the First Republic in the early 1990s, precipitated by exogenous shocks such as the end of the Cold War, the rise of regionalist protest, and the delegitimation of traditional parties in the wake of *Tangentopoli*, opened the path to the Second Republic. This new phase initially promised greater alternation and a simplified bipolar structure, with competition structured around centre-left and centre-right coalitions. However, while alternation became institutionalized, coalition instability, weak programmatic cohesion, and persistent internal fragmentation undermined the consolidation of a stable bipolar system.

The sovereign debt crisis of 2008-2009 marked a decisive rupture in this trajectory, signalling the exhaustion of bipolarism and the onset of a volatile multipolar configuration. In 2011, the Monti technocratic government exposed the limits of coalition-based stability and further eroded public trust in traditional party elites. The subsequent electoral cycle produced a highly fragmented landscape: The rise of the Five Star Movement as a major anti-establishment force, the reconfiguration of the right around Salvini's League, and the enduring fragility of the centre-left highlighted the erosion of the bipolar format and the growing centrality of populist mobilization. This phase was characterized by high electoral volatility, the emergence of new cleavages, and a shift towards leader-centred and personalized politics. In this sense, between 2011 and 2021 the Italian party system continues to oscillate between continuity and rupture. On the one hand, enduring patterns of fragmentation, weak institutionalization, and coalition instability persist; on the other, the entry of new actors and the recalibration of coalition logics continuously reshape the terrain of political competition. Table 6.1. defines the main political phases in Italy from 1946 to 2021.

Table 6.1. Political Phases in Italy, from 1946 to 2021.

Period	Political Configuration	Main Parties	Key Features
1946-1962	Fragmented anti-fascist democracy	Democrazia Cristiana Partito Comunista Italiano Partito Socialista Italiano Liberals and Monarchists	Post-fascist republican consolidation; centrist dominance; exclusion of anti-system parties; ideological polarization
1963-1979	Centre-left phase and Historic Compromise	Democrazia Cristiana Partito Comunista Italiano (external support) Partito Socialista Italiano Partito Socialista Democratico Italiano, Partito Repubblicano Italiano	PSI enters government; PCI gains strength; partial ideological convergence; still no alternation
1980-1991	Pentapartito (five-party coalition)	Democrazia Cristiana Partito Socialista Italiano Partito Socialista Democratico Italiano Partito Repubblicano Italiano Partito Liberale Italiano	Stable coalition governance; growing PSI leadership; systemic sclerosis; enduring PCI opposition
1992-1994	Traditional party system collapse	Emergence of Forza Italia (FI) and Lega Nord, Dissolution of Democrazia Cristiana; Partito Socialista Italiano	Tangentopoli scandal; end of Cold War; destruction of traditional party structure
1994-2011	Bipolarism of the Second Republic	Forza Italia-II Popolo della Libertà; Democratici di Sinistra- Partito Democratico Lega Nord Alleanza Nazionale Unione di Centro	Alternating centre-right and centre-left coalitions; unstable governance; attempts at system simplification
2011-2021	Fragmented multipolarism	Movimento 5 Stelle, Partito Democratico, Lega, Fratelli d'Italia, Forza Italia Azione and Italia Viva + minor centrists	Rise of populism; end of bipolarism; coalition volatility; increasing electoral volatility

Source: Author's elaboration.

The evolution of the Italian welfare state has been shaped by a complex interplay between governmental institutions and a wide range of social actors, particularly trade unions, cooperative organizations, and civil society entities. Historically, the Italian trade union movement exerted significant influence on national policy-making through corporatist mechanisms, especially during the era of centralized industrial relations between the 1970s and early 1990s (Leonardi & Pedersini, 2023). Among the three major confederations—CGIL (*Confederazione Generale Italiana del Lavoro*), CISL (*Confederazione Italiana Sindacati Lavoratori*), and UIL (*Unione Italiana del Lavoro*)—deep ideological cleavages shaped their strategies, policy preferences, and relationships with political parties. CGIL historically aligned with the Italian Communist Party and later with its successors (PDS, DS, and ultimately the Partito Democratico), consistently promoting a universalist and redistributive model of welfare. CISL, rooted in Catholic social thought, maintained close ties with the Democrazia Cristiana and, later, with centrist Catholic-inspired formations, favouring the principle of subsidiarity and supporting policies that preserved the primacy of family-based care. UIL, comparatively smaller, adopted a pragmatic and negotiation-oriented stance, often collaborating with socialist and reformist forces while maintaining greater autonomy from party structures (Ceron & Negri, 2017).

From the 1990s onwards, as the welfare state became increasingly decentralised and retrenched, union strategies evolved. Pensioners' unions—SPI-CGIL, FNP-CISL, and UILP-UIL—developed distinct organisational identities and strong territorial embeddedness (Leonardi & Pedersini, 2023). While the parent confederations continued to operate primarily at the national level, these pensioners' branches became key actors in local welfare governance, directly engaging with municipalities and regional authorities to co-design and monitor LTC services. According to Leonardi & Pedersini (2023), pensioners' unions increasingly embraced forms of “civil society unionism”, combining traditional collective bargaining with grassroots mobilisation. They participated in consultation bodies, advocated integrated home-care policies, and mobilised public opinion to defend the rights of dependent older adults. Their growing legitimacy derived from their capacity to represent an expanding demographic of older citizens directly affected by LTC policies.

Alongside unions, the cooperative movement—especially Legacoop and Confcooperative—has played a foundational role in shaping Italy's LTC ecosystem. Rooted in Catholic and socialist traditions respectively, these umbrella organizations represent social cooperatives that became central providers of domiciliary and residential care following the state's partial withdrawal from direct provision. In particular, *cooperative sociali di tipo A* (type A social cooperatives, providing social, health, and educational services) emerged as crucial actors under public procurement regimes, though often in contexts of weak regulation and limited coordination (Maino & Razetti, 2020). Both Legacoop and Confcooperative have consistently advocated stronger public-private partnership models, seeking to reconcile entrepreneurial flexibility with social objectives, though persistent tensions over labour standards and care quality remain. Complementing these dynamics, NGOs and volunteer-based associations have also expanded their role in LTC governance and service provision. This expansion of the third sector, as Lodigiani (2020) notes, reflects a form of “bottom-up mutualism” whereby community actors attempt to compensate for institutional shortcomings.

This chapter constitutes the first part of the reconstruction of policy and politics in the Italian decision-making process, with a focus on the dynamics between 2018 and 2021³⁵. The second part, presented in Chapter 7, addresses the dynamics of the decision-making process once it entered a more advanced stage, from mid-2021 to the end of 2024. This chapter retraces the process through which LTC entered the policy agenda, placing particular emphasis on ministerial dynamics and the key political turning points necessary to understand the government's initial moves within an emergency-driven socio-political context. At the same time, it examines the consolidation of a strong and unified social demand that gradually reshaped the boundaries of the policy debate. The chapter is organised as follows. Following this introduction, Section 2 reviews the evolution of LTC policy between 2000 and 2021, highlighting the persistence of a protectionist and familistic model despite increasing demographic pressures and growing social demands. The section presents data at both the national and regional

³⁵ The sections covering the period prior to 2018 are specifically intended to provide historical and institutional context and to enhance the understanding of issues directly related to the reform. Therefore, although the chapter focuses on the years 2018-2021, references to earlier developments are also included.

levels to illustrate the heterogeneity of service provision and funding patterns. It concludes by analysing the political landscape between 2019 and 2021, a period marked by oscillation between anti-establishment governments and technocratic executives, during which ministerial initiatives remained limited and largely reinforced a state of inertia in LTC policymaking. Section 3 explores how LTC moved from a marginal to a salient policy issue, reconstructing the ministerial response to the Covid-19 pandemic, with particular attention to the establishment of the Commissione Paglia and the debates it generated. It then traces the emergence of a coordinated and unified social demand for reform, which progressively crystallised within the framework of the PNRR, marking a decisive step in the reconfiguration of the LTC policy agenda. The chapter concludes by reflecting on the interplay between ministerial strategies, advocacy pressures, and broader political dynamics, setting the stage for the more in-depth analysis of policy reforms developed in the Chapter 7.

2. Contextual Factors and Political Dynamics in the Italian LTC Sector

Italian LTC policy is often characterised as inertial (Ranci & Pavolini, 2011; Costa, 2013; Ranci & Pavolini, 2015; Arlotti et al., 2018; Madama et al. 2019; Madama, 2019; Arlotti, 2020; Ranci et al., 2024). This label reflects not only the slow growth of LTC expenditure but also a specific political economy: A path-dependent trajectory in which micro-constituencies mobilise to defend discrete measures and competences—most visibly around regional discretion—within a weak or absent national legislative framework. From the early 1980s onward, LTC developed as a mosaic of disability-rights entitlements, selective service initiatives, and health-sector reforms, layered without a unifying strategy. The result was a durable equilibrium of cash-heavy, service-residual provision, marked by deep territorial variation and an enduring division of power between the Ministry of Health and the Ministry of Labour and Social Policies.

The section is structured as follows. Section 2.1 outlines the new and emerging social pressures within a protectionist long-term care system. Section 2.2 focuses on the functional, socio-demographic, and systemic imbalance pressures that have affected LTC over the past two decades. Finally, Section 2.3 reviews the policy trajectory since 1999, tracing the main developments and dynamics that have shaped the sector.

2.1. Contextual Factors: Emerging Social Pressures in the LTC System

This section presents the data concerning LTC. In continuity with Chapters 5 and 8, it revisits the so-called functional pressures characterizing the pre-reform period. Its contribution lies in centering the discussion on contextual factors and positioning them within the broader spectrum of institutional and

political determinants. Section 2.1.1. analyzes the state of LTC policy in Italy in the aftermath of the COVID-19 pandemic, while Section 2.1.2. focuses on regional dynamics³⁶.

2.1.1. LTC Care in the Wake of COVID-19: A Care Regime in Crisis³⁷

By early 2019, the condition of non-self-sufficiency in Italy mirrored a demographic context increasingly defined by population aging. Similar to Spain (Chapter 5) and Portugal (Chapter 8), Italy experienced a continuous rise in the proportion of older adults, accentuating the growing demands for long-term care.

Table 6.2. shows the demographic trends of the population aged 80 and over in Italy between 2000 and 2024. Both the absolute number of individuals in this age group and their share of the total population increase steadily over time: From about 2.2 million in 2000 (3.9% of the population) to over 4.5 million in 2024 (7.7%). Similarly, the proportion of those aged 80 and above within the older population (65+) rose from 21.6% in 2000 to around 31.8% in 2024. These figures illustrate the progressive ageing of the older population, with the ‘oldest old’ accounting for a growing share of Italy’s demographic structure.

Table 6.2. Demographic Trends of the Population Aged 80 and Above in Italy (2000-2024).

Year	80 years +	% over total population	% over 65+
2000	2.231.175	3.9	21.6
2005	2.845.688	4.9	25.1
2010	3.426.595	5.7	28.1
2015	3.956.213	6.5	30
2020	4.419.703	7.4	31.8
2024	4.543.122	7.7	31

Source: Author’s elaboration on DemoStat.

Table 6.3. reports estimate of the non-self-sufficient population aged 65 and over in Italy between 2000 and 2021. Both the absolute number of individuals and their proportion within the older population show a consistent increase over time. The number of non-self-sufficient people grew from about 2.1 million in 2000 to almost 4 million in 2021, while their share rose from 18.5% to 28.4% over the same period.

³⁶ It should be emphasized that the data presented extend beyond 2020-2021, as they also serve as a reference for Chapter 7; where available, the data are reported up to 2024. It is further specified that the data series begin from the first year available in the corresponding datasets.

³⁷ The data presented here refer to the period 2000-2024 (depending on the most recent year available). It should be noted that the timeframe considered extends prior to 2018, with the aim of outlining the evolutionary trajectory preceding that year and thus providing an account of pre-reform developments.

Table 6.3. Dependent Population, over 65 years old, in Italy (2000-2021).

Year	Estimated number of non-self-sufficient individuals, 65+	Percentage of non-self-sufficient population
2000*	2,106,279	18.5%
2005*	2,240,000	19.8%
2010*	2,400,000	19.8%
2015*	2,847,814	21.6%
2021**	3,935,982	28.4%

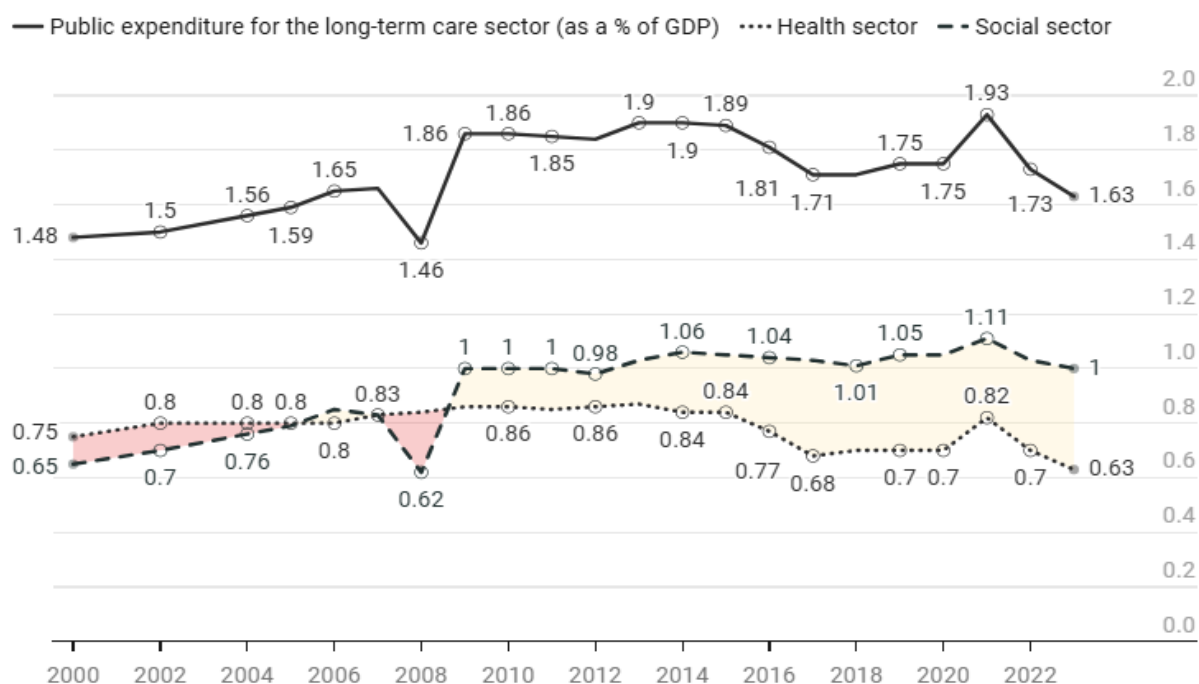
Note: The year 2010 represents an estimate based on ISTAT and NNA (2011) data. Post-2019 data are based on a different measurement and refer to a broader population, which accounts for the higher figures. The year 2021 is the most recent available estimate regarding the population aged 65 and over with limitations in activities of daily living.

Source: Author's elaboration on StatData* (2015-2021) and Cergas SDA** (2024; 2025).

In 2021, 63.5% of individuals aged 75 and over in Italy reported severe limitations in performing routine daily activities. While self-perceived health within this demographic improved between 2010 and 2021—evidenced by a decline in those reporting severe or very severe limitations from 73.2% to 63.5%—a substantial segment of the older population continues to face significant barriers to daily functioning. Moreover, OECD data further highlight critical gaps in long-term care provision. Approximately 56% of older individuals with at least one functional limitation do not receive adequate LTC services. Among those with three or more limitations in ADLs or IADLs, unmet care needs remain alarmingly high at 51%. These deficits are compounded by shifting demographic and societal patterns, notably the rise in older individuals living alone, which increased from 25.7% in 2009 to 29.8% in 2023.

Despite escalating demand, Italy's long-term care sector has witnessed both a lack of targeted regulatory reform and stagnation in public expenditure. Long-term care spending as a percentage of GDP illustrates this inertia: After peaking at 1.93% in 2021, public expenditure decreased to 1.63% by 2022. Healthcare-related spending within LTC fluctuated between 0.75% and 0.63% of GDP from 2000 and 2022, though a gradual decline has been observed in recent years. Conversely, social care expenditure showed greater volatility, rising from 0.65% of GDP in 2004 to a high of 1.11% in 2021, before receding to 1% in 2022 (see Figure 6.1.).

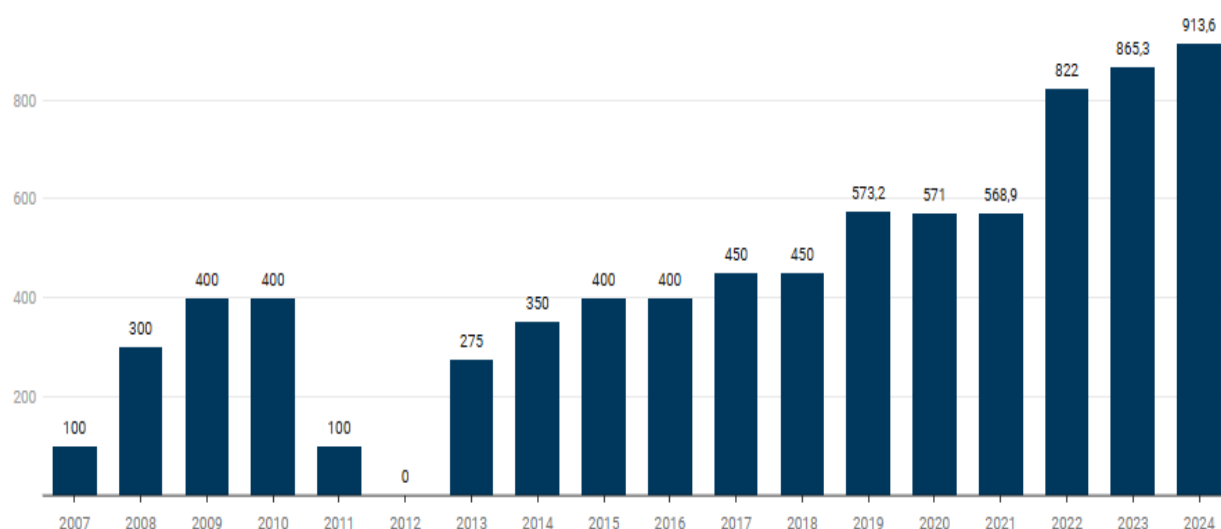
Figure 6.1. Public Expenditure for the LTC, Health and Social Care Sector, 2000-2022.



Note: Since no aggregate estimates of public LTC expenditure - combining both social and health components - are available prior to 2004, figures for 2000 and 2002 should be regarded as estimates. Source: Author's elaboration on StatData (Disabilità in cifre).

At the national level, the *Fondo per le Non Autosufficienze* (see 2.1.) has exhibited a progressive increase in allocations over time. Between 2007 and 2011, the Fund experienced steady growth, with annual allocations rising from €100 million to €400 million. However, this trajectory was abruptly interrupted in 2012, when funding was entirely suspended as part of broader fiscal consolidation measures linked to the economic crisis. This suspension represented a critical setback in the institutional development of the Fund. Funding resumed in 2013 at €275 million, followed by a gradual increase over subsequent years, reaching €450 million by 2016—a level that remained unchanged through 2018. From 2019 onwards, the Fund entered a phase of marked expansion. Allocations grew from €573.2 million in 2019 to €822 million in 2022, with projections indicating a further increase to €913 million by 2024 (Figure 6.2.).

Figure 6.2. Public Funds Allocated to Fondo per le non autosufficienze (2007-2024).

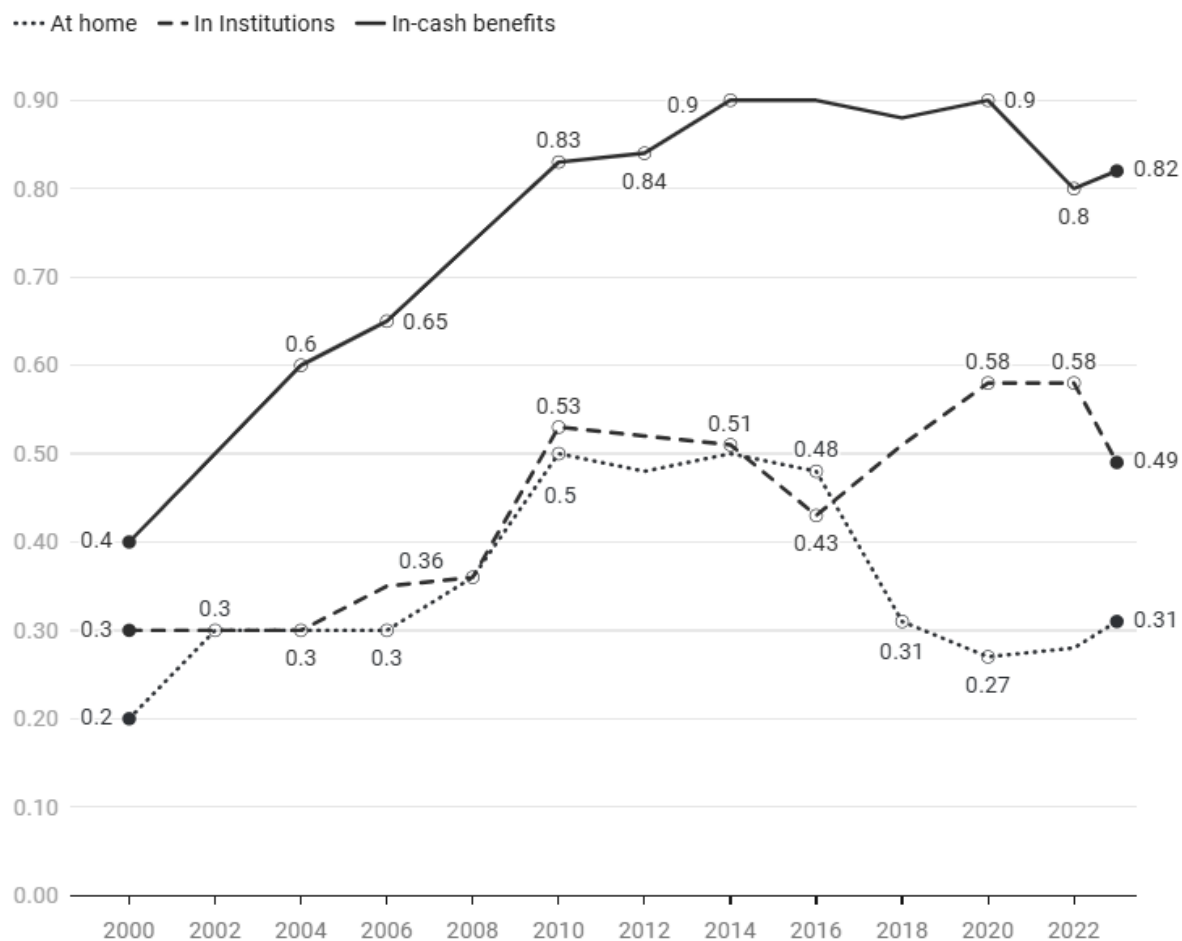


Note: In 2011, the allocation of €100 million was primarily directed toward interventions for patients with Amyotrophic Lateral Sclerosis (ALS). In 2012, the Fund was not financed. In 2020, the initial allocation of €571 million was increased by an additional €90 million, with €20 million earmarked for projects aimed at independent living for individuals with disabilities aged 18-64. This Fund was introduced in 2007.

Source: Author's elaboration on various Ministerial Decrees from the Ministry of Labor and Social Policies (2007-2024).

Cash benefits, particularly the *Indennità di Accompagnamento*, continued to represent the most significant component of long-term care expenditure as a share of GDP. These benefits, which provide direct financial support to individuals with care needs, increased from 0.4% of GDP in 2000 to a peak of 0.96% in 2021, highlighting the enduring reliance on cash transfers as a flexible tool to support both caregivers and care recipients (Figure 6.3.). While cash transfers remain the dominant pillar, the concurrent decline in in-home care spending and the volatile trajectory of institutional care expenditures underscore persistent difficulties in achieving an effective balance between different care provisions.

Figure 6.3. Long-Term Care Expenditure as a Percentage of GDP in Italy, by Function (2000-2023).



Note: Fluctuations are due to modifications in eligibility criteria for access measures as well as GDP.
Source: Author's elaboration on Ragioneria dello Stato, Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario, various Reports (2000-2023).

The total number of IdA benefits issued in Italy more than doubled between 2002 and 2024. This expansion was particularly pronounced during the first decade of the 2000s, after which the growth rate decelerated, though the overall trend remained upward. In real terms, however, the average value of the benefit has experienced a *steady* decline, with the most substantial reductions recorded in the past two years. By 2023, the inflation-adjusted value of the IdA had fallen to less than 85% of its 2002 level, illustrating the progressive erosion of its purchasing power³⁸ (Audino et al., 2024).

³⁸ Two primary dynamics account for this “numbers effect.” First, demographic aging—most notably the significant increase in the population aged 80 and over—has been a key driver. The probability of becoming non-self-sufficient rises sharply in advanced old age, particularly beyond the age of 80. Consequently, demographic pressures have been instrumental in sustaining the numerical growth of IdA recipients over time. Moreover, starting in 2010, specific policy measures were introduced to assess and verify the health-related eligibility criteria for new applicants and to re-evaluate the eligibility of existing beneficiaries. These measures included Article 20 of Law 102/2009, INPS Circular No. 131 of 28.12.2009, and Article 18, paragraph 22, of Decree Law 6.7.2011. These initiatives were part of a broader campaign to ensure compliance with eligibility standards, which may have

The family continues to represent the primary source of support for individuals with limited autonomy or non-self-sufficiency, particularly among lower-income groups. Familial support is most prevalent among individuals in the lowest income quintile, reaching 88%, and decreases progressively as economic resources increase, declining to 78.9% among those in the highest income quintile. In contrast, reliance on paid caregivers is predominantly observed among higher-income households, with the prevalence of paid care increasing alongside income levels and reaching 35.6% among individuals in the top income quintile (Ufficio Parlamentare di Bilancio, 2024).

In parallel, public expenditure on *Assistenza Domiciliare Integrata* for the older people, though modest in scale, exhibited fluctuating trends. Allocations stood at €119.8 million in 2011, declined to €104.9 million by 2013, and peaked at €123.8 million in 2016. Following this peak, ADI expenditures contracted to €101.9 million in 2020, before a slight recovery to €106.5 million in 2021. These divergent trajectories underscore the contrasting challenges and policy priorities in financing home care services for individuals with disabilities compared to the older persons (Istat dataset).

Assistenza Domiciliare Integrata utilization exhibited moderate yet fluctuating trends. In 2011, 0.46% of individuals over 65 utilized ADI services, but this share declined progressively, reaching a low of 0.29% in 2018 (Istat dataset). In the following years, however, ADI utilization experienced a partial recovery, increasing to 0.41% by 2021 (*ibidem*). These contrasting trends in SAD and ADI utilization reflect differing trajectories in the evolution of these home care services, with implications for their capacity to address non-self-sufficiency effectively. Currently, ADI represents the more structured service, coordinated by ASLs under the Ministry of Health's oversight (Gori et al. 2024).

As noted by Gori et al. (2024), ADI predominantly provides isolated interventions—such as medical, nursing, or rehabilitative services—that are episodic in nature and narrowly targeted at addressing specific clinical needs. These interventions are rooted in a hospital-centric logic, focusing on discrete pathologies rather than offering a holistic care framework capable of responding to the complex, multidimensional vulnerabilities associated with non-self-sufficiency. At present, home care services reach approximately 6.9% of the older population, reflecting a steadily increasing demand. However, these services are typically short-term in nature, with care episodes lasting, on average, only two to three months. Moreover, the intensity of care provision—measured in terms of hours of weekly assistance—remains limited. For example, 80% of older beneficiaries receive merely one to three home visits per month, underscoring the modest scope and fragmented character of current home care interventions (Figure 6.4.).

affected the pace of new approvals while maintaining the integrity of the system. The interplay of these factors highlights the dual pressures facing the IdA system: The demographic reality of a rapidly aging population and policy-driven efforts to regulate benefit distribution.

Figure 6.4. Intensity of ADI Service (annual monthly hours), 2000-2022.



Note: 2012 and 2013 data are missing. The year 2022 is the most recent year for which estimates are available.

Source: Author's elaboration on *Annuario Statistico del Servizio Sanitario Nazionale* (various years, 2000-2024).

In contrast, *Servizio di Assistenza Domiciliare* (SAD) operates within a socio-assistential framework, primarily targeting individuals whose conditions are compounded by additional socio-economic vulnerabilities, such as weak family networks or limited financial resources. This targeting approach reflects an increasing emphasis on addressing the broader context of social fragility, where the absence or weakness of familial and economic support systems becomes a key determinant in eligibility assessments, alongside the condition of non-self-sufficiency. However, this orientation positions SAD in a structurally residual and targeted role. Service coverage remains extremely limited, reaching only 1.4% of the older population in 2020, a continuation of a long-term contraction from 2.1% in 2004³⁹.

Turning to residential care, ISTAT data highlight a gradual decline in the availability of beds in socio-healthcare residences (e.g., *Residenze Sanitarie Assistenziali*, RSA) and socio-assistance facilities (e.g., day centers) between 2000 and 2021. Table 6.4. illustrates the evolution of residential care provision for the older people in Italy between 2000 and 2021. The number of beds increased steadily until 2010 and then stabilized at around 410,000 units, while the number of residents peaked in 2010 and

³⁹ A further critical weakness lies in SAD's insufficient integration with healthcare services. In 2020, only 0.5% of the older population—equivalent to 6.6% of home care recipients—accessed SAD in conjunction with home healthcare services. This figure has remained virtually stagnant over the past 15 years, indicating entrenched structural barriers to effective service coordination. These challenges are compounded by limited municipal capacity: As of 2020, 61% of local governments did not provide SAD integrated with home healthcare (Gori et al., 2024). This persistent fragmentation fundamentally undermines the development of a comprehensive, multidimensional care model necessary to meet the complex needs of non-self-sufficient individuals.

subsequently declined, particularly in 2020, before showing a partial recovery in 2021. The ratio of beds to the population aged 65 and over remained relatively stable at around 3%, whereas the share of non-self-sufficient older people living in institutions fell sharply after 2015. This decline largely reflects the rapid growth in the estimated non-self-sufficient population, which may also be linked to improved measurement techniques of dependency in Italy.

Table 6.4. Number of Beds for the Older Persons and Ratios to Population Aged 65+ and Non-Self-Sufficient Older People (2000-2021).

Year	Beds in socio-assistential residential facilities	Number of older persons residents in socio-assistential residential facilities	Ratio of the number of beds to the population aged 65 and over	Ratio of older persons residents in socio-assistential residential facilities to the total non-self-sufficient population
2000	321,747	216,126	3.1	10.3
2005	338,750	229,628	2.9	10.3
2010	424,705	294,913	3.5	12.3
2015	390,689	287,685	2.9	10.1
2020	411,992	255,153	2.9	6.5
2021	413,988	266,848	2.9	6.6

Note: The year 2021 is the most recent available. It should be noted that the post-2015 decline in the third indicator - the ratio of older residents in socio-assistential institutions over the total non-self-sufficient population - may be related to the increase in the number of non-self-sufficient older people. As specified in the note to Table 6.3, this increase might in turn be partly explained by the refinement of measurement techniques of the phenomenon in Italy.

Source: Author's elaboration on StatData and DemoStat.

The following section examines the pronounced regional disparities in Italy's long-term care landscape, focusing on the divergent models adopted by regional governments during a prolonged period of normative *vacuum* at the national level. In the absence of a cohesive legislative and policy framework, Italian regions have exercised considerable autonomy in structuring their long-term care systems, resulting in a mosaic of territorially distinct approaches.

2.1.2. A Fragmented System: Regional Disparities in the LTC sector

As in the Spanish case, LTC measures in Italy are delivered across three distinct governance levels. At the national level, the *Istituto Nazionale della Previdenza Sociale* administers monetary benefits, most notably the IdA. Healthcare services fall under the responsibility of the SSN, while social assistance, following the 2001 constitutional reform of Title V (Law No. 3/2001), has been placed under the exclusive legislative competence of the Regions. Local social services are designed and managed by municipalities and by *Ambiti Territoriali Sociali*, municipal *consortia* authorized at the regional level (Table 6.5.).

Within integrated care frameworks, healthcare costs are covered by the SSN, whereas social assistance expenses are co-financed by local governments, service users, and their families. The private sector also plays a significant role, particularly through the widespread employment of personal assistants (*badanti*) (Da Roit & Castegnaro, 2004; Da Roit & Facchini, 2010; Maino & De Tommaso, 2023).

Table 6.5. LTC Measures and Corresponding Responsible Authorities, as of 2024.

Responsible Authority	Measures
State	<i>Indennità di Accompagnamento</i> , Law 104/1992, fiscal/contributory benefits
Regions	Socio-healthcare services and interventions (home-based, semi-residential, residential, financial contributions)
Municipalities and <i>Ambiti Territoriali Sociali</i>	Social services and interventions (home-based, semi-residential, residential, financial contributions)

Source: Adapted from Giunco et al. (2024).

In the prolonged absence of comprehensive national legislation, regional policies and regulatory frameworks concerning the care of non-self-sufficient older individuals have exhibited remarkable dynamism. Regional legislative activity, as mapped by Fosti & Notarnicola (2020), underscores this proactive approach: Between 2015 and 2019, Italian regions introduced a total of 369 distinct legislative acts, averaging approximately 17 new measures per region. These initiatives primarily addressed strategic priorities such as needs assessment, objective-setting, and operational planning. Certain regions—namely Piemonte, Liguria, Friuli Venezia Giulia, Umbria, and Molise—emerged as particularly strategic in their policy orientations. For instance, Piemonte emphasized the formulation of new or revised care objectives, Molise focused on comprehensive assessments of the older population, while Liguria, Friuli Venezia Giulia, and Umbria developed integrated strategies combining needs assessments, objective identification, and action plans. Common thematic priorities across regions included the promotion of active aging, the revision of socio-healthcare planning frameworks, and alignment with national policy instruments such as the National Dementia Plan.

Given the persistent lack of harmonized data collection systems, the *Network per la Non Autosufficienza* (NNA) proposed a typology of regional clusters based on the prevailing mix of services and monetary transfers. One model, characterized by a strong focus on residential care, is predominant in northwestern regions such as Piemonte, Lombardia, and Liguria, where policy priorities favor institutional facilities over home-based services like ADI and SAD, or IdA. A second model, centered on health-oriented home care, is observed in regions such as Emilia-Romagna and Tuscany, where the deployment of ADI is extensive, while SAD and monetary transfers play a more marginal role. Conversely, in several southern regions—including Umbria, Campania, Puglia, and Calabria—the system is predominantly shaped by a cash-for-care model, wherein the attendance allowance serves as the primary mechanism for managing non-self-sufficiency, with minimal development of structured home or residential care services. Similar patterns can be observed in Spain, where decades of regional autonomy have accentuated territorial disparities in the absence of a strong national framework. In Italy, these differences were further consolidated after the 2001 constitutional reform, which devolved

legislative responsibility for social care to the Regions. The result has been a highly fragmented system, with wide variation in both service provision and resource allocation. This is particularly evident in the case of the SAD.

More specifically, in reference to SAD e ADI, spending data on SAD reveal sharp contrasts among Regions. Well-resourced northern regions such as Lombardia, Veneto, and Emilia-Romagna have historically invested heavily in these services, though Lombardia, for example, has seen its expenditure fall steadily since 2011 (Istat dataset). Smaller regions, such as Valle d'Aosta and Molise, allocate far lower sums and have cut spending in recent years. By contrast, Toscana has gradually increased its commitment, while Sardegna has remained relatively stable. Sicilia, instead, shows a dramatic decline, suggesting either retrenchment or a reorientation of services (*ibidem*).

Healthcare services also reflect these regional divides (Ministero della Salute, data retrieved from Annuario Sistema Sanitario Nazionale, 2000-2022). Data on ADI show that regions like Valle d'Aosta and Sardegna consistently provide more hours of care per beneficiary, while Veneto, Piemonte, and Lombardia deliver much less, often below the national average (Table 6.6.). Some areas, such as Toscana and Basilicata, have improved slightly in the most recent years, but others remain largely unchanged (*ibidem*). At the national level, the average intensity of ADI has stayed flat over two decades. Overall, the evidence points to a persistent North-South divide. Southern regions such as Sardegna, Sicilia, and Basilicata tend to offer more intensive home-based care, while northern regions rely more on institutional services or cash transfers. These differences reflect not only demographic and fiscal conditions, but also diverging policy priorities. They highlight the need for a more coherent national strategy to ensure equitable access to long-term care across Italy.

Table 6.6. Intensity of ADI, Number of Hours, per Region, 2000-2022.

	2000	2004	2008	2012	2016	2020	2021	2022
Veneto	21	14	7	10	5	5	14	6
Piemonte	32	24	20	15	10	9	9	9
Lombardia	24	19	16	18	12	11	11	11
Friuli-Venezia G.	11	12	21	28	14	14	25	13
Umbria	11	27	28	29	24	39	17	13
Lazio	24	14	21	21	23	8	8	13
Liguria	32	23	21	18	24	23	14	14
Italia	24	23	20	21	16	16	16	16
Toscana	25	16	27	22	9	26	25	25
Molise	16	29	48	36	27	19	30	26
Valle d'Aosta	3	243	177	37	26	54	48	29
Abruzzo	13	34	44	37	26	27	30	30

Emilia-Romagna	25	30	27	26	15	7	14	31
Marche	26	19	28	26	23	26	26	31
Campania	53	33	43	32	29	44	39	39
Puglia	66	35	14	36	38	15	16	41
Basilicata	58	29	68	81	31	32	36	41
Calabria	25	29	21	35	21	32	36	41
Sicilia	30	30	20	28	28	41	36	41
Sardegna	94	69	22	36	28	41	34	41

Source: Author's elaboration on Annuario Sistema Sanitario Nazionale (2000-2022).

At the regional level, distinct patterns of residential care provision emerge. Northwestern and Northeastern regions—such as Lombardia, Veneto, Friuli Venezia Giulia, and Piemonte—are characterized by high levels of institutionalization, with facilities averaging between 40 and 52 beds and a consistently high concentration of older residents (ranging from 81% to 85%). These regions reflect a care model that prioritizes residential infrastructures as the primary response to non-self-sufficiency. By contrast, Central regions including Emilia-Romagna, Toscana, and Marche maintain smaller facilities, averaging 23 to 28 beds, while still displaying a substantial proportion of older residents (approximately 75% to 78%). This suggests a selective institutionalization model in which residential care complements more extensive home-based services. Conversely, Southern regions such as Campania, Calabria, and Sicilia reveal structurally limited residential capacity, with facilities averaging 23 to 26 beds and significantly lower shares of older residents, with Sicily dropping to as low as 50%. Some regions represent notable outliers: For instance, Molise maintains relatively stable facility sizes but shows a marked increase in the proportion of older residents, from 69% to 84%.

Turning to cash benefits, Table 6.7. reports the ratio of IdA beneficiaries to the population aged 65 and over across Italian regions between 2000 and 2024. The figures highlight considerable territorial disparities. Southern regions such as Sicily, Lazio, Basilicata, and Sardinia record the highest levels, with ratios exceeding 4-5% by 2024, indicating a stronger reliance on cash benefits as a central instrument of long-term care provision. In contrast, Northern regions such as Lombardia, Veneto, and Emilia-Romagna show comparatively lower ratios, generally below 3% in 2020, though with some recovery projected by 2024. Central regions, including Marche and Umbria, display intermediate values, around 3-4% in recent years. At the national level, the IdA ratio increases from 2.35% in 2000 to a peak of 3.75% in 2005, stabilizes at around 3.3% until 2015, then declines to 2.46% in 2020 before rising again to 3.62% in 2024. Overall, the evidence underscores both the strong territorial variability in the use of monetary transfers and their dynamic trajectory over time, with an initial expansion, a contraction in the mid-2010s, and a subsequent recovery.

Table 6.7. Ratio of IdA Allocated over Population 65+, per Region, in Percentage Values.

	2000	2005	2010	2015	2020	2024
Piemonte	2,66	2,53	2,77	2,61	2,02	2,56
Friuli V.G.	1,91	2,35	2,36	2,75	2,27	2,94
Toscana	2,37	3,47	2,89	2,68	1,81	3,11
Lombardia	2,00	2,60	2,63	2,73	2,22	3,21
Emilia-Romagna	2,17	3,05	2,61	2,48	2,19	2,86
Liguria	2,14	2,72	2,68	2,79	2,33	2,95
Veneto	1,80	3,06	2,69	2,77	2,23	2,86
Sardegna	3,11	4,13	4,08	3,62	3,69	4,37
Italia	2,35	3,75	3,31	3,29	2,46	3,62
Marche	1,20	3,49	3,50	3,49	2,93	4,46
Abruzzo	0,67	3,81	3,47	3,33	2,43	3,67
Molise	1,06	2,03	3,42	3,71	2,48	3,88
Basilicata	2,68	4,68	3,75	3,57	3,46	4,66
Sicilia	1,57	2,70	3,84	3,67	3,57	5,02
Umbria	1,33	3,39	3,68	3,33	3,12	3,98
Lazio	1,64	4,43	4,09	3,86	3,50	5,40
Campania	2,39	3,48	4,10	3,78	2,73	4,10
Puglia	2,60	4,44	3,60	3,70	2,70	3,22
Calabria	1,95	3,16	3,12	3,12	2,60	3,61

Source: Author's elaboration on Osservatorio Statistico, Prestazioni agli invalidi civili - serie storica.

2.2. The Policy Trajectory from 2000 to 2018⁴⁰

The Italian welfare system's response to LTC has historically been marked by institutional fragmentation, uneven development, and strong reliance on family and informal networks. Despite recurring debates, systemic reforms have repeatedly failed, constrained by decentralization, fiscal austerity, and shifting political priorities. Since 2000, Italy has witnessed ambitious initiatives—such as the Framework Law No. 328/2000 and the establishment of the *Fondo per le Non Autosufficienze* (FNA)—but these have often been undermined by weak implementation and unstable funding. This section traces the evolution of Italian LTC policies from 2000 to the mid-2020s, highlighting enduring weaknesses, partial innovations, and the contested recognition of caregivers.

⁴⁰ This section is intended to provide context for the period prior to 2018, which constitutes the focus year of the chapter, as do all references made to developments before 2018.

Law No. 328/2000, the “Framework Law for the Implementation of the Integrated System of Social Intervention and Services,” represented a landmark attempt to modernize a fragmented welfare system. It aimed to ensure equity and coordination by establishing a territorially decentralized network of social services, managed primarily by municipalities and regions but with input from civil society and the third sector. The law introduced the *Fondo Nazionale per le Politiche Sociali* (FNPS) to distribute resources according to demographic and socio-economic criteria. Importantly, Article 15 targeted non-self-sufficient older people, mandating integration between social and healthcare services, while Article 16 introduced care allowances. Article 22 proposed *Livelli Essenziali delle Prestazioni Sociali*, designed to guarantee uniform access to essential social services, i.e. as subjective rights, in analogy to the *Livelli Essenziali di Assistenza* in healthcare.

However, implementation lagged. Only partial LEPS were defined by 2017, and the absence of a unified LTC framework meant that reforms failed to transform everyday practices. As Pavolini and Ranci (2008) observed, the law offered a blueprint for integration but did not overcome structural fragmentation. The constitutional reform of Article 117 in 2001 devolved social assistance to the legislative authority of regions, further fragmenting the system. While the state retained responsibility for “essential levels of services concerning civil and social rights,” most decision-making power shifted to regional and municipal levels. This reinforced territorial disparities: Innovative northern regions like Emilia-Romagna developed more robust networks, while weaker administrations in the South struggled to provide consistent services.

At the same time, the Berlusconi government pursued pension reforms and labor market flexibilization, sidelining investment in social policy. Outsourcing, accreditation, and professionalization modernized some services, but systemic ambitions faded under fiscal austerity and centrifugal federalism. Healthcare reforms advanced more decisively. Building on Legislative Decree 229/1999, a 2001 Prime Minister’s Decree (*Decreto del Presidente del Consiglio dei Ministri*, DPCM) clarified socio-healthcare services for dependent older people and introduced cost-sharing rules between the SSN, municipalities, and families. Yet the lack of objective criteria left ample room for regional divergence.

Between 2002 and 2005, parliamentary attention to LTC increased, with several draft bills proposing the establishment of a national fund and the definition of essential service levels. Among the most ambitious initiatives was the reform advanced by Minister Girolamo Sirchia, inspired by the German LTC insurance model. The proposal envisioned a scheme that would initially operate on a voluntary basis and later become mandatory, covering an estimated 1.2 million dependent individuals at a projected cost of €10 billion. However, fiscal assessments indicated that the actual costs would likely be two to three times higher, ultimately undermining the initiative’s viability. Another significant initiative was the 2003 White Paper on Welfare, which outlined the creation of a *Fondo per la Non Autosufficienza*. Yet its reliance on earmarked taxation met with strong criticism, and the plan was eventually shelved. The Sirchia-Maroni Commission also failed to deliver concrete results, leading to the collapse of systemic LTC reform under the combined weight of fiscal constraints and shifting

government priorities (Costa, 2013; Ranci & Pavolini, 2013). Table 6.8. summarizes all legislative proposals in the field of LTC advanced during the period 2004-2005.

Table 6.8. Legislative Proposals in the LTC (2002-2005): Various Dimensions.

Name of Proposals	Proponent	Target	Main Content (in brief)
Establishment of a Social Protection and Care System for Dependent Older People	Battaglia et al. (15/01/2002)	Older dependent individuals (65+ years)	National Fund for Non-Self-Sufficiency Support Introduction of a Compulsory Social Insurance Scheme
Social and Health Safeguards for Dependent Individuals	Di Virgilio et al. (29/10/2002)	Dependent individuals (all ages)	National Fund for Non-Self-Sufficiency Support Introduction of a Compulsory Social Insurance Scheme
Measures in Support of Dependent Older People	Castellani et al. (09/11/2002)	Older dependent individuals (65+ years)	National Fund for Non-Self-Sufficiency Support Solidarity contribution funded by workers and businesses
Provisions to Support the Condition of Dependency	Bindi et al. (28/11/2002)	Dependent individuals (all ages)	Essential Levels of Social Assistance Services (LEPS) National Fund for Non-Self-Sufficiency Support Financed through General Taxation
Regulations for the Determination of Essential Levels of Health Care for Dependent Individuals and for the Enhancement of Pension Benefits for Disadvantaged Groups	Valpiana (14/03/2003)	Dependent individuals (all ages)	National Fund for Non-Self-Sufficiency Support Universality of Health and Social Assistance Services Increase in Pensions for Disadvantaged Individuals Financed through General Taxation
Establishment of the Fund for the Autonomy of Persons with Disabilities	Rodoghiero et al. (02/07/2003)	Dependent individuals (all ages)	Establishment of Fund for the Autonomy of Persons with Disabilities Financed through General Taxation
Support Measures for Dependent Older People	Paoletti Tangheroni (10/11/2003)	Older dependent individuals (65+ years)	Financial Support for Families of Non-Self-Sufficient Older People Integration with Social and Healthcare Policies Promotion of Home Care to Reduce Public Costs
Provisions to Promote the Quality of Life of Dependent Individuals	Martini (14/05/2005)	Dependent individuals (all ages)	Recognition and Individualized Plan for Non-Self-Sufficiency Establishment of Dedicated Facilities and LEPS Financed through General Taxation

Source: Authors' elaboration.

The short-lived Prodi II government (2006-2008) reopened space for reform. Advocacy by trade unions and civic groups led to the establishment of the *Fondo per le Non Autosufficienze* in 2007, with €299 million allocated in its first year. Draft Law 3284 defined non-self-sufficiency comprehensively and promoted health-social integration. Yet the government's premature fall prevented full implementation. Without defined LEPS, FNA allocations were absorbed by pre-existing regional

programs rather than institutionalizing universal rights. Although the fund was later made permanent (2012), the absence of binding criteria perpetuated regional inequalities.

From 2006 onwards, the prospect of a structural reform of long-term care progressively faded, giving way to a series of categorical, micro-targeted measures primarily aimed at strengthening territorial healthcare and redefining the division of responsibilities between central and regional authorities. These reforms were designed to enhance resource efficiency while simultaneously shifting financial and organisational responsibility away from the central state, particularly as rising care costs became unavoidable due to profound socio-demographic transformations. The 2008 financial crisis further reinforced this territorial turn by prioritising community-based medicine and integrated local care networks. Legislative Decree 153/2009 played a pivotal role in this transition by redefining pharmacies as key providers of domiciliary and socio-healthcare services. The decree authorised pharmacies to deliver medicines, medical devices, and treatments directly to patients, while also facilitating access to nursing and physiotherapy services. In addition, pharmacies expanded their role into preventive care, pharmacovigilance, and diagnostic support, thereby embedding themselves within integrated territorial care systems.

Subsequently, the 2009 State-Regions Agreement further reinforced home-based care (*Assistenza Domiciliare Integrata*, ADI) and established *Punti Unici di Accesso* (PUA), designed as one-stop access points for LTC referrals, assessment, and service coordination. The introduction of Law 38/2010 marked another significant step forward by formally recognising palliative care and pain therapy as essential healthcare rights. The law mandated the creation of national networks, the development of hospice services, the expansion of home-based palliative care, and specialised professional training. This legal framework represented a substantial rights-based advance for individuals living with chronic and terminal conditions, laying the foundation for a more person-centred approach to end-of-life care.

Between 2012 and 2016, LTC policy in Italy was characterised by institutional instability and the enduring effects of fiscal austerity⁴¹. The *Network per la Non Autosufficienza* (Platform, onward) established in 2009 as a coalition of advocacy organisations, consistently campaigned for structural reforms aimed at integrating services, expanding entitlements, and increasing public investment. However, its proposals resulted in only modest funding increases and limited policy adjustments. A notable example of this constrained reform environment was Minister Maurizio Sacconi's proposal for the creation of a universal LTC fund, which ultimately failed to gain sufficient political and financial support. Incremental advances were achieved under the Renzi government: In 2015, the *Fondo per le Non Autosufficienze* was made permanent, marking a symbolic step towards stabilising LTC financing. Additionally, Law 208/2015 extended FNA coverage to individuals affected by rare and terminal

⁴¹ The FNA fluctuated dramatically: €400 million in 2009-2010, cut to €100 million in 2011, suspended in 2012, restored at €275 million in 2013, €350 million in 2014, €400 million in 2015, and reduced to €250 million in 2016. Only from 2017 was it stabilized at €450 million, but without a statutory framework (Arlotti, 2012).

neurodegenerative disorders, signalling a modest, yet important, recognition of emerging care needs within the policy framework.

Continuing the trend of categorical reforms, in 2012 the INPS launched the Home Care Premium (HCP) scheme, specifically targeting public sector employees and their families. Conditional on means-testing and Activities of Daily Living assessments, the programme provided cash-for-care benefits explicitly tied to the formal employment of caregivers, thereby introducing a significant departure from the unconditional nature of the *Indennità di accompagnamento*. Evaluations by Arlotti et al. (2020) highlight two key contributions of the HCP scheme. First, it partially reduced inequalities embedded in the IdA by linking benefits to demonstrated care needs. Second, it strengthened accountability by connecting financial transfers to verified caregiving arrangements. Nonetheless, the scheme's impact remained constrained due to significant compliance burdens, strict eligibility requirements, and limited coverage, which led many households to continue relying on informal and flexible care arrangements.

In the following years, two additional strategic planning tools emerged to strengthen policy coordination. The National Dementia Plan (2014), updated every five years, established integrated care pathways, regional service networks, and anti-stigma campaigns to improve access and quality of dementia care. Similarly, the National Plan for Chronicity (2016, renewed until 2024) promoted person-centred care models, emphasised early intervention, and supported the expansion of home-based services within an integrated care framework.

Overall, the first 19 years of the 2000s were characterised by policy inertia, producing few reforms that were categorical, residual, and minimalistic in scope. Substantial changes were largely absent, with the notable exceptions of the stabilisation of the *Fondo per le Non Autosufficienze* and the introduction of general strategic plans—such as the *Piano Nazionale per le Demenze* and the *Piano Nazionale per la Cronicità*—which primarily acknowledged specific risks associated with LTC and dependency. The transition to the Second Republic further reinforced instability, as fragmented bipolarism and coalition volatility hindered the formation of consistent policy agendas. This institutional fragility was exacerbated by the 2001 constitutional reform, which introduced a more federalised governance structure. The reform amplified territorial disparities by empowering the wealthier northern regions while leaving weaker southern administrations dependent on cash-based allowances, most notably the *Indennità di accompagnamento*. Informal labour markets, limited recognition of caregivers, and uneven service provision remained structural features of the system, confirming the sector's persistently low political salience (Maino & De Tommaso, 2023).

Although Law 328/2000 laid the groundwork for a more systematic reform of the sector, the measures implemented were, in practice, mostly residual and categorical. The *Fondo per le Non Autosufficienze*—initially conceived as an experimental and “low-cost” instrument—represented an attempt by the centre-left to reposition itself on an issue that had gained prominence following the establishment of the Onofri Commission in 1997 and the subsequent approval of Law 328/2000. This dynamic partly resembled the Spanish trajectory during the same period; however, unlike in Spain,

Italy failed to achieve a genuine path departure, largely due to fragile and ideologically fragmented coalition governments, which prevented the emergence of a cohesive reform strategy. In the absence of *Livelli Essenziali delle Prestazioni Sociali* and enforceable subjective rights to access LTC services—except for the IdA, which retains a universalistic character—the only consolidated entitlements were those guaranteed by the *Livelli Essenziali di Assistenza*. However, these LEA entitlements are limited to healthcare services—including home-based and residential care—and therefore address only one dimension of LTC policy (see Chapters 1 and 2). This institutional asymmetry contributes to explaining the fragmented nature of the LTC system, both in terms of the diversity of measures and the persistent division of competences between the social and healthcare domains. Territorial healthcare reforms and the gradual recognition of palliative care rights have somewhat reinforced community-based services, while targeted innovations—such as the Home Care Premium and national strategies on dementia and chronic conditions—introduced incremental but modest improvements. Nevertheless, the Italian LTC system continues to rely heavily on families and migrant care workers, while the formal recognition of caregivers’ rights remains partial and largely symbolic.

The COVID-19 pandemic and the launch of the National Recovery and Resilience Plan (PNRR) temporarily revived the policy debate and opened a window of opportunity for systemic reform. Yet, persistent centrifugal governance dynamics, weak inter-institutional coordination, and limited political prioritisation continue to obstruct the development of a comprehensive, integrated LTC framework. Internal differentiation—both within provinces and across regions— as in the Spanish case (albeit through different mechanisms), became involved in the decision-making process, particularly in Italy following the enactment of the Delegated Law No. 33 of 2023.

2.3. From Anti-Establishment Government to Technocratic Executives (2018-2021)

Section 2.3. provides details on the political context between 2018 and 2021 and on the role of long-term care in the election preceding the two unelected governments that took office before the reform (the Conte II Government and the Draghi Government). On the one hand, the aim is to frame the political-institutional context during the complex Covid-19 emergency (Section 2.3.1.). On the other hand, Section 2.3.2. retraces the salience of long-term care in the electoral manifestos presented by political parties ahead of the 2018 campaign, immediately preceding the Conte I Government. Although the latter was not directly involved in long-term care policymaking, 2018 marked the last electoral year before the transition to the centre-right government led by Giorgia Meloni (see *infra*). The discussion of the 2018 manifestos is therefore intended to shed light on party positioning and on the salience attributed to long-term care, in comparison with subsequent developments.

2.3.1. From Governo Conte I to Governo Draghi (2018-2021)

Between 2018 and 2021, the transition from the Conte I government to the Conte II coalition and finally to the technocratic Draghi government encapsulates the volatile dynamics of Italy’s party system in the so-called “Third Republic.” These years exposed the fragility of populist alliances when faced with

governance responsibilities and demonstrated the strategic recalibrations of parties in response to both electoral pressures and crisis-induced institutional constraints.

The Conte I government (June 2018 - September 2019), formed by an unprecedented alliance between the Five Star Movement (*Movimento 5 Stelle*, M5S) and Matteo Salvini's League (Lega), represented the height of Italy's populist moment (Giannetti et al., 2020). This "yellow-green" coalition was ideologically fragmented from the outset. The M5S, originally rooted in digital direct democracy and welfare populism, aligned with Salvini's right-wing sovereigntist and anti-immigration agenda primarily out of anti-establishment convergence rather than policy coherence (Giugliano, 2019).

Despite its rhetoric of radical change, empirical analyses of Conte I's legislative activity indicate continuity with prior governments, with the League exerting disproportionate influence over policy priorities (Giannetti et al., 2020). Tensions escalated over flagship policies, such as the *Reddito di Cittadinanza*, which became a highly politicized welfare initiative, becoming a strategic positioning issue within coalition dynamics, reflecting both intra-coalitional competition and broader party system volatility (Colombo et al., 2025). The politicization of the RdC was not isolated but embedded in a broader logic of political exchange within the Conte I coalition, where policy concessions were strategically negotiated to align disparate party agendas⁴². This "policy barter" allowed both parties to secure emblematic victories for their respective electorates, despite the absence of a coherent, shared welfare agenda. The result was a governance model characterized by selective policy entrepreneurship, where coalition stability hinged on the reciprocal toleration of each party's flagship measures, irrespective of their programmatic compatibility.

The European Parliament elections of May 2019 marked a pivotal moment. Salvini's League surged to 34% of the vote, doubling its share from the 2018 general elections, while the M5S plummeted to 17% (Chiaromonte et al., 2020). Interpreting this as a mandate for his leadership, Salvini attempted to trigger snap elections by withdrawing support from the government in August 2019. However, rather than precipitating new elections, Salvini's move catalyzed the formation of a new parliamentary majority between the M5S and the centre-left Partito Democratico, resulting in the Conte II government (Tronconi & Valbruzzi, 2020). The Conte II coalition, inaugurated in September 2019, marked a significant ideological and strategic shift. While Conte I had embraced sovereigntist rhetoric, Conte II presented itself as a moderate, pro-European executive, seeking to stabilize Italy's international standing (Guidi & Moschella, 2021). The coalition also included the centrist Italia Viva, led by former Prime Minister Matteo Renzi, whose role would later prove decisive in triggering another government crisis.

⁴² A paradigmatic example of this dynamic was the mutual trade-off between the *Reddito di Cittadinanza*, championed by the M5S, and the Quota 100 pension reform, strongly advocated by the League (Colombo et al., 2025).

The outbreak of the COVID-19 pandemic in early 2020 radically transformed the Italian political agenda. The Conte II government responded with strict lockdown measures and emergency economic interventions, positioning Giuseppe Conte as a unifying figure during the initial phases of the crisis (Ieraci & Ripamonti, 2025). However, the pandemic exacerbated latent tensions within the coalition, particularly regarding the governance and allocation of the EU-funded National Recovery and Resilience Plan. The PNRR process became a *locus* of intra-coalitional conflict, with disputes centering on Conte's centralization of decision-making and the distribution of economic resources (Guidi & Moschella, 2021).

However, the fragile *equilibrium* sustaining the Conte II coalition unraveled in January 2021, when Matteo Renzi's Italia Viva withdrew its parliamentary support. Officially citing governance inefficiencies and the coalition's inadequate capacity to design and oversee the PNRR, Renzi's defection precipitated a renewed phase of political instability (Guidi & Moschella, 2021). The loss of its parliamentary majority forced the Conte II government into a crisis, thereby opening the path for a technocratic-led intervention to restore executive coherence and institutional credibility. Given the pandemic and the critical phase of PNRR negotiations with the European Commission, President Sergio Mattarella rejected the prospect of immediate elections. Instead, he mandated Mario Draghi, former President of the European Central Bank, to form a technocratic government of national unity. The Draghi government, inaugurated in February 2021, assembled an unprecedentedly broad coalition, including the PD, Forza Italia, Lega, M5S, and smaller centrist formations, with only Giorgia Meloni's Fratelli d'Italia opting for a role in the opposition.

De facto, the appointment of Draghi represented a temporary suspension of traditional party competition in favor of technocratic competence and European credibility. Draghi's primary objectives were the implementation of the PNRR, vaccination campaigns, and restoring Italy's economy while securing institutional stability⁴³. All in all, while the Conte I government was characterized by intra-coalitional polarization and a fragmented populist agenda (Tronconi & Valbruzzi, 2020), Conte II adopted a more pragmatic, centrist orientation but ultimately failed to withstand the pressures of coalition management amid an unprecedented health and economic crisis. The Draghi government, though effective in stabilizing Italy's position within the EU and expediting the PNRR's initial phases, highlighted the limitations of technocratic governance in a context of deep-seated party system fragmentation. Table 6.9. illustrates the Government, its main parties, political orientation and opposition parties, between 2018 and 2022.

⁴³ Further details are provided in Section 3.1 of this Chapter.

Table 6.9. Government Between 2018 and 2022: Conte I and Draghi Government.

Government	Main Parties	Prime Minister	Political Orientation	Opposition Parties
Conte I (06/2018-09/2019)	M5S, Lega Nord	Giuseppe Conte	Populist, anti-establishment; left-populist (M5S) + right-wing populist/nationalist (Lega)	Partito Democratico (PD), Forza Italia (FI), Fratelli d'Italia (FdI), + smaller centrist/liberal parties
Conte II (09/2019-02/2021)	M5S, PD, LeU, Italia Viva (from late 2019)	Giuseppe Conte	Centre-left, pro-European, reformist	Lega, Fratelli d'Italia
Draghi (02/2021-10/2022)	PD, M5S, Lega, Forza Italia (FI), Italia Viva (IV), LeU, centrists	Mario Draghi	Technocratic, national unity, <i>pro-European</i>	Fratelli d'Italia

Source: Author's elaboration.

2.3.2. LTC in the Electoral Manifestos of the Political Parties in the 2018 Election

As anticipated, this section analyses the electoral manifestos presented by political parties during the 2018 campaign, immediately preceding the legislature of the Conte I Government. The rationale, as mentioned, is that this was the last direct election before the succession of two unelected governments, Conte II and the technocratic government led by Draghi. From a politics-oriented perspective, it is therefore particularly relevant to examine the parties' positions on long-term care just before the onset of the policymaking process between 2020 and 2021.

At the dawn of the 2018 general elections, LTC appeared to be a policy domain largely confined to left-wing political agendas, mirroring the Spanish context of the 1996 elections, where the issue of dependency was prominently championed by the PSOE. In Italy, as will be discussed below, the PD stood out as the sole political actor to explicitly frame LTC as a structural reform. Meanwhile, adjacent themes—such as care for older people and familial support—surfaced in the platforms of the Lega and the nascent Movimento 5 Stelle, albeit in more fragmented and instrumental forms.

Among all the parties analyzed, the PD presented the most comprehensive and programmatically coherent policy vision for long-term care. The party identified non-self-sufficiency as a national priority requiring systemic intervention: *“Non-self-sufficiency: Economic support, care services, and investment in autonomy”* (PD, 2018: 42). Acknowledging Italy's structural delay in addressing LTC compared to its European counterparts, the PD advanced a multi-pronged reform agenda. First, the party proposed a revision of the *IdA*, committing to a scaling of benefits proportional to the severity of dependency: *“The allowance will increase for everyone and will double for the most severe cases”* (*ibidem*). In addition, the PD pledged to introduce standardized assessment systems to evaluate care needs and to universalize home care services as a right of citizenship. A further *axis* of the program concerned the professionalization of home caregivers: *“Develop a genuine system of training and qualification for family caregivers”* (PD, 2018: 43). This policy platform situated LTC firmly within a

rights-based, universalist welfare model, seeking to institutionalize care responsibilities beyond the household and reduce the socio-economic inequalities.

The Movimento 5 Stelle, initially positioned on the spectrum of “left populists,” emerged as the leading party in the 2018 elections. However, its approach to LTC was less coherent and lacked a structured policy framework. The M5S platform centered on systemic governance reforms and citizen empowerment but failed to articulate a comprehensive strategy for addressing non-self-sufficiency. In its healthcare program, the party acknowledged demographic aging and advocated for participatory governance mechanisms within care facilities for older people: “Innovation of strategies to protect and support the older people—including through the inclusion of significant representation of patients or family members in the management of care facilities for older people” (M5S, 2018: 12). Despite this recognition of emerging needs, the *manifesto* failed to provide concrete measures to expand LTC services or reform existing benefit structures. The term “non autosufficienza” was absent from the document, and no proposals were advanced concerning the Indennità di Accompagnamento or the development of in-home care pathways. Rather, the M5S’s welfare agenda prioritized the introduction of the Reddito di Cittadinanza, framing social policy primarily through the lens of poverty alleviation and income support. Consequently, the party’s engagement with LTC can be characterized as implicit and governance-oriented, with a rhetorical emphasis on decentralization, transparency, and participatory management, but limited attention to service delivery or systemic care infrastructure.

On the right⁴⁴ of the political spectrum, the Lega’s 2018 electoral manifesto offered explicit yet narrowly scoped references to non-self-sufficiency and LTC, deeply rooted in a familialist and subsidiarity-oriented welfare philosophy. The party identified demographic aging as a critical policy challenge, advocating for localized care solutions to support families. The manifesto stated: “The problem of population aging must be addressed through the creation of an organic and territorially widespread network of low-intensity healthcare and socio-healthcare facilities to help families face the *Dopo di Noi*⁴⁵ scenario” (Lega, 2018: 44). This proposal primarily targeted the issue of adult disability, with a focus on chronic and neurodegenerative diseases. Furthermore, the Lega advocated for the full tax deductibility of home caregiving expenses: “100% deductibility of expenses for domestic caregivers and home assistance” (Lega, 2018: 45). However, these measures, while indicative of an

⁴⁴ It is worth noting that, for the 2018 elections, the centre-right coalition (comprising Fratelli d’Italia, Lega, Forza Italia, and Noi con l’Italia) presented a joint electoral manifesto.

⁴⁵ It refers to measures designed to ensure the welfare and autonomy of individuals with severe disabilities after the death or incapacity of their primary family caregivers, typically parents. The concept gained legislative recognition with Law No. 112/2016, which established specific provisions to support the de-institutionalization of persons with disabilities and to promote individualized care pathways beyond the traditional family environment. The law introduced mechanisms such as special needs trusts (*trusts per il Dopo di Noi*), personalized care plans, and incentives for community-based living arrangements. Although originally conceived with a primary focus on disability policy, the term has also been adopted in political discourse to address broader concerns related to long-term care and older people dependency, particularly in relation to familialist welfare models that rely on intergenerational caregiving.

intent to provide incremental support, did not amount to a comprehensive LTC reform agenda. The *manifesto* contained no references to revising existing monetary benefits or integrating health and social care services. The Lega's approach reinforced the primacy of the family as the default provider of care, positioning the state in a subsidiary role, primarily responsible for offering fiscal incentives and limited infrastructural support.

Finally, the manifestos of Forza Italia and Fratelli d'Italia did not contain any explicit references to non-self-sufficiency, long-term care, or older people dependency. Both parties framed welfare in general terms, emphasizing family support, tax relief, and social security, but failed to engage with the specificities of LTC provision. FI's manifesto expressed broad support for subsidiarity and fiscal decentralization, while FdI foregrounded the defense of traditional family roles, without addressing the implications of demographic aging or the need for formal care services.

In sum, the 2018 electoral programs of Italian parties revealed a fragmented and asymmetrical engagement with long-term care. The PD positioned LTC in its welfare agenda, framing it as a public responsibility and articulating a reform strategy. In contrast, the M5S addressed the issue in a fragmented and instrumental manner, while the Lega adopted a familialist approach focused on localized infrastructural support and fiscal incentives. FI and FdI, for their part, refrained from engaging with the issue altogether, adhering to a residualist vision that placed primary caregiving responsibilities on the family. These programmatic positions not only shaped the coalition dynamics of the subsequent Conte I and Conte II governments but also foreshadowed the persistent marginalization of LTC within Italy's welfare agenda. Table 6.10. reports political parties' vision of LTC and its components, in 2018.

Table 6.10. Vision of LTC, Main Political Parties as in the 2018 Electoral Manifestos.

Dimension	Partito Democratico	Movimento 5 Stelle	Lega	Forza Italia / Fratelli d'Italia
Main vision of LTC	Frames long-term care as a public responsibility; proposes structural reforms to expand in-kind services.	Focus on governance transparency and citizen participation in care facility management; lacks structured LTC reform.	Supports localized, low-intensity care facilities; frames family as primary caregiver with state providing supportive infrastructure.	No explicit vision on LTC; implicit reliance on family-based care structures.
Primary policy objective	Promotion of individual autonomy, reduction of inequalities, and professionalization of care work.	Improve governance efficiency, reduce healthcare waste, and enhance community-level participation.	Support families through infrastructural investments and tax deductions; no systemic LTC reform.	General support for family welfare and tax relief, without sector-specific LTC policies.
Preference: in-kind vs. in-cash benefits	In-kind benefits emphasized; reform of Indennità di Accompagnamento linked to severity, and investment in home-based services.	Not explicitly defined	In-cash benefits promoted through tax deductions for familial caregivers.	Implicit preference for in-cash support via tax relief measures.
Role of the state	Central and proactive role; the state as main provider and regulator of LTC services.	Not explicitly defined	Subsidiary role; state aids families without replacing informal caregiving networks.	Residual and subsidiary role; welfare responsibility largely left to families.
Preferred policy instruments	Expansion of public services, standardization of care assessments, professional training for family caregivers.	Decentralization, transparency measures, citizen representation in service governance.	Fiscal incentives, infrastructure investments for low-intensity care, and deductibility of home assistance costs.	Broad fiscal measures; no specific LTC instruments detailed.

Source: Author's elaboration in 2018 electoral party manifestos.

2.3.3. In the Absence of Political Junctions: Ministerial Inertia and the Bureaucratic Drift of LTC—The LEA, LEPS, and the *Piano per le Non Autosufficienze*

As anticipated, the formation of the “yellow-green” coalition government (Conte I) did not substantially alter the trajectory of LTC policy in Italy. Despite shifts in government, the issue of non-self-sufficiency remained peripheral in the political agenda. Opposition parties, preoccupied with framing and power struggles around the *Reddito di Cittadinanza* (see Natili & Fabris, 2024; Colombo et al., 2025), did not perceive LTC as a salient political issue warranting immediate intervention. As previously discussed (see Section 2.3.1.), this period was characterized by a peculiar political configuration: The rise of a populist, anti-establishment movement (M5S) compelled the PD to reposition itself on traditionally leftist issues, while simultaneously narrowing the strategic focus of all parties to a handful of highly politicized policies, notably the minimum income scheme.

Consequently, the policy trajectory of LTC between 2018 and mid-2020 was predominantly driven by ministerial bureaucracies rather than political leadership. In the absence of strong political will or societal demand for reform, the *locus* of action remained within the technical and administrative spheres, particularly through the renewal of the National Non-Self-Sufficiency Plan (*Piano Nazionale*

per la Non Autosufficienza). The Ministries of Social Policies, Disability, and Health continued to operate in *silos* (see Chapter 4), lacking an overarching, integrated vision of non-self-sufficiency as a multidimensional policy challenge⁴⁶.

The policy developments prior to 2018 (see note 1) had temporarily brought the issue of long-term care back to the forefront. In 2018, Italy's main pensioners' trade union confederations—FNP CISL, SPI CGIL, and UILP—collectively advanced a policy proposal titled “*Una proposta nazionale unitaria sulla non autosufficienza*”. This document advocated for the adoption of a comprehensive national law on non-self-sufficiency, adequately funded and structurally integrated. Building on the principles of Decree 147/2017, the proposal called for the formal definition and enforcement of LEPS, aligned with LEA standards. Key elements included the integration of cash benefits with service provision, the adoption of individualized care plans based on multidimensional assessments, and the establishment of a dedicated national fund to guarantee uniform service quality and mitigate territorial disparities.

These converging trajectories—ministerial policy initiatives and the mobilization of organized civil society—served to reintroduce long-term care into the policy conversation, even if LTC was not yet prioritized as a central political issue. The politicization of anti-poverty strategies, particularly in the context of the *Reddito di Cittadinanza*, inadvertently created a window of opportunity for re-framing LTC within broader welfare debates (IT23, Former Administrative Director - Ministry of Labour and Social Policies). The first National Non-Self-Sufficiency Plan was adopted in 2019, covering the *biennium* 2019-2021. The Plan was conceived as a strategic tool to guide the allocation of FNA resources, standardize regional planning efforts, and facilitate the gradual implementation of LEPS across the national territory. Nevertheless, the Plan fell short of providing a comprehensive operational definition of non-self-sufficiency capable of differentiating care pathways based on varying levels of need intensity. In its initial iteration, the Plan focused predominantly on individuals with severe disabilities, while acknowledging the necessity of developing a national assessment tool to transcend diagnostic categories and capture the multifaceted dimensions of care needs.

At the onset of the COVID-19 pandemic, the system was constrained by the three classical dynamics of Italian long-term care: Fragmented interventions, residual funding, strong regionalisation, and, above all, the absence of a comprehensive legislative-regulatory as well as strategic framework at the national level. Reform attempts—limited in scope and primarily regulatory—were sidelined by the emergence of other governmental priorities (e.g., *Reddito di Cittadinanza*, *Quota 100*), in favour of coalition-political

⁴⁶ In 2017, the approval of the LEPS revived long-term care debates, despite their dormant status since Law 328/2000. Legislative Decree No. 147/2017, central to Italy's anti-poverty strategy, aligned major social funds with multi-year plans (National Social, Anti-Poverty, and Non-Self-Sufficiency Plans) and established the Network for Social Protection and Inclusion. In the LTC field, the decree emphasized independent living, home-based and community-based care, and operationalized LEPS through the biennial Non-Self-Sufficiency Plan. In parallel, the 2017 update of the LEA mandated integrated care pathways for non-self-sufficient persons, end-of-life patients, and persons with disabilities, refining cost-sharing mechanisms and governance of residential services.

dynamics that strengthened the role of specific parties within the new configuration of the Italian party system. The existing *equilibria*, however, were disrupted. This is the topic of the following sections.

3. From Zero to One Hundred? LTC in Italy, from Neglected to Salient (2020-2021)

The outbreak of the COVID-19 pandemic profoundly reshaped the dynamics of Italy's political landscape. Between 2020 and 2021, Italian political parties faced an unprecedented public health emergency that compelled a comprehensive reassessment of policy priorities. This period also coincided with a reconfiguration of strategic political coalitions, culminating in the formation of the Draghi Government (the so-called “national unity” government), whose alignments proved markedly less predictable than those of the Conte I Government. The volatility of these alliances subjected parties to a form of political stress-testing, akin to the systemic pressures experienced during previous economic crises, such as the 2008 financial collapse. Within this context of heightened competition for legitimacy and shifting power *equilibria*, parties were compelled to navigate emerging policy terrains in search of renewed relevance. It is within this fluid and uncertain environment that the reform of LTC resurfaced on the political agenda, as evolving governance demands, and external constraints created potential windows of opportunity for intervention in a policy area long characterized by institutional inertia. The first part of the section (3.1) analyzes the initial ministerial initiative and the emergence of a strong and unified social demand. The second part (3.2) discusses the incorporation of long-term care as a structural milestone within the PNRR.

3.1. The Introduction of LTC into the Political Agenda

Before delving into the detailed dynamics of policy change, this section examines how LTC gained renewed political salience during the COVID-19 pandemic. It first explores the government's early ministerial responses to the crisis and the processes of legitimation exchange underpinning them (3.1.1.). It then investigates the emergence of a strong and unified social demand, which contributed to reshaping the agenda-setting process (3.1.2.).

3.1.1. The Ministerial Initial Reaction to the COVID-19 Pandemic: Dynamics of Legitimation Exchange and the Emergence of Early Responses in the Formation of the “Commissione Paglia”

In September 2020, as Italy confronted the devastating impact of COVID-19 on its long-term care system, the Ministry of Health, under Minister Roberto Speranza, established its first structured policy response: The Commission for the Reform of Health and Social Care for the Older Population—commonly known as the Paglia Commission—via a Ministerial Decree issued on September 8, 2020. This initiative directly responded to the disproportionate mortality rates in residential care facilities, where it was estimated that around 50% of Italy's pandemic-related deaths occurred (Ministero della Salute, 2020).

The Commission was mandated to facilitate a transition from an institution-centered eldercare model to an integrated framework based on home and community care, while also fostering broader societal

reflection on the dignity, rights, and care of non-self-sufficient older individuals⁴⁷. On September 21, 2020, Monsignor Vincenzo Paglia, President of the Pontifical Academy for Life and affiliated with the Community of Sant'Egidio, was publicly announced as the Commission's chair. Minister Speranza described this appointment as a "strategic step" signaling a cultural shift in the conceptualization of eldercare (Ansa, 2020; Avvenire, 2020; Quotidiano Sanità, 2020). The exchange of legitimacy operated on two levels. On the one hand, the decision served politically to rebuild relations with the Catholic Church following tensions over the RU486 abortion pill decision. On the other hand, the Catholic Church—despite some internal divisions—positioned itself on a crucial issue for its charitable and caregiving mission, while at the same time restoring legitimacy to a government in the midst of an emergency crisis, forced to curtail individual freedoms in order to address the public health emergency.

However, the appointment provoked immediate criticism and polarized responses. On the day of the announcement, the Gay Center raised concerns that choosing a religious figure risked marginalizing older LGBTQ+ individual, who often lack traditional family support. It stressed that "institutions are secular and must consider all social realities," urging Minister Speranza to ensure inclusive leadership of the Commission (Gay Center, 2020). Criticism intensified through secularist organizations. Maurizio Mori, President of the Consulta di Bioetica, condemned the appointment as institutional subordination to religious interests (Capocci, 2020). Roberto Grendene of the Unione degli Atei e Agnostici Razionalisti accused Speranza of favoring "a healthcare model that is private and religious," criticizing the continued public funding of religiously affiliated services (*ibidem*).

These critiques formed a broader oppositional coalition, positioning the Commission as not merely a technical-administrative body but also a symbolic arena testing the boundaries of secularism, participatory governance, and policy legitimacy. On September 22, MP Rosa Menga (M5S), supported by twelve co-signatories from the same party, formalized this critique through an immediate parliamentary inquiry, questioning "the criteria or evaluations which led the Minister to appoint an ecclesiastical figure as Commission president" (Camera dei Deputati, 2020a). Simultaneously, labor

⁴⁷ The composition of the Commission was deliberately distinctive, including not only experts but also writers and journalists: Mons. Vincenzo Paglia (Grand Chancellor, Pontifical Theological Institute for the Sciences of Marriage and Family; President); Prof. Leonardo Palombi (Professor of Epidemiology, University of Tor Vergata; President, Italian Society of Hygiene - Lazio Section; Secretary); Dr. Andrea Urbani (Director General for Healthcare Planning, Italian Ministry of Health); Dr. Gianni Rezza (Director General for Health Prevention, Italian Ministry of Health); Prof. Mario Barbagallo (Professor of Geriatrics, University of Palermo; President, International Association for Gerontology and Geriatrics, European Region); Ms. Edith Bruck (Writer and Poet); Dr. Velia Bruno (President, Evaluation and Verification Unit for Public Investment in Health); Prof. Silvio Brusaferro (President, Italian National Institute of Health - ISS); Ms. Maite Carpio (Director and Journalist); Prof. Giampiero Dalla Zuanna (Professor of Demography, University of Trento); Prof. Paola Di Giulio (Professor of Nursing Sciences; Vice President, Italian Higher Health Council); Prof. Nerina Dirindin (Professor of Public Economics and Health Policy, University of Turin); Ms. Simonetta Agnello Hornby (Writer); Prof. Giuseppe Liotta (Professor of Public Health, University of Tor Vergata; Coordinator, European Partnership on Active Ageing); Prof. Alessandro Pajno (Jurist; former President of the Italian Council of State); Prof. Paolo Vineis (Professor of Social Epidemiology, Imperial College London, UK).

unions contributed operational concerns: The SPI-CGIL criticized the exclusion of labor organizations from the Commission, emphasizing the necessity of involving both care workers and recipients in the reform process.

Responding to these pressures, the Ministry of Health clarified that the Commission was a "think tank"—a multidisciplinary forum meant to "provide ideas, insights, and reflections upon which the Ministry will act," rather than a governing authority (Camera dei Deputati, 2020b). This repositioning aimed to mitigate accusations of governance overreach while retaining symbolic influence. Additionally, the Ministry underscored the Commission's pluralistic composition, see note 6. This eclectic group was presented as evidence of a comprehensive approach addressing eldercare's multifaceted dimensions (*ibidem*). Undersecretary Sandra Zampa further defended the Commission, framing it as a forum where "diverse human, cultural, religious, and professional perspectives converge to form a holistic policy vision" (Camera dei Deputati, 2020b). Despite these assurances, MP Menga maintained a critical stance, highlighting the exclusion of key frontline actors—such as general practitioners, social workers, and psychologists—whose practical experience is crucial for feasible and sustainable policy outcomes. Menga also advocated for structured and continuous dialogue between Parliament and the Ministry, particularly regarding the use of EU recovery funds in long-term care reforms (Camera dei Deputati, 2020b).

Through these developments, two distinct coalitions emerged. The institutional coalition—comprising the Minister of Health, Monsignor Paglia, and faith-based media outlets like *Avvenire*—promoted moral renewal and epistemic pluralism, framing the Commission as essential to eldercare reform. Conversely, the critical coalition—including secularist organizations (Gay Center, UAAR, Consulta di Bioetica), trade unions (SPI-CGIL), and dissenting politicians (Menga and M5S co-signatories)—advocated secular governance, participatory legitimacy, and inclusive professional representation, challenging both the legitimacy and structure of the Commission.

In this initial phase of debate, the conflict—still relatively muted—was characterized by three primary cleavages: (1) symbolic-ethical legitimacy *versus* technical governance; (2) secularism *versus* religious influence in public welfare; and (3) top-down appointments *versus* demands for participatory and inclusive representation. The Ministry's framing of the Commission as a "think tank" strategically sought to accommodate criticisms without fundamentally altering its leadership. Throughout 2020, the Commission produced no immediate tangible outcomes. Its concrete contributions only emerged in 2021 with the *ISTAT-Paglia Commission Report* (Istat e Ministero della Salute, 2021) and the *Charter of the Rights of Older Persons and the Duties of Society* (Ministero della Salute, 2021), both of which influenced subsequent policy debates and legislative initiatives⁴⁸.

⁴⁸ These topics are addressed in greater detail in Chapter 7 of this dissertation.

3.1.2. From Neglected to Salient: The Emergence of a Strong and Unified Social Demand for LTC in the PNRR

In the aftermath of the appointment of the Paglia Commission in September 2020, the issue of LTC re-emerged within Italy's public and political discourse, largely in response to the devastating impact of the COVID-19 pandemic on RSAs (Ranci, 2023). Despite high expectations surrounding its establishment, the Commission's activities remained confined to a "reflective and epistemic function" (IT2, Expert - Ministerial Commission, Ministry of Health): While its outputs were intellectually valuable, they failed to translate into actionable policy proposals within the legislative process.

This *inertia* became particularly evident in January 2021, when Prime Minister Giuseppe Conte's second government (a coalition between the Five Star Movement and the Lega) approved the initial draft of the PNRR. Although the Plan was conceived to address Italy's structural weaknesses exacerbated by the pandemic, it notably lacked a comprehensive strategy for LTC reform. The measures outlined followed pre-existing trajectories—such as reinforcing *Assistenza Domiciliare Integrata*—and adhered to the guidelines of the 2019-2021 National Plan for Non-Self-Sufficiency. Consequently, the draft Plan offered fragmented interventions focused on healthcare services and territorial assistance, without an overarching, integrated vision for long-term care.

A turning point occurred in February 2021 when the Conte II government collapsed following Italia Viva's withdrawal of parliamentary support. Prime Minister Conte's resignation prompted President Sergio Mattarella to oversee consultations for a new executive. In a context of acute political fragmentation and institutional urgency, Mattarella entrusted Mario Draghi with the task of forming a new government: The resulting Draghi government was a national unity coalition, encompassing nearly all parliamentary forces except FdI. This political transition redefined not only the governing coalition's composition but also the technical and administrative architecture responsible for drafting the PNRR. Draghi's primary mandate was to finalize and implement the PNRR in accordance with the European Union's Next Generation EU programme. The formation of this technocratic-national unity executive marked a shift: From a coalition structured around an electoral mandate to a governance arrangement driven by institutional emergency and external conditionalities tied to EU funding mechanisms (Guardiancich et al., 2022). However, his leadership also exposed the contradictions inherent in such a broad coalition. The M5S experienced significant internal divisions, as many of its parliamentarians were uneasy about collaborating with Salvini's Lega within a pro-European technocratic executive.

The Lega itself faced ideological dilemmas. Salvini's pivot from sovereigntist populism to supporting Draghi's technocratic agenda alienated portions of his electoral base, diminishing his credibility, and fueling discontent within the party ranks (Ieraci & Ripamonti, 2025). Conversely, Fratelli d'Italia, by choosing to remain outside the governing coalition, successfully positioned itself as the sole credible voice of opposition, consolidating its appeal among national-conservative voters and setting the stage for its electoral ascendancy. Concurrently, Italy's policy advisory architecture—historically centralized within Ministerial Cabinets—underwent a process of pluralization, expanding to incorporate a more

heterogeneous network of advisors, including technocrats, senior civil servants, academic experts, and think tank professionals (Improta, 2022).

The academic and media debate interpreted this shift as a recalibration of Italy's welfare policy agenda, aligning with EU social investment paradigms and reopening the possibility for a structural reform of long-term care (Di Vico, 2021; Ferrera, 2021; Gori, 2021). Amid the turbulence of the preceding months, and in reaction to the glaring omission of an LTC reform strategy in the PNRR draft, a broad coalition of civil society organizations mobilized to fill this policy void. In March 2021, the *Network Non Autosufficienza*—composed of scholars, public and private service managers, and consultants, and joined informally by nine additional organizations⁴⁹—launched a coordinated platform aimed at securing the inclusion of LTC reform within the PNRR framework. The absence of strong political pressure groups on this issue had historically prevented reform attempts from advancing, making the mobilization of the Platform particularly significant (IT37, Expert - Social Services Agency "Ambito 9", Jesi).

The coalition's policy platform, titled "*Costruire il futuro dell'assistenza agli anziani non autosufficienti in Italia*" (Building the Future of Elder Care in Italy), explicitly called for embedding a national LTC reform agenda within the PNRR. The document framed the Recovery Plan as a unique and non-repeatable policy window to address Italy's long-standing structural deficiencies in eldercare provision. The proposal outlined a systemic overhaul of the LTC system, advocating for an integrated governance model capable of coordinating health and social care interventions. It identified critical infrastructural gaps—most notably, the absence of a comprehensive data and knowledge system for mapping LTC needs and services—and proposed the establishment of a unified access framework for beneficiaries. This phase of elaboration was described by participants as a "cenacolo," a laboratory-like setting where experts and activists, working remotely during the pandemic, collectively developed a new vision of eldercare (IT30, Expert - Federsanità Toscana).

Furthermore, the Platform advocated for the structural transformation of residential care facilities, envisioning their conversion into flexible, community-based service hubs that could deliver both residential and home-based care tailored to local needs. Central to the proposal was the concept of multidimensional care, explicitly rejecting the narrow, clinically-centered paradigm that had historically dominated Italy's LTC policy landscape. The platform not only presented a detailed and actionable reform blueprint but also functioned as a catalyst for broader societal mobilization. Following its publication, numerous additional organizations endorsed the proposal, thereby amplifying

⁴⁹ The NNA collaborated with a wide range of stakeholders, including AIMA (Italian Alzheimer's Disease Association), Alzheimer Uniti Italia, Cittadinanzattiva, Confederazione Parkinson Italia, Federazione Alzheimer Italia, Forum Disuguaglianze Diversità, Forum Nazionale del Terzo Settore, La Bottega del Possibile, with the institutional backing of Caritas Italiana.

the coalition's visibility and political influence. Within this process, Professor Gori⁵⁰ assumed a pivotal role, serving as an intermediary figure who bridged internal coalition dynamics with external institutional stakeholders (IT30, Expert - Federsanità Toscana; IT32, Expert - Fondazione Don Gnocchi).

3.2. The Inclusion of the LTC Reform in the PNRR

In April 2021, in the final version of the PNRR, Prime Minister Mario Draghi incorporated LTC reform as a structural priority, a decision subsequently ratified by Parliament with broad cross-party support. This marked a significant policy shift, explicitly acknowledging the need for a systemic overhaul of Italy's fragmented LTC framework.

Mission 5 of the PNRR—dedicated to Social Inclusion and Cohesion—includes Component 2 (Social Infrastructure, Families, Communities, and the Third Sector), whose first section focuses on Social Services, Disability, and Social Exclusion. Within this framework, three investment lines directly addressed LTC-related challenges. Investment 1.1: Support for vulnerable individuals and prevention of institutionalization for non-self-sufficient older adults aimed to promote independent living solutions and foster de-institutionalization through home and community-based care alternatives. Investment 1.2: Pathways to autonomy for individuals with disabilities emphasized the enhancement of home care services and targeted personalized support. Investment 1.3: Addressing severe social marginalization was designed to provide temporary housing solutions and to establish assistance hubs (*stazioni di posta*) for immediate care needs.

Alongside these investments, two strategic reforms were outlined: Reform 1.1 concerned the development of a Framework Law on Disability, elaborated through a parallel legislative process; Reform 1.2 focused on the creation of a comprehensive intervention system for non-self-sufficient older adults, envisioned as a parliamentary delegation law to establish an integrated framework of LEPS for eldercare. Scheduled for adoption by the end of the parliamentary term (Spring 2023), this reform aimed to formalize the principles articulated in the National Non-Self-Sufficiency Plan and to reinforce cross-sectoral integration with healthcare services, particularly those outlined under Mission 6 of the PNRR. Yet, as underlined by IT33 (Advisor, Office of the Prime Minister, Draghi Government), Reform 1.2 was introduced without earmarked resources, relying only on existing mission funds, which severely limited its transformative potential (*ibidem*).

The most significant financial commitment in this area was linked to Investment 1.1, with €307.5 million allocated to the conversion of traditional RSA facilities into clusters of autonomous apartments, designed to replicate the care standards of institutional settings while simultaneously promoting

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independent living. Table 6.11. summarizes the LTC-related investments included under Mission 5 of the PNRR.

Table 6.11. Investments and Reforms in Mission 5 of PNRR addressed to LTC.

Investments and Reform	Title	Content	Planned Actions	Funding
Investment 1.1	Social Infrastructure for Inclusion	Development of integrated social services for vulnerable groups, including dependent individuals	Creation of innovative services and support for community-based initiatives.	€500 million
Investment 1.2	Home Care Enhancement	Strengthen home-based care for the older people and non-self-sufficient individuals.	Implementation of new technologies and expansion of professional training in domiciliary assistance.	€700 million
Reform 2.1.	System of Interventions for Non-Self-Sufficient Elderly	Introduce a unified model for care for older persons focused on non-self-sufficient individuals.	Definition of essential service levels and simplification of access to services.	Not defined

Source: Author's elaboration on PNRR.

Simultaneously, Mission 6 of the PNRR, dedicated to Health, introduced a series of reforms under Component 1, aimed at strengthening proximity care networks, local healthcare facilities, and telemedicine (Table 6.12.). One of the explicit objectives of this component was to enhance territorial healthcare services, particularly in response to the demographic pressures of an aging population, ensuring alignment and integration with the social care interventions outlined in Mission 5. Specifically concerning LTC, Investment 1.2—titled “Home as the Primary Place of Care and Telemedicine”—set the target of expanding home care services to reach 10% of the population aged 65 and over by mid-2026, in accordance with best practices observed in other European welfare systems. The intervention primarily focuses on older individuals (65+) affected by chronic conditions and/or those classified as non-self-sufficient, aiming to foster care delivery models that prioritize home and community-based settings over institutional care pathways. An essential component of this investment was the enhancement of telemedicine infrastructures, which are intended to facilitate broader access to remote healthcare services, improve patient monitoring, and support integrated care pathways for chronic and complex conditions. The total financial allocation directed toward Investment 1.2 amounted to €4 billion.

Table 6.12. Investments and Reforms in Mission 6 of PNRR, directly or indirectly addressed to LTC.

Investments and Reform	Title	Content	Planned Actions	Funding
Reform 1.1.	Proximity networks, facilities, telemedicine, and National Health, Environment, and Climate Network	Reform to ensure uniform standards and integration between healthcare, environment, and climate change.	Adoption of uniform criteria for the territorial network and "One Health" vision between health and environment.	-
Investment 1.1.	Community Health Centers and Patient Care	Creation of territorial facilities to improve integrated health and social care.	Establishment of new Community Health Centers and enhancement of existing ones.	€2 billion
Investment 1.2.	Home as the Primary Place of Care and Telemedicine	Implementation of telemedicine to ensure healthcare delivery directly at home.	Development of digital platforms and teleconsultation and teleassistance services. The investment aims to increase the volume of home care services to cover, by mid-2026, 10% of the population aged 65 and over.	€4 billion
Investment 1.3.	Strengthening Intermediate Healthcare and Its Facilities (Community Hospitals)	Strengthening facilities for short stays and non-complex treatments.	Construction and improvement of Community Hospitals to support the territorial healthcare system.	€1 billion

Source: Author's elaboration on PNRR.

The inclusion of LTC reform in the Draghi government's agenda was made possible by a specific constellation of factors.

First, the transition from the Conte II to the Draghi cabinet reopened the drafting of the PNRR, thus generating what interviewees consistently described as a "historic window of opportunity" to unlock a field that had remained paralyzed for decades (IT31, Expert - IRCCS INRCA). Civil society actors and experts, coordinated within the *Network Non Autosufficienza*, exerted strong and visible advocacy pressure, ensuring that at least a minimal reform commitment would be integrated into the national plan (*ibidem*). Civil society organizations interpreted the introduction of an LTC milestone in the PNRR as both an unprecedented political window and a highly fragile commitment. As IT13 (Representative, Legacoop) stressed, the Plan created "a hinge moment" in which fragmented actors were compelled to recognize that the institutional opportunity could only be seized through collective mobilization rather than isolated advocacy. From the perspective of service providers, the risk was that LTC would remain marginal to the Plan's health- and performance-oriented priorities, unless an organized coalition articulated a systemic vision of non-self-sufficiency as a structural welfare challenge. IT29 (Representative, Cittadinanzattiva) similarly emphasized that the absence of LTC from the first drafts of the Plan underscored the persistence of Italy's long-standing neglect in this policy domain. The inclusion of a specific milestone was not the product of governmental foresight but rather the direct outcome of coordinated advocacy by a group of stakeholders, which framed the pandemic's impact on older adults as a legitimacy crisis for the Italian welfare state.

Second, the very nature of the Draghi government facilitated the process: As a technocratic cabinet with an exceptionally broad parliamentary majority, its political mandate revolved almost exclusively around PNRR implementation. In this context, LTC reform appeared as a policy “without enemies,” broadly acceptable across party lines, and thus more feasible than other, more contentious reforms (IT33, Advisor, Office of the Prime Minister, Draghi Government).

Third, the translation of societal mobilization into actionable policy proposals was made possible by the advocacy of key intermediaries, most notably Cristiano Gori, who acted as a broker between civil society and the executive. His role was instrumental in moving the issue beyond the confines of the Ministry of Labour and placing it at the center of government decision-making, particularly at Palazzo Chigi, where inter-ministerial coordination could be achieved (IT33, Advisor, Office of the Prime Minister, Draghi Government). However, as it will be clear later on in Chapter 7, this coalition-based pressure secured the milestone, but also highlighted the limits of political ownership: The Draghi government accepted the reform as an agenda item without translating it into a broader reconfiguration of welfare state priorities.

4. Conclusions

This chapter has analysed how the Italian LTC sector moved from political neglect to increasing salience between 2000 and 2021, focusing on the interaction between a growing social demand for reform and the policy supply articulated by political parties and government institutions. The findings reveal a gradual yet non-linear process in which external shocks, advocacy pressures, ministerial initiatives, and partisan strategies interacted to shape the political agenda, producing significant but incomplete shifts in policy priorities. It should be noted that this chapter deliberately covers developments up to 2021, as it focuses on the introduction of long-term care reform onto the political agenda after twenty years of institutional inertia. It is also worth specifying that the politics dynamics directly related to the decision-making process are examined in Chapter 7 of this dissertation.

First, the chapter demonstrated that the COVID-19 pandemic acted as a catalyst rather than a sole driver of change. Structural vulnerabilities in LTC—fragmented governance, underfunded services, and persistent territorial inequalities—had long been known but remained marginal within the national policy debate. The pandemic, however, dramatically exposed these weaknesses, triggering widespread public indignation, particularly in response to the high mortality rates in residential care facilities, and mobilising a broad coalition of civil society actors, pensioners’ unions, professional associations, and caregiving organisations around a unified social demand. This demand moved beyond calls for increased funding, instead framing LTC as a citizenship right requiring a systemic reconfiguration of care provision, cash benefits, and territorial equity within a cohesive national framework.

Second, political parties reacted to these growing pressures in differentiated ways, revealing clear asymmetries in the policy supply. The PD framed LTC as a structural reform priority, embedding it

within a universalist welfare vision and advocating stronger state responsibility, service integration, and professionalisation of care work. In contrast, the M5S approached LTC indirectly, prioritising anti-poverty measures such as the *Reddito di Cittadinanza* and decentralised governance mechanisms, while avoiding systemic reforms of benefits or services. The Lega adopted a familialist paradigm, favouring fiscal incentives, tax deductions for home care, and low-intensity territorial facilities, thereby preserving the primacy of informal caregiving. Meanwhile, Forza Italia and Fratelli d'Italia largely bypassed LTC altogether, embedding care for older people care within broader narratives of tax relief and family support without proposing sector-specific measures.

These diverging partisan positions strongly influenced the dynamics of coalition governments. Under Conte I (2018-2019), LTC remained peripheral, overshadowed by conflicts over flagship measures such as the *Reddito di Cittadinanza* and *Quota 100*. During Conte II (2019-January 2021), the alignment of M5S and PD created a more favourable environment for reform; however, persistent intra-coalitional fragmentation and competing welfare priorities delayed significant initiatives. It was only with the formation of the Draghi government in February 2021, supported by an exceptionally broad parliamentary majority and framed by the drafting of the PNRR), that LTC reform entered the strategic agenda more explicitly.

Third, the chapter shows that the interaction with ministerial and technocratic structures was crucial in reshaping the agenda but also revealed deep tensions between institutional inertia and societal demands for systemic change. On the one hand, ministerial initiatives—such as the establishment of the Commissione Paglia, the operationalisation of the *Livelli Essenziali delle Prestazioni Sociali*, and the *Piano per le Non Autosufficienze*—reflected a normative and incremental approach aimed at consolidating existing frameworks and refining eligibility criteria rather than transforming the architecture of the LTC system. On the other hand, the pandemic catalysed a unified and assertive social demand, led primarily by the Network per la Non Autosufficienza, which pushed far beyond these limited adjustments, calling for a comprehensive overhaul of the LTC regime based on universal rights, integrated care pathways, and stronger national coordination.

The Commissione Paglia played a pivotal yet contested role in this process. Its creation within the Ministry of Health was not only a technical response to the pandemic but also the result of political bargaining between Monsignor Vincenzo Paglia and Minister Roberto Speranza. While Paglia's appointment reflected a strategy of re-legitimation following previous controversies related to his positions on bioethical issues, it also provoked criticism regarding the presence of an ecclesiastical figure within a commission addressing predominantly secular policy concerns. These debates highlighted the growing politicisation of LTC governance and contributed to renewed ministerial engagement with the sector.

It is within this context that LTC's unexpected inclusion in the PNRR must be understood. The Plan elevated LTC beyond the scope of incremental measures already envisaged in existing instruments, such as *Assistenza Domiciliare Integrata* under Mission 6, and instead framed it as part of a broader

systemic vision of welfare reform. The convergence of three factors was decisive: An exogenous shock—the pandemic—which opened a rare window of opportunity by exposing structural failures; public mobilisation and advocacy pressure, embodied by the Platform, which consolidated a pro-public coalition comprising 47 organisations at its inception; ministerial technocratic leadership, supported by expert networks and European resources, which reframed LTC within the strategic architecture of the PNRR.

From this perspective, the period 2018-2021 represents a transitional phase in which LTC moved from neglect to salience but remained constrained by Italy's path-dependent welfare model. While the pandemic created *momentum* for rethinking the balance between family, state, and market in care provision, systemic transformation was limited by three enduring constraints: Fragmented governance between ministries and regions, partisan cleavages over welfare priorities, and resource asymmetries exacerbated by decades of fiscal austerity. By linking the dynamics of social demand and policy supply, the chapter demonstrates that LTC's elevation within the PNRR was less the outcome of coherent party strategies than the result of a contingent alignment between stakeholders and experts, ministerial entrepreneurship, and unprecedented European funding. While civil society actors successfully reframed care as a collective responsibility, political institutions have so far struggled to convert this *momentum* into substantive and enduring policy innovation.

Chapter 7. The Politics of LTC Reform in Italy between 2021 and 2024: Confronting Legge Delega 33/2023 and Decreto Legislativo 29/2024

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1. Introduction

As highlighted in Chapter 6, the Italian LTC sector experienced an unprecedented turning point during the COVID-19 pandemic (2020-2021), after decades of institutional inertia. The health crisis acted as a juncture, exposing deep-seated structural weaknesses in the system of care for non-self-sufficient older adults, including institutional fragmentation, territorial disparities, chronic underfunding, and an excessive reliance on families as primary care providers. In response, the government established the

Paglia Commission in 2020, tasked with developing a value-based and normative framework aimed at shifting the system from a predominantly residential model towards a proximity-oriented approach, centred on home- and community-based care and grounded in the protection of older adults' dignity. However, the Commission's composition—led by an ecclesiastical figure and excluding trade unions, service providers, and frontline professionals—sparked controversy.

The drafting of the PNRR, under strong supranational conditionalities, positioned LTC reform among Italy's strategic priorities for post-pandemic recovery. In 2021, the Draghi government incorporated the structural reform of LTC into the final version of the PNRR, thereby opening an unprecedented policy window. Within this context, an unusual advocacy coalition emerged: The *Patto per un Nuovo Welfare per la Non Autosufficienza* (hereafter, *Patto*). By bringing together trade unions, scientific associations, third-sector organisations, and service providers, the *Patto* became a pivotal actor, simultaneously exerting external pressure through public mobilisation and providing technical expertise to policymakers. Its capacity to translate fragmented demands into a coherent policy narrative significantly shaped the early legislative agenda.

The subsequent adoption of Law 33/2023 and Legislative Decree 29/2024 resulted from the interaction between the government, ministerial bureaucracies and commissions, and this advocacy coalition. As will be shown, the dynamics of political exchange were strongly influenced by the characteristics of competing coalitions and, specifically, by the interplay between partisan logics and the evolving configuration of social demand. The transition from the Draghi government to the Meloni government in 2022 marked a decisive shift from a relatively technocratic and consensus-driven approach to a more politically contested arena. The parliamentary debate on Law 33/2023 exposed deep ideological cleavages between party coalitions. While the law introduced significant innovations—including the institutionalisation of the *Sistema Nazionale per la Non Autosufficienza*, the creation of a unified assessment system, and the gradual transformation of the existing cash allowance into a *Prestazione Universale*—its provisions remained deliberately generic, leaving key implementation measures to be defined through Legislative Decree 29/2024. The implementation phase revealed a reconfiguration of coalitions and a renewed partisan contestation. The decree diluted several of the law's initial ambitions, reflecting the governing coalition's preference for maintaining a family-centred, low-cost care regime and prompting advocacy actors—particularly the *Patto*—to mobilise once again to defend previously secured achievements.

In line with Chapter 6, this chapter argues that LTC reform in Italy is shaped less by demographic or fiscal imperatives than by the sequencing of coalition alignments under enduring institutional constraints. The baseline architecture remains familistic and cash-centred, layered upon a territorially fragmented service system. Three structural features sustain this *equilibrium*: Electorally entrenched cash entitlements that are politically costly to recalibrate, a multilevel governance framework that amplifies regional heterogeneity and multiplies veto points, and the persistently low salience of LTC, which favours low-conflict instruments and incremental adaptation. Within this structure, reform trajectories do not follow linear functional pressures but instead emerge from patterns of political

exchange among pro-family, pro-public, and pro-market coalitions. External shocks, supranational constraints, and venue shift temporarily recalibrate bargaining power, but it did not produce path-breaking transformations.

Empirically, the chapter traces two “coalition seasons” to illustrate how the same institutional setting can generate divergent trajectories depending on the brokers of political exchange, the decision-making venues, and the policy instruments selected. In the first season, a technocratic window combined with external constraints enabled partial convergence on institutional design and coordination, opening a potential gate for path departure. In the second season, fiscal caution and the relocation of decision-making to implementation arenas reshaped the logic of political exchange, resulting in selective, market-mediated expansions while reinforcing the familistic core of the LTC system. These oscillations are not anomalies but rather predictable outcomes in a low-salience policy sector, where distributive conflicts are displaced into disputes over policy instruments, procedural timelines, and levels of government.

Against this backdrop, the chapter examines the trajectory of Italy’s LTC reform across four interconnected dimensions. Section 2 analyses the agenda-setting phase and the drafting of the *Legge Delega* before the change of government, focusing on coalition formation between 2021 and 2023, the role of the Turco Commission, the consolidation of social demand through the *Patto*, and the government’s positioning within an uncertain constellation of measures, from the 2022 Budget Law to the Prime Minister’s Office Commission. Section 3 explores the transition from the draft *Legge Delega* to the final approval of Law 33/2023 under the Meloni government, examining the re-emergence of political contestation, the debates in the 10th Committee on Social Affairs and the Chamber of Deputies, and the ideological cleavages revealed during parliamentary consultations. Section 4 focuses on the shift from the delegated law to the implementing decrees, analysing the polarisation of positions, the role of parliamentary committees and the Unified State-Regions Conference, and the unilateral compromise represented by Legislative Decree 29/2024. Finally, the last Section concludes by assessing the strategies adopted by the *Patto* following the adoption of the implementing decrees and considering the most recent developments in LTC policymaking.

2. The Draft of *Legge Delega* Before Government Alternation (2021- Aug. 2022)

This section examines the transition from the agenda-setting phase to the drafting of the *Legge Delega* in the period preceding the governmental alternation of 2022. Section 2.1. analyses the dynamics that characterised the first “season” of coalition formation in support of LTC reform between 2021 and 2022. Section 2.2. then explores the political and institutional dynamics that shaped the pathway towards the delegated law, highlighting how social and political actors operated within a broader context of “depoliticisation” between 2021 and 2022. The section extends up to the end of the Draghi legislature, which, as will be shown, marks a turning point in the decision-making process on LTC in Italy.

2.1. The First Season of Coalition Formation during the Government Alternation

As noted by De Tommaso & Maino (2023) and Maino (2024), following the inclusion of LTC structural reform within the Italian PNRR, both the Draghi government and the expanding advocacy coalition—which would later consolidate into the *Patto*—initiated efforts to draft the reform's legislative framework. However, this process was not characterized by seamless coordination. As will be discussed in the following sections, the policy-making arena soon revealed fragmented coalitions, each advancing divergent visions of what LTC reform should entail. Rather than a unified reformist front, the interaction between institutional actors and civil society produced a contested policy field, where alliances were fluid and often issue-specific, reflecting underlying tensions between competing paradigms of care, resource allocation priorities, and differing interpretations of the state's role in the LTC domain. Section 2.2.1. analyses the role of the Turco Commission, established within the Ministry of Labour and Social Policies, which laid the groundwork for developing a policy framework aimed at integrating LTC within broader welfare reforms. Section 2.2.2. explores the emergence and institutionalisation of social demand through the *Patto*, a pivotal advocacy coalition aggregating trade unions, third-sector organisations, and service providers. Finally, Section 2.2.3. investigates the government's positioning and ministerial strategies within an unclear constellation of measures, spanning from the 2022 Budget Law to the establishment of the Prime Minister's Office Commission, highlighting how fragmented initiatives coexisted with growing social mobilisation.

2.1.1. The Turco Commission of the Ministry of Labour and Social Policies

In May 2021, the Ministry of Labor and Social Policy—under Andrea Orlando (Partito Democratico)—established a Ministerial Committee chaired by Livia Turco, officially named the *Commission for Social Interventions and Policies for Non-Self-Sufficiency*. Initially conceived as a technical body to develop the Essential Levels of Social Services, the Commission's mandate was rapidly expanded to include drafting a comprehensive legislative proposal for LTC reform, following the inclusion of LTC among Italy's commitments within the PNRR.

The Commission's first output was the elaboration of the LEPS on non-self-sufficiency, which was approved by the 2022 Budget Law under the Draghi government. This work constituted a foundational step for the development of the *Piano per le Non Autosufficienze* (see *infra*), of which the Ministry of Labor was in charge. In parallel, the Commission was entrusted with drafting a full legislative proposal—the *Bozza Legge Delega Anziani*—which was formally delivered to Minister Orlando and subsequently transmitted to the Presidency of the Council of Ministers, Legislative Office. Once the Commission delivered the draft law, its role was considered completed⁵¹. The subsequent stages—consisting of

⁵¹ One of the outputs of the Commission in 2022 was the publication of *Lavoro sulle Residenze Sanitarie Assistenziali*. Building on the work of the previous commission established in 2020, the report examined the relationship between residential care facilities and human rights (Senato della Repubblica, 2022).

interministerial negotiations, technical reviews, and political bargaining—were handled by the Presidency of the Council (“Commissione Paglia 2”, see *infra*), involving the heads of Cabinet, department directors, and Legislative Offices from the respective ministries.

Between May and December 2021, the Turco Commission functioned as a hybrid forum, combining expertise from academia, regional administrations, and third-sector organizations⁵². Its meetings, convened in response to PNRR-imposed deadlines, allowed for an open yet pragmatic negotiation process. However, this flexibility also exposed the Commission to structural vulnerabilities, especially given the asymmetrical power of institutional actors like INPS, MEF, and the Ministry of Health, who maintained *de facto* veto power over core components of the reform (IT23, Former Administrative Director, Ministry of Labour and Social Policies; IT33, Advisor, Office of the Prime Minister, Draghi Government).

The internal debates within the Commission revolved around three central axes: The political sensitivity surrounding the *Indennità di accompagnamento*, the regulatory structure of LTC services, and the prevailing care provision model. Both IT1 (Expert - Ministerial Commission, Ministry of Labor and Social Policy) and IT23 described the IdA as an untouchable pillar, whose reform was politically unviable within the Commission's deliberations. On regulatory structure, several interviewees underlined the tensions between proponents of a universalistic, publicly governed model and those advocating for a mixed system leveraging private and third-sector providers (IT1, Expert - Ministerial Commission, Ministry of Labor and Social Policy; IT23, Former Administrative Director, Ministry of Labour and Social Policies; IT32, Expert - Fondazione Don Gnocchi). Additionally, concerns about the risk of re-institutionalization through PNRR-funded community hospitals were raised, cautioning against the uncritical expansion of semi-institutional care structures (IT23, Former Administrative Director, Ministry of Labour and Social Policies; IT32, Expert - Fondazione Don Gnocchi).

Despite these cleavages, the Turco Commission delivered a cohesive draft law to the Ministry of Labor in December 2021 (then officially presented in January 2022). However, as Turco herself acknowledges, the Commission's role was strictly preparatory. At the heart of the proposal was the institutional strengthening of *Ambiti Territoriali Sociali*, designed to serve as the operational hubs for the planning, delivery, and monitoring of social services at the local level. This was intended to overcome the chronic

⁵² Unlike the preceding *Paglia Commission*, this body brought together a group of experts and practitioners in the field of long-term care: Livia Turco (Chair); Don Vinicio Albanesi (Community of Capodarco); Pietro Barbieri (European Economic and Social Committee - CESE); Fabrizio Barca (Forum on Inequalities and Diversity); Aldo Bonomi (Consortium for Territorial Development Agents - A.AS.TER); Nerina Dirindin (University of Turin); Cristina Freguja (Italian National Institute of Statistics - ISTAT); Alessandro Goracci (Italian Ministry of Labour and Social Policies); Cristiano Gori (University of Trento); Angelo Marano (Italian Ministry of Labour and Social Policies); Paolo Onelli (Italian Ministry of Labour and Social Policies); Emmanuele Pavolini (University of Milan); Antonella Pezzullo (Local Health Authority No. 1, Naples); Francesco Poli (National Association of Social Workers); Alfonsina Rinaldi (Expert in Social Policies); Nino Santarelli (Marche Region); Miriam Totis (Friuli Venezia Giulia Region); and Tiziano Vecchiato (Emanuela Zancan Foundation, Nonprofit).

territorial fragmentation of LTC governance by ensuring homogeneous standards across municipalities, while fostering integrated coordination with the healthcare system through *Punti Unici di Accesso* (i.e., PUA), hosted within community care facilities. In line with Law 328/2000, the draft law also introduced the formalisation of LEPS as legally enforceable rights, elevating social services from discretionary provisions to entitlements protected under national law. This move was explicitly aimed at closing the gap between the constitutional guarantee of universal social rights and the actual territorial disparities in service provision.

The proposal also introduced the *Budget di Cura e Assistenza*, a financial instrument designed to consolidate all available resources—monetary benefits, in-kind services, and fiscal incentives—into a personalized assistance plan (*Progetto Assistenziale Individualizzato*) co-designed with the beneficiary and their family. This mechanism aimed to ensure flexibility, accountability, and user-centered planning, while progressively reducing the reliance on cash benefits in favor of structured service provision. Moreover, the proposal foresaw specific measures for the formal recognition and support of informal caregivers, including pathways for training, psychological support, and the gradual extension of social security protections. This aspect was seen as critical to addressing the gendered nature of informal care work and its socio-economic implications.

The draft law also explicitly committed to the gradual deinstitutionalization of care, promoting *nuova domiciliarità* models—such as co-housing, solidarity condominiums, and family-based residential alternatives—as a structural alternative to traditional care homes. Yet, the Commission was also the *locus* of profound tensions that reflected the unresolved dilemmas of Italian LTC policy. As IT1 noted, the debates exposed both the technical difficulties and the political vulnerability of the Commission's work: Although its draft law was coherent and ambitious, unresolved distributive conflicts and the veto power of key institutional actors—most notably the Ministry of Economy and Finance and INPS—cast long shadows over its prospects of full implementation (IT1, Expert - Ministerial Commission, Ministry of Labor and Social Policy). In this sense, the Commission functioned less as a decisive policymaking arena and more as a preparatory *forum*, producing a blueprint whose realization would depend on subsequent interministerial negotiations and political bargains.

It was within these spaces of discretion that the actions of the *Patto per un Nuovo Welfare sulla Non Autosufficienza* found their place.

2.1.2. Formalizing Social Demand: The *Patto per un Nuovo Welfare per la Non Autosufficienza*

On July 21, 2021, the *Patto* was formally established as a coalition of scope, explicitly designed to influence the policy trajectory of Italian LTC reform. On the day of its foundation, the coalition presented a policy document outlining *Cinque Punti*—five core reform principles deemed essential for the forthcoming legislative process (Patto, 2021).

The *Patto's* organizational design combined inclusivity with strategic coordination. Under the

coordination of Professor Cristiano Gori, the coalition rapidly expanded to 51 member organizations, encompassing civil society associations, the three main trade unions (CGIL, CISL, UIL), third-sector entities, and policy experts. Its governance model was structured around a *Cabina di Regia* (Steering Committee), responsible for strategic leadership and policy drafting, and a *Comitato di Coordinamento* (Coordination Committee), tasked with external relations and operational management. From January 2022, seven thematic working groups were activated, focusing on key policy domains such as financing, governance, service integration, and the role of informal caregivers.

As IT29 (Representative, Cittadinanzattiva) and IT38 (*Patto's* Coordinator) emphasized, the *Patto* embodied a hybrid model of action, simultaneously exerting advocacy pressure while offering technical consultancy to policymakers. On one hand, it mobilized a wide array of stakeholders through campaigns, media interventions, and parliamentary lobbying, raising the political salience of LTC reform. On the other, it positioned itself as a credible technical interlocutor, furnishing detailed briefs and legislative proposals to ministerial actors (IT29, Representative, Cittadinanzattiva). This dual-track approach proved crucial in accessing what was otherwise a highly technocratic and closed decision-making arena, particularly given that civil society had been excluded from formal consultation processes during the drafting of the PNRR.

According to several interviewees—IT31 (Expert - IRCCS INRCA); IT32 (Expert - Fondazione Don Gnocchi); IT34 (Expert - ARS)—the *Patto's* distinctiveness lay in its ability to aggregate and reframe fragmented sectoral demands into a coherent policy narrative. This narrative was anchored in three overarching objectives: Overcoming institutional fragmentation in LTC governance; ensuring stable and adequate public financing; embedding LTC within a rights-based framework, grounded in universal entitlements.

The coalition was explicitly conceived as a time-limited structure, committed to dissolving upon the enactment of the implementing decrees scheduled for March 2024. This institutional design carried a strategic message: The *Patto* sought to highlight its focus on concrete reform outcomes rather than organizational perpetuation (IT29, Representative, Cittadinanzattiva; IT38, *Patto's* Coordinator). As IT33 (Advisor, Office of the Prime Minister, Draghi Government) and IT35 (Secretary General, Cittadinanzattiva; Former Head of Technical Secretariat, Ministry of Health, Draghi Government) argued, the temporary nature of the coalition reflected a pragmatic reading of the Italian institutional context, where advocacy success depends on creating a united front with a clear exit horizon.

The *Patto* represented a “hinge moment,” compelling otherwise fragmented actors to coordinate under a common platform and preventing LTC reform from being absorbed into sectoral silos (IT29, Representative, Cittadinanzattiva). In practice, the *Patto's* advocacy strategies operated on multiple, mutually reinforcing levels. It engaged in direct lobbying of parliamentary groups across the political spectrum; organized high-profile public events, such as the annual *Forum sulle Non Autosufficienze*; and leveraged media campaigns to frame LTC as a societal rather than sectoral issue. “We knew that simply waiting for institutional commissions to deliver results would lead nowhere. The *Patto's* strength was in creating external pressure while providing internal solutions” (IT29, Representative,

Cittadinanzattiva). This hybrid positioning allowed the *Patto* to serve as a broker between grassroots mobilization and technocratic expertise. IT31 captured this dynamic succinctly: “*the Patto’s added value was its ability to mediate between the grassroots and the technocracy, translating complex sectoral needs into actionable legislative proposals*” (IT31, Expert - IRCCS INRCA). Yet, the *Patto* also faced constraints. Its credibility with policymakers was contingent upon maintaining unity among diverse constituencies—from unions defending cash benefits to service providers seeking to strengthen the supply side—thus requiring constant negotiation and compromise within the coalition itself.

In March 2022, the *Patto* presented its most comprehensive proposal: The *Sistema Nazionale Assistenza Anziani* (SNAA), a National System for Care for Older Persons designed to structurally reform Italy’s LTC system for non-self-sufficient older adults (Patto, 2022a). The SNAA was conceived as an integrated governance framework unifying all health and social public measures—monetary benefits, domiciliary care, semi-residential and residential services—under coordinated state-regional-municipal governance. Its architecture rested on three core innovations: (1) A single-entry access point; (2) A standardized multidimensional needs assessment tool (*Valutazione Nazionale di Base*, VNB); and (3) The transformation of the *Indennità di accompagnamento* into a *Prestazione Universale per la Non Autosufficienza*, calibrated according to care intensity.

The SNAA also redefined the logic of service provision by articulating a continuum of person-centered, diversified responses, prioritizing home- and community-based care whenever possible. Special attention was devoted to informal caregivers and private care workers (*assistenti familiari*), advocating for their professional recognition, training, and integration into formal networks. On financing, the proposal combined a commitment to public funding of essential levels of assistance (LEA and LEP) with the gradual development of second-pillar integrative schemes. *De facto*, the SNAA was not conceived as a patchwork of incremental measures but as a transformative blueprint to establish a structured, universal, and rights-based LTC system in line with European best practices.

As several interviewees noted, this ambition constituted both the coalition’s strength and its vulnerability: While it offered policymakers a ready-made vision, it also crystallized distributive conflicts around benefits, funding, and governance that the *Patto* itself could not resolve (IT29, Representative, Cittadinanzattiva; IT30, Expert - Federsanità Toscana; IT32, Expert - Fondazione Don Gnocchi; IT33, Advisor, Office of the Prime Minister, Draghi Government; IT34, Expert - ARS; IT37, Expert - Social Services Agency).

2.1.3. The Government’s Positioning: Ministerial Action within an Unclear Constellation of Measures

Between May 2021 and March 2022, both the Turco Commission and the *Patto* had formally presented their respective proposals for LTC reform. Yet governmental action unfolded within an increasingly opaque constellation of overlapping and parallel decision-making processes, which several interviewees

described as emblematic of Italy's fragmented welfare governance (IT23, Former Administrative Director, Ministry of Labour and Social Policies).

In July 2021, the *Piano Sociale Nazionale dei Servizi Sociali* (2021-2023) formally acknowledged LTC as a priority policy area, explicitly recognizing non-self-sufficient individuals as a central target group for social inclusion strategies. This trajectory was subsequently reinforced by two major policy milestones: The 2022 Budget Law (Law 234/2021) and the *Piano Nazionale per la Non Autosufficienza* (PNNA 2022-2024). Nevertheless, these initiatives were widely described as “*parallel and uncoordinated processes*,” symptomatic of the absence of an overarching governance structure capable of aligning objectives and avoiding duplication (IT35, Secretary General, Cittadinanzattiva; Former Head of Technical Secretariat, Ministry of Health, Draghi Government).

The 2022 Budget Law, particularly paragraphs 159-171, focused on the definition and implementation of *Livelli Essenziali delle Prestazioni Sociali* for non-self-sufficiency. This measure followed an expected trajectory, largely in continuity with the PNNA 2019-2021 and the recommendations of the Turco Commission (IT23, Former Administrative Director, Ministry of Labour and Social Policies). Yet, as IT29 (Representative, Cittadinanzattiva) underlined—a point also confirmed by IT33 (Advisor, Office of the Prime Minister, Draghi Government) and IT35 (Secretary General, Cittadinanzattiva; Former Head of Technical Secretariat, Ministry of Health, Draghi Government)—the *Patto* played a decisive role in ensuring that LTC reform remained politically salient, successfully lobbying for increased allocations to the *Fondo per la Non Autosufficienza* (FNNA). Through coordinated advocacy involving unions, civil society, and third-sector actors, the coalition secured progressive increases in the FNNA: €100 million in 2022, €200 million in 2023, €250 million in 2024, and €300 million annually from 2025. These were later augmented to €915.3 million for 2024 and €965.3 million for 2025, alongside the establishment of an information flow system to monitor expenditure.

Still, as IT4 (Expert, Itinerari Previdenziali) observed, this financial strengthening occurred in the absence of a coherent strategic framework for integrating public and private interventions. Since 2007, fiscal incentives had been available to promote second-pillar LTC coverage via mutual funds, yet governance remained fragmented, lacking systemic coordination between public provision and supplementary private schemes. “*The absence of a coherent public-private integration framework perpetuates a dualism that risks exacerbating territorial and socioeconomic disparities*” (IT4, Expert, Itinerari Previdenziali).

Parallel reforms further contributed to institutional complexity. Law 22/2021 on Disability came into force on December 31, 2021, as part of Mission 5 of the PNRR, adding another sectoral layer intersecting with LTC. Soon after, in May 2022, the Ministry of Health approved Ministerial Decree 77/2022 (DM 77/22), redefining organizational models and standards for territorial healthcare (Reform 1.1, M5C1). Although not explicitly targeting LTC, DM 77/22 introduced critical guidelines for community care networks, home services, and telemedicine infrastructures. Yet, it was developed and implemented in

a *vacuum*, without structured coordination with parallel social care reforms (IT37, Expert, Social Services Agency).

The result was what IT35 (Secretary General, Cittadinanzattiva; Former Head of Technical Secretariat, Ministry of Health, Draghi Government) termed a “policy labyrinth”: Each ministry pursued its own reform trajectory, generating procedural redundancies and diluted coherence. In theory, the Presidency of the Council of Ministers (PCM) should have acted as the coordinating authority; in practice, it failed to exercise meaningful leadership, assuming a merely symbolic role devoid of operational leverage (IT35). This vacuum reinforced the dominance of ministerial bureaucracies—primarily the Ministry of Labour, the Ministry of Health, and INPS—whose competing logics frequently clashed.

In January 2022, the government attempted to address this fragmentation by creating the *Commissione per le politiche in favore della popolazione anziana* under the Presidency of the Council, chaired by Monsignor Vincenzo Paglia. Its dual mandate was both ideational and operational: To elaborate a comprehensive reform proposal addressing demographic ageing and to carry out immediate interventions, such as a nationwide census of eldercare facilities in collaboration with the Carabinieri, targeting illicit and informal care homes

However, as IT35 (Secretary General, Cittadinanzattiva; Former Head of Technical Secretariat, Ministry of Health, Draghi Government) and IT37 (Expert - Social Services Agency) unanimously emphasized, the second “Paglia Commission” was more symbolic than substantive. *“The Commission was created to project an image of coordination but lacked binding legal instruments or budgetary control to actually steer the reform process,”* remarked IT2 (Expert - Ministerial Commission, Ministry of Health). IT31 (Expert - IRCCS INRCA) similarly described its vision as *“rights-based but structurally weak,”* pointing out that while the Commission succeeded in reframing ageing in terms of universal rights and territorial care, it failed to anchor these proposals in binding legislation. Likewise, IT37 (Expert - Social Services Agency) noted that the Commission was excluded from resource allocation, limiting its role to that of a consultative body without operational leverage.

Yet, despite its limited institutional leverage, the vision articulated by the Paglia Commission—although never consolidated into a formal written report—became pivotal in shaping the “collage” of policy inputs that culminated in the first draft of the *Legge Delega Anziani* at the end of the Draghi legislature. In this sense, its contribution was less about producing binding regulatory frameworks than about injecting a normative orientation—centered on dignity, rights, and community-based care—that was later absorbed, selectively, into the broader reform trajectory.

2.2. Towards the Delegated Law: The Positioning of Social and Political Actors in a Context of “Depoliticization”

Between 2021 and 2022, Italy’s LTC reform debate consolidated around three major proposals, each reflecting distinct coalitional logics and institutional perimeters: The *Patto per un Nuovo Welfare sulla*

Non Autosufficienza, the Turco Commission, and the Paglia Commission. The *Patto*'s proposal (Patto, 2022a) framed LTC as a universal and legally enforceable right, calling for the creation of a SNAA that would unify all existing measures—monetary transfers, domiciliary services, and residential care—under a single governance system coordinated across State, Regions, and *Ambiti Territoriali Sociali*. Central to this proposal was the replacement of the *indennità di accompagnamento* with a *Prestazione Universale* tailored on health and social needs, linked to a standardized national assessment tool (VNB) and accessed through a single-entry point (i.e., PUA). Financing was to be gradually expanded up to 2% of GDP, combining national public funds with integrative schemes. Importantly, the *Patto* emphasized the strategic strengthening of home and community-based services, explicitly aiming to reduce the overreliance on institutional care. Equally central was the recognition of informal caregivers and migrant care workers (*assistenti familiari*), for whom the proposal envisaged structured support, training, and professionalization measures (Patto, 2022a).

The Turco Commission's draft law (Ministero del Lavoro e delle Politiche Sociali, 2022) converged with the *Patto* on several axes—particularly the institutional reinforcement of *Ambiti Territoriali Sociali*, the integration of health and social services via *Punti Unici di Accesso*, and the codification of *Livelli Essenziali delle Prestazioni Sociali* as justiciable rights. However, it diverged in its incrementalism: Unlike the *Patto*, it did not propose dismantling the *indennità di accompagnamento*, which was treated as politically untouchable (IT1, Expert - Ministerial Commission, Ministry of Labor and Social Policy; IT23, Former Administrative Director, Ministry of Labour and Social Policies). Instead, the draft law suggested a cautious rebalancing between in-cash and in-kind benefits, deferring more radical redistributive decisions to future legislative decrees. Furthermore, while it acknowledged the gendered role of informal care, its measures for caregivers were more limited compared to *Patto*'s systemic redesign. In short, the Turco Commission produced a structurally ambitious yet politically constrained blueprint, seeking equilibrium between innovation and feasibility.

The Paglia Commission's contribution represented a third pole, distinctive in its normative orientation. Rooted in ecclesiastical and civil-society networks, it framed LTC around dignity, solidarity, and proximity care (IT2, Expert - Ministerial Commission, Ministry of Health). Its proposals included a tenfold expansion of home-care hours, promotion of family- and community-based alternatives to institutional care, and the mobilization of parishes, volunteer networks, and religious associations as proximity infrastructures. However, the proposal lacked detailed provisions on financing and governance, functioning more as a discursive and moral catalyst than as an operational reform plan. As several interviewees emphasized, the Paglia Commission's value lay in reframing ageing and care as national priorities, contributing normative legitimacy to reform, even if its concrete institutional impact was limited.

Convergences among the three proposals included recognition of LTC as a structural policy priority, no longer marginal within the welfare agenda; the centrality of territorial governance through *Ambiti Sociali Territoriali* (ATS) and integrated access points; a shared emphasis on expanding home and community-based care and progressively reducing reliance on institutionalization. Divergences,

however, were equally evident: For instance, with regard to cash benefits, the *Patto* proposed transforming the IdA into a new universal benefit, conditional on the level of dependency and earmarked for the purchase of services on the market, while the Turco Commission opted for incremental adjustments, and the Paglia vision largely bypassed the issue. On financing, the *Patto* demanded a significant and quantified expansion (up to 2% GDP), the Turco Commission remained deliberately vague, and the Paglia proposal avoided specifying funding sources. Overall, The *Patto* advanced a broader and more systemic vision. It seeks to bring together cash benefits, services, and institutional arrangements within a single policy design, explicitly addressing the challenge of integration between social and healthcare systems. From this perspective, long-term care is conceptualised as a new social risk, endowed with its own governance structure and dedicated policy instruments, rather than as a mere extension of pre-existing policy domains.

Taken together (Table 7.1), these three trajectories constituted the composite foundation of the first *Legge Delega Anziani* (October 2022). Each proposal (*Patto*, Turco and Paglia) was underpinned by a distinct definition of the problem. Policy learning therefore did not occur in a “harmonious” environment; rather, it emerged through the development of solutions in which different problem definitions coexisted, overlapped, and at times diverged. The resulting reform design aggregates multiple visions and objectives, held together more by an exceptional convergence of circumstances than by a unified overarching vision.

Table 7.1. Comparative LTC Reform Proposals: Patto, Turco and Paglia Commission (2022).

Dimension	Patto (2022)	Turco Commission	Paglia Commission
Social Right, Recognition of LTC	Universal and enforceable social right to LTC	Codification of LEPS as legally enforceable entitlements	Emphasis on dignity and proximity care as moral imperatives; rights framed more in ethical than juridical terms
Financing and Coverage	Progressive increase of public funding up to ~2% of GDP; national LTC fund as main financing pillar, complemented by second-pillar schemes	Strengthening of the <i>Fondo Non Autosufficienza</i> ; budget consolidation through <i>Budget di Cura e Assistenza</i> (pooling cash + services)	Silent on financing mechanisms; focus on vision and values rather than fiscal sustainability
Eligibility Criteria	National standardized multidimensional assessment (<i>Valutazione Nazionale di Base</i>). Eligibility linked to assessed care needs	Eligibility through PAI (<i>Progetto Assistenziale Individualizzato</i>), integrating benefits and services; multidimensional assessment formalized in law	Broad and inclusive vision; emphasis on reaching all older persons, but without formal criteria or assessment tools
Multilevel Governance	Strong national steering + ATS as operational hubs; coordination across State-Regions-Municipalities	Reinforcement of ATS as planning/delivery hubs; stronger coordination with healthcare system via <i>Punti Unici di Accesso</i>	Focus on community and civil society networks; limited discussion of institutional multilevel governance
Regulatory Aspects (Public-Private)	Integration of informal caregivers and <i>assistenti familiari</i> into formal networks; mixed provision but under public coordination	Recognition of private/third-sector providers, but within a universalistic public governance framework; cautious balance	Reliance on parishes, voluntary associations, religious institutions; regulation largely absent
In-cash	Transformation of IdA into a universal care allowance modulated by needs	Maintenance of IdA as “untouchable”, but integrated within <i>Budget di Cura</i>	No explicit proposal; general support for income integration through solidarity channels
In-kind	Expansion of domiciliary and community-based services; continuum of care responses prioritizing home-based solutions	Development of LEPS-based service provision, deinstitutionalization through “ <i>nuova domiciliarità</i> ” models (co-housing, social housing, etc.)	Strong emphasis on home care and proximity networks; visionary, but weak on operationalization

Source: Author’s elaboration.

The three proposals advanced during the “first coalition season” preceded what eventually converged into the more uniform and generic draft elaborated by the Ministry of Labor and Social Policies, which was approved—albeit in a provisional form—shortly before the end of the Draghi government’s term. This synthesis became possible due to the exceptional political context of the Draghi government, which—aware of both the urgency of the issue and the window of opportunity opened by the NRRP—approved the enabling act before leaving office in October 2022, thereby passing it on to the subsequent government.

The final outcome, inherited by the newly established Meloni government, amounted to a confused puzzle of the three original visions, which left several ambiguities unresolved. Nevertheless, this process marked a turning point: For the first time, long-term care was formally recognized as a new social risk within the Italian welfare state. Crucially, the draft also placed the reform of the *Indennità di accompagnamento* on the political agenda, thereby demonstrating the effectiveness of a strong and unified demand within a fragmented and path-dependent institutional context.

3. Delegated Law 33/2023 and Legislative Decree 29/2024: From Depoliticization to Political Contestation (Sept. 2022-2024)

This section examines the transition from the draft Legge Delega to the final approval of Law 33/2023 under the Meloni government, analysing how shifting political *equilibria* and coalition dynamics reshaped the trajectory of LTC reform. It focuses on the second “season” of coalition formation, marked by the re-emergence of political contestation and the increasing salience of ideological cleavages in the policy debate (3.1.) The second part of the section turns to the implementation phase, exploring the shift from the delegated law to the drafting and approval of the legislative decrees (3.2.).

3.1. The Reinsurgence of Political Contestation during the Neo-Meloni Government

In September 2022, Fdi’s electoral success combined ideological consistency with strategic moderation. While maintaining nationalist, socially conservative, and Eurosceptic positions (Ronchi & Cigna, 2024), Meloni projected institutional credibility and international reliability, committing to NATO, the EU, and NRRP continuity. Her government’s core agenda blended right-wing populist themes—immigration control, law-and-order, and national identity—with fiscal prudence. Welfare policy shifted toward conditionality, replacing the universal *Reddito di Cittadinanza* with selective, work-conditioned benefits (*ibidem*). Coalition dynamics diverged from earlier centre-right governments. As Genovese & Vassallo (2023) argue, the 2022 elections re-established the majoritarian principle and ideological polarization, leading to a structurally coherent government with a democratic mandate. Bull & Polverari (2025) describe this shift as a “return to politics”: A political government replacing technocratic compromise. The opposition was fragmented and strategically incoherent. The PD, despite being the main opposition force, was mired in a leadership transition and had failed to coordinate electorally with M5S. The latter, while regaining rhetorical consistency, remained isolated and lacked allies. Centrist actors, such as Azione and Italia Viva, sought to construct a liberal-progressive pole but lacked territorial penetration and cohesion. This fragmentation weakened parliamentary checks and enabled the governing coalition to consolidate its dominance during its initial phase. Compared to the 2018 elections, the issue of non-self-sufficiency is explicitly addressed in the 2022 electoral platform of the M5S, which incorporates key elements of the proposals advanced by the *Patto*. By contrast, the centre-right coalition did not include this issue among its priorities and, as will be shown, proved unprepared to respond to the “unusual” positioning of the measure within the policy agenda.

This subsection traces the legislative trajectory that led from the initial draft of the *Delegated Law 33/2023* to the enactment of the definitive text, analysing how shifting political equilibria and coalition dynamics shaped both the content and direction of LTC reform. It begins by examining the early negotiations surrounding the draft text, highlighting the strategic interactions between governmental actors, ministerial bureaucracies, and advocacy coalitions that influenced its preliminary design

(3.1.1.). It then turns to the debates within the 10th Committee on Social Affairs and the subsequent Senate approval, which marked a decisive step in the legislative process while exposing the first signs of partisan contestation (3.1.2.). The analysis continues with the consultations held in the Chamber of Deputies, where divergent policy preferences and ideological cleavages between party coalitions became increasingly visible and where advocacy actors played a growing role in shaping the policy discourse (3.1.3.). Finally, the subsection assesses the final provisions of Law 33/2023, situating them within the broader political and institutional dynamics of the period and highlighting the strategic compromises that left crucial implementation measures to be defined in subsequent legislative decrees (3.1.4.).

3.1.1. From the Draft to the Delegated Law 33/2023

Between April and September 2022, Italy experienced a period of intense political turbulence that coincided with a phase of coalitional realignment and policy repositioning. While the reform of LTC had already been established as a milestone within the PNRR, the issue of non-self-sufficiency remained largely absent from the central narratives of the electoral campaign. Nonetheless, various actors mobilized to influence the policy agenda in anticipation of an imminent government transition. The *Patto* took the lead by formally requesting that the Draghi government proceed with the approval of the draft of Delegated Law before the expected shift in executive leadership (Patto, 2022b; 2022c).

On 10 October 2022, during its final session, the Draghi government's Council of Ministers unanimously approved the draft framework law on the reform of care for non-self-sufficient older persons. This version was received positively by a wide segment of civil society, with *Patto* describing it as a “solid foundation” for further implementation (Patto, 2022d). Yet, as highlighted in Section 3.2.4., the draft bore the marks of an ambiguous compromise between the three coalitions involved: While converging on the recognition of long-term care as a universal and subjective social right, they diverged sharply on the formulation of its concrete instruments— “a puzzle, with pieces from each coalition assembled without an overarching design” (IT33, Advisor, Office of the Prime Minister, Draghi Government).

The resulting text enshrined the establishment of a centralized national governance system—while acknowledging the role of regions and local authorities in policy implementation—a hybrid allocation of responsibilities across the social and healthcare sectors, and the reform of the *Indennità di accompagnamento* through the introduction of a universal benefit (*Prestazione Universale*), conditional upon service uptake and modulated according to individual care needs. It also outlined the expansion of residual social services, the introduction of a standardized multidimensional needs assessment, and a national plan for active ageing.

At the same time, the newly installed Meloni government, while reshuffling ministerial bureaucracies, began to engage with the LTC agenda. By March 2023, the draft legislation had reached parliamentary debate and was scheduled for final approval in both the Senate and the Chamber of Deputies. An

interviewee, recalling the transition, remarked that *“the Draghi draft offered a platform that the new government could hardly ignore, but the political will to move forward in continuity was far less clear”* (IT3, Welfare and Health Secretariat, PD). The specific content of the Delegated Law and subsequent Legislative Decree will be discussed in Section 4.2.

In preparation for this new political phase, the *Patto* identified three strategic priorities: First, to ensure that its legislative proposal was embedded within the 2023 Budget Law; second, to sustain the parliamentary process of the enabling law by directly engaging with key government figures, including the Deputy Minister of Labour and Social Policies, Maria Teresa Bellucci, and the Undersecretary of State for Health, Marcello Gemmato; and third, to cultivate constructive relationships with members of the new parliamentary majority.

Between October 2022 and January 2023, the *Patto* resumed dialogue with the incoming government, most visibly through a public meeting convened at the CNEL in January 2023. As IT29 (Representative, Cittadinanzattiva) explained: *“We tried to reopen a space of dialogue with the new government, stressing continuity and technical credibility, but soon realized that the channels would narrow.”* As will become evident following the approval of Law 33/2023—and the subsequent closure of formal dialogue channels by the government—the configuration of social demand underwent significant reshaping, both at the aggregate level (through the repositioning of the *Patto* as a coalition) and at the individual level (through the differentiated strategies of its member organizations).

3.1.2. The Debate in the 10th Committee on Social Affairs and the Approval by the Senate

On 30 January 2023, during the 4th session of the 10th Standing Committee on Social Affairs, Minister Calderone formally announced the commencement of the legislative process for the approval of the delegation law on LTC, aiming for ratification by March 2023. She described it as a “historic reform” (Senato della Repubblica, 2023). Between 2 February and 1 March 2023, the Committee held its referent stage hearings, and on 8 February, representatives of stakeholder organisations—including unions, third-sector associations, and advocacy groups—were summoned for formal consultation.

A crucial cleavage in the parliamentary debate revolved around the recognition of LTC as a social right. A progressive coalition⁵³ (PD, AVS) advocated for LTC to be established as a universal entitlement anchored in social citizenship. Their flagship proposal called for the creation of a *Sistema Nazionale per le persone Anziane non Autosufficienti* (i.e., SNAA), described in the amendments as *“a permanent organisational framework for the joint governance of all public measures dedicated to care for older persons”* (Senato della Repubblica, 2023: 9). The SNAA was envisaged as a vehicle to *“program in an integrated way all services and interventions... with active participation of social partners and sectoral associations”* (Senato della Repubblica, 2023: 9). This position framed LTC not simply as a service

⁵³ It included senators from the Partito Democratico (PD) and Alleanza Verdi e Sinistra (AVS)—notably Susanna Camusso (PD), Sandra Zampa (PD), and Matteo Magni (AVS).

provision, but as a codified social right embedded in national welfare architecture.

In contrast, a centre-right and centrist bloc⁵⁴ adopted a more residualist and subsidiary approach. This coalition upheld the primacy of the family and local communities in care for older persons, expressing reservations toward expansive state-led governance. *Italia Viva/Azione*, for example, explicitly called for the institutional recognition of RSA (nursing homes), to be “*valorised as a fundamental support for older people not assistable at home*” (Senato della Repubblica, 2023: 14). This vision reflected a stratified model, in which the state intervenes primarily through regulation and subsidiarity rather than as a direct guarantor of universal rights.

Disagreements also emerged over financing and coverage. The PD-AVS alliance pressed for dedicated and additional funding, warning that without earmarked resources the reform risked becoming a rhetorical exercise. They proposed explicit provisions ensuring that “*additional resources... be allocated by legislative provisions*” (Senato della Repubblica, 2023: 7), thereby institutionalising financial commitments. By contrast, senators from Fdl, Lega, and centrist parties favoured restrictive wording to ensure fiscal discipline, repeatedly stipulating that reforms occur “*within the limits of available resources*” (*ibidem*).

A further line of cleavage concerned eligibility criteria. The progressive bloc advocated for a multidimensional threshold of access, aligned with a biopsychosocial model. PD, for instance, proposed linking access to the *Valutazione Multidimensionale Unificata* and *Progetto di Vita Individuale*, the latter described as a “*plan ensuring personalised support... involving families and legal guardians*” (Senato della Repubblica, 2023: 3). In sharp contrast, Lega and Fdl senators promoted stricter biomedical thresholds, for instance prioritising access for “*the over-80 population*” or individuals with chronic degenerative diseases (Senato della Repubblica, 2023: 29). This orientation restricted access to the most severely dependent, thereby narrowing the pool of potential beneficiaries.

The multilevel governance dimension revealed equally divergent views. The PD-AVS coalition proposed an institutionalised, vertically integrated system, coordinating state, regions, and municipalities through binding programming mechanisms (Senato della Repubblica, 2023: 9). This model echoed the tradition of territorial social planning embedded in Law 328/2000. In contrast, right-wing and centrist actors advocated for consultative, non-binding arrangements, privileging local autonomy and resisting hierarchical integration, in line with the subsidiarity principle.

Tensions were also evident in the regulation of public-private provision. The progressive camp called for strict public oversight and quality assurance mechanisms. Amendment 2.51 explicitly required that accreditation of private and third-sector providers be contingent on “*staff competence, continuity of care, respect for labour rights, and patient dignity*” (Senato della Repubblica, 2023: 15). This stance aimed to resist the commodification of care by setting enforceable standards. Conversely, *Italia*

⁵⁴ It included senators from Fratelli d'Italia (Fdl) (e.g., Zullo, Berrino), Lega (e.g., Guidolin, Mazzella), and centrist figures such as Daniela Sbröllini (*Italia Viva/Azione*).

Viva/Azione promoted a logic of monitoring and performance assessment, proposing a “nationwide census of RSA” and oversight by AGENAS, the Regional Agency of Healthcare Services (Senato della Repubblica, 2023: 11), effectively consolidating the role of private providers within a pluralist care regime.

Finally, the cash vs. in-kind debate functioned as a proxy for the deeper ideological divide. The PD-AVS coalition unambiguously supported in-kind services, integrated within community-based networks, and cautioned against excessive monetisation of care, which they argued would perpetuate inequalities. Although centre-right amendments did not explicitly promote in-cash transfers, their emphasis on informal and family-based care—defined as assistance provided “*voluntarily and gratuitously*” (Senato della Repubblica, 2023: 3)—signalled a preference for low-cost, non-professionalised solutions, implicitly reinforcing the traditional reliance on allowances such as the *Indennità di accompagnamento*, rather than its reform into a universalised, needs-based service. Table 7.2. Illustrates political parties’ coalitions and respective positions on the LTC.

Table 7.2. Political Parties’ Coalitions and Respective Positions on the LTC in the Senate.

Coalition	Position on LTC	Key Proposals (with amendment refs)
Progressive (PD, AVS)	Universalism, integrated public LTC	SNAAs as national system (2.12); PAI and VMU (1.7); budget guarantees (2.7, 2.8); LEP expansion (2.300); regulation of RSA labour and quality (2.51)
Conservative (Fdl, Lega)	Subsidiarity, selective support, familial care	Age-based eligibility (G3.200); home care prioritisation (2.21); RSA census (2.201); caregiver recognition (1.300)
Centrist (Italia Viva, Azione)	Mixed model with public-private cooperation	RSA valorisation (2.203); co-programming with 3rd sector; monitoring systems via AGENAS (2.201)

Source: Author’s elaboration.

3.1.3. Consultation in the Congress of Deputies: Unveiling Political Cleavages in the LTC

In March 2023, the Italian Parliament opened a structured debate on Delegated Law 33/2023 on LTC for older persons. Proceedings—initiated in the XII Committee on Social Affairs (14–15 March) and continued in the Chamber of Deputies (20–21 March)—exposed a stable alignment of party coalitions and a layered configuration of institutional, ideological, and governance cleavages. Two consolidated blocs dominated: The governing right-wing coalition—Fdl, Lega, and Forza Italia—and the opposition, comprising Partito Democratico - Italia Democratica e Progressista (PD-IDP), M5S, Azione/Italia Viva, and AVS.

Fdl, as *rapporteur*, formally introduced the discussion by presenting the law as a technical instrument to streamline service delivery through territorial integration and individualized care plans. He emphasized that “*this enabling law is not about details; it is meant to delegate to the Government the task of issuing legislative decrees*” (Camera dei Deputati, 2023: 52). This preference for a “*light legal architecture*” typified the governing coalition’s strategy: To ensure rapid approval consistent with PNRR commitments while explicitly avoiding demands for enforceability, justiciable entitlements, or

binding financial provisions.

The opposition contested this technocratic framing from the outset. Andrea Quartini (M5S) proposed recognizing caregiving as a protected social function, warning that “*caregivers risk becoming sacrificial victims of a fragmented system*” (Camera dei Deputati, 2023: 103). Italia Viva/Azione endorsed the principle but advocated a separate legislative vehicle. In plenary, AVS intensified the critique, characterizing the bill as a “*technocratic shell*” lacking rights-based guarantee (Camera dei Deputati, 2023: 19). The rejection of these proposals confirmed the majority’s preference for steering instruments over normative codification.

A second axis of contention concerned financing and coverage. PD criticized the absence of earmarked resources; Braga argued that “*the law is fundamentally empty without binding resources*” (Camera dei Deputati, 2023: 17). Italia Viva/Azione recalled that Vice-Minister Bellucci (Fdi) herself had once abstained from the Family Act due to a lack of funding. Bellucci responded that resources would be allocated in future budget laws—an argument echoed across majority benches. This position underscored the governing coalition’s fiscally minimalist, executive-led orientation, in sharp contrast to the opposition’s insistence on statutory guarantees.

Eligibility criteria were similarly contested. M5S and PD opposed the age-based restriction to older persons, advocating a life-course approach that would include younger individuals with chronic disabilities. AVS stressed that “*non-self-sufficiency does not begin at 65*” (Camera dei Deputati, 2023a: 20). All amendments to broaden eligibility were rejected, confirming the government’s preference for administratively parsimonious thresholds, while the opposition converged on universalistic access.

Governance arrangements crystallized a center-periphery cleavage. The law established a central interministerial committee (CIPA) without binding roles for regions or third-sector actors. Opposition members—including PD, AVS and M5S—proposed amendments to guarantee territorial and civil-society participation, invoking the constitutional principle of subsidiarity (Camera dei Deputati, 2023: 16). Their rejection consolidated the government’s centralist approach, privileging hierarchical coordination over multilevel co-governance.

Further divergence emerged over service-delivery models. The majority prioritized standardized in-kind services, notably domiciliary care (ADI/SAD). By contrast, PD advanced a “*care and assistance budget*” (amendment 1.7), combining monetary transfers and services to enhance flexibility and personalization. Although supported by AVS and echoed across opposition benches, the proposal was rejected, reflecting the majority’s resistance to hybrid models of provision.

Debates on monitoring and regulation revealed opposing understandings of public-private responsibility. M5S called for binding impact evaluations (amendment 2.37), whereas the majority resisted regulatory tightening, favoring executive discretion and light-touch oversight. This divergence maps onto broader ideological cleavages between a rights-based, accountability-oriented opposition and a governing coalition prioritizing flexibility and administrative control.

Rhetorically, the blocs constructed the reform in antithetical terms. The government—through Vice-Minister Bellucci—presented it as an “*epochal reform*” (Camera dei Deputati, 2023: 21), lauding flexibility and speed; the opposition depicted a missed opportunity devoid of substantive guarantees. As PD summarized, the law privileges “*programming over rights*” (Camera dei Deputati, 2023: 17). Across all dimensions, alignments remained stable: The governing parties acted as a cohesive bloc, while the opposition coalesced into a substantive policy coalition that bridged organizational diversity through shared normative and institutional concerns.

These political-ideological divisions correspond to the cleavages summarized in Table 7.3. Saliency is high along the family-state and church-state dimensions, and medium-to-high along the state-periphery and private-public dimensions, indicating pronounced internal divisions on the issues at stake.

Table 7.3. Political Cleavages Emerged from Chamber of Deputies’ Consultation.

Cleavage	Pole 1 – Governing coalition (Fdl, Lega, FI)	Pole 2 – Opposition (PD, M5S, Italia Viva/Azione, AVS)	Saliency
State-Periphery	Centralized governance; creation of CIPA without binding regional/third-sector roles; reliance on national planning and hierarchical coordination.	Multilevel governance; institutionalized co-decision across national-regional-local levels; formal participation of regions and civil society.	Moderate-High
State-Market	Executive-led flexibility; light-touch oversight; preference for standardized in-kind services (ADI/SAD); no rights-based entitlements in the enabling law; reliance on future budget laws and implementing decrees.	Rights-based guarantees and binding standards (accreditation, impact evaluation); stronger public accountability; openness to mixed cash-and-services instruments (e.g., “care and assistance budget”).	Moderate-High
State-Family	Implicit reliance on informal family care; administrative steering over social rights.	Legal recognition and support of caregivers (rights, respite, professionalization).	High
State-Church	Not explicitly articulated in Chamber debate; de facto involvement of ecclesial actors in other fora acknowledged; no open contestation.	Likewise, not explicit; opposition rhetoric generally secular/rights-based; cleavage remained submerged during debate.	High (implicit)

Source: Author’s elaboration.

A comparison between the Senate (January-March 2023) and the Chamber of Deputies (March 2023) debates on the Delegated Law 33/2023 reveals a notable shift in both tone and focus. In the Senate, discussions assumed a predominantly institutional and technical orientation, with opposition parties advancing structured proposals such as the establishment of the SNAA, multidimensional assessment tools (VMU/PAI), and binding accreditation standards. The cleavage lines were therefore drawn around competing governance models (integrated versus ministerial centralism) and eligibility criteria (biopsychosocial versus biomedical thresholds). By contrast, deliberations in the Chamber were more rhetorical and politically polarized: Opposition actors emphasized the law’s “emptiness,” denounced its lack of enforceable rights and resources, and warned against centralist drifts, while the governing coalition defended a light and flexible legal architecture.

This evolution from institutional-technical contestation in the Senate to symbolic-political confrontation in the Chamber underscores how party alignments remained stable, but the framing of

conflict shifted from detailed institutional design to broader struggles over legitimacy, credibility, and the normative meaning of reform.

3.1.4. The Final Output: Law 33/2023

Approved by Parliament in April 2023, Law 33/2023—*Delega al Governo in materia di politiche in favore delle persone anziane*—marked a significant milestone in the institutional architecture of LTC in Italy, particularly for non-self-sufficient older persons. The law was passed with broad bipartisan support, although the Partito Democratico ultimately abstained in protest over the removal of several provisions relating to caregivers that had appeared in earlier drafts.

Despite these tensions, the reform has been widely interpreted as a turning point in Italy's LTC policy landscape, building on prior reforms such as Law 227/2021 (disability reform) and Legislative Decree 77/2022 (reorganization of primary care within the National Health Service). Law 33/2023 introduces a more integrated and standardized approach to eldercare, with the explicit aim of strengthening domiciliary services, enhancing coordination between health and social sectors, and modernizing the national care allowance system. Its institutional centerpiece is the creation of the SNAA, a permanent coordinating framework between state, regional, and municipal levels of government. While the SNAA does not enshrine a formal social right to care, it provides the first stable legal and administrative infrastructure for multi-level governance in the sector. As specified in Art. 3(1)-(2), co-governance is assigned to the Ministry of Health and the Ministry of Labour and Social Policies, operationalized through harmonized planning documents, including a triennially updated *Programma nazionale per la popolazione anziana non autosufficiente* (Art. 3).

A cornerstone of the reform is the Unified Assessment System, which seeks to establish nationally consistent eligibility criteria. This is composed of two interlocking instruments: The *Valutazione Nazionale Multidimensionale dell'Anziano* (VAMNA), a centrally defined tool (Art. 4), and the locally managed *Unità di Valutazione Multidimensionale* (UVM), responsible for individualized evaluations and drafting of personalized care plans (*Progetti Assistenziali Individualizzati*, PAI). These mechanisms are supported by already known (see Chapter 6) *Punti Unici di Accesso*, one-stop entry points intended to simplify administrative procedures and improve user accessibility (Art. 4). Together, they reflect a hybrid design: Centralization through VAMNA, combined with subsidiarity through UVMs and PUAs, thereby balancing uniform standards with territorial autonomy.

Most importantly, the transformation of the *Indennità di accompagnamento*. Law 33/2023 mandates a gradual introduction of the *Prestazione universale per la non autosufficienza* (Art. 5), a non-means-tested benefit-complementary to IdA-whose amount would be graduated according to assessed levels of need. Beneficiaries may opt to receive support either as a cash allowance or as a package of in-kind services, including domiciliary care and regulated personal assistance. This represents the first legal recognition of a dual-modality model in Italian LTC policy, maintaining universalism while aligning resources more closely with assessed needs, in accordance with the principles of the PNRR (Missione 5, Componente 2, Investimento 1.2).

Additional provisions address the quality of residential care (Art. 6), calling for improvements in infrastructure, staffing, and professional competencies, though without binding enforcement or dedicated funding mechanisms. Similarly, the law delegates the definition of *Livelli Essenziali delle Prestazioni Sociali* (LEPS) for older adults to subsequent decrees issued jointly by the Ministry of Labour, the Ministry of Health, and regional authorities (Art. 7). Provisions for workforce development and informal caregiving (Art. 8) establish training programs and possible financial incentives but stop short of granting legal recognition or enforceable rights to caregivers. The dilution of caregiver provisions was a decisive factor behind the PD's abstention and criticism from advocacy groups.

In sum, Law 33/2023 institutionalized a layered governance model that balances national coordination with regional implementation, and service standardization with individualized provision. While the law opened the way for potentially transformative reforms, i.e. path departure—particularly through the redesign of the care allowance and the institutionalization of SNAA—it remained heavily dependent on future decrees and financing laws for its operational definition and enforceability.

Once the institutional “frame” was established, the challenge became filling it with substantive content. In the aftermath of Law 33/2023, the political and societal debate entered a new phase, marked by the reopening of partisan and coalition polarisation. This shift laid the groundwork for what can be described as the *second season of coalitions*. As will be shown in the following section, the dynamics of this new phase differed profoundly from those that had characterised the earlier trajectory leading to the approval of the Delegated Law, revealing a reconfiguration of alliances, strategies, and conflict lines within Italy's long-term care politics.

3.2. The Second Season of Coalition Formation: The Legislative Decree 29/2024

Unlike the preparatory phase of Law 33/2023 under the Draghi government—during which technocratic leadership had temporarily “pacified” and thus levelled out existing cleavages in an emergency political context—the Meloni government brought political divisions over the substance of the reform back into sharp relief. Law 33/2023 incorporated many of the provisions advocated by the *Patto per un Nuovo Welfare sulla Non Autosufficienza*, attesting to its influence, yet it failed to secure the financial resources required for full implementation. The new right-wing government deliberately—and explicitly in parliamentary discussion—kept the law's provisions “generic,” postponing the definition of key implementation measures to the stage of legislative decrees (scheduled for March 2024).

Although Law 33/2023 was widely regarded as a potential path departure from the existing fragmented and familist model (see Section 4.1.3.), the subsequent Legislative Decree No. 29/2024 signalled a likely return to inertia, reinforcing the traditional protectionist and family-centered architecture of Italian long-term care. Its only substantive innovation lay in the formal recognition of long-term care as a distinct social risk within the Italian welfare state—a symbolic but politically significant step.

On 25 January 2024, the Council of Ministers approved the Draft Legislative Decree (*Schema di Decreto*

Legislativo attuativo, Camera dei Deputati, Atto n. 121, 2024), which was subsequently submitted to parliamentary discussion and formally adopted in March of the same year. In the months preceding its approval, the Patto⁵⁵ intensified its mobilization: Between April and October 2023 it organized seven thematic working groups, whose results were consolidated into three major documents—the *Guida alla comprensione della Legge Delega 2023* (Patto, 2023a), the *Proposte per la Legge di Bilancio 2024* (Patto, 2023b), and the *Proposte per i Decreti Legislativi attuativi della Legge 33/2023* (Patto, 2023c). These initiatives culminated in the publication of a *Manifesto* (2023d) in December 2023, formally submitted to the Meloni government, with direct transmission of the proposals to Vice-Minister Maria Teresa Bellucci at the Ministry of Labour and Social Policies. Interlocution with the Ministry of Health, by contrast, proved considerably more difficult, reflecting institutional turf boundaries and divergent priorities.

At the same time, Monsignor Vincenzo Paglia continued to occupy a distinctive—if increasingly marginal—position within the policy arena. In 2023 he published a position book reiterating his advocacy for proximity care, relational dignity, and intergenerational solidarity, thereby maintaining a visible moral voice in the broader political spectrum on non-self-sufficiency (Paglia, 2023). Taken together, these dynamics illustrate the opening of what may be termed the *second season of coalitions*: A phase no longer characterized by technocratic consensus-building, but by renewed polarization, strategic repositioning, and the attempt—particularly by the *Patto*—to preserve the fragile gains achieved under Draghi while adapting to the constraints of a markedly different political and institutional context.

This section analyses the second “season” of coalition formation, focusing on the transition from the delegated law to the adoption of the legislative decrees between 2023 and 2024. It explores how the dynamics of political exchange shifted during the implementation phase, where technical negotiations intersected with renewed partisan contestation over the future of LTC policy. The analysis begins by examining the increasingly polarized positions among governmental actors, advocacy coalitions, and interest groups, highlighting the tensions between supporters and opponents of the reform (3.2.1.). It then considers the negative, yet non-binding advisory opinions issued by the parliamentary committees and the Unified State-Regions Conference, which reflected institutional resistance and the persistence of territorial heterogeneity (3.2.2.). Finally, the subsection assesses the approval of Implementing Decree 29/2024, interpreted as a unilateral compromise by the governing coalition. While the decree

⁵⁵ The *Patto*’s proposal in March 2023 called for the re-establishment of thematic working groups to address key components of the reform, including governance of the SNAA and CIPA, access procedures, home and residential care services, the universal benefit, family carers, and system monitoring. Based on the structure of the final Decree Law, these groups were tasked with producing both a draft Legislative Decree, limited to the law’s explicit mandates but open to technical annexes, and an explanatory report clarifying and justifying the proposed measures with supporting data and references. Work was to draw on prior *Patto* documents, notably the 2022 Proposals, with the option of submitting out-of-scope ideas separately. Drafts were due by June 2023 and final proposals by September, to be consolidated into a comprehensive package by October for government approval by January 2024.

introduced selective adjustments and clarified certain operational measures, it also diluted several of the ambitions contained in Law 33/2023, illustrating how institutional fragmentation and fiscal constraints constrained the scope of reform (3.2.3.).

3.2.1. Within the “Powering” Context: Competing Stakeholders’ Coalitions

The recognition of LTC as a social right represented the broadest common denominator across the coalition that mobilised around Italy’s 2023-2024 reform process. Stakeholders from trade unions and pensioner organisations to user advocacy groups, professional bodies, providers, and mutual aid societies emphasised that Law 33/2023 at least formally inscribed the principle that non-self-sufficiency was no longer to be addressed through discretionary transfers or fragmented projects, but through structured entitlements. For the unions of retired workers, this constituted *“a long overdue recognition of what families and local services had been carrying alone for decades”* (IT7, Representative, FNP CISL; IT36, Representative, SPI CGIL), while IT29 (Representative, Cittadinanzattiva) celebrated the law as a *“framework of shared principles”* that elevated LTC to the rank of citizenship right. Entrepreneurial pensioner associations likewise welcomed the symbolic advance, though they were quick to underline that recognition without funding was *“purely rhetorical, and far behind European standards”* (IT9, Representative, CNA; IT14; IT15, Representative, ANAP/CUPLA). In this sense, the rhetoric of rights was inseparable from the debate on financing and coverage, with nearly all categories highlighting the structural weakness of Italy’s LTC expenditure—around 1% of GDP compared to the European average of 2-4%—and warning that the reform risked being *“an unfunded mandate”* (IT19, Representative, FederCentri; IT24, Representative, Federsolidarietà).

On the operational level, the most consistent cross-sectoral consensus concerned eligibility and access mechanisms. There was widespread agreement on the need for a single-entry point (i.e., PUA) and a national model of multidimensional assessment, integrating health, social, and environmental indicators. Scientific societies were especially insistent on this principle: Representatives of SIGG argued that *“without comprehensive geriatric assessment, rights remain nominal”* (IT22, Representative, SIGG), while SIGOT framed the assessment as *“the only safeguard against clinical arbitrariness and territorial inequities”* (IT12, Representative, SIGOT). Professional associations reinforced this demand, with the nurses’ federation (FNOPI) highlighting the role of the *Infermiere di Famiglia e di Comunità* in coordinating home-based assessments, and the National Council of Social Workers insisting that recognition of LTC must also entail institutional recognition of social work in care planning (IT21, Representative, CNOAS). Unions, advocacy organisations, and even providers echoed these calls, noting that the proliferation of parallel procedures through INPS, ASL, and municipal social services currently produces *“confusion and exclusion rather than rights”* (IT10, Representative, La Bottega del Possibile).

A further terrain of convergence emerged around the imperative to overcome the entrenched dualism between health and social care, historically split between the Ministry of Health and the Ministry of

Labour/Social Affairs. Respondents across categories agreed that integrated care plans should become the rule, linking hospital discharge pathways, domiciliary services, and municipal support in a single trajectory. The integration of financing streams was seen as a prerequisite: *“Unless there is a unified budget of care, integration will remain a slogan”* (IT10, Representative, La Bottega del Possibile). Providers pointed to the risk that excessive localisation of budgets could exacerbate territorial inequities, while unions argued for strong national steering to enforce uniformity (IT36, Representative, SPI CGIL).

The expansion of domiciliary services was likewise identified as a normative baseline. Advocacy groups such as Alzheimer Uniti and La Bottega del Possibile promoted the *“right to remain at home”* as a principle of autonomy and user preference (IT8, Representative, Alzheimer Uniti; IT10, Representative, La Bottega del Possibile), while unions endorsed domiciliary care as both a quality-of-life imperative and a cost-effective alternative to institutionalisation (IT36, SPI CGIL; IT7, FNP CISL; UILP, 2024). Even provider organisations formally recognised the need to strengthen home support, though with important caveats. For ARIS and Diaconia Valdese, domiciliary expansion had to be matched with sustainable financing and professional staffing, while UNEBA and ANASTE warned that any narrative delegitimising institutional provision⁵⁶ risked ignoring the complex needs of the most severely dependent (IT20, Representative, UNEBA; IT5, Representative, ANASTE).

Another unifying theme was the recognition of informal caregivers. Nearly all categories endorsed measures ranging from respite services to fiscal incentives and contributory credits, recognising the crucial role families and migrant care workers play in sustaining Italy’s LTC regime. Assindatcolf, representing domestic employers, placed particular emphasis on the need to *“formalise and professionalise the domestic care market”* (IT11, Representative, Assindatcolf), linking the recognition of LTC as a right with the recognition of families as employers and with the extension of legal and contributory protections. Advocacy groups highlighted the psychosocial burden of caregiving, calling for training and support structures (IT8, Representative, Alzheimer Uniti), while unions demanded fiscal and pension measures to compensate time spent in care (IT7, Representative, Italian Federation of Pensioners, FNP CISL). Finally, a point of broad agreement concerned the establishment of a dedicated national LTC fund, designed to replace fragmented project-based financing with a stable resource

⁵⁶ The Coordinamento Interassociativo del Settore Sociosanitario (CIASS) currently brings together fourteen associations operating in the socio-healthcare sector. Its membership includes a broad spectrum of organisations representing both public and private service providers. These range from associations of private hospital operators (such as the Associazione Coordinamento Ospedalità Privata, ACOP, and the Associazione Italiana Ospedalità Privata, AIOP) and mixed public-private managers (AGeSPI), to umbrella organisations for residential and community-based services for older people and persons with disabilities (ANASTE, ANFASS, ANSDIPP, UNEBA). It also encompasses faith-based providers (ARIS), business and cooperative federations (CONFAPI, Confcooperative Sanità, Confcooperative Federsolidarietà, Legacoop Sociali, AGCI), and regional employer associations (Unindustria). As indicated in these sources, CIASS operates as a unified platform representing the collective interests of private socio-healthcare service managers, providing a stable framework for coordination on issues such as collective bargaining and the financial sustainability of tariff systems.

envelope. For unions, this was “*the only way to guarantee continuity and equality*” (IT36, SPI CGIL), while providers argued that without a dedicated fund, reforms would be hostage to annual budget negotiations (IT24, Representative, Federsolidarietà).

Yet beneath these consensual priorities, the coalition fractured along several substantive axes of divergence. The first and perhaps most politically salient divide concerned the orientation of the care model. Advocacy groups and unions positioned domiciliary care as the normative baseline, framing residential institutions as a residual option. Alzheimer Uniti stressed that “*the right to autonomy is, first of all, the right to remain at home*” (IT8, Representative, Alzheimer Uniti), and La Bottega del Possibile added that “*residential solutions should not be default, but last resort*” (IT10, Representative, La Bottega del Possibile). In contrast, large provider organisations with substantial residential infrastructure strongly resisted what they perceived as delegitimisation. UNEBA argued for a continuum of care “in which each modality—home, semi-residential, and residential—has equal dignity” (IT20, Representative, UNEBA), while ANASTE emphasised that for the most severe forms of dependency, “institutional settings are not residual but indispensable” (IT5, Representative, ANASTE). Faith-based providers like ARIS and Diaconia Valdese positioned themselves closer to community-based solutions, highlighting subsidiarity and the role of local networks (IT16, Representative, ARIS; IT18, Representative, Diaconia Valdese).

The second major cleavage revolved around the design of benefits: Cash versus services. Caregiver associations (i.e., Assindatcolf) argued for a universal and flexible cash benefit, ideally traceable and linked to fiscal deductibility, which they presented as a tool for family autonomy and the formalisation of domestic employment (IT11, Representative, Assindatcolf). In contrast, unions, most providers, and professional bodies defended services as the primary delivery mode, relegating cash to a supplementary role tied to personalised care plans. FNP CGIL warned that “*maintaining unconditional cash transfers risks perpetuating fragmentation and discouraging service uptake*” (IT7, Representative, Italian Federation of Pensioners, FNP CGIL), while scientific societies like SIGG and SIGOT opposed stand-alone cash on clinical grounds, arguing that it must be embedded within structured pathways (IT22, Representative, SIGG; IT12, Representative, SIGOT). The design of pilot schemes for a new *prestazione universale* became emblematic of these tensions: While advocacy groups criticised proposed benefit levels as too low to support genuine autonomy, providers feared that without conditionality, cash would replicate the limitations of the existing *indennità di accompagnamento*.

A third axis of divergence emerged around governance and integration. While all endorsed the principle of *integrazione socio-sanitaria*, preferences for institutional design diverged. La Bottega del Possibile advocated a unified “*budget di cura*” consolidating all streams (IT10, Representative, La Bottega del Possibile), while CARD promoted a district-centred governance model with robust coordination powers (IT6, Representative, CARD). Cooperative providers such as Legacoop emphasised formalised co-planning between public authorities and the third sector (IT13, Representative, Legacoop), whereas unions demanded strong national oversight to prevent territorial inequities (IT36, Representative, SPI CGIL). Faith-based providers favoured decentralised, community-based governance (IT16,

Representative, ARIS; IT18, Representative, Diaconia Valdese). Professional bodies, finally, underscored governance arrangements that positioned their own roles centrally: FNOPI argued for nurses as gatekeepers of domiciliary care, while CNOAS stressed the need for social workers to lead the assessment and planning phases (IT21, Representative, CNOAS).

A fourth contentious issue was the public-private balance in financing. Mutual aid societies such as FIMIV advanced the idea of a “second mutualistic pillar,” formally recognised in early drafts of the reform, which would complement public funding with additional resources raised through mutual societies (IT25, Representative, FIMIV). FIMIV emphasised that this was “mutualistic rather than insurance-based, grounded in the principles of the social economy” (IT25, Representative, FIMIV), designed to guarantee lifelong protection and reinvest surpluses into communities. Yet the proposal was ultimately excluded, partly due to resource constraints and partly due to what mutualists described as “*a cultural prejudice that assimilates mutuality to private insurance*” (IT26, Representative, FIMIV). Discussion of this option was suspended, though the possibility of revisiting it in the future was not ruled out.

All in all, the LTC reform process crystallised a dual dynamic: On the one hand, broad consensus on foundational priorities such as the recognition of LTC as a social right, the need for stable financing, integrated eligibility and assessment mechanisms, domiciliary expansion, caregiver support, and the establishment of a national LTC fund; on the other, persistent divergences over the orientation of the care model, the cash-services balance, the institutional design of governance, and the scope for mutualistic financing and third-sector participation. The result is a coalition united around a shared discursive umbrella but divided over the distributive and institutional choices that will ultimately determine whether the recognition of LTC becomes an enforceable right or remains a lowest common denominator. It is worth emphasizing that the Pact remained united, and continues to be so, throughout the period under consideration. The dynamics highlighted here illustrate the reshuffling of internal coalitions which, as a result of the political choices discussed—and those that will be addressed in the following sections—accentuated certain divisions in positioning.

Table 7.4. presents the positions of the main actors, both those consulted in advisory settings and those participating in the *Patto*.

Table 7.4. Stakeholder Positions on Long-Term Care Reform in Italy, 2023-2024.

Group	Main Mapped Actors included	Social Right - Recognition	Financing & Coverage	Eligibility Criteria	Multilevel Governance	Regulatory Aspects (Public-Private)	In-cash	In-kind
Trade Unions	SPI-CGIL; FNP-CISL; UILP	LTC is framed as a universal citizenship right and enforceable entitlement.	Demand a stable, dedicated national LTC fund; structural financing at EU-comparable levels; oppose diverting FNA to pilots.	Universal access; single access (PUA) with national, standardised UVM; equal access across regions.	Strong national steering to reduce territorial inequities; LEPS-LEA harmonisation; avoid excessive decentralisation.	Favour public leadership; recognise third sector's role within public rules; sceptical of 'second pillar'.	Defense of IdA as a universal, cash-based benefit; supplementary and needs-graded; must be embedded in personalised care plans; criticise unconditional IdA.	Priority to services and domiciliary expansion; integrated health-social care plans.
Service Providers	UNEBA; ANASTE; Legacoop; Federsolidarietà; ARIS; Diaconia Valdese	Recognition tied to legitimacy of a continuum of provision (home, semi-residential, residential).	Stable dedicated funding; avoid depleting FNA; cost-recognition for quality standards and staffing.	National standards with local flexibility; oppose restrictive age limits; ensure access parity.	Mixed preferences: district authority; co-programmazione/co-progettazione with public; unified budget <i>per case</i> .	Strengthen accreditation; fair labour contracts (art. 51 D.Lgs. 81/2015); recognise third sector's strategic role.	Services as primary; cash conditional and plan-linked to avoid fragmentation.	<i>Continuum</i> of care; upgrade residential and semi-residential; domiciliary expansion; prevention/rehab (incl. terminal & active-ageing offers).
Entrepreneurial Pensioner Associations	ANAP/CNA Pensionati; ANPA - Confagricoltura Pensionati	Recognition welcomed but Italy lags EU; risk of purely rhetorical rights without delivery.	Call for structural funding and coverage expansion; highlight chronic underfunding.	Universal access with differentiation by assessed need; streamline bureaucracy; single access point.	Simplify: national framework with delegated delivery; reduce fragmentation.	Open to mixed provision; stress regularisation/professionalisation of domestic carers.	Support universal, flexible, traceable cash (with fiscal deductibility) to empower families.	Favour robust domiciliary services (telemedicine, integrated teams); current hours insufficient.
User & Advocacy Organisations	Cittadinanzattiva; Alzheimer Uniti; AISLA; La Bottega del Possibile	Right to autonomy and to remain at home; person-centred plans as concrete expression of rights.	Stable, dedicated fund; avoid slicing existing social funds; align with LEPS/LEA guarantees.	Single access + standardised UVM; include caregiver in UVM; contest age thresholds (e.g., >70).	Integrated pathways across SSN and social services; co-planning with third sector; national floor + local co-production.	Third sector central, not residual; simplify accreditation; enforce quality and labour standards.	Prefer flexible cash but only within plans; warn unconditional cash entrenches fragmentation/informality.	Domiciliary care as baseline; prevention and active ageing; upgrade ADI standards and coverage.
Employer Associations of Domestic Caregivers	ASSINDATCOLF, Domina	LTC recognition tied to recognition of family as employer and of domestic care as regulated work.	Incentivise formalisation via fiscal tools and contributory recognition; reduce grey market.	Eligibility pathways should enable/recognise domestic employment within plans.	Favour proximity and flexible arrangements that include household-level contracting.	Prioritise labour formalisation and standards; neutral on mutualistic finance.	Strongly favour cash/vouchers to support legal hiring and continuity of care.	Support domiciliary services complementing private employment; training for caregivers.

Mutual Aid Societies	FIMIV	Mutuality as a complementary instrument to realise social rights without displacing public responsibility.	Advocate a mutualistic second pillar: lifetime membership, solidarity pooling, reinvestment of surpluses.	Complementary coverage aligned with assessed need; no risk selection; support for prevention and non-self-sufficiency.	Territorial, social-economy governance; partnerships with local authorities and providers.	Seek legal recognition distinct from private insurance; accreditation hooks for mutuals.	Neutral cash/services to be integrated within care plans and mutual support schemes.	Support both home and residential services; pilots with community nursing and prevention.
Scientific Societies (SIGG, SIGOT, CARD)	SIGG; SIGOT; CARD	Recognition tied to clinical legitimacy and evidence-based pathways (CGA/UVM).	Invest in evidence-based domiciliary and intermediate care; resource standards and staffing.	Mandatory comprehensive geriatric assessment within UVM; standardised tools; defined professional roles.	District-centred governance (CARD); clinical leadership for integrated care pathways.	Prioritise public guarantees; quality and safety standards across providers.	Oppose stand-alone cash; allow only when embedded in care plans tied to assessed need.	Structured pathways spanning home, community, intermediate and residential care.
Professional Associations	FNOPI (nurses); CNOAS (social workers)	Recognition entails institutional recognition of professional roles in assessment and care planning.	Finance team-based models, IFeC deployment, tele-assistance, and training; address workforce gaps.	Embed nurses (IFeC) and social workers in UVM; define roles/task-shifting and skill-mix.	Professions central in district teams; clear mandates and accountability.	Regulate support staff (e.g., AIC registers); standards for digital literacy and teleassistance.	Supplementary only; avoid cash as substitute for services.	Home/community integrated care; digital/tele-assistance to ensure continuity.

Note: The organisations mapped here are those that most actively participated in the decision-making process and, by virtue of their role, were also invited to hearings in the Senate (though not all of them).

Source: Author's elaboration

Moreover, the transition from the Draghi to the Meloni government marked a decisive turning point in the LTC reform process. Interviewees consistently described a narrowing of participatory channels, with the inclusive working groups of the Draghi phase giving way to selective bilateral consultations limited to a few “representative” actors (CGIL, 2024; CISL, 2024; UIL, 2024). As one advocacy representative observed, this shift amounted to “*symbolic inclusion followed by substantive exclusion*” (IT29, Representative, Cittadinanzattiva). Political actors similarly noted the contrast between the technocratic, expert-driven drafting of Law 33/2023 and the subsequent phase of Legislative Decree preparation, which was increasingly shaped by electoral considerations and partisan logics (IT3, Welfare and Health Secretariat, PD). As institutional engagement waned, competition within the coalition intensified. Organisations sought to secure visibility and policy concessions individually, often undermining the *Patto*’s collective bargaining power (IT36, Representative, SPI CGIL; IT24, Representative, Federsolidarietà; IT5, Representative, ANASTE).

Dissatisfaction also surfaced within the *Patto*’s internal dynamics. Trade unions voiced discomfort at sharing the negotiation table with service providers who were simultaneously their counterparts in collective bargaining (IT36, Representative, SPI CGIL), while some providers resented what they perceived as the disproportionate influence of smaller yet more vocal advocacy organisations (IT24, Representative, Federsolidarietà). This tension translated into visible fractures: Three high-profile withdrawals underscored the fragility of the coalition. In mid-2023, SPI CGIL and UILP announced their departure, citing the erosion of strategic cohesion and what they described as governmental divide-and-rule tactics (SPI CGIL, 2024; UILP, 2024). Shortly thereafter, Federsolidarietà also withdrew, criticising the tokenistic nature of consultation and lamenting the impossibility of advancing hybrid service-cash models within increasingly polarised debates (IT24, Representative, Federsolidarietà).

A more fundamental challenge came from Fondazione Promozione Sociale, which—although never a formal member of the *Patto*—presented an explicitly oppositional stance in its 2024 Senate hearing (IT27, Representative, Fondazione Promozione Sociale). FPS rejected the conceptual foundations of the reform, denouncing the assimilation of *anziano non autosufficiente* to *persona con disabilità* and instead insisting on the designation *anziani malati cronici non autosufficienti* as the only pathway to ensure full protection under the SSN. It criticised the proposed *Sistema Nazionale per la popolazione Anziana non Autosufficiente* as a redundant duplication of the SSN and condemned the reform of the *IdA* for replacing a universal entitlement with a discretionary and non-universal scheme.

Between 2021 and 2023, several significant parallel proposals shaped the debate on LTC reform in Italy. Fondazione Easy-Care (2022) introduced the “Dote di Cura”, aiming to transform the *Indennità di Accompagnamento* from a mere cash transfer into a personalised care budget for

accredited services, promoting a more integrated, user-centred system. FISH and FAND urged a broader, more inclusive approach, criticising the draft reform's focus on older adults and stressing the need for greater recognition of persons with disabilities and legal status for family caregivers (AS 1461). Finally, the Italian Association of Actuaries (2023) proposed creating a National Fund for Non-Self-Sufficiency and introducing a mandatory LTC social insurance scheme, financed through employment-based contributions, to complement cash benefits and strengthen coordination and sustainability.

3.2.2. The Negative, yet Non-Binding, Advisory Opinion issued by the Committees and the Unified State-Regions Conference

Legislative Decree No. 121 on policies for older persons—presented on 31 January 2024 by the Minister for Parliamentary Relations under the Meloni Government and examined for opinion by the 5th Standing Committee (Budget) and the 10th Standing Committee (Social Affairs, Health, Public and Private Labour, and Social Security)—was approved with observations on 5 March 2024.

In the 5th Committee, rapporteur Gelmetti (Fdl) foregrounded fiscal compliance as the dominant evaluative criterion. Measures ranging from communication campaigns (Art. 4) to flexible work for older employees (Art. 5) were assessed against explicit financial-invariance clauses, with repeated reminders that implementation must occur “*within resources available under existing legislation.*” The same logic governed telemedicine (Art. 9), physical-activity promotion (Art. 12), senior cohousing (Art. 15), and quality requirements for residential facilities (Art. 31). Particular scrutiny was applied to PNRR funds, treated as loans with potential balance-sheet implications, and to the *Prestazione universale* (Arts. 34-36): The Committee recommended setting the monthly amount at approximately €833 and requested justification for the assumed 23% share of severely dependent beneficiaries, noting that the definition of severe need was deferred to an INPS regulation. The Committee's non-obstructive opinion with conditions signalled majority support (Fdl, Lega, FI) grounded in fiscal prudence; opposition members did not mount substantive challenges in this venue.

Proceedings in the 10th Committee were more conflictual and hearing driven. M5S and PD pushed for a short cycle of hearings to test coherence with the enabling law; Fdl agreed, framing hearings as a procedural safeguard. Substantive criticism then emerged: M5S flagged the absence of a clear framework for residential care and of monitoring for essential social-service levels and deemed the decree “*completely unsatisfactory,*” citing territorial fragmentation, over-reliance on secondary regulation, unresolved caregiver recognition, and exclusion of non-older people severely dependent persons. PD condemned the age cut-off as discriminatory, the weak health-social integration, and the lack of dedicated resources.

Defending the text, FdI called for a holistic reading centred on multidimensional assessment; *rapporteur* Zaffini (FdI) stressed that resource ceilings flow from the enabling law and that reliance on ministerial decrees is standard practice. As the deadline approached, Zaffini issued a favourable opinion with observations—expanding monitoring (Art. 21) and preserving beneficiary choice between in-kind and cash benefits (Arts. 34-36)—while leaving unresolved opposition claims on universality, funding levels, and the age criterion. Vice-Minister Bellucci framed the decree as a rights-guaranteeing reform, highlighting a home-care trial phase and signalling an intention to seek additional resources at implementation. In the decisive session, PD-IDP argued the decree “hollows out” the delegation and reduced it to a narrowly targeted anti-poverty measure. The amended opinion prevailed, and alternative opposition drafts were rejected.

Across both committees, party lines reflected this split: The centre-right majority backed the decree in both committees; PD-IDP and M5S opposed it in Social Affairs on grounds of equity, universality, and service integration, while declining to contest it procedurally in Budget.

Framing the debate along classical cleavages (Table 7.5.): On State-Periphery, the majority emphasised national standards and fiscal uniformity, while the opposition foregrounded territorial disparities and protections for special-statute autonomy. On State-Market, the majority favoured executive-led steering, financial invariance, and reliance on secondary regulation within a mixed-economy of provision; the opposition argued for robust public responsibility, justiciable entitlements, binding standards, and tighter oversight of private and third-sector providers. On Family-State, the majority leaned toward family responsibility—casting the Universal Allowance as residual support that preserves choice—whereas the opposition advocated a universalist, state-centred approach to dependency. Finally, on Church-State, both blocs converged on a secular framing; disputes centred on fiscal prudence and service design, not confessional divides.

Table 7.5. Political Cleavages Activated in Committee Debates.

Cleavage	Majority (FdI, Lega, Forza Italia)	Opposition (PD-IDP, M5S, SVP-PATT)	Salience
State-Periphery	Prioritizes national standards and fiscal uniformity; central steering and secondary regulation; limited attention to territorial disparities (except autonomy claims in principle).	Highlights territorial fragmentation of LEPS (essential social-service levels); calls for stronger monitoring and enforcement; protects special-statute regions and autonomous provinces.	High
State-Market	Executive-led flexibility and financial invariance; reliance on ministerial decrees; mixed-economy delivery with light-touch new obligations; preserves beneficiary choice between cash and in-kind (Arts. 34-36); cautious on cost-raising quality mandates (Art. 31).	Emphasizes public responsibility and rights-based entitlements; demands binding standards, accreditation, impact evaluation, and transparent costing; tighter oversight of private/third-sector providers; warns against deferring core definitions to secondary norms (e.g., INPS regulation on “severe need”).	High
State-Family	Denounces age-based and selective benefits as discriminatory; presses for universalistic access, caregiver recognition, and integrated health-social services.	No legal recognition of caregiving as a protected/compensated function; implicit reliance on informal family care; administrative steering over social rights.	High
State-Church	No explicit confessional framing; secular-technocratic discourse.	Same; cleavage remains latent.	Low

Source: Author’s elaboration

3.2.3. “All That Could Be Done”: The Unilateral Compromise of Implementing Decree 29/2024

On 10 March 2024, Legislative Decree No. 29/2024 was published in the *Gazzetta Ufficiale*. In the absence of new structural and additional resources, the Unified Conference of Regions rejected the decree following strong opposition from the Conference of Regions and Autonomous Provinces. Resistance was spearheaded by Emilia-Romagna, Puglia, Campania, and Tuscany, while most other regions also voiced concerns. A central point of contention concerned the definition of target beneficiaries for socio-healthcare services and the LEPS, which were restricted to individuals aged 70 and older. This limitation not only excluded the 65-69 cohort that was already integrated within territorial care systems but also created inconsistencies with existing regional legislation. Legacoop further argued that the institutional backlash within the Unified Conference was “*inevitable, given the combination of unfunded mandates and disregard for regional competences*” (IT13, Representative, Legacoop). Table 7.6. reports the main differences between Delegated Law 33/2023 and Legislative Decree 29/2024.

Table 7.6. Delegated Law 33/2023 and Legislative Decree 29/2024.

Measure	Legal reference in Delegated Law 33/2023	Legal reference in Legislative Decree 29/2024	Delegated Law 33/2023	Legislative Decree 29/2024
National System for Non-Self-Sufficient Older Adults (SNAA)	Art. 2, comma 3 e seguenti Art. 4, comma 2, lettere b, c	Art. 21	Establishes a permanent framework for unified governance and coordination of social and healthcare measures for non-self-sufficient older adults, while preserving state, regional, and municipal responsibilities and promoting integration across separate jurisdictions.	Limits integrated governance to socio-health services; preserves fragmented responsibilities across sectors.
Multidimensional Assessment of Older Adults	Art. 4, paragraph 2, lett. l	Art. 10	Establishes a dual evaluation framework: a state-led assessment (VAMU) using a new tool, and a locally managed assessment (UVM) linked to the first. The local evaluation builds upon information gathered at the state level.	<i>Confirmed</i>
Essential Levels of Performance (LEPS) and Monitoring	Art. 4, paragraph 2, lett. d	Art. 22	Identifies LEPS for non-self-sufficient older adults, integrating them with the existing Essential LEA to ensure harmonization between the two frameworks.	<i>Confirmed</i>
Home Care Services	Art. 4, comma 2, lettera n	Art. 29	Establishes a dedicated home care model for non-self-sufficient older adults, focusing on appropriate duration and intensity of interventions, multidisciplinary professional involvement, and integrated service delivery.	Initially introduced by the 2021 Budget Law and the NRRP, this reform was later abolished by Legislative Decree 29/2024.

Residential Services	Art. 4, paragraph 2, lett. q	Art. 30 and Art. 31	Includes provisions for adequate staffing, ensuring professional competencies, and improving living environments, but lacks a strategic plan for the future of residential care in Italy.	Substantial decisions are deferred to an additional decree from the Ministry of Health, to be completed within 120 days, focusing exclusively on socio-health services.
In-cash Transfer	Art. 5, comma 2, lettera a, 1	Art. 34	Access is guaranteed based on the need for assistance (universalistic criteria), with the amount increasing according to care needs. Introduces the option between monetary transfers and personal care services.	A pilot program targeting individuals over 80 years old with an ISEE (Equivalent Economic Situation Indicator) below €6,000.
Professional Caregivers	Art. 5, comma 2, lettera a, 2 e lettera b, 2	Art. 38	Provides support for the regular payment of family caregivers through universal service options and the reorganization of incentives. Promotes professional qualifications by establishing national training standards	Article 38 of the Implementing Decree defers to guidelines to be issued within 90 days, which Regions "may" use as a reference.
Familiar Caregivers	/	Art. 39	<i>Not included</i>	Their role is assessed to identify the specific care tasks performed, evaluate their stress levels, and determine their needs. ⁵⁷
Palliative Care	Art. 4, paragraph 2, lett. o	Art. 32	Guarantees access to palliative care for all non-self-sufficient older adults with chronic and progressive conditions across all care settings, including home, hospital, outpatient clinics, and residential facilities.	<i>Confirmed</i>
Adults with Disabilities	Art. 4, paragraph 2, lett. s	Art. 28	Ensures the right to access services specific to their pre-existing disability and simplifies procedures to obtain interventions designed for older adults.	<i>Confirmed</i>

Source: Author's elaboration on Law 33/2023 and Legislative Decree 29/2024.

The outcome of the legislative phase diverged sharply from expectations generated by Law 33/2023. The only concrete measure introduced was a supplementary and experimental modification of the IdA: The *Prestazione Universale per gli Anziani Non Autosufficienti*, restricted to individuals aged over 80 with an annual household income below €6,000. This minimal reform was widely labelled a "half-baked reform" (Ronchi & Cigna, 2024) and interpreted as a case of "policy inaction" (Ranci et al., 2024).

Patto firmly opposed the reform. Its members not only developed detailed technical proposals for the drafting of the legislative decrees (published in February 2024) (Patto, 2023b) and for securing

⁵⁷ The role of the caregiver was formally recognized and defined for the first time by Law 205/2017 (the 2018 Budget Law, Article 1, paragraphs 254-256), which, in paragraph 255, identifies the caregiver as a "person who assists and cares for specific individuals."

adequate financing—explicitly linking their demands to the 2023 and 2024 Budget Laws (Patto, 2023a)—but were also actively involved throughout the approval process of both the framework law and the first legislative decree. Despite these sustained contributions, the *Patto* repeatedly criticized Legislative Decree No. 29/2024, publicly describing its content as a “betrayal” of the framework law’s principles (Patto, 2024). Also, in February 2024 the *Patto* first published a comprehensive evaluation of the Legislative Decree (2024a) and then its own proposals to modify the Legislative Decree which was, in substance, ignored (Patto, 2024b). “*Civil society provided the government with a coherent technical roadmap, but its main points were ignored*” (IT32, Expert - Fondazione Don Gnocchi). Similarly, “*the decree dismantled the spirit of Law 33/2023, reducing it to a budgetary exercise*” (IT29, Representative, Cittadinanzattiva).

A further point of contention concerned financing. The decree failed to allocate new resources, relying exclusively on the *Fondo Nazionale per la Non Autosufficienza*. IT33 observed that “*without structural and additional funding, the system cannot scale beyond symbolic reform*” (IT33, Advisor, Office of the Prime Minister - Draghi Government). Similarly, the choice to rely solely on the FNA “*signals a political unwillingness to universalize access*” (IT13, Representative, Legacoop). *De facto*, taking a step back, IT1 added a parliamentary perspective, noting that “*the legislature was well aware of the financial void but deliberately left the burden to implementing decrees*” (IT1, Expert - Ministerial Commission, Ministry of Labor and Social Policy). IT3, reflecting on her experience within the PD, argued that “*the exclusion of binding financial mechanisms explains why opposition parties converged on abstention or criticism*” (IT3, Welfare and Health Secretariat, PD).

From a broader analytical perspective, the trajectory of LTC reform cannot be reduced to mere inaction. The broad convergence around universality, integration, domiciliary expansion, caregiver recognition, and stable funding created the political conditions for the adoption of Law 33/2023. Yet, unresolved divergences over care models, benefit design, governance, and sectoral roles diluted these gains during the phase of decrees. The narrowing of participatory channels under the Meloni government, combined with strategic withdrawals and persistent distributive conflicts within the coalition, ultimately curtailed the translation of shared principles into binding, well-funded, and operational provisions. Legislative Decree No. 29/2024 therefore embodies both the potential and fragility of broad-based coalitions in politically sensitive welfare domains: Such alliances can secure symbolic and legislative breakthroughs, but without mechanisms to manage internal fractures and resist external exclusion, their influence in the decisive implementation phase remains precarious.

4. The New Strategy of the *Patto* after the Legislative Decrees and the Most Recent Developments (2024-present)

The publication of Legislative Decree No. 29/2024, widely regarded by stakeholders as a “missed opportunity,” prompted a strategic recalibration within the *Patto*. Having initially concentrated

on shaping the framework law, the coalition reoriented its advocacy toward four priorities: First, close scrutiny of the forthcoming 22 implementing decrees; second, the reopening of dialogue with the national government; third, the cultivation of alliances with regional administrations, understood as pivotal actors in implementation; and fourth, a discursive shift “from principles to people,” aimed at anchoring advocacy in the lived realities of older persons and their families. In organizational terms, the *Patto* consolidated its internal governance by appointing three coordinators—Cristiano Gori, Vanni, and Pesaresi—entrusted with steering the coalition throughout the legislature of Prime Minister Meloni, and potentially beyond. This strategic adjustment not only signals continuity but also reflects an awareness of the protracted temporal horizon of the reform, where influence will be exercised less through constitutional anchoring and more through the incremental shaping of regulatory detail, territorial alliances, and public narratives.

Following the approval of Law 33/2023, implementation moved into a fragmented and politically contentious phase centred on Legislative Decree 29/2024 and a *cascade* of further acts. Substantively, the decree *partially* rewrites the delegation: It narrows the SNAA to social measures only—thus re-inscribing, rather than overcoming, the structural separation between health and social care envisaged in the framework law—and defers the unified assessment architecture to a later decree, with experimentation slated for 2026 and full entry into force in 2027 (thereby prolonging multi-track access and administrative duplication).

It also replaces the planned transformation of the IdA into a needs-graded universal benefit with a temporary, means-tested pilot limited to a small cohort in 2025-2026, and drops the envisaged reform of domiciliary care in favour of generic guidelines—choices that collectively signal a retreat from system integration to incrementalism, which highlights (i) the contraction of the SNAA perimeter, (ii) the postponement of the two-tier assessment to 2026-2027, (iii) the replacement of a universal, graded allowance with a short-term, income-tested measure lacking a proper evaluation plan, and (iv) the cancellation of the domiciliary-care overhaul. In parallel, the age threshold introduced during drafting—restricting LEPS and socio-health eligibility to 70+—triggered formal resistance in the Unified Conference and practical conflicts with regional legislation, with interviewees linking the provision both to fiscal containment and to the enduring influence of INPS assessment logics.

At the same time, several actors acknowledged that, despite widespread disappointment, a few structural levers survive—above all the two-level assessment (national + local)—though their effects are postponed and contingent on subsequent decrees. The decree itself requires 22 further implementing acts, a design that pushes meaningful choices forward in time and away from parliamentary scrutiny.

Civil-society coalitions responded by intensifying technocratic advocacy: The *Patto* issued detailed proposals for the decrees and for financing via the 2023-2024 budget cycles, then condemned the approved text as a “betrayal” of the delegation’s integrative spirit, chiefly because it added no

new, structural resources and leaned entirely on the FNA (IT32, Expert - Fondazione Don Gnocchi; IT29, Representative, Cittadinanzattiva; IT37, Expert - Social Services Agency). Interviews further converge on two governance risks. First, territorial actors—regions and especially municipalities—were weakly involved in the regulatory design despite being ultimate implementers; this omission jeopardises feasibility and equity in rollout (IT35, Secretary General, Cittadinanzattiva; IT29, Representative, Cittadinanzattiva). Second, without dedicated, multi-year funding, the decree’s “generic” architecture is likely to crystallise into path inertia rather than system change, a concern raised across political and administrative interlocutors (IT1, Expert - Ministerial Commission, Ministry of Labor and Social Policy; IT3, Welfare and Health Secretariat, PD).

Concretely, the “next steps” now hinge on (a) the decree that operationalises the unified assessment on the 2026-2027 timetable (still postponed); (b) the *suite* of acts defining LEPS content, monitoring indicators, and territorial management tools—anticipated by the Ministry of Labour’s Working Group established by Decree No. 267/2023 (still postponed); (c) residential-care standards and staffing requirements (currently diffuse and region-dependent, but currently postponed in final output); and (d) caregiver measures. With regard to caregiver measures, the debate remained highly fragmented and only partially integrated into the broader reform of long-term care. An inter-ministerial working table was activated in 2023, but no comprehensive implementing decree was adopted. Instead, a first legislative initiative was put forward by the Democratic Party through Bill S.24 (XIX Legislature), filed in October 2022 and discussed during 2023-2024, which aimed to provide a statutory framework for family caregiving by defining its role, establishing financial support, ensuring respite and domiciliary services, and granting labour market protections and fiscal benefits (Senato della Repubblica, Atto n. 24, 2022). This initiative was complemented in August 2024 by a second proposal tabled in the Chamber of Deputies by the PD, intended to institutionalize caregivers’ rights within the implementation of Law 33/2023. In parallel, the Ministry of Disability adopted a more limited financial instrument: By Ministerial Decree, criteria and allocation mechanisms were defined for the distribution of €30 million from the *Fondo unico per l’inclusione delle persone con disabilità*, earmarked for the years 2024-2026 to support initiatives recognising the social and economic value of non-professional family care.

5. Anything *but* Quiet Politics: The Return to Partisan Politics and Its Effect on the Coalitions in Play to Explain the LTC Reform

Read through the lens of the Chapter 2 framework, the Italian LTC system can be characterized as a protectionist model, underpinned by a residual and familistic model of service provision. Despite recurring reform initiatives, its core architecture remains centred on familial care and monetary transfers, while recent measures have primarily introduced procedural coordination mechanisms and symbolic recognition, layered upon an already fragmented delivery structure. The central analytical puzzle is therefore not the presence of functional pressures, but rather the dynamics of coalitional alignment: Which actors were able to aggregate interests, at what juncture, and under which conditions. The explanation ultimately turns on the transition from a first to a second coalition season, and on how the logic of political exchange shifted from technocratic pacification

to partisan re-polarization. Table 7.7. illustrates the steps in process tracing mechanisms in the Italian case.

Table 7.7. Steps in Process Tracing Mechanisms in Italy.

Steps in the Mechanism	Reference to Mechanism	Observable Indicators	Season 1 - (Potential) Path departure	Season 2 - Selective Expansion and <i>substantial</i> inertia
1. Problem pressure	Mechanism 1	Convergence of external shock and opening of a reform <i>momentum</i>	Covid-19 pandemic and EU conditionalities (PNRR milestones)	Partial exit from the emergency phase and closure of the window of opportunity created by functional pressures
2. Institutional path dependence	Mechanism 2	Policy legacy and vested interests in institutions	High levels of horizontal and vertical decentralization; increasing pressure from the National Health System (SNS); a residual social care sector; and a strong reliance on universal cash benefits (Indennità di accompagnamento).	
3. Opening of an institutional gate	Mechanism 2	Political and institutional dynamics	Political context, including the transition to a technocratic government and the influence of the European Union.	Closure of an institutional gate following government alternation and the reorganization of administrative and bureaucratic structures.
4. Puzzling	Mechanism 3	Shared policy solutions and strategic framing	Initial predominance of the framing promoted by the Pact, centred on universalism and the guarantee of social and individual rights. However, the absence of pre-existing puzzling prior to the reform resulted in substantial misalignment in the framing of long-term care (as reflected in the work of three ministerial commissions).	Worsening misalignment in the framing of the reform and the progressive closure of channels of dialogue between social and political actors.
5. Powering	Mechanism 3	Party competition	Absent in the initial phase, which was characterized by a technocratic government (Draghi Government, 2021-2022). - Achievement of a lowest common denominator. - Identification by the Democratic Party (PD) of a political incentive in pursuing the reform.	Present and more pronounced in the second phase, marked by a government characterized by differentiated electoral priorities (Meloni Government, from 2022 onwards). Strategic use of social and political cleavages to reframe the reform within politically salient lines of conflict.
6. Emergence of a dominant coalition	Mechanism 3	Coordinated action during crisis or reform window	Strategic aggregation of demand through a purpose-based social	Subsequent disaggregation of social demand in the phase

			coalition, represented by the <i>Patto</i> .	following the Draghi Government. Limited capacity for puzzling combined with an increase in powering, leading to the progressive closure of channels of dialogue with societal actors.
7. Strategic political exchange	Core Mechanism	Types of strategic exchanges and compensatory mechanisms implemented by social and political actors	Fragmented. Limited initial permeability to social and political interests and incentives.	Absent or discontinuous
8. Reform outcome	<i>Explanandum</i>	Structural change disrupting path dependency	Potential path departure. Expansion of services and recalibration of cash benefits.	Substantive inertia, coupled with risk recognition. Service stagnation and expansion of cash transfers.

Source: Author's elaboration.

Contextual Factors and Functional Pressures

The pandemic briefly disrupted this *equilibrium*, exposing the fragility of residential care and raising public expectations for change. Two key factors contributed to the opening of an institutional gate for a potential path departure, which, however, materialized only as partial inertia through a selective expansion centered on the *Prestazione Universale*.

Importantly, the groundwork had already been laid by earlier institutional developments. Legislative Decree No. 147 of 2017 had introduced the *Piano Nazionale per la Non Autosufficienza*, signaling renewed ministerial attention to LTC. Yet, given the low salience of the issue in a period dominated by more visible welfare debates (*Reddito di Cittadinanza*, *Quota 100*), the strategy followed a path of continuity: Incremental increases to the *Fondo per la Non Autosufficienze* without a comprehensive, system-wide vision.

The pandemic altered this *calculus*. The reputational shock of excess mortality, coupled with sustained advocacy by organized civil society, facilitated the emergence of a cohesive “coalition of purpose.” Within this environment, the Democratic Party, operating in the Draghi government, identified LTC as a strategic axis for political repositioning in the fragile post-emergency context.

The inclusion of LTC reform in the Italian PNRR was made possible by a highly specific institutional configuration. The technocratic nature of the Draghi government, underpinned by an exceptionally broad parliamentary majority, re-centered decision-making at Palazzo Chigi. This shift temporarily softened the chronic fragmentation of welfare policymaking—traditionally split between the Ministry of Labour, the Ministry of Health, and INPS—by creating an interministerial coordination

mechanism tied directly to EU conditionalities. The PNRR functioned both as an external constraint and as an opportunity structure: To comply with the European Commission's deadlines and access Next Generation EU funds, the government was compelled to articulate reforms that transcended ministerial silos.

Within this configuration, LTC emerged as a policy “without enemies,” politically acceptable across parties and ministries. The Ministry of Labour, led by Andrea Orlando, capitalized on the preparatory work of the Turco Commission; the Ministry of Health incorporated LTC into broader territorial care reforms (DM 77/2022); and the MEF accepted the reform as fiscally neutral in the short term, since no earmarked resources were attached. The Presidency of the Council acted as the broker arena, enabling otherwise parallel ministerial trajectories to converge. Intermediary actors—most notably Cristiano Gori and the *Patto per un Nuovo Welfare sulla Non Autosufficienza*—played a crucial bridging role by providing ready-made proposals, thereby lowering transaction costs in interministerial bargaining.

In this sense, the reform was not the outcome of strong political ownership but rather the product of an unusual constellation: External EU constraints, central coordination at Palazzo Chigi, and societal advocacy that temporarily overcame Italy's entrenched ministerial silos.

Pro-Public, Family, and Market Coalitions: Cleavage Dynamics and Compromise

The first coalition season coalesced under the Draghi national-unity executive, when the reputational shock of COVID-19 intersected with EU conditionalities via the PNRR and temporarily muted partisan conflict. Decision-making was re-centred at Palazzo Chigi, producing what interviewees described as a “deliberative suspension” of ordinary rivalries: Technical fora gained traction and cross-coalitional dialogue became feasible in a sector that is typically low-salience and siloed. Within this configuration, long-term care entered the PNRR agenda as a structural reform milestone, with Mission 5 (Social Inclusion & Cohesion) and Mission 6 (Health) anchoring proximity care and a 10% home-care target for the 65+ population by mid-2026, backed by €4 billion for “home as the primary place of care” and telemedicine.

Three policy streams structured this phase and mapped onto coalitional spaces.

The first was the Turco Commission (MLPS). Established in May 2021 under Minister Andrea Orlando, the Commission produced the LEPS for non-self-sufficiency (approved in the 2022 Budget Law) and completed a draft Delegated Law by December 2021. Its hybrid composition—academia, regions, and third-sector representatives—delivered an institutional blueprint featuring single access points (PUA), a standardized needs assessment (VNB), and territorial governance. Yet it deliberately avoided explicit new financing and encountered classic veto players (MEF, INPS, Ministry of Health). Politically sensitive knots included the “untouchable” *Indennità di accompagnamento*, centralization versus mixed governance, and the risk of re-institutionalization through PNRR

community hospitals. The Commission's strategy balanced "innovative impetus" with feasibility, yielding a structurally ambitious yet politically constrained design.

The second stream was the *Patto per un Nuovo Welfare sulla Non Autosufficienza*. Beginning in July 2021, this broad civil-society coalition (major unions, third-sector organizations, advocacy groups, and policy experts) aggregated fragmented demands into a rights-based, universalistic platform. Its flagship proposal—the Sistema Nazionale Assistenza Anziani (SNAA)—sought to unify cash and services under coordinated state-region-municipal governance, with PUA, a national assessment tool (VNB), transformation of the *Indennità di accompagnamento* into a needs-graded universal allowance (Prestazione Universale), prioritization of home and community care, and recognition and professionalization of informal caregivers and migrant care workers. The financing mix combined stable public coverage of LEA/LEPS with a second-pillar component. In parallel, Patto secured progressive increases to the Fondo per la Non Autosufficienza, pushing allocations toward ~€1 billion by 2025.

The third stream was the Paglia Commission (Presidency of the Council). Ideationally powerful, this forum emphasized dignity, proximity care, and intergenerational solidarity, calling for a ten-fold increase in home-care hours and mobilization of civil-society and religious networks. Yet it remained non-committal on financing and institutional design, functioning more as a discursive catalyst than as an executive lever.

The composite draft that emerged in October 2022 selectively fused these trajectories: A central steer with territorial delivery (SNAA), single entry points (PUA), a standardized needs assessment (VNB) interfacing with UVM, and—crucially—the political inscription of *Indennità di accompagnamento* reform through a needs-graded universal allowance with a services-for-cash option. This marked the first formal codification of LTC as a distinct social risk and placed IdA redesign squarely on the agenda.

The political exchange of *Season One* was one of technocratic pacification. The executive offered institutional anchoring and agenda access to an unusually broad societal coalition, while deferring distributive conflict (no earmarked new resources; future decrees for operational details). Civil-society actors traded maximalist claims for a credible legislative vehicle; unions and providers accepted coordination devices promising future leverage; ministerial veto players tolerated symbolic advances so long as fiscal neutrality held. Law 33/2023 consolidated this frame but stopped short of creating new justiciable social rights or committing fresh financing. The law opened pathways (particularly via IdA redesign and SNAA institutionalization) yet hinged implementation on later decrees and budget laws—the stage at which partisan politics would return.

The change of majority in late 2022 re-politicized the terrain of LTC reform. What had previously been negotiated under Draghi within a technocratic, low salience register now shifted into a more

openly partisan arena. Parliamentary debates surrounding Law 33/2023 crystallized stable alignments across institutional, ideological, and governance cleavages. On one side, the governing right-wing bloc—comprising FdI, Lega, and Forza Italia—promoted flexibility, subsidiarity, and fiscal prudence; on the other, opposition forces (PD-IDP, M5S, A-IV-RE, AVS) emphasized enforceable rights, stable financing, and stronger multilevel governance. These competing visions expressed themselves through two interrelated divides: A state-periphery divide, contrasting standardized, centrally coordinated service packages (favoured by reformist actors and the Patto) with flexible *budget-di-cura* and voucher-style instruments designed for families; and a governance divide, pitting central executive committees with limited roles for regions and the third sector against stronger multilevel checks and participatory designs.

The hinge moment arrived in early 2024, when the government adopted Legislative Decree No. 29/2024, the first implementing act of Law 33/2023. The decree effectively contracted the universalistic ambition of the original law. It narrowed the SNAA to the social sphere, leaving the health-social split untouched; postponed the two-level needs assessment to 2026-2027; replaced the universal redesign of the *Indennità di accompagnamento* with a means-tested pilot limited to 2025-2026; abandoned the planned domiciliary-care overhaul; and required 22 further implementing decrees, fragmenting accountability and deferring decisive choices far into the future. In this sense, the decree reaffirmed Italy's traditional protectionist and family-centred architecture. Its most visible novelty—the formal recognition of LTC as a distinct social risk—was symbolically significant but weakly transformative in the absence of new resources, enforceable rights, or binding national standards.

Compared with the technocratic pacification of the Draghi period, this second coalition season reshaped the logic of political exchange. In the first season, the government had traded institutional architecture and agenda access for calm and fiscal prudence, with EU deadlines disciplining veto players and granting civil society a seat at the table. In the second season, by contrast, symbolic recognition in reaching PNRR milestone and experimental measures, i.e., *Prestazione Universale*, were offered in exchange for budget neutrality and executive discretion. Policy definition was deliberately shifted into 2024-2025 decree cascades and ministerial arenas, where fiscal guardians such as the MEF and veto-heavy actors like the Regions and INPS could reassert their primacy. The outcome was a strategy of temporal displacement (pushing decisions into the future) and procedural fragmentation (splitting responsibility across multiple decrees) resulting in a re-familization of outcomes beneath the veneer of organizational reform.

In this reconfigured environment, actors recalibrated their strategies. The *Patto* shifted from agenda-setting to watchdogging, producing advocacy papers, a December 2023 *Manifesto*, and, after the decree, focusing on monitoring the 22 implementing acts, rebuilding dialogue with Parliament, and forging alliances with regional executives. Yet it also denounced the decree as a betrayal of the spirit of Law 33/2023. The Regions, through the State-Regions Conference, emerged as pivotal veto holders, objecting to age-threshold restrictions, unfunded mandates, and scope

narrowing, with several northern regions arguing that the decree conflicted with their existing LTC legislation. Providers raised concerns over regulatory ambiguity and the absence of resources, while unions and advocacy groups warned that, without structural funding beyond the *Fondo Non Autosufficienze*, access and coordination devices such as PUA and VAMNA risked becoming empty shells. Meanwhile, the government majority defended the decree as an “epochal reform,” emphasizing agility, subsidiarity, and respect for fiscal prudence. Parliamentary rapporteurs repeatedly invoked “financial invariance” to reassure the MEF and signal continuity with a familist and fiscally cautious trajectory.

The Draghi period had approximated a temporary pro-public alignment. Crisis salience, EU conditionality, and technocratic governance enabled the inscription of universalistic design elements into Law 33/2023, such as the SNAA, standardized assessment tools, domiciliary prioritization, and initial recognition of caregiver roles. Yet because these programmatic victories were budget-light and institutionally contingent, their durability was fragile from the outset. By contrast, the second coalition season reconfigured the opportunity structure. Pro-family and pro-market preferences gained relative weight: Family bonuses, *budget-di-cura*, and cash allowances regained primacy; providers lobbied for outsourcing and accreditation; and fiscal actors locked in budget neutrality. Participatory channels narrowed, EU conditionalities receded, and the universalistic vector inscribed in 2023 was gradually diluted.

The net effect is that the second coalition season marks a shift from inclusive programming to fiscally bounded containment. What remains is a hybrid *equilibrium*: LTC has been symbolically codified as a social risk, and new organizational devices such as SNAA and PUA have been introduced (Maino, 2024). Yet the cash-centred familist model remains intact, and structural reform has once again been deferred to an indefinite future. Rather than producing a genuine path departure, the trajectory underscores how windows of opportunity can quickly narrow into low-cost compromise, yielding symbolic reassurance more than substantive recalibration.

All in all, season one under Draghi represented a brokered, technocratic exchange: The government traded agenda access and institutionalization (SNAA, assessment, IdA on the docket) for civil-society discipline and cross-party calm. The *Patto* and scientific societies accepted “architecture first” to lock in the gate. Rights were anticipated, not delivered. Season two under Meloni instead represented a containment exchange: The government traded recognition and procedural scaffolding for budget neutrality and executive control via decrees, narrowing the coalition by restricting eligibility (70+), piloting instead of universalizing, and deferring key choices. Stakeholders responded by re-mobilizing, regionalizing alliances, and contesting fiscal clauses—yet the centre held, because the package preserved familism, minimized fiscal exposure, and maintained symbolic reformism.

The strategic *fulcrum* is the *Indennità di accompagnamento*. In season one, converting IdA into a graded, dual-modality universal benefit was the fragile lever for path departure. In season two,

the shift to a means-tested, short-term measure removed that lever; the system reverted to cash-dominance and fragmented services, with integration delayed and service expansion left discretionary.

First, the Italian case illustrates a dynamic reinterpretation of the “window of opportunity” from the formulation to the implementation phase, particularly in relation to the forthcoming legislative decrees. As highlighted by Maino (2024), this stage was characterized by the adoption of a “*minimum common denominator*” among a wide constellation of actors, which enabled the recognition of LTC as a “new social risk.” The transition to the Meloni government, however, marked the partial closure of this window, allowing micro-interests to resurface and privileged an “affordable compromise” between social partners and the government. In the absence of a structured dialogue, policy choices have reflected a logic of minimum effort and maximum political return, seeking above all to avoid potential *blame attribution* in the case of overly ambitious reforms.

Second, the resurgence of partisan logics unfolded within a context shaped by several structural and political constraints:

- The absence of LTC from the electoral manifesto of the centre-right coalition, which focused primarily on employment and family policies;
- The “forced inheritance” of the technocratic government’s agenda, with the approval of the draft framework law in October 2023; and
- The reshuffling of ministerial bureaucracies, which weakened existing expert-led networks established under the PNRR and complicated inter-institutional coordination.

Third, the shift toward political polarization—following two years of “technocratic peace”—exacerbated divisions among political actors, as reflected in parliamentary debates and within the *Patto* itself. Italy’s LTC reform trajectory has been anything but a case of “*quiet politics*.” A first, technocratic phase opened an unprecedented window and laid the groundwork for potential path departure, while a second, partisan phase constrained these possibilities through fiscal containment and venue-shifting strategies. The outcome is a hybrid equilibrium: Symbolic recognition of LTC as a social risk; procedural steps toward unified access; and, simultaneously, the reassertion of familistic logics via the centrality of cash transfers, postponed integration, and selective, territorially uneven service expansion. Whether the structural levers that survived—especially the two-level needs assessment—will eventually catalyze a renewed reformist coalition depends on three interrelated factors: The content of the 22 implementing acts, the alignment of regional authorities, and the ability of societal actors to sustain pressure not only for institutional architecture but also for adequate resources and enforceable rights.

All in all, this trajectory is not an exception; rather, it reflects a recurring dynamic in contexts where political agendas are crowded with competing priorities, governmental attention shifts rapidly from one issue to another, and more complex reforms lose salience; where administrative

systems are fragmented and lack the consolidated capacities required to translate general principles into operational rules, leading implementation to slow down or to be simplified; and where political oversight of this phase is discontinuous—due to changes in governments, ministers, or priorities—shifting the centre of decision-making towards cautious, well-established solutions. As a result, reforms that originate with high ambitions are progressively scaled back: not because the will to change is entirely absent, but because, in practice, adapting existing arrangements proves easier than building something genuinely new and innovative.

Finally, the marginal role of regions in the formulation of both Law 33/2023 and the subsequent Legislative Decree 29/2024 further confirms this hybrid, “affordable” equilibrium. The process aimed to minimize and “level down” potential conflicts between the state and the regions—historically one of Italy’s most contentious cleavages—by leaving subnational authorities to operate within a weak regulatory framework, highly open to discretion, and largely unsupported by additional financial resources.

Chapter 8. The Politics of Decreto Lei 101/2006 in Portugal

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1. Introduction

Portugal is the last of the three empirical cases examined in this thesis. As argued in Chapter 3, Portugal long resembled a residual LTC regime in which low de-familisation and low de-commodification coexisted with a fragmented, under-resourced service mix and heavy reliance on households and non-state provision. By the late 1990s a cautious turn had begun—most visibly the introduction of a modest, selective cash benefit for dependency—yet without a commensurate expansion of enforceable entitlements or a unified architecture for community services. The question animating this chapter is therefore not whether Portugal executed a wholesale regime change, but how a pattern of selective, path-dependent expansion became politically feasible and

why, even under favourable electoral conditions, reform stopped short of a redistributive overhaul.

Two sets of developments define the background. The first concerns the party system and the evolving structure of political representation after democratisation. Since the mid-1990s, competition stabilised around alternation between the Socialist Party (PS) and the Social Democratic Party (PSD), while the Communist-Green alliance (CDU) and the new-left Bloco de Esquerda (BE, founded in 1999) pluralised the left without provoking systemic rupture. Patterns of elite-mass congruence suggest that while the far left and communists often positioned themselves further left than their voters, PS exhibited comparatively higher programmatic congruence with its electorate, helping the party claim a mandate to modernise public services while defending universal guarantees (Belchior, 2008).

In parallel, Europeanisation progressively narrowed governments' room for distributive *manoeuvre*. From the late 1980s, EU structural funds and, after Maastricht, the logics of the Economic and Monetary Union (EMU) brought hard budget constraints and a new governance vocabulary that privileged managerialism and coordination over entitlement expansion (Magone, 2006). The confluence of bipolar competition, modest left fragmentation, and EMU discipline shifted partisan conflict from redistribution toward the design of administratively tractable instruments—precisely the terrain on which “integration” in LTC could advance without large fiscal commitments (Magone, 2006).

The second development concerns the long maturation of Portugal's third sector and its incorporation into welfare delivery. Across the 1980s and 1990s, the state consolidated a cooperation regime in which financing and steering remained public while a dense network of non-profit providers—*Instituições Particulares de Solidariedade Social* (IPSS) and the historically embedded *Misericórdias*—delivered residential, day, and domiciliary supports. The *Carta Social* documents capture the scale effects of this regime: By 2000, the stock of owner-entities had grown markedly relative to 1998, with especially rapid increases among non-profit organisations in interior districts and a more recent emergence of for-profit providers in selected territories.

Within this political-institutional field, Chapter 8 advances an analytical claim. Portuguese LTC reform between 2000 and 2006 is best understood as a coalition-led coordination platform produced under hard macro-constraints and mediated by particularistic demand from strategically located organisations. On the supply side, the PS majority of 2005 re-cast “integration” as a grammar of public law—joint steering by Health and Social Security, territorial coordination structures, standardised typologies for convalescence/medium/long stay, and a home-first pathway—while keeping open a contracting channel with public, non-profit, and, selectively, private providers at regulated prices.

On the centre-right, PSD and CDS-PP accepted the logic of freeing acute-care bottlenecks and strengthening primary care but read “integration” through the lens of fiscal control and administratively tractable pluralism. On the left, BE and CDU articulated a rights-first orientation—expanding public and proximity services, constraining co-payments, and resisting “privatisation by stealth.” Compared with 1999-2002, these positions were more sharply differentiated—especially after BE’s parliamentary consolidation—yet none displaced EMU-era budget discipline or the bargaining leverage of professional orders and third-sector federations that controlled implementation capacity.

Demand-side dynamics are crucial in this case. Unlike Spain and Italy, where higher issue salience occasionally aggregated universalist claims, Portugal’s low-salience environment channelled conflict into elite bargaining. Hospitals sought a discharge valve and predictable step-down capacity; primary care sought community teams; medical orders defended clinical leadership and protocol-based governance; nursing organisations tied “integration” to enforceable staffing and case-management standards; and the social economy sought long-term contracts and price stability to redeploy installed capacity. The cooperation regime documented in the Carta Social meant that where these actors were organisationally dense, service expansion followed; where they were thin, territorial deficits persisted.

The upshot is a distinctive form of policy change—selective expansion through institutional layering. The RNCCI strengthened steering, standardisation, and visibility; increased in-kind capacity through regulated pluralism; and stabilised a joint health-social governance grammar that could “travel” within fiscal ceilings. At the same time, the cash layer remained essentially untouched, and dependency was not recoded into a justiciable social entitlement. Portugal therefore moved toward a more integrated, procedurally robust LTC field while remaining within the residual quadrant set out in Chapter 2: Unpaid family care still anchors provision; the third sector remains the dominant arm of delivery; and territorial inequalities track the geography of organisational capacity.

This Chapter is structured as follows. After the introduction, Section 2 explores the contextual factors that shaped the policy agenda, analysing the structural weaknesses of the Portuguese LTC system at the turn of the century, persistent territorial disparities, and the growing social pressures associated with demographic aging and rising care needs. It also traces the transformation of the political landscape, focusing on the rise of the *Bloco de Esquerda* and the dynamics of PS-PSD bipolarisation between 1999 and 2002, with particular attention to the programmatic priorities revealed during the 2002 general elections. Section 3 investigates coalition formation in support of LTC reform between 2000 and 2004. It analyses the first legislative proposals and parliamentary debates, the political alternation following the PSD’s return to power, and the positioning of political parties and other key stakeholders. Special attention is paid to the fragmented governance context and the processes through which diverse actors—political parties, professional associations, unions, and third-sector organisations—mobilised resources and

strategies to influence policy outcomes. Finally, the fourth section focuses on the negotiations and political exchanges leading to the creation of the RNCCI in 2006. It examines the evolving configuration of stakeholders' interests, the parliamentary debates preceding the reform, and the approval of *Decreto-Lei* No. 101/2006. The concluding section highlights how partisan dynamics, ideological cleavages, and institutional constraints interacted to produce a compromise solution that redefined the boundaries between health, social policy, and the role of the third sector in the provision of care.

2. Contextual Factors and Political Dynamics in the Portuguese LTC Sector

Before 2006, Portugal—much like Spain—was generally classified within a residual LTC system in which families were presumed to be the primary providers of support and the state intervened only minimally (Ferreira, 2000; Carreira da Silva, 2017). Also in Portugal, yet this settlement came under mounting strain as demographic and social trends accelerated: Fertility declined, populations aged, and women's labour-market participation rose, eroding the supply of unpaid care and the gendered division of caregiving on which the model implicitly relied (Guerrero & Naldini, 2007). Consequently, the traditional caregiving architecture was increasingly unsustainable, pointing either to a reconfiguration of welfare arrangements—through new mixes of services, cash supports, and coordination—or to a deepening crisis in elder-care provision (Pichler & Wallace, 2007).

The remainder of this section proceeds as follows. Section 2.1 reviews the contextual drivers—new and emerging social pressures—shaping a residual LTC system under stress. Section 2.2 then turns to the political arena, examining how party competition and institutional constraints conditioned the range of feasible policy responses.

2.1. The Contextual Factors: Emerging Social Pressures in the LTC

The sections that follow present, first, descriptive evidence on long-term care in Portugal between 2000 and 2006 (Section 2.1.1.) and second, the country's territorial fragmentation—across provinces and between urban and rural areas (Section 2.1.2.).

2.1.1. LTC at the Turn of the Century: A Residual System

By 2005, individuals aged sixty-five and older accounted for more than 17% of the national population, and in several inland districts dependency ratios exceeded 30%, exacerbating demand for formal care. These demographic patterns coincided with broader socio-economic challenges, including rural depopulation, limited labour market opportunities, and inadequate transport infrastructure, which complicated care delivery in low-density regions. Furthermore, the LTC system continued to rely heavily on informal and family-based caregiving, particularly in rural provinces where institutional coverage remained low. Despite substantial investments, Portugal

still had one of the lowest formal LTC coverage rates in Western Europe during the early 2000s. In practice, families—and predominantly women—bore the primary responsibility for eldercare, often without adequate financial or professional support. This dependence on informal provision reinforced gendered inequalities in both care burdens and labour market participation.

Table 8.1. presents data on the population aged 65 and over in Portugal between 1990 and 2006, highlighting both its growth in absolute numbers and relative proportions. The total population aged 65+ increased steadily from 1,356,709 in 1990 to 1,828,617 in 2006. Consequently, the share of older adults over the total population rose from 13.6% to 17.4% over the period. Within this group, the proportion of individuals aged 80 and over also grew, increasing from 19.2% in 1990 to 22.8% in 2006, indicating a progressive ageing of the older population segment.

Table 8.1. Demographic Trends of the Population Aged 80 and above in Portugal (1990-2006).

	65+ Total	% 65+ over total population	% 80+ over 65+
1990	1,356,709	13.6%	19.2%
1995	1,508,091	14.2%	20.7%
2000	1,677,287	16.3%	21.2%
2006	1,828,617	17.4%	22.8%

Source: Author's elaboration on INE Portugal dataset.

Since the establishment of democracy in Portugal in 1974, a significant number of social protection and health associations have been created, totaling 5,060 organizations, which represent 9.7% of the 51,958 associations in existence (INE Portugal dataset). By 2006, social service associations accounted for 13.7%, health-related associations for 1.4%, and religious associations for 15.6% of the 45,543 registered associations (*ibidem*). Additionally, 48% of the workforce within the associative sector is employed in the provision of social services (Almeida et al. 2021). The provision of social services in Portugal was predominantly managed by IPSS, which operates 80% of the solidarity-based network of social facilities. Consequently, social services represented a disproportionately large segment of Portuguese civil society, underscoring the critical role of private and nonprofit organizations in social welfare provision (Pereirinha & Murteira, 2016; Branco, 2017).

As for in-kind services, Table 8.2. provides data on the development of long-term care institutions, available places, and users in Portugal between 1998 and 2006. Three main types of services are considered: Nursing homes, day care centres, and home-based care services. For nursing homes, the number of institutions grew from 1,181 in 1998 to 1,572 in 2006, with available places increasing from 49,059 to 63,087. The number of users followed a similar trend, rising from 47,129 to 61,313 (INE Portugal dataset). The users-to-places ratio remained relatively stable, slightly decreasing from 96.1% in 1998 to 97.2% in 2006, indicating near-full occupancy (*ibidem*). Day care centres expanded from 1,341 institutions in 1998 to 1,899 in 2006, while available places rose from 46,273 to 60,813. Users, however, peaked in 2004 (42,158) before slightly declining to 41,507 in

2006, resulting in a users-to-places ratio drop from 78.5% in 1998 to 68.2% in 2006, suggesting underutilisation in later years. Finally, home-based care services showed the most significant expansion. The number of places increased dramatically from 38,022 in 1998 to 78,268 in 2006, and users rose from 30,645 to 70,450. The users-to-places ratio also improved from 80.6% in 1998 to 90.0% in 2006, indicating a growing reliance on home-based solutions (*ibidem*). Between 1998 and 2006, Portugal experienced a significant expansion of long-term care services, with notable growth in the number of institutions, available places, and users. While nursing homes maintained consistently high occupancy rates, day care centres showed signs of underutilisation in later years. By contrast, home-based care services expanded rapidly and achieved higher utilisation levels.

Table 8.2. Institutions, Places and Users in Nursing Homes, Day Care Centres and Home-Based Care Services.

	Institutions			Places			Users		
	1998	2004	2006	1998	2004	2006	1998	2004	2006
Nursing homes	1.181	1.517	1.572	49.059	58.565	63.087	47.129	56.535	61.313
Day care centre	1.341	1.766	1.899	46.273	57.591	60.813	36.328	42.158	41.507
Home-based care services	-	-	-	38.022	61.429	78.268	30.645	58.992	70.450

Source: Author's elaboration on INE Portugal dataset.

Compared to Table 8.1, between 1998 and 2006, the availability of LTC services in Portugal increased, but overall coverage remained limited relative to the growing older population. The total number of places across nursing homes, day care centres, and home-based care rose from approximately 133,000 in 1998 to 202,000 in 2006, improving the coverage ratio from 9.8% to 11.0% of the population aged 65 and over (INE Portugal dataset). This expansion was largely driven by the rapid growth of home-based care services, while nursing homes maintained high occupancy rates and day care centres showed signs of relative underutilisation. Despite these improvements, the overall offer of LTC services remained modest compared to demographic ageing trends, suggesting a persistent gap between demand and supply.

Regarding cash benefits, the *Complemento de Dependência* shows, as reported in Table 8.3, the evolution of its beneficiaries between 2000 and 2006, both in absolute numbers and as a proportion of the population aged 65 and over. The number of beneficiaries rose from 174,720 in 2000 to 221,199 in 2006, corresponding to an increase in coverage from 10.4% to 12.2% of the 65+ population (INE Portugal dataset). Despite some fluctuations—most notably a decline in 2003—the overall trend reflects a gradual expansion of access to this cash benefit aimed at supporting dependent older adults. Its generosity has progressively increased over time while preserving its original design as a residual and complementary measure, rather than evolving into a

comprehensive, stand-alone care allowance. Access remains selective and is restricted to pensioners with a medically certified condition of dependency (*nível 1 and 2*).

Table 8.3. Number of Beneficiaries of the Complemento de Dependência, 2000-2006.

Year	N. of beneficiaries	% over 65+
2000	174.720	10.4%
2001	189.220	11.2%
2002	199.145	11.5%
2003	170.729	9.7%
2004	178.549	9.9%
2005	214.952	11.8%
2006	221.199	12.2%

Source: Author's elaboration on INE Portugal dataset.

2.1.2. A Fragmented System: Provincial Disparities in the LTC

During the period under analysis, persistent territorial disparities between metropolitan and rural areas remained a defining feature of the Portuguese LTC system. In the early 2000s, the institutional framework governing LTC provision was highly decentralised and heavily dependent on non-profit organisations, particularly the *Instituições Particulares de Solidariedade Social* and the *Misericórdias*, which accounted for approximately 70% of all facilities by 2000 (Ministério do Trabalho e da Solidariedade, 2000). Drawing on data from the *Carta Social* reports (2000-2006), this section examines the expansion of service provision, the diversification of care modalities, and the enduring regional disparities that continued to shape the Portuguese LTC sector. Despite significant national efforts to improve coverage, access to services remained heavily conditioned by geographical location and institutional capacity.

At the turn of the *millennium*, Portugal faced a profound mismatch between demographic ageing and the limited capacity of its LTC infrastructure. In 2000, the population aged 65+ reached nearly 1.68 million, while those aged 80+ represented more than 356,000 individuals (Ministério do Trabalho e da Solidariedade, 2000). However, the number of available institutional places remained inadequate. There were 1,356 nursing homes, 1,526-day care centres, and approximately 38,000 home-care slots nationwide, translating into a national coverage rate of around 20% for older adults.

This aggregate figure masked substantial provincial inequalities. Lisbon, Porto, and Setúbal concentrated nearly 45% of all institutional capacity, resulting in coverage rates exceeding 30% of the local 65+ population. In contrast, interior regions such as Beja, Évora, Castelo Branco, and Bragança recorded coverage levels below 12%, revealing structural gaps in access (Ministério da Segurança Social e do Trabalho, 2001). These early disparities reflected both historical path dependency and institutional asymmetries. Districts with consolidated IPSS networks attracted

more investments and developed better infrastructures, while territories with weaker organisational capacity lagged behind. In 2001, for example, while Porto had over 12,000 institutional places, Beja offered fewer than 1,200, despite a higher share of older adults relative to its total population (Ministério da Segurança Social e do Trabalho, 2001).

By 2002, the government launched initiatives to coordinate social and healthcare services, yet governance remained fragmented and strongly dependent on cooperation agreements with IPSS (Ministério do Trabalho e da Solidariedade, 2002). This funding model intensified inequalities: Municipalities with robust networks of providers obtained larger allocations, while those in rural areas lacked bargaining power and administrative capacity. The *Carta Social 2003* revealed widening disparities. The national average coverage rate for institutional LTC stood at approximately 21%, but vast regional contrasts persisted (Ministério da Segurança Social e do Trabalho, 2003). Lisbon exceeded 35% coverage, while Bragança, Guarda, and Beja remained below 10%. These gaps translated into an uneven capacity to respond to demographic pressures: Whereas Porto offered 6.2 institutional places per 100 older adults, Castelo Branco had fewer than 2.5.

From 2004 onwards, policy discourse increasingly prioritised the diversification of care modalities. The government promoted home-based and community care to enable ageing in place and contain institutionalisation costs (Ministério do Trabalho e da Solidariedade Social, 2004). Programmes such as PARES (Programa de Alargamento da Rede de Equipamentos Sociais) provided funding for new infrastructures, but the expansion of services remained spatially unbalanced. Utilisation data highlight contrasting trends. Nursing homes operated near full capacity throughout the period, with occupancy rates above 96%, signalling chronic undersupply relative to demand. Day care centres, by contrast, experienced underutilisation: Although available places increased from 46,273 in 1998 to 57,591 in 2004, the users-to-places ratio fell from 78.5% to 72.3% (Ministério do Trabalho e da Solidariedade Social, 2005).

Meanwhile, home-based care services experienced the most dynamic growth. Available places more than doubled between 1998 and 2005, rising from 38,022 to 78,268, while users increased from 30,645 to nearly 59,000. Utilisation rates approached 90% by 2005, signalling a growing policy and social preference for community-based models. However, access remained geographically uneven: In Lisbon, over 20% of older adults received home-based services, compared to less than 8% in inland Alentejo (Ministério do Trabalho e da Solidariedade Social, 2005). The *Carta Social 2006* (Ministério do Trabalho e da Solidariedade Social, 2006) provides the clearest evidence of systemic territorial disparities. At the national level, institutional LTC coverage averaged 26.2%. Yet 47 municipalities – mostly in Alentejo, Beira Interior, and Trás-os-Montes – reported coverage below 15%, compared to more than 40% in Lisbon and Porto. In Setúbal, for example, there were 5.8 institutional places per 100 older adults, while Portalegre offered just 1.7. These inequalities were compounded by funding asymmetries. Coastal regions, particularly Lisbon, Porto, and Braga, benefited disproportionately from EU co-financing and PARES funding streams, while resource-

scarce inland municipalities lacked the institutional capacity to apply for competitive grants. Consequently, the expansion of LTC services tended to replicate existing patterns of territorial advantage, privileging metropolitan regions while leaving structurally vulnerable territories underserved.

By the end of 2006, the Portuguese LTC system was marked by three interrelated dynamics: Overall expansion, persistent fragmentation, and deepening territorial disparities (PT1—Academic Expert, Centre for Administration and Public Policies, Universidade de Lisboa; PT2—Academic Expert, Department of Social Work, Universidade de Lisboa). While the number of institutional places and home-care slots grew significantly, coverage remained insufficient in regions with the highest levels of ageing, particularly in the interior. Three structural drivers explain these patterns. First, demographic pressures were uneven: Rural municipalities aged faster, with over 25% of their population aged 65+, yet received proportionally fewer resources. Second, institutional asymmetries favoured territories with stronger IPSS networks, reinforcing historical inequities in service provision. Third, the policy design lacked redistributive mechanisms: Funding followed project proposals rather than objective indicators of need, resulting in a two-speed system where access to care depended more on geography than on dependency levels. This fragmentation also reinforced social inequalities (PT1—Academic Expert, Centre for Administration and Public Policies, Universidade de Lisboa; PT2—Academic Expert, Department of Social Work, Universidade de Lisboa). In underserved areas, families – and particularly women – compensated for the lack of formal provision by assuming unpaid care responsibilities, intensifying gendered disparities in caregiving. Moreover, the absence of a unified governance framework limited integration between health and social care, preventing the development of person-centred, continuous LTC pathways (PT3—Legal Counsel, Integrated Continuing Care Directorate, Santa Casa da Misericórdia de Lisboa).

2.2. The Rise of the *Bloco de Esquerda* and PS-PSD Bipolarism (1999-2002)

The years from 1999⁵⁸ to 2004 were marked by intensified competition between Portugal's two principal parties—the Socialist Party (PS) and the Social Democratic Party (PSD)—frequent alternations in office, and a deepening Europeanization that progressively circumscribed domestic policy autonomy.

The 1999 legislative elections marginally strengthened the PS to 44.1% and 115 seats—still one short of a majority—while the PSD, now led by José Manuel Durão Barroso, secured 32.3%. Significantly, the Left Bloc (*Bloco de Esquerda*, BE) entered parliament for the first time with two

⁵⁸ Although the Chapter focuses on the period between 2000 and 2006, the reference to 1999 is included as it pertains to the electoral elections held shortly before the turn of the new century, thus providing useful context for defining the political configuration that shaped Portuguese society during those transitional years.

deputies, signalling incremental pluralization on the left (Freire & Baum, 2003). Portugal’s institutional setting made minority governance viable. Under its variant of “negative parliamentarism”, governments do not require a formal investiture vote but must avoid defeat; presidents designate a formateur, and executives remain in power as long as they withstand censure (Fernandes et al. 2016). This arrangement lowers entry barriers for minority cabinets while fostering incentives for issue-by-issue bargaining in parliament—a configuration that proved crucial for the PS in the late 1990s. Table 8.4 illustrates the election results of the 1999 general election in Portugal.

At the mass level, however, the political climate was marked by high disaffection: Turnout declined, external efficacy was low, and disengagement—rather than protest—became the modal response to dissatisfaction (Magalhães, 2005). This passive political culture reduced extra-institutional pressures on governments, encouraging elites to manage conflict within parliamentary channels and to favour technocratic recalibration over expansive distributive projects (*ibidem*).

Table 8.4. Election Results in the 1999 General Election in Portugal.

Party	Vote Share (%) 1999	Seats 1999	Government 1999
Partido Socialista	44.1	115	Governing party (minority); no coalition
Partido Social Democrata	32.3	81	Main opposition
CDS-Partido Popular	8.3	15	Opposition
CDU (PCP-PEV)	9.0	17	Opposition
Bloco de Esquerda	2.4	2	Opposition

Source: Author’s elaboration on Comissão Nacional de Eleições (1999).

The emergence of the BE reconfigured the supply side of the centre-left and increased the transaction costs of PS minority rule. Organizationally, BE fused extra-parliamentary far-left and new-left currents with strong social-movement linkages, translating anti-globalization, anti-privatization, and inequality frames into a parliamentary voice. Its initial breakthrough in 1999, followed by a modest advance in 2002, signalled that left-wing competition would no longer revolve around the traditional PS-PCP duopoly. Programmatically, BE’s new-left profile diverged from both PS’s “modernizing social democracy” and the PCP’s traditional communist repertoire. It coupled the defence of universal public services with feminist, LGBTQ+, and civil-liberties agendas; foregrounded labour precarity and “new social risks”; and advocated social investment at odds with post-Maastricht budget orthodoxy.

During the 1999-2002 legislature, BE exerted sustained pressure on education, health, and social-policy domains and vocally opposed privatization and public-sector downsizing. The result was a more contested left space, with BE and PCP competing for ownership of welfare-statist and anti-liberalization frames. This dynamic reduced PS’s bargaining latitude on its left flank while raising the reputational costs of centrist compromises. Institutionally, fragmentation mattered precisely

because EMU rules were compressing fiscal space: Under negative parliamentarism, the feasible coalition set narrowed and issue-by-issue bargaining intensified, pushing the PS toward managerial recalibration within tight fiscal envelopes while leaving PCP and BE free to articulate sharper critiques without bearing executive responsibility (Fernandes, 2016).

2.2.1. The 2002 General Elections: The Programmatic Priorities of the Political Parties

As in the Spanish case (Chapter 5) and the Italian cases (Chapters 6 and 7), this section examines the electoral manifestos of the main Portuguese parties in the campaigns preceding the approval of the LTC reform. Following a chronological approach, the focus is on the 1999 and 2002 elections, with the former marking the last contest before the turn of the century and the latter occurring on the eve of the RNCCI reform.

Between 1999 and 2002, long-term care did not feature among the headline priorities of Portuguese parties, much as in Italy. Party competition revolved instead around the transformation of the National Health Service and the reconfiguration of the welfare system at large. Within this broader agenda, however, left and right advanced contrasting visions with significant implications for the governance of dependency care.

The CDU (PCP-PEV) adopted a programmatic approach centred on strengthening primary care, improving coordination between primary and secondary services, and prioritising “continuidade de cuidados” (continuity of care) alongside “desenvolvimento do apoio domiciliário” (development of home-based services). These proposals treated continuity and domiciliary services as central organisational priorities of the SNS, embedded in a normative discourse that stressed humane, accessible care, democratic governance, and the protection of users’ rights. Dependency risks were framed as a collective public responsibility, to be addressed through investment, integration, and publicly delivered services rather than outsourcing to private or voluntary providers (Partido Comunista Português, 1999; 2002).

The Socialist Party (PS) in 1999 presented health as the “new priority of social policy” within a broader project of modernisation and rule-based regulation. Its manifesto emphasised social cohesion and a “nEw generation” of social policies, but it did not articulate a distinct LTC blueprint. Instead, the PS positioned the state as both regulator and enabler: Public services were to be upgraded, core social rights safeguarded, and system sustainability pursued through managerial reform rather than retrenchment. Comparative analyses consistently locate the PS to the left of the PSD in the 1990s in terms of welfare-state expansion and market regulation, while noting its pragmatic, performance-oriented framing. By 2002, following Guterres’s resignation, the PS softened its universalist register, emphasising competitiveness and national cohesion under stable public finances. Although administrative efficiency and macroeconomic credibility became

central objectives, the party did not advocate a doctrinal withdrawal from public provision (Partido Socialista 1999; 2002).

The Bloco de Esquerda, formed in 1999, entered the party system with a rights-based and anti-marketisation platform defending universal public services across all welfare sectors. While less detailed than the CDU in engineering care coordination, BE treated the SNS as a political good to be protected and expanded. It framed emerging social risks—such as precarity, poverty, and gendered inequalities of care—as requiring tax-funded, universal responses rather than contributory fragmentation or voluntary provision. By 2002, BE remained a small but coherent pole on the left, reinforcing demands for publicly delivered services and for social investment, including home and community-based support (Bloco de Esquerda, 1999; 2002).

The Social Democratic Party (PSD) adopted a markedly different approach. In 1999, its manifesto opened with a liberal-conservative critique of dependency, framing income loss as central and portraying “passivity” and “paternalism” as problematic outcomes of a statist model. It prioritised initiative, efficiency, and non-state solutions, implying a greater role for private and social providers, user choice, and community responsibility. By 2002, the PSD’s programme evolved into a mixed-economy model. The PSD-led XV Constitutional Government, formed in coalition with the CDS-PP, defined the SNS as a “combined and integrated system” in which public, private, and social providers coexist under state regulation, with user choice explicitly established as an organising principle. While affirming solidarity and equity as core values, the government distanced itself from what it portrayed as a “statist, centralising and bureaucratic” model, favouring non-state providers whenever these could deliver greater efficiency at lower costs. In LTC terms, this amounted to a quasi-market template characterised by plural provision, strong regulation, and freedom of choice (Partido Social Democrata, 1999; 2002).

Within the coalition, the CDS-PP contributed a Christian-democratic familist orientation that had remained stable since the late 1990s. Its doctrine grounded social policy in subsidiarity and a strong valorisation of the family, while legitimising the social economy (Misericórdias, IPSS) as co-producers of welfare. The party favoured a mixed-provision model in which the state guarantees financing and sets regulatory frameworks but does not monopolise delivery. Applied to LTC, this translated into publicly guaranteed access combined with social and private provision, with the family positioned both as a normative centre and as a beneficiary of supportive measures such as respite care, tax relief, and domiciliary services (Partido Popular, 1999; 2002).

Across the 1999–2002 window, the electoral manifestos revealed three distinct policy grammars that prefigured Portugal’s hybrid settlement in LTC. The PS pursued a solidarist modernisation agenda that placed universalism and social rights at its core, while addressing system performance and fiscal sustainability through managerial reforms. By contrast, the PSD—joined by the CDS-PP after 2002—advanced a liberal-communitarian challenge to dependency that evolved into a regulated pluralism model based on mixed provision, user choice, and family centrality. Finally,

the CDU and, normatively, the BE defended universalist protection, with the CDU articulating the most detailed proposals for integrated LTC, including continuity of care, primary-care-led coordination, home support, and step-down capacity within the SNS, while BE politicised universalism and resisted privatisation.

These positions reflected divergent conceptions of responsibility, solidarity, and efficiency. The PS promoted managerial universalism compatible with integrated-care principles; the PSD and CDS-PP prioritised plural provision under public regulation; and the CDU and BE defended public, universal solutions, albeit with different degrees of programmatic specificity. By 1999, the foundations of a community-based and integrated care model were already visible, particularly on the left, and the PS's managerial universalism proved flexible enough to incorporate several CDU-inspired proposals without ideological friction. The centre-right coalition that took office in 2002 supplied the governing grammar of regulated pluralism, scaling support for dependency through partnerships with the social economy while retaining a public financing guarantee. BE's contribution was to politicise the defence of universal provision and resist the commodification of care, maintaining financial accessibility and equity as central concerns. Table 8.5 presents the positions of Portuguese political parties, based on their electoral manifestos, between 1999 and 2002.

Table 8.5. Vision of LTC and its Components in Electoral Manifestos of Portuguese Political Parties, 1999 and 2002.

Dimension	Partido Socialista	Partido Social Democrata	PCP-PEV	Centro Democrático e Social - Partido Popular	Bloco de Esquerda
Main vision of LTC	Universalist, state-anchored pillar of welfare; LTC understood as an extension of the SNS with integrated, publicly steered services.	Mixed-economy model with regulated plural provision (public-social-private) and user choice; LTC as a field for managed competition and subsidiarity.	Universal public service; LTC as a right guaranteed through the SNS and public social protection, with anti-privatization emphasis.	Familist-subsidiary mix; LTC delivered chiefly by the social economy (IPSS/Misericórdias) with the State as enabler.	National, rights-based public care system; de-familizing and de-commodifying orientation within a strengthened public sector.
Primary policy objective	Social cohesion and equity via improved access and service quality; managerial modernization and fiscal sustainability without retrenchment.	Reduce dependency and raise efficiency; expand access through plural providers and structured choice under fiscal discipline.	Universal access and equality; strengthen continuity and proximity of care; protect users' rights through public capacity.	Support families and proximity networks; guarantee minimums while leveraging community/family-based providers.	De-commodify care, advance gender equality, and protect caregivers through public guarantees and expanded services.
Preference: in-kind vs. in-cash benefits	Tilt to in-kind services (publicly provided/commissioned), with targeted income support where needed.	Balanced or cash-leaning mix (allowances/vouchers) to enable choice; in-kind via contracted providers.	Predominantly in-kind public services; cash is complementary and non-substitutive.	Openness to in-cash supports (allowances, tax reliefs) alongside in-kind via social providers.	Primarily in-kind public services; income supports for caregivers framed as statutory rights (e.g., paid leave, pension credits).
Role of the state	Guarantor, regulator, and strategic planner; upgrades public administration and coordinates health-social interfaces.	Financer and rule-setter; steers markets and social economy, contracts out provision, safeguards equity via regulation.	Principal provider, expands public networks and removes financial barriers.	Enabler and co-financer; partners with IPSS/Misericórdias; sets standards but avoids provision monopolies.	Primary provider/guarantor; builds a public care service and tightens regulation to limit marketization.
Preferred policy instruments	Primary-care-led integration; expansion of publicly funded home/community services; performance management; selective contracting under public control.	Purchaser-provider splits; competitive contracting with social/private actors; user choice mechanisms; targeted caregiver support.	Investment in primary care; home-care expansion and step-down/convalescent beds; elimination of user charges; public hiring and infrastructure.	Caregiver allowances and tax deductions; vouchers/respite schemes; contracting with IPSS; community-based home support.	Statutory caregiver rights (leave, income replacement, pension rights); expansion of domiciliary/day services; curbs on user charges; public workforce growth.

Note: Positions synthesize party programmes and governing documents in 1999 and 2002 election. "LTC" was rarely named explicitly; categories reflect each party's stated approach to health, social protection, family policy, and service delivery as proxies for LTC design choices.

Source: Author's elaboration on electoral parties' manifestos (1999 and 2002).

The salience attributed by the parties to certain long-term care issues was also shaped by the regulatory evolution of the sector, which, as will be discussed in the following sections, underwent multiple changes between 2000 and 2005, culminating in the comprehensive reform of 2006. These

transformations were supported by specific coalition and policy configurations that ultimately led to the adoption of Decree-Law No. 126 of 2006.

3. Coalition Formation in Support of Reform (2000-2004)

Between 2000 and 2004, Portugal experienced a decisive reconfiguration of LTC, evolving from small-scale experimental initiatives to the formal establishment of the *Rede Nacional de Cuidados Continuados Integrados* in 2006. This transition unfolded against the backdrop of structural pressures—rapid population ageing, the growing prevalence of chronic disease, and rising social expectations for integrated health and social support—which highlighted the limitations of existing fragmented and residual arrangements (Sanches & Santana Pereira, 2010). Historically marked by uneven development and institutional segmentation, the Portuguese welfare state faced mounting demands to strengthen coordination across ministerial and sectoral boundaries (Magalhães, 2013). Although successive governments recognised the need to ensure linkage and continuity of care, alternation in office and coalition bargaining repeatedly reshaped both the pace and the design of reform.

This section is structured as follows. Section 3.1 examines the initial legislative proposals on LTC and the corresponding parliamentary debates surrounding this policy area. Section 3.2 analyses the return of the Social Democratic Party to power, outlining the political dynamics that shaped this transition. Section 3.3 situates the decisions adopted by the centre-right government in the field of LTC and focuses on the positioning of the main political parties during this period. Section 3.4 identifies the stances of the most relevant institutional and non-institutional actors involved in the policymaking process, while Section 3.5 discusses the political cleavages that emerged between 2000 and 2004 and highlights key drivers that help explain the decisions taken by the incumbent government.

3.1. The First Legislative Proposals on LTC and the Related Parliamentary Debates

Between 2000 and 2002, the Portuguese Parliament developed a series of *proto*-long-term care instruments, even though LTC had not yet been articulated as a distinct policy pillar. On the centre-right, the *Partido Social Democrata* introduced *Projecto de Lei No. 221/VIII* (Asembleia da Republica, 2000a) on “support for the permanence and integration in the family of older people and persons with disabilities.” The proposal was explicitly familist-subsidiary: The household was designated as the preferred locus of dignified care, while institutionalisation was framed as a residual and last-resort option.

The PSD’s instrument mix was operational and highly specific. It included tax deductions for hiring care personnel and for health expenditures, subsidised home adaptations, a means-tested monthly

allowance, and special caregiver leave of up to three years, supported by a social-security subsidy. Service delivery relied on the IPSS and the Misericórdias, linked beneficiaries to health centres for clinical and nursing follow-up and assigned programme organisation and monitoring to regional social-security centres. In doing so, the PSD design formalised a bridge between social protection and primary care within a state-steered framework. The bill's smooth progress through committee signalled a degree of cross-party willingness to deliberate familist solutions under public rules.

Shortly after the PSD proposal in 2000, the BE intervened in 2001 by reframing the distributive problem. Portuguese households, it argued, “support 40% of health expenditure” amid comparatively low public outlays, generating structural inequalities of access (Asembleia da Republica, 2001a). The proposed remedy was a rebalancing toward tax-financed coverage within the Serviço Nacional de Saúde and a greater investment in the public provision core, rather than relying on user-side subsidies (Asembleia da Republica, 2001b; 2001c; 2001d).

For BE, poor access was not the natural by-product of resource scarcity but the result of missing state capacity. Its critique catalogued a series of systemic governance failures: The absence of SNS accounts since 1998, non-constituted national bodies, lack of strategic planning and information systems, inadequate quality policies, insufficient workforce planning, and deficient public-health instrumentation. From this perspective, multi-level governance itself became the precondition for continuity of care. Normatively, BE equated privatisation with “going backwards in health,” treating marketisation as a mechanism that increased out-of-pocket costs and eroded universalism. BE's silence on cash allowances or tax credits, combined with its implicit rejection of restrictive eligibility rules, implied a low-barrier, needs-based entry into publicly guaranteed services (Asembleia da Republica, 2001a; 2001b; 2001c).

This intervention prompted a partial realignment of the centre-left government with BE's demands, though the Partido Socialista adopted a more moderate vision of welfare expansion. In his State of the Nation address on 28 June 2001, Prime Minister António Guterres articulated a different but overlapping position. He defended the “social state” model against what he described as a right-wing “catastrophe” discourse yet anchored this defence within the framework of EMU-compatible fiscal consolidation (Asembleia da Republica, 2001e). For the PS, macroeconomic credibility and programmatic discipline were preconditions for sustaining social rights. The government therefore rejected privatisation as a shortcut to fiscal adjustment, instead placing emphasis on strengthening central coordination and execution capacity, rather than pursuing immediate service expansion at any cost (Asembleia da Republica, 2001f).

In 2002, two PS initiatives further expanded the rights-and-governance perimeter. *Projecto de Resolução No. 168/VIII* (Asembleia da Republica, 2002a) reframed ageing as a multidimensional vulnerability requiring prevention, proximity, and systematic evaluation. It called for an expansion of the Integrated Support Programme for the Older Persons, greater state involvement and funding, and flexible family-usable responses (day, night, and weekend home support; short-stay

admissions for respite). Additional measures targeted anti-isolation, community integration, and school-based pedagogy on elder rights, alongside the gradual creation of a public eldercare network “in strict complementarity” with private provision. The proposal also introduced fiscal incentives to families and mandated annual reporting to Parliament.

Soon after, *Projecto de Lei No. 526/VIII* (Asembleia da Republica, 2002b) established municipal and national Commissions for the Protection and Promotion of the Rights of Older Persons. Conceived as non-judicial bodies with functional autonomy, these commissions were tasked with promoting rights, preventing abuse, and intervening in situations of risk. Their competences—defending fundamental personal rights, promoting primary and palliative care, prioritising dependent persons’ interests even vis-à-vis family or institutional preferences, training professional groups, and ensuring mandatory inter-agency collaboration—amounted to a governance architecture oriented toward detecting need, coordinating actors, and producing actionable data.

De facto, PSD and PS proposals intersect more than they collide. The PSD embedded familism within a rule-bound, state-steered regime, orchestrating care through primary care and social security while leveraging household labour and third-sector capacity. The PS, by contrast, constructed a universalist and preventive perimeter, anchored in rights-based governance, proximity instruments, and multi-level oversight.

Analytically, these proposals mapped onto two intersecting axes (Table 8.6.). Along the familism-subsidiarity axis, the PSD advanced the clearest position, prioritising household centrality, residual institutionalisation, and cash-type supports. Along the state-periphery axis, the PS delineated the governance perimeter within which dependency risks should be managed, explicitly linking care to primary and palliative services. The axes, however, were not orthogonal: Both approaches converge on proximity care and on a networked delivery model premised on interoperability among social security, primary care, and the social economy. Yet the trade-offs differ: the PSD approach contains immediate public outlays by mobilising family labour and third-sector capacity, at the risk of stratification where family resources are weak; the PS’s governance-heavy model exposes hidden need and legitimates capacity expansion but requires sustained institutional investment.

Table 8.6. Early Proposals for the Restructuring of the Long-Term Care Sector, 2000-2002.

Proponent	Target	Core proposal
PSD – Projecto de Lei No. 221/VIII (2000)	Dependent older persons (60+) and adults with disabilities (18+); family caregivers and households facing isolation/precarious housing.	Make family permanence/integration the default and institutionalization residual; create a state-steered, familist regime with tax deductions, subsidized home adaptations, monthly cash allowance, and up to 3 years of special caregiver leave, coordinated by social security and linked to primary care; deliver services via IPSS/Misericórdias in a mixed economy.
PS – Projecto de Resolução No. 168/VIII (2002)	Older persons—especially those in dependency—and their families; the national care network (public and private).	Reinforce elder rights and build a proximity-care repertoire: expand community/home supports (day/night/weekend), create short-stay respite options, combat isolation, consolidate a public network in complementarity with private provision, and require periodic evaluation/reporting to Parliament.
PS – Projecto de Lei No. 526/VIII (2002)	Older persons at risk of abuse/neglect; municipal and national governance structures.	Establish Municipal Commissions (plus a National Commission) for the Protection and Promotion of Older Persons' Rights; mandate inter-agency coordination and mandatory reporting; embed promotion of primary and palliative care, data collection (quarterly/annual reports), and non-judicial protection to prioritize the dependent person's best interests.

Source: Author's elaboration.

Although LTC was not yet articulated as a distinct policy field, the 2000-2002 parliamentary initiatives reveal a gradual discursive shift from residual, family-led arrangements toward an integrated, governance-oriented framing of dependency risks. PSD's proposals institutionalised a familist-subsidiary logic within state-regulated frameworks, while PS introduced a rights-based vocabulary centred on prevention, continuity, and multi-level coordination. The intervention of BE further politicised state capacity, reframing poor access as a governance failure rather than a problem of scarcity and calling for tax-financed universal provision within the SNS. Across these trajectories, the language of integration, proximity, and coordination progressively replaced ad hoc solutions, laying the conceptual foundations for the RNCCI. In effect, this early phase of debate generated an ideational and discursive shift that compelled parties to clarify their positions on long-term care—positions increasingly intertwined, in the Portuguese case, with the broader reorganisation of health policies.

3.2. Between Alternations of Minority Governments: The PSD's Return to Power

The 2002 handover from António Guterres's Socialist minority to José Manuel Durão Barroso's PSD-CDS coalition marked a profound alignment of Portugal's policy grammar under tightening EMU constraints. In the late 1990s, Socialist governments had attempted to reconcile social-democratic investment with fiscal prudence, but the feasible space for distributive policy narrowed as eurozone rules hardened and Europeanization shifted the *locus* of political contestation from macroeconomic levers to sectoral design (Royo, 2010). Politically, recurrent PS minority governments required issue-by-issue bargaining with parties to their left, increasing the transaction costs of reforms involving taxation, social security financing, and public employment.

The immediate trigger for alternation was the PS's poor performance in the 2001⁵⁹ local elections and Guterres's subsequent resignation. The president's dissolution of parliament and call for early elections produced an orderly alternation that underscored the institutional maturity of Portugal's semi-presidential regime (Freire, 2006). Within this institutional framework, domestic discretion became increasingly mediated by EMU membership and the rules of the Stability and Growth Pact (Magone, 2004; Royo, 2009).

Early elections in March 2002 returned the PSD to power, and José Manuel Durão Barroso formed a coalition government with the CDS-PP, inaugurating the XV Constitutional Government on 6 April 2002. The coalition prioritised fiscal consolidation, public-sector restructuring, and market-oriented liberalisation to restore budgetary discipline and comply with eurozone rules. Crucially, this programme presented restraint not as an ideological choice but as a structural imperative embedded within EMU's governance framework (Magone, 2004; Royo, 2009). At the party-system level, competition stabilised into a bipolar PS-PSD dynamic, while the *Bloco de Esquerda* and the Portuguese Communist Party sustained gradual pluralisation without triggering systemic rupture (Freire & Baum, 2003). Survey data from the late 1990s through the early 2000s reveal a paradoxical attitudinal baseline: Widespread democratic disaffection—low political interest, high perceptions of inefficacy, and declining turnout—coexisted with relatively strong regime support. Rather than elite-challenging activism, these trends reflected passivity and disengagement (Magalhães, 2005). Table 8.7. illustrates results in the 1999 general elections in Portugal.

Table 8.7. Election Results in the 1999 General Election in Portugal.

Party	Vote Share (%) 2002	Seats 2002	Government 2002
Partido Socialista (PS)	37.8	96	Main opposition
Partido Social Democrata (PPD/PSD)	40.2	105	Governing party (coalition with CDS-PP)
CDS-Partido Popular (CDS-PP)	8.7	14	Junior coalition partner (with PSD)
CDU (PCP-PEV)	7.0	12	Opposition
Bloco de Esquerda (BE)	2.7	3	Opposition

Source: Author's elaboration on Comissão Nacional de Eleições (2002).

This attitudinal configuration helps explain why the 2002 alternation produced a sharp policy pivot—toward fiscal consolidation and, in specific sectors such as long-term care, a shift toward

⁵⁹ By 2001, fiscal headwinds intensified further. EMU entry and the Stability and Growth Pact reduced the scope for discretionary spending and pushed social policy onto the terrain of managerial reform (Royo, 2009). Exogenous shocks compounded these pressures. The Hintze Ribeiro bridge disaster in March 2001 undermined public confidence in state capacity, while the PS's poor performance in the 2001 municipal elections precipitated Guterres's resignation in December 2001, framed explicitly as an attempt to avoid "a swamp of political instability" (Freire & Lobo, 2006).

medicalised provision—without triggering extra-institutional destabilisation. Citizens' disengagement muted mobilisational threats, while institutional rules channelled conflict into government-formation bargaining and programmatic negotiation within parliament (Fernandes, 2016).

Further two analytical lenses help explain how the PSD converted a plurality of votes into a cohesive right-of-centre governing programme for 2002-2004. First, leader effects were unusually consequential. Using Portugal's first post-election study, Costa Lobo shows that voters' affective evaluations of party leaders were substantively important for PS, PSD, and CDS-PP in 2002, independent of socio-structural variables and left-right proximity. By contrast, leader effects were negligible for BE and had declined for the CDU over time (Costa Lobo, 2006). Second, a territorial political-economy lens reveals a strong geographic structuring of electoral outcomes. Municipal results clustered spatially, residuals were autocorrelated, and unemployment impacted party vote shares asymmetrically—positively for PS, negatively for PSD—once municipal incumbency was controlled for (Caleiro & Guerreiro, 2005).

Between 2002 and 2004, the PSD-CDS government tilted decisively toward a residualising and selective stance: Family benefits were re-targeted, access to the minimum-income scheme was tightened, and the framework law introduced a three-pillar pension architecture—a capped pay-as-you-go base, a mandatory funded tier, and voluntary private savings—even though fiscal ceilings complicated transition financing. This shift was not purely ideological. As Ferreira notes, it built on enduring institutional continuities: Centralised state steering, heavy reliance on third-sector provision in social action, and the political marginality of social security in broader agendas. Together, these features made selective recalibration administratively tractable under EMU constraints while rendering universalistic expansions politically exposed.

In government, Barroso's XV Constitutional Cabinet translated EMU-compatible priorities—deficit correction, cost control, and administrative hierarchy—into sectoral designs favouring visible, tractable reforms over cross-pillar integration. In long-term care, this produced a medicalised template: A health-led network subordinating community-based institutions (IPSS) to hospitals and primary care centres, while excluding the social-protection axis from core governance (Serra-Simões, 2019). Seen through Ferreira's lens, this was the care-sector analogue of the broader centre-right turn: Privileging residualism and selectivity, formalising contractual relations with third-sector providers, and postponing the institutional costs of building co-equal health-social governance. The choice set was path-dependent: Leader-centred competition and territorially uneven pressures rewarded measures deliverable through clinical hierarchies and contractual management, particularly while the left lacked a cohesive legislative bloc. Distributionally, consolidation costs were salient—especially for public employees and lower-income households—even as the deficit fell below the Stability and Growth Pact's 3% threshold in 2004.

At the party-system level, competition consolidated into a bipolar PS-PSD dynamic. BE's parliamentary presence and the CDU's persistence signalled gradual pluralisation without systemic rupture, while Europeanization constrained programmatic divergence, shifting contestation toward the micro-politics of standards and governance (Freire & Baum, 2003; Magone, 2004; Royo, 2009). The centre-right's approach—residualising social protection, signalling pension pluralisation, and medicalising long-term care—fits Ferreira's diagnosis of Portuguese reform discontinuities while leveraging enduring continuities: State steering, third-sector partnerships, and fiscal discipline. The result was a durable policy pivot—most visibly a health-led LTC model—whose downstream consequences for coverage, access, and cross-sectoral coordination outlasted the legislature (Magone, 2004; Caleiro & Guerreiro, 2005; Costa Lobo, 2006; Royo, 2009).

3.3. The Centre-Right Government's Policy Reforms and Portuguese Political Parties' Positioning on LTC

Following the 2000-2002 *biennium*, under the PSD Government, between 2002 and 2004, ministerial decision-making on dependency and long-duration care shifted from experimental pilots toward the formal institutionalisation of integration within the health sector. A central turning point was the *Resolução do Conselho de Ministros* No. 59/2002, which explicitly defined the creation of a Rede Nacional de Cuidados Continuados Integrados—initially designated *Rede Mais*—as a strategic priority. The resolution framed integrated continuous care as a dual responsibility of the health and social protection sectors, emphasising solidarity, equity, and universality as guiding principles, while calling for the development of local networks combining public, private, and non-profit providers. It identified domiciliary care, temporary institutionalisation, rehabilitation units, and community-based services as central instruments, setting a normative foundation for intersectoral coordination and explicitly mandating shared governance between the Ministry of Health and the Ministry of Labour and Solidarity (*Resolução do Conselho de Ministros* No. 59/2002).

The alternation in office in 2002 introduced a distinctive LTC-adjacent grammar into the parliamentary record, shaped by the PSD-CDS coalition's priorities. On 21 June 2002, the CDS-PP's presentation of the *Lei de Bases da Família* recentred the family as the “most effective response” to social risks, portraying family solidarity as “indestructible” and positioning households as the natural *locus* of care. Public provision was reframed as state steering rather than state monopolisation, with delivery delegated to associational providers such as IPSS and Misericórdias. This template of “supported familism” combined categorical cash recognitions, such as family-linked supplements, with community-based responses delivered through the social economy. It privileged regulated pluralism—public rule-setting combined with non-profit execution—while avoiding the fiscal and institutional costs of constructing a new social-care pillar from scratch.

Prime Minister Durão Barroso reinforced this orientation in his State of the Nation address of 10 July 2002, where he fused fiscal consolidation and microeconomic reform with an explicitly health-anchored delivery strategy for continuing care. He proposed public-private partnerships not only with private actors but also with the social sector, particularly the *Misericórdias*, (PT4—Department Coordinator, Cooperativa António Sérgio para a Economia Social). This discourse fixed hospitals and primary-care centres as the hubs of coordination, normalised multi-channel contracting as the preferred mechanism for capacity expansion and framed the state's role as guarantor and purchaser rather than exclusive provider.

The government's social-security package of 12 July 2002 supplied the redistributive and categorical detail underpinning this strategy. It announced a four-year convergence plan aligning minimum pensions with the net minimum wage for 1.5 million pensioners, introduced a "family complement" for low-income beneficiaries with older spouses, and created a new contingency category—"absolute and definitive incapacity"—to cover irreversible clinical conditions in cases where contributory histories were insufficient. Alongside these cash-based measures, the package introduced partial pensions with part-time work, prioritised positive discrimination for older persons with high dependency, and pledged to expand subsidised service networks, stimulate domiciliary care, and favour institutions operating in socially vulnerable areas. Capacity expansion proceeded primarily through subsidised non-profit contracts and PPPs, consolidating a mixed-economy model under health-sector coordination. Financing was organised as state-steered, multi-channel purchasing, with the public sector retaining regulatory authority while relying on associational providers for implementation.

Two legislative milestones operationalised these objectives. *Decreto-Lei* No. 60/2003 established a national framework for primary health care provision, clarifying missions, competencies, and responsibilities while creating a legal scaffold for co-responsibility in care pathways linking health centres, hospitals, and community-based providers. Although the law did not explicitly adopt long-term care terminology, it laid the administrative foundations for ADI-style multidisciplinary teams to act as gateways for dependent persons, particularly around hospital discharges and domiciliary follow-up. In parallel, hospital governance reforms advanced *gestão empresarial* and contractual logics, strengthening managerial authority, performance-based agreements, and discharge management protocols to reduce readmissions and standardise transitions across care settings.

A second milestone came with *Decreto-Lei* No. 281/2003, adopted by the XV Constitutional Government, which created the first health-sector network for long-duration care under the Ministry of Health. The decree codified hospital-to-community pathways defined medical and nursing responsibilities, and authorised contracts with community-based organisations such as IPSS and *Misericórdias*. However, by situating the emerging network firmly within a health-led governance model, the reform relegated the social-protection sector to a marginal role, relying on coordination rather than joint steering. While this medicalisation provided a long-overdue legal structure and improved discharge-to-community continuity, it also reproduced some of the

institutional fragmentation that the late-1990s pilots had sought to overcome. Table 8.8. reports what described below.

Table 8.8. Legislative Decisions About Long-Term Care, 2002-2003.

Year & Legal Act	Primary Objective
2002 – <i>Resolução do Conselho de Ministros</i> No. 59/2002	To define the National Network for Integrated Continuous Care (Rede Nacional de Cuidados Continuados Integrados, “Rede Mais”) as a strategic policy priority
2003 — <i>Decreto-Lei</i> No. 60/2003	To reorganise primary health care and improve care pathways between hospitals and community-based services
2003 — <i>Decreto-Lei</i> No. 281/2003	To create the first health-sector network for long-duration care under the Ministry of Health

Source: Author’s elaboration.

Read comparatively, the parliamentary and ministerial record between 2002 and 2004 reveals three distinct policy grammars in the emerging field of LTC. Regarding the centre-right decisions at the start of the decade, the structuring of the LTC debate across the main political parties becomes particularly clear. During these years, the discussion was primarily shaped by Bloco de Esquerda, Partido Socialista, and the PSD-CDS coalition (Asembleia da Republica, 2002c; 2002d; 2002e; 2002f; 2002g; 2002h; 2002i; 2002l; 2002m; 2003a; 2003b; 2004a; 2004b; 2004c). Unlike the dynamics that would unfold in later stages, BE adopted a markedly more radical position, strongly aligned with pro-public expansion and the strengthening of universalist guarantees (*ibidem*). By contrast, PS pursued a more moderate governance-oriented strategy, while the PSD-CDS coalition promoted familist-subsidiary solutions grounded in mixed delivery models (*ibidem*). These debates took place within a highly fragmented institutional context, where long-standing, deeply embedded provider structures (see Chapter 3) constrained the room for manoeuvre. The political cost of unpopular reforms was extremely high, amplified by the challenges posed by Portugal’s difficult transition towards compliance with EU fiscal and macroeconomic requirements.

BE articulated a rights-based universalism, demanding tax-financed rebalancing and expanded service-side investment within the SNS while resisting privatisation and marketisation. The PS defended universal public guarantees but linked them to fiscal prudence and managerial reform under EMU constraints, privileging in-kind guarantees while rejecting privatisation as an adjustment tool. The PSD-CDS coalition operationalised supported familism within a framework of regulated pluralism, combining targeted cash transfers with capacity scaling through PPP-driven partnerships and social-economy contracting under hospital and primary-care leadership. This familist-managerialist compromise recentred households as key actors, consolidated the SNS’s primacy in long-term care governance, and institutionalised a model of state-steered, multi-channel purchasing—a configuration that would decisively shape the hybrid architecture of the RNCCI introduced in 2006.

Table 8.9. summarizes political parties’ positioning on the LTC issues, between 2002 and 2004.

Table 8.9. Political Parties' Positioning on the LTC Issues, 2002-2004.

Dimension	BE	PS	PSD-CDS
Social Right, Recognition of LTC	Strong universalism: LTC framed as a universal social and health right	Universal recognition, but constrained by EMU-related fiscal discipline	The family is framed as the "natural community of care," combined with selective recognition of rights
Financing & Coverage	Fully tax-financed; universal coverage	Tax-financed, but under strict budgetary limits; universal coverage prioritized	Multi-channel financing: the state acts as guarantor and purchaser, but financial and operational risks are shared through PPPs and social-economy contracts; coverage is targeted rather than universal
Eligibility Criteria	Broad and universal, with no clinical gatekeeping	Universal in principle, but instruments and thresholds remain undefined	Implicit targeting via clinical gatekeeping ("older people" and "terminal patients" defined in hospital and primary-care pipelines) plus categorical criteria (minimum pensions, "absolute incapacity")
Multilevel Governance	Centralized governance through the state; SNS provides an integrated architecture	The state as central guarantor, but with managerial decentralization and procedural reforms	Multi-level governance: hospitals and primary-care centres function as coordination hubs; IPSS and Misericórdias play a central role; the state regulates and purchases but does not directly produce
Regulatory Aspects (Public-Private)	Strong opposition to privatization and PPPs; preference for fully public provision	Rejection of privatization as an adjustment mechanism, but acceptance of organizational reforms	PPPs institutionalized as a core instrument; "regulated pluralism" model: the state sets rules, while non-profit and private actors execute
In-cash instruments	Not detailed; implicit preference for universal rather than categorical benefits	No explicit emphasis on cash transfers; focus remains on service guarantees	Extensive use of categorical cash transfers: minimum pension convergence, "family complement," support for "absolute incapacity," and positive discrimination for highly dependent older persons
In-kind instruments	Expansion of universal public provision within the SNS	Priority given to maintaining universal in-kind guarantees, without large-scale capacity expansion	Expansion through PPPs and contracts with IPSS/Misericórdias: step-down beds, continuing-care facilities, subsidized equipment, and domiciliary support

Source: Author's elaboration.

3.4. Mapped Stakeholders' Positioning at Stake vis-à-vis the LTC Reform

In the previous sections, the analysis examined the positioning of political parties vis-à-vis specific government decisions on LTC. In this section, by contrast, the focus shifts to the role of non-state actors—what, in this thesis, is conceptualised as the policy demand—between 2000 and 2004. During this period, the drafting and approval of LTC reforms (see *infra*, Section 4) reflected a multi-level, intersectoral decision-making process that mobilised political, professional, and social stakeholders. At the political level, the Ministry of Health and the Ministry of Labour and Social Solidarity jointly steered the process, formalising coordination through a *despacho conjunto* that defined shared competences and operational procedures. Beyond ministerial leadership, the government conducted an extensive technical consultation with professional bodies, notably the *Ordem dos Médicos* (OM), *Ordem dos Enfermeiros* (OE), *Federação Nacional dos Médicos* (FNAM),

Federação Nacional dos Sindicatos de Enfermeiros (FNSE), *Sindicato Independente dos Médicos*, and the *Sindicato dos Fisioterapeutas Portugueses*. This process effectively embedded sectoral expertise into the emerging policy framework, ensuring that professional knowledge shaped both the design and implementation phases. At the territorial and operational level, the process also incorporated major social-economy organisations—most prominently the *União das Misericórdias Portuguesas (UMP)* and the *Instituições Particulares de Solidariedade Social (IPSS)*—and actively engaged the *Associação Nacional de Municípios Portugueses* to secure municipal alignment and strengthen implementation capacity.

Prior to full reform, and especially between 2000 and 2004, the *Ordem dos Médicos* (*Ordem dos Médicos*, 2000a; 2000b; 2001a; 2001b; 2001c; 2002a; 2002b; 2002c; 2003a; 2003b; 2004a; 2004b; 2004c) supported by the *Sindicato Independente dos Médicos*—acted as a central veto player whenever proposals appeared to expand the social-care pillar at the expense of health-sector primacy in LTC. Analysis of OM documents from this period shows a critical yet collaborative posture: The OM accepted the goals of integration and continuity, but resisted changes perceived as diluting physician autonomy, clinical standards, or the central coordinating role of the SNS. Its position became most salient during the design of Decreto-Lei No. 281/2003, which established the first health-sector network for long-duration care under the Ministry of Health. The OM welcomed recognition of dependency as a distinct organisational domain and endorsed networked provision to coordinate discharges, primary care, and domiciliary support, while insisting that integration remain clinically led and that multidisciplinary teams operate under medical supervision to ensure protocol compliance and treatment continuity. Tensions sharpened as the XV Constitutional Government expanded *gestão empresarial* and contractual mechanisms. The OM warned that managerial imperatives and hard budget constraints could subordinate clinical judgment and compromise quality for frail populations; it was particularly sceptical of outsourcing to IPSS and *Misericórdias* without safeguards protecting the SNS's coordinating authority and the governance of complex, multi-morbidity care (PT4). In practice, the *Ordem* combined policy partnership—contributing to the design of domiciliary programmes, rehabilitation units, and team structures—with a guardian role defending three principles: SNS centrality in LTC coordination, medical leadership in care planning, and balanced health-social governance. These stances anticipated later RNCCI implementation frictions, where hospital-led care, primary-care coordination, and community provision had to be reconciled.

Alongside the OM, the *Federação Nacional dos Médicos (FNAM)* (Agência Lusa, 2001a, 2001b, 2001c, 2002a, 2002b, 2003a; *Diário Económico*, 2002g; *Jornal de Notícias*, 2003) emerged as the most vocal opponent of the 2002-2004 reform package, articulating a dual critique of managerialisation and the medicalisation of LTC. FNAM rejected the government's portrayal of hospital empresarialisation and the creation of the *Rede de Cuidados Continuados Integrados* as neutral efficiency measures, arguing that they undermined clinical autonomy, introduced risks of creeping privatisation, and aggravated territorial inequalities (Agência Lusa, 2004b). Transforming hospitals into sociedades anónimas under managerial logics, in FNAM's view, prioritised financial metrics

over outcomes, eroded accountability, and subordinated medical decision-making (Jornal de Notícias, 2003).

Its critique extended to LTC governance, warning that channelling continuing-care pathways through health-led hierarchies could divert scarce hospital resources toward lower-intensity care without commensurate investment in primary and community infrastructures (Agência Lusa, 2002a).

FNAM also decried the fragmentation of professional authority, criticised the absence of clear eligibility and financing guarantees, and cautioned that increasing reliance on contracted providers – IPSS and Misericórdias – would yield heterogeneous standards and regional asymmetries (Diário Económico, 2002g). Normatively, it defended a clinician-centred, publicly funded model anchored in professional autonomy, equity of access, and strong state responsibility, casting the government’s version of “integration” as a redefinition of the SNS social contract toward managerial control, partial outsourcing, and selective guarantees (Agência Lusa, 2003a). This stance positioned FNAM as a veto player in early implementation, shaping parliamentary debate and ministerial negotiation and slowing full cross-sectoral consolidation until RNCCI formalisation in 2006.

The *Ordem dos Enfermeiros* (2000a; 2000b; 2001a; 2001b; 2001c; 2002a; 2002b; 2002c; 2003; 2004a; 2004b; 2004c; 2004d; 2004e), supported by the *Sindicato dos Fisioterapeutas Portugueses* on scope-of-practice issues, positioned itself as a professional regulator seeking to embed LTC within a clinically robust, community-oriented framework while resisting managerial reforms that threatened quality and continuity. The OE endorsed integration provided nursing competences were explicitly recognised in pathway design and nurses held defined responsibilities for case management and discharge planning. It argued that integration required enforceable professional standards, adequate staffing, accredited training, and ethical oversight; contractualisation with social-economy providers or hospital-enterprise arrangements was acceptable only if minimum staffing, supervision, and auditable quality assurance were secured. The Order linked employment stability to quality, warning that precarious contracts undermine the relational continuity on which proximity based LTC depends. By the eve of the RNCCI, the OE thus offered a conditional endorsement of proximity-first integration: Networked provision and selective partnerships were acceptable if clinically led, standard-based, and properly resourced.

On the social sector side, the *União das Misericórdias Portuguesas* positioned itself as a pivotal non-state provider and institutional broker, leveraging its historical role within the Portuguese welfare mix (Agência Lusa, 2002c, 2002d). Building on a 2000 partnership with the *Fundação para a Saúde*, it proposed converting an initial set of facilities into continuing-care units within a broader plan to rehabilitate roughly thirty premises (Agência Lusa, 2002c). The UMP framed LTC as simultaneously a social responsibility and a strategy to relieve hospital congestion, emphasising proximity and cost-efficiency and lobbying for SNS conventions to ensure stable financing (Jornal

de Notícias, 2000). It also invested in workforce development via the creation of the Instituto de Formação Continuada em Saúde (IFCS) in 2002 (Agência Lusa, 2002d, 2002e; Jornal de Notícias, 2002) and prepared to compete for hospital construction and management contracts through the Misericórdias/Saúde vehicle, aligning with the government's preference for public-non-profit partnerships (Agência Lusa, 2004a). At the same time, UMP intermittently criticised regulatory delays and licensing uncertainty around hospital concessions, calling for more predictable frameworks (Agência Lusa, 2004c). In parallel, IPSS consolidated their role as indispensable partners in the government's strategy of regulated pluralism (Agência Lusa, 2000a). However, municipal authorities occasionally contested regional decisions that favoured IPSS/Misericórdias without robust local consultation, exposing governance tensions between central steering and local accountability.

All in all, on the one hand, ministries sought to institutionalise integration within a health-led network; medical organisations defended autonomy and clinical primacy; nursing regulators linked integration to enforceable standards and stable staffing; and third-sector providers leveraged proximity and cost advantages to expand provision under contract. The RNCCI that followed would crystallise this hybrid settlement—state steering and medical leadership coupled with social-economy execution—while leaving open the familiar trade-offs among universalist guarantees, managerial efficiency, and equitable territorial access. Table 8.10. summarizes Portuguese stakeholders positioning between 2000 and 2004.

Table 8.10. Portuguese Stakeholders Positioning on LTC Dimensions, 2000-2004.

Dimension	Ordem dos Médicos	FNAM	Ordem dos Enfermeiros	UMP	IPSS
Social Right, Recognition of LTC	Accepts dependency as a relevant policy domain but resists treating LTC as a stand-alone social right.	Opposes separating LTC from health policy, frames entitlement via SNS and medical decision-making.	Supports framing LTC as a right but ties it to quality standards and professional competences.	Strongly promotes recognition of LTC as a universal entitlement, anchored in state-funded plural provision.	It endorses a rights-based approach but stresses proximity and community-based coverage.
Financing & Coverage	Warns that budget ceilings and outsourcing fragment financing and reduce SNS equity.	Criticizes outsourcing and managerialisation, argues for direct public investment in SNS infrastructure.	Supports expanded coverage but links financing adequacy to workforce stability and minimum staffing ratios.	Positions itself as a cost-efficient partner	Advocates networked financing via public contracts, emphasising territorial capillarity and home-based provision.
Eligibility Criteria	Advocates for clinically driven assessments to avoid overloading hospitals and SNS.	It insists eligibility must remain under medical protocols and adequate funding.	Supports multidisciplinary assessments with defined nursing roles in case management and discharge planning.	Backs broader eligibility to maximise access, positioning itself as a key provider of community care.	Endorses hybrid criteria, emphasising flexibility to respond to local needs and prevent exclusion.
Multilevel Governance	Prefers centralised SNS governance to maintain clinical consistency nationwide.	Defends strong central control to avoid territorial inequalities.	Supports decentralisation if accompanied by clear standards and professional oversight.	Gains privileged access through direct contracts, integrating seamlessly within central-regional coordination.	Similar to UMP but more locally embedded, leveraging municipal partnerships to strengthen community delivery.
Regulatory Aspects (Public-Private Mix)	Warns of risks to clinical governance if LTC delegated to non-medical providers without supervision.	Criticizes private and third-sector involvement, framing it as a step toward creeping privatisation.	Accepts plural provision but conditions participation on accredited teams, auditable quality, and nursing leadership.	Embraces contractualisation, leveraging historical legitimacy to negotiate favourable agreements.	Actively benefits from pluralism, using territorial embeddedness to expand service provision and secure public funding.
In-cash Instruments	Prefers direct investment in SNS facilities, opposes cash transfers to families.	Rejects in-cash schemes, argues funds should strengthen public provision.	Positions neutral, prioritising service-based investment and stable nursing employment.	Does not promote direct payments, focuses on securing public contracts for service delivery.	It concentrates on service provision rather than individual cash benefits.
In-kind Instruments	Supports network creation but insists on physician-led coordination to safeguard quality.	Backs expansion but warns reallocating hospital resources to LTC risks undermining acute care.	Strongly supports in-kind expansion, linking integration to defined nursing competences and adequate staffing.	Promotes rapid scaling of in-kind services, highlighting cost advantages and proximity-based models.	Actively invests in home-based, day-care, and palliative services, positioning itself as indispensable in territorial LTC delivery.

Source: Author's elaboration.

3.5. Defining Coalition Formation Between Stakeholders and Parliamentary Debates

As in the cases of Spain and Italy (see Chapters 5 and 7), the institutional configuration of LTC in Portugal between 2000 and 2004 emerged from the negotiated interaction of three analytically distinct coalitions – pro-public, pro-market, and pro-family – whose competing framings, policy instruments, and delivery strategies collectively shaped the early governance architecture of the sector. Under the XV Constitutional Government led by the PSD-CDS coalition, the process culminated in the creation of a medicalised, health-led LTC network, formally institutionalised through *Decreto-Lei No. 281/2003*. Yet this outcome reflected not ideological consensus but a series of negotiated compromises among political parties, professional bodies, and social-economy actors, each pursuing distinct priorities within a fragmented institutional landscape.

The pro-public coalition, composed of primary-care clinicians, public-health professionals, and social-policy administrators, conceptualised dependency as a multidimensional social risk requiring cross-sectoral integration, continuity of care, and proximity-based solutions. In practice, however, this coalition remained largely in the background during this period and the subsequent phase, playing an ideational role in reframing LTC as a new social risk rather than driving the concrete formulation and implementation of policies. Its influence is visible in the late-1990s pilots – *Unidades de Apoio Integrado* (UAI) and *Apoio Domiciliário Integrado* (ADI) – and in the *Resolução do Conselho de Ministros No. 59/2002*, which established the Rede Nacional de Cuidados Continuados Integrados (RNCCI). The resolution envisioned an integrated joint framework combining home-care teams, autonomy-promotion day centres, and short-, medium-, and long-stay units. Yet while this coalition shaped the vocabulary and design principles of integration, it lacked control over budgets, infrastructures, and delivery mechanisms, limiting its ability to institutionalise co-equal governance between the health and social sectors.

In contrast, the pro-market coalition – composed of hospital managers, Ministry of Health technocrats, fiscally conservative administrators, and professional organisations such as the *Ordem dos Médicos* and the *Federação Nacional dos Médicos* – proved to be decisive in shaping implementation. It framed LTC primarily as a clinical management problem, prioritising hospital efficiency, cost containment, and administrative tractability, and positioning the health sector as the natural coordinator of LTC provision. The OM endorsed integration in principle but insisted on physician-led multidisciplinary teams and the preservation of SNS centrality to safeguard clinical authority and continuity of treatment. FNAM, by contrast, adopted a more oppositional stance, criticising the *gestão empresarial* reforms that transformed hospitals into *sociedades anónimas* and opposing the outsourcing of LTC provision to IPSS and *Misericórdias*. It warned that these measures subordinated clinical autonomy to managerial imperatives, risked creeping privatisation, and exacerbated territorial inequalities. These preferences became institutionalised in *Decreto-Lei n.º 281/2003*, which consolidated a health-led governance model, subordinated community providers administratively to hospitals and primary-care centres, and entrenched a paradigm based on single-ministry control and measurable performance outputs.

The pro-family coalition, rooted in PSD-CDS ideological frames and supported by the União das Misericórdias Portuguesas (UMP) and the Instituições Particulares de Solidariedade Social (IPSS), provided the political legitimisation for the health-led model while promoting a strategy of supported familism. In a welfare regime where households already bore a disproportionate share of care responsibilities (Wall et al., 2001), the coalition sought to recognise informal caregiving, expand in-kind services, and selectively contract social-economy organisations rather than constructing a fully public LTC pillar. The UMP leveraged its territorial reach and historical legitimacy to secure direct policy influence and privileged implementation roles. A 2004 cooperation protocol with the Ministry of Health planned 49 agreements and 363 new LTC beds within the RNCCI, but implementation lagged, and occupancy rates remained below expectations (Ministério da Saúde, 2013). This reliance on UMP/IPSS contracts allowed the government to “purchase” capacity through health-ministry financing while postponing structural investments in public social infrastructures, thereby consolidating the regulated pluralism that would later characterise the RNCCI.

These three coalitions diverged sharply in their problem framings, governance preferences, and delivery strategies, yet their interaction produced a hybrid and fragmented settlement. The pro-public coalition framed LTC as a social right requiring multidimensional, proximity-based responses and advocated joint health-social governance. The pro-market coalition conceptualised dependency as a clinical management issue, institutionalising hospital-led pathways under the Ministry of Health. The pro-family coalition recentred households as the primary locus of care, complementing public provision with non-profit contracting without granting regulatory parity to social-economy actors. In practice, the pro-market and pro-family coalitions-controlled implementation, leveraging their access to resources, infrastructures, and political authority, while the pro-public coalition retained agenda-setting influence but lacked institutional power. The resulting settlement, crystallised in the early 2000s, was health-led, selectively pluralised, and fiscally constrained, anticipating the tensions that would persist through the full institutionalisation of the RNCCI in 2006.

The alternation in office in 2002 further consolidated this trajectory by embedding a new LTC-adjacent grammar into the institutional record. The PSD-CDS coalition’s priorities, articulated most clearly in the CDS-PP’s *Lei de Bases da Família*, repositioned the family as the “most effective response” to social risks, framing household solidarity as “indestructible” and shifting public support toward associational providers such as IPSS and Misericórdias. This strategy institutionalised regulated pluralism, where the state retained strategic steering while delegating delivery to social-economy organisations. It combined categorical cash transfers (e.g. family supplements, incapacity benefits) with in-kind community-based services, producing a model of supported familism that legitimised household centrality while avoiding the fiscal and institutional costs of creating a new public social-care pillar (Diário da Assembleia da República, I Série, No. 022, 21 June 2002).

Prime Minister Durão Barroso embedded this orientation within a broader framework of fiscal consolidation and microeconomic reform, positioning hospitals and primary-care centres as the nodes of coordination while expanding capacity through public-private partnerships (PPPs) and contracts with social-economy providers. Financing became state-steered but multi-channel: The government acted as guarantor and purchaser while delegating operational risk through contracts. Eligibility criteria were implicitly defined, as “older people” and “terminal patients” were identified as priority groups, effectively placing clinical gatekeeping within hospital and primary-care hierarchies. Instruments remained predominantly in-kind, privileging beds, step-down facilities, and domiciliary care over structured cash entitlements.

Against this backdrop, partisan contrasts sharpened. The *Bloco de Esquerda* advocated a tax-financed expansion within the SNS, resisting privatisation and framing LTC as a universal right. The *Partido Socialista* defended universal guarantees but accepted EMU-related fiscal discipline, supporting managerial reforms while rejecting large-scale outsourcing; its proposals privileged in-kind service guarantees while leaving eligibility and cash instruments largely undefined. By contrast, the PSD-CDS coalition operationalised supported familism and regulated pluralism, combining a redistributive base of categorical transfers with in-kind expansion via PPPs and contracts with IPSS and Misericórdias, all coordinated through hospital and primary-care leadership.

Between 2002 and 2004, reforms consolidated a trajectory initiated in the late 1990s but recentred LTC within the health sector, privileging instruments that were administratively tractable under tight fiscal constraints. Four structural factors drove this outcome. First, the hospital-centric path created by the post-1979 development of the SNS entrenched medical hierarchies as the most effective levers for producing visible outputs (Guillén, 2002). Second, Portugal lacked a robust public social-care infrastructure: Community-based LTC was dominated by non-profits, so full integration would have required significant state-building (Santana, 2010). Third, the familist welfare baseline simultaneously exposed the need for public support while enabling governments to postpone costly investments, relying on households and third-sector providers (Wall et al., 2001; Simoni & Trifiletti, 2004). Finally, EMU-era fiscal rules favoured reforms that were administratively self-contained and measurable, making medicalisation a fiscally compatible mode of governance.

The settlement’s limits followed directly from its premises. By framing LTC primarily as a health-sector problem, reforms eased hospital discharge pressures but left home-based and community services underdeveloped— “the weakest, least cared-for link” in the chain (Santana et al. 2007). In short, the centre-right achieved administratively tractable gains under fiscal constraint but failed to address the systemic challenge of scaling social capacity and support for families. These unresolved tensions resurfaced in the 2006 creation of the *Rede Nacional de Cuidados Continuados Integrados*, when new coalitional dynamics and institutional learning reopened the debate on co-governance between health and social sectors.

4. The *Rede Nacional de Cuidados Continuados Integrados* in 2005-2006

After a period of executive instability and public dissatisfaction with the centre-right Social Democratic Party, the Socialist Party secured an absolute parliamentary majority in the 2005 legislative elections, capitalising on growing demands for effective governance and renewed social investment. This outcome gave the Sócrates government an unusual window of political opportunity, allowing it to advance an ambitious reform agenda without the constraints of coalition bargaining and to pursue a far-reaching restructuring of social and health policies (De Giorgi & Moury, 2015).

The 2005 alternation of government reflected both electoral dynamics and the broader institutional context of Portuguese politics. While PS and PSD shared a broadly pro-European orientation and a commitment to modernising the welfare state, they diverged in policy instruments, the sequencing of reforms, and the balance between public guarantees and plural provision. This produced what De Giorgi & Moury (2015) describe as a “bounded alternation”, where governments could redefine priorities but operated within the fiscal and institutional constraints imposed by EU governance.

Portugal also faced structural fiscal imbalances and sluggish growth within a highly integrated euro area, where investor confidence and sovereign bond spreads increasingly conditioned domestic policymaking (Yakubovskiy et al., 2021). Although the sovereign debt crisis had not yet erupted, the Sócrates government inherited an environment where the anticipation of European fiscal surveillance shaped national priorities. Against this backdrop, PS positioned itself as a technocratic reformer, aiming to reconcile budgetary discipline with the modernisation of welfare and health services while restoring confidence among domestic constituencies and European actors (*ibidem*).

Within this strategic framework, the 2005 Government Programme outlined a comprehensive plan to restructure LTC and integrate previously fragmented health and social responses. Building on the principles of the earlier Rede Mais initiative, the programme prioritised cross-sectoral coordination, the development of community-based proximity services (*Serviços Comunitários de Proximidade*, SCP), and the expansion of integrated professional care for individuals with chronic dependency (Serra-Simões, 2019). These commitments culminated in the creation of the National Network for Integrated Long-Term Care (*Rede Nacional de Cuidados Continuados Integrados*, RNCCI), institutionalised through Decree-Law no. 101/2006.

Section 4 is structured as follows. Section 4.1 analyses the interests and positions of the main stakeholders involved in decision-making during 2005-2006; Section 4.2 examines parliamentary debates preceding the reform; and Section 4.3 discusses the approval and institutionalisation of the RNCCI in June 2006.

4.1. Between General and Particularistic Interests: The Positioning of Stakeholders

Between 2005 and 2006, the LTC reform process did not fundamentally alter the coalitional dynamics reconstructed in Section 3.3, but it intensified tensions between system-wide policy objectives and the particularistic claims of key sectoral stakeholders. While the creation of the *Rede Nacional de Cuidados Continuados Integrados* aimed to establish a coordinated, integrated framework, the reform process revealed persistent struggles over professional authority, resource allocation, and institutional roles.

At the professional level, the *Ordem dos Médicos* (2005a; 2005b; 2005c; 2006a; 2006b; 2006c) consolidated its demand for clinical leadership in care integration, insisting that multidisciplinary teams within the RNCCI operate under physician-led governance. Supported by both the *Sindicato Independente dos Médicos*, and the *Federação Nacional dos Médicos*, the OM reinforced claims for professional autonomy, advocating that clinical directors be elected by doctors themselves and that clinical protocols remain central to network management. While the OM did not oppose the principle of regulated pluralism, its support for partnerships with private providers and third-sector organisations – particularly the *União das Misericórdias Portuguesas* and the *Instituições Particulares de Solidariedade Social* – remained conditional on binding agreements that ensured uniform quality standards and direct clinical accountability.

The *Ordem dos Enfermeiros* (2005a; 2005b; 2005c; 2005d; 2006a; 2006b; 2006c), backed by the *Federação Nacional dos Sindicatos de Enfermeiros* and the *Sindicato dos Fisioterapeutas Portugueses*, broadly maintained its earlier support for integration but introduced new priorities linked to workforce capacity, territorial equity, and governance reform. The OE highlighted a structural shortage of nursing professionals and called for increased public investment and modernised human-resources policies capable of allocating staff more flexibly according to demographic and epidemiological needs. While supportive of integrated care models, it warned against implementing overlapping reforms – such as hospital restructuring, emergency-service reorganisation, and RNCCI expansion – without evaluating their cumulative impact. Crucially, the OE tied the success of the RNCCI to the full deployment of *Unidades de Saúde Familiar*, arguing that proximity-based, multidisciplinary primary-care teams were essential to reducing unnecessary hospitalisations and ensuring effective care transitions.

On the social-economy side, the UMP consolidated its position as a strategic policy partner, evolving from an ad hoc contractor during 2002-2004 into a formally recognised co-executor within a long-term, state-steered programme (Agência Lusa, 2005b; Jornal de Notícias, 2005a). The government's 2005 suspension and renegotiation of UMP protocols triggered a public dispute over costs, occupancy, and governance, with opposition parties mobilising and local authorities contesting the impact on planned units (Agência Lusa, 2005a, 2005b; Jornal de Notícias, 2005a). Presidential interventions simultaneously encouraged a renewed State-Misericórdias compact, signalling political space for reconfiguration rather than rupture (Agência Lusa, 2005c). UMP

leadership pushed back against allegations of undue gains and pressed for predictable contractual frameworks (Agência Lusa, 2005d), while the ministry argued that existing bed supply was already sufficient and required re-allocation and clearer referral pathways (Jornal de Notícias, 2005b).

By early 2006, policy crystallised around an integrated continuing-care network, with UMP offering medium- to long-term capacity and the government defining typologies, financing, and co-stewardship with Social Security (Agência Lusa, 2006a, 2006b). In this settlement, the 2006 national protocol in Águeda institutionalised the Misericórdias' central role, leveraging installed capacity for convalescence, rehabilitation, and long-stay units, while IPSS participation expanded under contractual mechanisms that tied funding and performance to health-sector priorities rather than stand-alone social-policy goals (Agência Lusa, 2006b).

Overall, the 2005-2006 phase deepened the hybrid governance model of LTC, combining state steering, sectoral expertise, and third-sector execution within a framework of regulated pluralism. The RNCCI emerged as a negotiated settlement: Professional bodies – including the OM, FNAM, SIM, OE, and FNSE – conditioned their support on preserving medical authority, clinical standardisation, and workforce adequacy, while social-economy actors – particularly the UMP and IPSS – secured institutional recognition and resource flows that strengthened their structural role in LTC delivery. The resulting governance architecture reflected a strategic balance between system-wide public-policy objectives and the corporatist and organisational interests of key stakeholders, embedding diverse actors within a coordinated yet asymmetrically empowered framework.

4.2. A “Crowded” Party Positioning on the LTC on the Eve of the Reform

Between 2005 and 2006, political competition over LTC in Portugal evolved from the general integrationist rhetoric of the early 2000s to more concrete disputes over the boundaries of public responsibility, the modalities of financing and governance, and the role of different providers within the emerging system. This transition coincided with the absolute parliamentary majority secured by the PS in the 2005 elections, which provided an unprecedented window of political opportunity to move beyond pilot programmes and establish a fully institutionalised framework for LTC provision. The creation of the *Rede Nacional de Cuidados Continuados Integrados* marked a critical juncture in this process, institutionalising a new governance architecture intended to overcome the historical fragmentation between health and social responses.

The legislative cornerstone of the reform was Decree-Law 101/2006, which defined LTC as a coordinated set of preventives, rehabilitative, and palliative services. Building upon the integrationist ambitions first articulated in the late 1990s, the decree prioritised home-based care, invested in the expansion of community facilities, and introduced standardised typologies for convalescence, medium-stay, and long-stay care. Governance was conceived as a joint

responsibility of the Ministry of Health and the Ministry of Labour and Social Solidarity, while regional and local coordination structures were formally established later in 2006 through Council of Ministers Resolution 168/2006 to ensure territorial articulation and multi-level coordination. In doing so, the PS translated its longstanding ambition for integration into the grammar of public law, recognising dependency as a collective responsibility, embedding co-funding mechanisms across pillars, and creating contractual pathways for public entities, non-profit organisations (IPSS, Misericórdias), and selected private providers operating under uniform, state-regulated prices.

Compared to its positioning between 2000 and 2004, the PS's strategy in 2005-2006 represented both continuity and innovation. While the party had previously advocated incremental reforms that privileged prevention, community-based services, and flexible family support within the constraints of EMU-driven fiscal discipline, the institutionalisation of the RNCCI marked a decisive turn toward a state-anchored integrationist model. Budgetary debates illustrate this shift clearly: Health Minister António Correia de Campos repeatedly reassured Parliament that convalescence and medium-stay units would remain free of user charges. These guarantees reflected the PS's intention to expand service coverage without introducing price barriers at the point of use, thereby reaffirming its commitment to universal accessibility while reshaping the governance architecture toward multi-level co-steering and regulated pluralism.

The centre-right opposition, represented by the Social Democratic Party and the People's Party (CDS-PP), positioned itself differently, combining continuity with significant adaptation relative to the period 2000-2004. Under the XV Constitutional Government (2002-2004), PSD and CDS-PP had jointly advanced a model of supported familism, privileging informal caregiving, strengthening the role of third-sector providers, and experimenting with integration largely through hospital-centred mechanisms under the Ministry of Health. By 2005-2006, while the PSD accepted the integrationist rationale of the RNCCI, it reframed its support within the language of fiscal credibility and managerial feasibility (Asembleia da Republica, 2005). In the 2006 State Budget hearings, PSD deputies questioned the government's cost projections, the sequencing of new units and teams, and the adequacy of managerial controls, insisting that implementation remain budget-neutral and administratively tractable. The CDS-PP, meanwhile, retained its familist framing but adapted it to the emerging institutional architecture, emphasising the need to recognise informal caregivers while defending the legitimacy of contracting non-state providers. However, CDS-PP consistently warned against "building a parallel public pillar at speed" and advocated for a three-pillar model combining public guarantees, social-economy delivery, and funded private options. Taken together, PSD and CDS-PP shifted from the expansionary familism of the early 2000s to a position more compatible with the PS's regulated pluralism, while introducing stronger constraints around fiscal sustainability and market-compatible governance (Asembleia da Republica, 2006a; 2006b; 2006c; 2006d; 2006e).

On the left, the *Bloco de Esquerda* and the Communist-Green alliance consolidated their earlier pro-public orientation but further radicalised their positions during the RNCCI reform process. Between 2000 and 2004, BE had primarily framed poor access to care as the result of missing state capacity, calling for tax-financed expansion within the SNS and resisting marketisation. By 2005-2006, BE's discourse evolved into an explicit rights-first agenda, opposing user co-payments and expressing scepticism towards hospital-centred command chains that, in its view, risked marginalising community-based services. Similarly, CDU anchored its interventions in the defence of universal public guarantees, frequently reminding Parliament that "social rights cannot be suspended due to financial constraints." Both parties sought to limit contracting with private actors, preferring to reserve this role primarily for non-profit providers acting as complements rather than substitutes to public services. In comparison to the early 2000s, the left became more assertive in defending a fully public LTC model and increasingly critical of the PS's openness to plural provision, even under regulated conditions (Asembleia da Republica, 2005; 2006f; 2006g).

The legislative design of the RNCCI ultimately reflected a negotiated settlement among these competing visions. The PS institutionalised a state-led framework that embedded multi-level governance, joint financing, and regulated pluralism, while deliberately protecting affordability. The PSD and CDS-PP accepted the principle of state steering but leveraged contracting to favour a broader non-state footprint and purchased capacity, reframing social rights as compatible with choice and targeted mechanisms of access management. Meanwhile, BE and CDU successfully shaped the debate on affordability and proximity but were unable to prevent the consolidation of a mixed-economy delivery model in which public, non-profit, and private providers coexisted under public regulation.

By 2006, the RNCCI had institutionalised a national LTC system that was state-anchored, territorially coordinated, jointly financed, and delivered through a regulated network of heterogeneous providers. This governance model combined the PS's integrationist ambition with market-compatible mechanisms favoured by the centre-right and affordability protections championed by the left. Compared to the fragmented pilots of the early 2000s, the reform represented a qualitative shift: Long-term care was no longer an experimental field but a central pillar of social and health policy. Yet this settlement also carried forward unresolved tensions, particularly regarding the balance between public guarantees, plural provision, and fiscal sustainability, which would continue to shape the trajectory of LTC policy in the following decade.

Table 8.11. provides a summary of the positions adopted by Portuguese political parties between 2005 and 2006.

Table 8.11. Emerging Cleavages from Parliamentary Debates Among Political Parties, 2005-2006.

Cleavage	PS (2005-2006) - Governing party	PSD	CDS-PP	BE	CDU	Salience
State - Periphery	Anchors LTC in central co-governance: Strong coordination between Ministry of Health and Ministry of Social Security; territorial teams act as extensions of state policy	Accepts territorial coordination but treats local teams as managerial relays implementing central targets; minimal local autonomy	Advocates for local IPSS/Misericórdias as co-producers of services; prefers state steering but decentralised delivery through the social economy	Favors public territorial infrastructures to guarantee proximity, equity, and universal coverage	Supports decentralised public planning with strong state-funded local capacities to ensure territorial equity	Low
State - Market	Implements regulated pluralism: Public guarantee + contracting with IPSS/Misericórdias and private providers under state-set prices	Welcomes PPP expansion and broader use of contracting, prioritising efficiency and market-compatible governance	Actively promotes plural provision and privileges the social economy; sees private and faith-based actors as central delivery partners	Opposes PPP-driven pluralism; defends SNS-led provision; allows IPSS only as secondary complements	Same as BE: rejects PPP expansion and insists on public dominance; IPSS accepted only as complements under public control	High
State - Family	Integrates caregiver training and limited household support within the public network; prioritises formal services over kinship reliance	Frames families as co-responsible actors, expecting them to complement public provision; supports managed expansion to control liabilities	Champions supported familism: family as “natural community of care,” promotes categorical benefits (e.g. family complement) and mobilisation of informal care through social-economy delivery	Advocates reducing family burden via expanded state-led services; opposes shifting responsibility onto households	Similar to BE: promotes public services to relieve families rather than substitute formal care with unpaid labour	High
State - Church	Normalises IPSS/Misericórdias as contracted partners within a state-regulated framework; integrates faith-based providers without granting them strategic autonomy	Welcomes faith-based providers as efficient delivery actors, treating them as key capacity builders	Strongly privileges Misericórdias and faith-based IPSS, seeing them as historical pillars of welfare provision; seeks to strengthen their contracting role	Wary of confessional substitution of the state; supports IPSS only under strict public oversight	Shares BE’s stance: sceptical of expanding faith-based influence; accepts IPSS as complements, not substitutes	Medium-high

Source: Author's elaboration.

4.3. The Decreto Lei No. 101/2006

The creation of the National Network for Integrated Long-Term Care (*Rede Nacional de Cuidados Continuados Integrados*) through Decree-Law no. 101/2006 marked a turning point in Portugal's institutional response to dependency and chronic illness, establishing a coordinated framework at the interface between health and social protection. Rather than constructing a new public pillar from scratch, the reform capitalised on Portugal's pre-existing, dense ecosystem of third-sector providers while embedding a new model of state-led coordination, standardised typologies of care, and joint financing between the Ministry of Health and the Ministry of Labour and Social Solidarity. The RNCCI's objectives were threefold: To promote autonomy and delay functional decline; to integrate fragmented health and social responses for individuals with complex care needs; and to provide structured support to families, recognising their central role in care provision while refraining from presuming their availability. As such, the RNCCI represents a paradigmatic shift from a hospital-overflow and family-default model towards a state-coordinated *continuum* that links acute care, primary care, and social supports through a structured governance architecture and a regulated mixed-economy delivery system.

The RNCCI's financial architecture reflects its dual institutional anchoring. Its design combines resources from two separate pillars—health and social care—resulting in a hybrid financing model that has shaped both its expansion and its constraints. On the health side, services are funded from general taxation through the national health budget, while the social-support components are co-financed through the social security budget and means-tested user co-payments. This approach allowed the government to scale capacity rapidly by contracting a wide network of existing providers, particularly non-profit institutions (IPSS) and *Misericórdias*, while simultaneously integrating SNS infrastructures such as hospital beds, rehabilitation units, and primary-care resources into the continuum of long-term care provision. However, this hybrid financing regime also produced enduring structural tensions. Because funding flows are tied to two distinct budgetary authorities, expansion has been limited by fragmented resource planning, differential growth rates, and occasionally conflicting spending priorities. Moreover, because the cost structures of contracted providers are heterogeneous, uniform price schedules imposed centrally have generated territorial asymmetries in capacity, coverage, and access. Despite significant growth in installed places since 2006, recent administrative monitoring and external audits confirm that persistent inequalities remain, particularly between metropolitan areas and rural regions, where dependency rates are highest but service density is lowest. These imbalances reflect both the historical geography of non-profit infrastructure and the limited elasticity of the public investment envelope. The absence of a dependency-sensitive financing formula has exacerbated these gaps: While assessed need determines access, it does not consistently govern the allocation of resources, resulting in variability in waiting times, time-to-placement, and effective coverage.

Eligibility for services within the RNCCI departs from traditional income-based entitlement models, relying instead on a structured, multidimensional assessment of clinical, functional, and social conditions. Referrals to the network originate predominantly in hospitals, particularly following acute events such as strokes or decompensations, but primary-care teams and community social services also play a growing role in initiating applications. Once referred, patients undergo evaluation by Local Coordination Teams (*Equipes de Coordenação Local*), multidisciplinary groups composed of clinicians, social workers, and rehabilitation specialists. These teams assess health status, functional limitations, cognitive impairment, and the household's effective capacity to provide care, thus integrating clinical and social dimensions into a single eligibility framework. The assessment allocates individuals to standardised typologies defined by the decree: Convalescence units for short post-acute stays of up to 30 days; medium-duration rehabilitation units for recovery programmes lasting 30 to 90 days; long-stay maintenance units for chronic dependency exceeding 90 days, often including respite functions; and ambulatory modalities such as day-care units focused on autonomy promotion and home-care teams embedded in primary-care groupings. Where local capacity is exhausted, cases escalate to Regional Coordination Teams (*Equipes de Coordenação Regional*) which manage waiting lists and reallocate placements within territorial catchments. Crucially, the RNCCI rejects the assumption of unconditional family availability, requiring instead a documented assessment of informal caregiving potential and explicitly incorporating household resources and social supports into eligibility decisions. This multidimensional approach represents a significant normative innovation in a familistic welfare context, but implementation studies highlight persistent frictions. Qualitative evidence indicates that inconsistent referral practices, late hospital signalling, variable documentation standards, and divergent interpretations of inclusion criteria at the hospital-community interface can delay placement, thereby undermining the network's intended responsiveness.

The RNCCI's governance model is deliberately multi-level, seeking to weave together acute, rehabilitative, and community-based care into a coherent institutional continuum. Central stewardship initially rested with the Mission Unit for Integrated Continuing Care (*Unidade de Missão para os Cuidados Continuados Integrados*), later transitioning to the Central Administration of the Health System (*Administração Central do Sistema de Saúde*), which develops service standards, contracts providers, and aggregates monitoring data at the national level. Regional Coordination Teams translate these national guidelines into territorial plans, calibrating capacity targets and resource allocation across Portugal's five Regional Health Administrations. At the operational tier, Local Coordination Teams manage case allocation, monitor ongoing care trajectories, and ensure articulation between hospitals, primary care, and community services. Hospital Discharge Management Teams and Community Integrated Care Teams constitute the hinge between inpatient and community-based care, a node repeatedly identified in research as a critical bottleneck. Performance at this interface shapes both time-to-placement and appropriateness of care: When discharge planning fails or referral pathways are poorly

synchronised, patients experience unnecessary delays or mismatches between assessed need and allocated service. While the governance framework represents a structural innovation aimed at overcoming Portugal's historical hospital-centrism, its effectiveness remains uneven across territories, reflecting variation in local team capacity, hospital engagement, and inter-institutional coordination.

From a regulatory perspective, the RNCCI codifies a public guarantee delivered through a model of regulated pluralism, combining central state oversight with a mixed-economy delivery chain. Service provision is distributed across three provider categories: The backbone of capacity is supplied by non-profit IPSS and Misericórdias; National Health Service units deliver specialised inpatient care and integrate acute infrastructures into the continuum; and a smaller for-profit segment contributes additional flexibility in capacity expansion. All providers operate under standardised contract-programmes that define typology, price schedules, quality obligations, and reporting requirements. This pluralistic configuration has two faces. On the one hand, it accelerates expansion by mobilising pre-existing infrastructures and leveraging the organisational reach of the third sector (PT3—Legal Counsel, Integrated Continuing Care Directorate, Santa Casa da Misericórdia de Lisboa). On the other, it requires the central administration to maintain equity, quality, and cost control across providers whose ownership structures, staffing models, and territorial distribution vary substantially. Recent evaluations from the Tribunal de Contas highlight two interrelated challenges. First, administratively fixed price schedules, uniform across heterogeneous provider types, are not systematically linked to either dependency intensity or documented outcomes, limiting the network's ability to align costs with quality or incentivise efficient provision. Second, persistent territorial asymmetries reflect not only historical infrastructure gaps but also weaker regulatory levers in regions with high reliance on third-sector providers. As a result, while the RNCCI institutionalised a nationwide service grammar, its implementation has produced variable entitlements in practice, leaving coverage equity as an ongoing policy challenge.

At the instrumental level, the RNCCI is overwhelmingly service-oriented, prioritizing in-kind provision over cash transfers. Its architecture focuses on installed capacity—beds, domiciliary teams, and day-care units—rather than income-based supports for families. Within the network, the only explicit cash instrument is the means-tested co-payment applied to the social-support component of care, calibrated to household resources; the health component remains fully tax-financed. Separate social-assistance programmes continue to provide financial benefits for low-income dependent individuals, but these sit outside the RNCCI's institutional perimeter, reinforcing its character as a delivery-driven rather than cash-driven intervention. Comparative analyses underline the cautious nature of Portugal's stance on cash allowances: Unlike models in countries such as Germany or Austria, where long-term care insurance underwrites generalised entitlements to in-cash benefits, the RNCCI prioritises service expansion through contracting and capacity-building. While this strategy has enabled rapid institutionalisation of a nationwide framework, it also reproduces a persistent bias towards bed-based solutions, as administrative

and contractual mechanisms for domiciliary and day modalities have proven harder to scale. This imbalance matters for equity because home-based services are precisely those most capable of offsetting the socially patterned limits of informal caregiving in a familistic context. Empirical studies highlight the distributive implications: Where domiciliary teams are scarce, lower-income households face longer waits, greater out-of-pocket costs, and higher reliance on family labour, particularly among women. Addressing these structural biases would require integrating the multidimensional assessment of need not only into eligibility but also into the financing formula, pricing regimes, and territorial planning instruments.

Nearly two decades after its creation, the RNCCI has transformed the institutional landscape of long-term care in Portugal, embedding a state-coordinated continuum that spans health and social domains, integrates multidimensional assessments, and mobilises regulated pluralism to scale capacity. Yet, persistent tensions remain between its integrationist ambition and its fiscal, organisational, and territorial constraints. While the network has successfully reduced avoidable hospital occupancy and established a coherent national governance grammar, its objectives of equitable territorial coverage, robust home-first provision, and dependency-sensitive financing remain incompletely realised. These gaps suggest that the RNCCI's next frontier lies not in further expanding the contracting lane but in consolidating its fiscal and operational architecture, ensuring that the multidimensional concept of "need" that governs access also determines the flow of resources and the pace at which proximity-based services can grow. Table 8.12. summarizes the RNCCI dimensions, across instruments and mechanisms.

Table 8.12. Dimensions, Instruments and Mechanisms of the RNCCI.

Dimension	Instruments	Mechanisms
Financing & Coverage	Hybrid financing model: The health component funded through general taxation (SNS budget) and the social-support component co-financed by the Social Security budget and means-tested co-payments. Uniform price schedules applied nationally.	Joint stewardship by the Ministry of Health and the Ministry of Labour and Social Solidarity; financial planning coordinated centrally by the Central Administration of the Health System (ACSS).
Eligibility Criteria	Comprehensive assessments combining clinical, functional, and social dimensions; standardised typologies: Convalescence, medium-duration rehabilitation, long-stay/maintenance, day care, home care.	Eligibility evaluated by Local Coordination Teams (ECL); when local capacity is saturated, Regional Coordination Teams (ECR) manage reallocations and waiting lists.
Multi-level Governance	Multi-tiered governance: UMCCI (initial central stewardship) → ACSS (standards, contracting, monitoring); Regional Coordination Teams plan territorial capacity; Local Coordination Teams manage case allocation.	National guidelines cascade down through five Regional Health Administrations to local operational teams embedded within primary-care clusters; Discharge Management Teams link hospitals and community services.
Regulatory Provision	Contract-programmes define typology, prices, reporting obligations, and quality standards; non-profit IPSS and Misericórdias provide backbone capacity, complemented by SNS units and a small for-profit segment.	The state retains full regulatory authority through the ACSS, setting prices, allocating contracts, and monitoring performance and outcomes.
Instrumental Level	Service continuum includes convalescence units (≤30 days), medium-duration rehabilitation units (30-90 days), long-stay maintenance units (>90 days), palliative care, day units, and home-care teams. Co-payments on social components remain means-tested and limited; health components fully tax-financed.	National network integrates inpatient and ambulatory tiers, anchored in primary care and supported by community-based multidisciplinary teams.

Source: Author's elaboration

5. Balancing Partisanship and Elite-Driven Demand: The Political Exchange in a Constrained Political Context

The Portuguese case closes the empirical arc of this monograph with a configuration best described as selective expansion: An incremental, largely inertial institutionalisation of a proximity-based, health-social network under regulated public-private collaboration, with no redesign of the residual and means-tested cash layer. In the typology developed in Chapter 2, Portugal remains in the residual quadrant. The 2006 reform attempts a move toward de-familisation by expanding in-kind services and coordination, but the change materialises primarily as regulatory codification and managerial integration; the financing perimeter, eligibility logics, and the core reliance on unpaid family care largely persist. How and why did this transition occur?

Table 8.13. provides an overview of the mechanisms analysed.

Table 8.13. Step in Process Tracing Mechanisms in Portugal.

Steps in the Mechanism	Reference to Mechanism	Observable Indicators	Empirical Observations
1. Problem pressure	Mechanism 1	Convergence of external shock and opening of a reform <i>momentum</i>	Demographic ageing, rising female employment, media scandals in hospital
2. Institutional path dependence	Mechanism 2	Policy legacy and vested interests in institutions	Vertical and horizontal fragmentation; NHS universalism-imbalance; residualism of social assistance
3. Opening of an institutional gate	Mechanism 2	Political and institutional dynamics	Political context: government alternation and divisions within the left (notably the role of the <i>Bloco de Esquerda</i>). At the European level, policy orientations stressed the need to ensure the economic and fiscal sustainability of selected sectors while promoting policy dialogue under the framework of the European Pillar of Social Rights.
4. Puzzling	Mechanism 3	Shared policy solutions and strategic framing	Substantial absence of a prior policy learning or problem-solving process preceding the reform. The ideational framing focused on socio-health integration, conceived as a tool to improve the economic and financial sustainability of the sector.
5. Powering	Mechanism 3	Party competition	The policy initiative was promoted by the far-left party (<i>Bloco de Esquerda</i>). In the absence of clear policy ownership, the centre-right governing parties (PSD-CDS) reshaped the terms of political competition in favour of market-oriented solutions.
6. Emergence of a dominant coalition	Mechanism 3	Coordinated action during crisis or reform window	The policy process involved the strategic aggregation of support from distinct constituencies, including healthcare professionals oriented toward the expansion of the National Health Service (SNS)—as opposed to the social care pillar—and faith-based organizations.
7. Strategic political exchange	Core Mechanism	Types of strategic exchanges and compensatory mechanisms implemented by social and political actors	Unidirectional process (narrow and elite-driven)
8. Reform outcome: path departure	<i>Explanandum</i>	Type of Change	Selective expansion - Targeted expansion of healthcare services, primarily benefiting medical professionals and clinical sectors. - Targeted expansion of social services, particularly in the area of social work and community-based provision.

Source: Author's elaboration.

Contextual Factors and Functional Pressures

Portuguese LTC evolved under a conservative-corporatist legacy that privatised need and moralised entitlement during the *Estado Novo* (1933-1974), with access mediated by occupational status, charity, and “deservingness” rather than citizenship. The *Misericórdias* and other associative actors became de facto providers of elder care in the absence of a public LTC pillar, especially in rural territory, entrenching a geography of unequal care and gendered burdens within households. Democratic consolidation and the creation of the SNS, in 1979 universalised healthcare, but did not embed LTC as a social right: The SNS remained hospital-centred and curative, while the social domain relied on subsidiarity and delegated provision to IPSS/*Misericórdias*. During the 1980s-1990s, policy layering recognised IPSS as public-utility entities and formalised program contracts scaled domiciliary/day services through co-financing and municipal partnerships, and introduced a modest, last-resort cash transfer (*Complemento por Dependência*, 1999) that acknowledged dependency as a risk without creating a universal entitlement. On the health side, continuity-of-care entered the statute book (*Lei de Bases da Saúde*, 1990), ARS were created (1993), hospital discharge units piloted, and EU-funded experiments proliferated, but without a national LTC regime. In short, by 2000 Portugal had a dense but uneven third sector, a hospital-centric SNS, limited cash support, and a highly familialist norm, all of which pre-structured the feasible set for reform.

These legacies interacted with new functional pressures. Rapid population ageing raised the share of 65+ above 17% by 2005 and pushed the 80+ cohort to nearly one quarter of older adults, while dependency ratios surpassed 30% in several interior districts; at the same time, territorial disparities in supply persisted, with coverage concentrated along the coast and metropolitan areas (*Carta Social*, 2006). Hospitals faced recurrent “bed-blocking” because intermediate, rehabilitative, and home-care alternatives were thin; primary care lacked community teams able to manage complex, chronic trajectories; and informal caregiving carried increasing costs in time and foregone labour. Under EMU fiscal constraint and low public salience of LTC, these pressures made “integration” attractive only insofar as it could deliver visible throughput gains and coverage extensions without creating an entitlement-heavy pillar.

Opening of an Institutional Gate

The Socialist Party’s absolute majority in 2005 provided political room to move from experimentation to institutionalization, but the institutional gate had been pried open earlier by centre-right reforms. Between 2002 and 2004, the PSD-CDS government launched *Rede Mais* (*Resolução* 59/2002), reorganised primary care (*Decreto-Lei* 60/2003), and created a first health-sector network for long-duration care (*Decreto-Lei* 281/2003). These measures normalised inter-ministerial cooperation, routinised contractual relations with IPSS/*Misericórdias*, and embedded hospital-to-community pathways and discharge management—precisely the operational templates that a national network could scale.

Decree-Law 101/2006 transformed that administratively tractable template into a co-governed *continuum*: Dependency was recognised in public law as an object of integrated preventive, rehabilitative, and palliative services; standardised typologies (convalescence, medium stay, maintenance) were defined; co-funding between Health and Labour/Social Solidarity was instituted; and multi-level coordination was created by Resolution 168/2006. Critically, the law did not displace delegated provision but formalised it under public tariffs, opening contracting channels with public entities, IPSS/Misericórdias, and selected private providers. In the language of Chapter 4, the gate opened at the intersection of problem pressure, organisational routines, and coalition incentives. Hospitals needed step-down capacity to protect acute throughput; primary care required community partners to reduce avoidable admissions and stabilise discharges; the social economy sought stable, rule-bound revenue streams; and professional orders accepted integration if clinical leadership and enforceable standards were guaranteed. The RNCCI thus translated the slogan of “integration” into allocative, contractual, and accountability mechanisms capable of travelling across sectors and territories without redefining the distributive core of the welfare settlement.

Pro-Public, Market and Family Coalitions

Coalitional dynamics explain the specific mix of instruments and the governance grammar that emerged. The pro-public coalition—primary-care clinicians, public-health professionals, and social-policy administrators—had shaped the ideational turn toward continuity, prevention, and proximity since the late 1990s and provided the conceptual blueprint for a home-first, multidisciplinary model. Yet it lacked control over budgets, infrastructures, and contracts, and therefore left a discursive rather than executive imprint.

The pro-market coalition—hospital managers, Health-ministry technocrats, and medical elites organised around the *Ordem dos Médicos* and FNAM—held the implementation levers. It endorsed integration but insisted on physician-led governance, protocolised pathways, and single-hierarchy accountability, resisting managerialisation that might undermine clinical authority and warning against outsourcing without strong medical oversight. This coalition tilted the network toward clinical command chains, with hospitals and primary-care centres as coordination hubs and measurable outputs as performance currency (Santana, 2010; Calado et al., 2019).

The pro-family coalition—ideologically rooted in PSD-CDS frames and organisationally anchored in the *Misericórdias* and the IPSS universe—supplied the capacity backbone. Territorial capillarity and historical legitimacy allowed these providers to scale beds and teams quickly under cooperation agreements, but their strategic preference was regulated pluralism: Stable prices, long-term contracts, and delegated operational autonomy under state steering (Pereira, 2014; Santana et al., 2016). The result is familist-adjacent: Formal services expand, but households continue to absorb substantial care, and the cash tier remains selective and residual (Decreto-Lei 265/1999; Carolo & Pereirinha, 2010).

Partisan alignments map to these coalitions but evolved from the 2000-2004 baseline. The PS legislated a state-anchored, jointly financed network with territorial coordination and a mixed economy under regulated prices; the centre-right accepted integration as an efficiency/throughput policy, emphasising fiscal control and contracting rather than direct public provision; the left (BE, CDU) defended universal guarantees and proximity while resisting pluralism that could entrench “privatisation by contract.” Because LTC salience remained low, these cleavages crystallised less in mass politics than in the micro-politics of standards, eligibility, and tariffs, where professional orders and social-economy federations wielded organisational leverage disproportionate to electoral weight.

This negotiated compromise explains the hybrid profile of the RNCCI. Pro-public actors secured legal recognition of dependency as a collective responsibility and embedded multidisciplinary proximity. Pro-market actors maintained medical primacy and measurable, hospital-anchored coordination. Pro-family actors obtained long-term contractual security and a central operational role. The settlement is therefore state-steered, clinically led, and plural in execution, but also path-dependent on the territorial density of non-state providers and on household caregiving.

The Logic of Political Exchange: Cleavage Dynamics and Particularistic Interests in a Constrained Political Context

Seen through the political-exchange lens developed in Chapter 4, the 2006 settlement cleared because it aligned a reformist executive’s need for visible, fiscally compatible problem-solving with the particularistic demands of strategically placed organisations that controlled implementation capacity. Under EMU constraints and low public salience, bargaining clustered among elite stakeholders rather than mass constituencies. The government secured a nationally legible response to bed-blocking, population ageing, and territorial inequality without constructing a new public pillar. Hospitals obtained a reliable discharge valve and predictable referral pathways; primary care gained community teams; professional orders preserved clinical leadership and standard-based practice; and the social economy locked in stable prices, long-term contracts, and formal recognition as co-executors. Each actor, in short, extracted a domain-specific gain consistent with its organisational interests and comparative advantages.

The costs of agreement are visible in the limits of change. Uniform tariffs and standardised categories simplified purchasing and scaled capacity but were only weakly indexed to dependency intensity or outcomes, blunting cost-quality alignment. Because contracting amplified pre-existing organisational density, growth mapped onto the geography of strong provider networks: Coastal districts scaled rapidly, while interior territories lagged, especially in domiciliary and day modalities. Where local coordination capacity was thin, referral bottlenecks persisted, revealing that multi-level governance is only as strong as its operational foundations. Crucially, the cash layer remained untouched beyond the modest *Complemento por Dependência*: No universal allowance and no structured support capable of shifting risk from families to the state, leaving de-familisation incomplete.

The cleavage structure helps explain why an expansive reform was politically improbable even as “integration” gained ideational traction. Although the radical left (BE, PCP) acted as agenda entrepreneurs and helped move dependency onto the policy radar of the centre-right in the early 2000s, their universalist framing did not translate into broad, mobilised social demand. On the demand side, claim-making was dominated by particularistic interests—above all clinical-medical corporations and territorially embedded third-sector providers—whose preferences were oriented to governance prerogatives, contracting stability, and operational tractability rather than entitlement expansion. In a low-salience field, these organised interests occupied the pivotal nodes along several intersecting cleavages. Along the public-private axis, medical orders accepted integration but insisted on physician-led command chains and measurable outputs, while IPSS and *Misericórdias* preferred regulated pluralism under public tariffs; along the family-state axis, neither actor coalition pressed for a universal cash entitlement that would materially reallocate risk from households; and along the centre-periphery axis, territorial asymmetries in provider density endowed coastal districts with disproportionate bargaining power. The result was a coalition *equilibrium* that favoured contract-ready coordination over rights-expanding legislation. Put differently, the ideational shift on the partisan supply side was not matched by a correspondingly universalist social demand; the demand that mattered for implementation was particularistic, clinically, and organisationally grounded, and thus steered reform toward selective expansion and managerial integration. In this configuration, “path departure” was structurally costly and politically under-incentivised; what proved feasible was institutional layering consistent with inherited capacities and constraints.

All in all, Portugal’s transition is best read as layering under binding legacies. Functional pressures created demand for integration; earlier managerial and pilot innovations opened an institutional gate; and a coalition-robust, particularism-sensitive exchange produced a coordination regime that could travel without revising the distributive contract. The RNCCI strengthened steering, visibility, and service capacity through regulated pluralism, but it neither considered LTC as an enforceable social entitlement nor rebalanced the cash/in-kind mix. Accordingly, Portugal remains in the residual quadrant: More integrated and procedurally robust than in the 1990s, yet still reliant on unpaid family care, territorially uneven non-state provision, and selective monetary support.

Chapter 9. Conclusions: The Comparison among the Three Countries and the Potential for Inference

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1. Introduction: An Overview of the Main Argument

This dissertation seeks to address a gap in the political science literature on LTC by offering an interpretative framework for understanding LTC reforms in Southern European countries. On the one hand, the study reconstructs the positioning of social and political actors, placing particular emphasis on the interaction between the demand for and the supply of policy. On the other hand, it provides a comprehensive account of policy development in three countries that share similar institutional characteristics but have followed divergent reform trajectories. To this end, the dissertation engages critically with dominant theories of welfare state development and moves beyond their explanatory limits by developing a policy-specific analytical framework tailored to the political dynamics of the LTC sector.

While functionalist and historical neo-institutionalist approaches capture important structural constraints and path-dependent dynamics shaping LTC reform, they fall short of providing a comprehensive explanation of policy change. Functionalist accounts privilege demographic ageing, increased longevity, and rising female labour market participation as sources of problem pressure; however, they are unable to account for persistent cross-national divergence in reform trajectories under broadly similar socio-economic conditions. Historical neo-institutionalism, in turn, foregrounds policy legacies and institutional veto points, but systematically underplays

political agency, strategic interaction, and the contingent exploitation of windows of opportunity by political and social actors. Actor-centred perspectives, including Power Resources Theory and ideational approaches, provide additional analytical leverage. However, their explanatory capacity is limited in a policy domain marked by weakly mobilised beneficiaries, low electoral salience, and the coexistence of divergent—at times contradictory—ideas within the same policy field. This ideational and power fragmentation reduces the possibility of anticipating *ex ante* the emergence of stable or convergent political alliances. In response to these limitations, this thesis advances strategic political exchange as the central analytical framework for explaining—and anticipating—the direction, timing, and scope of LTC policy trajectories.

At its core, as outlined in Chapter 4, political exchange theory conceives policy reform as the outcome of bargaining and compromise between the *demand side*—organized societal actors such as unions, pensioner groups, care providers, family associations, and employers—and the *supply side*, namely political parties and governments operating under fiscal, electoral, and institutional constraints. Unlike functionalist or institutionalist explanations, this approach foregrounds the interaction of actors, where preferences are not fixed but strategically adjusted, and where reform emerges when mutual incentives align. In the LTC field, this perspective is particularly compelling because of three distinctive features: Low political salience, high policy complexity, and fragmented interest representation.

The low political salience of LTC implies that it rarely occupies a central position in electoral competition or in the dynamics through which political actors seek to build electoral support. Older adults with care needs, informal caregivers, and precariously employed care workers exhibit limited capacity for collective mobilisation, thereby reducing the expected electoral returns of ambitious reform initiatives. At the same time, the high degree of policy complexity associated with LTC further constrains reform prospects. LTC is inherently multi-sectoral, spanning health care, social services, pensions, and family policy, and is governed across multiple institutional levels. Fragmented and partially competing interests compound these difficulties: trade unions, family associations, service providers, and non-profit organisations often pursue divergent objectives, weakening demand-side pressure for comprehensive change. These characteristics make LTC reform unlikely to emerge from ideological commitment alone. Rather, reform depends on governments' ability to construct viable political coalitions by selectively aligning heterogeneous interests through negotiated exchanges.

The types of exchange mechanisms are well established in the comparative political economy literature. The first is *concertation*, a formalized negotiation process typical of neo-corporatist systems, where governments and major interest groups co-produce policy. Although weaker in Southern Europe, moments of concertation can still occur, particularly when unions and employer associations are brought into fiscal or labor market reforms that indirectly touch on care. The second is *lobbying*, characteristic of pluralist systems, in which providers, family associations, or pensioner unions seek to influence government agendas by framing LTC as urgent or by offering

technical expertise. The third—and most relevant for the LTC sector—is strategic political exchange, in which heterogeneous actors, lacking institutionalized cooperation, nonetheless find temporary convergence on specific goals. This form of exchange explains why reforms in LTC often take hybrid shapes that partially satisfy divergent preferences.

Coalition-building lies at the core of strategic political exchange. In the LTC domain, three main poles of interest can be identified, each associated with a distinct competitive logic: the expansion of public provision (e.g. trade unions, civil society organisations), the expansion of market-based provision (e.g. private providers and employers' associations), and the expansion of familistic and conservative arrangements (e.g. churches and faith-based actors). Each pole promotes different policy priorities and normative visions of care.

Public-oriented actors, such as trade unions, professional associations, and civil society organisations representing older people, prioritise the expansion of publicly funded services, enhanced regulatory capacity, and the professionalisation of the care workforce. Market-oriented actors—including for-profit providers, employers' associations, and segments of the non-profit sector—advocate the commodification of care through outsourcing, accreditation systems, and flexible service provision, all of which contribute to the expansion of private care markets. Family-oriented actors, such as pensioners' unions and family associations, tend to defend cash-for-care schemes and allowances that enable households to retain autonomy over caregiving arrangements. Their position is grounded both in cultural norms of familialism and in the material interest of preserving retirees' purchasing power.

Under ordinary circumstances, these interests pull in opposing directions: families defend cash transfers, market actors demand deregulation and outsourcing, while pro-public coalitions push for direct service provision. Reform becomes politically feasible, however, when governments succeed in strategically aligning these competing interests within hybrid coalitions. Policy designs that combine cash benefits with service entitlements, for example, allow each pole to secure partial gains while accepting compromise. Such hybrid arrangements are not accidental. Rather, they constitute the institutionalised outcome of political exchange, whereby governments broker agreements that balance competing claims under conditions of fiscal constraint and electoral risk.

From a predictive perspective, both the likelihood and the substantive direction of LTC hinge on actors' capacity to construct such coalitions. Chapter 4 identifies several mechanisms through which coalition alignment can be achieved. First, issue reframing can elevate the political salience of LTC by linking it to broader and more electorally resonant cleavages. When framed as a gender equality issue, LTC mobilises support from feminist organisations and progressive parties; when articulated as a labour market concern—by emphasising its role in enabling female employment—it becomes attractive to trade unions and employer-oriented actors. Second, resource dependency creates incentives for alignment: non-profit providers reliant on public subsidies may support government reform initiatives in exchange for stable funding, while for-profit providers may

accept increased regulation when it guarantees predictable reimbursement schemes. Third, risk minimisation strategies lead governments to prioritise reforms that diffuse costs while distributing benefits broadly, thereby limiting political and reputational exposure. Hybrid coalitions are particularly effective in this regard, as they allow multiple actors to claim policy gains while blurring underlying distributive conflicts.

On the supply side, governments operate under fiscal constraints, coalition considerations, and reputational risks. In highly fragmented party systems, policymakers tend to be particularly cautious: investing political capital in low-salience issues such as LTC is often perceived as unattractive. Beyond moments of opportunity, government intervention becomes politically viable when it generates positive payoffs, especially in coalition terms, and when the issue becomes politicized. In this sense, inter-party competition produces a powering effect by increasing the salience of the policy problem. Moreover, in contexts marked by exogenous shocks, governments may exploit windows of opportunity to introduce LTC reforms as part of broader reform packages. Under these conditions, aligning with demand-side actors becomes less costly and can even be politically advantageous. An additional explanatory layer concerns the activation of cleavages. When LTC reforms are successfully linked to a cleavage that resonates with a wider electorate, their chances of political adoption increase. Cleavage activation thus functions as a *symbolic anchor*, enabling governments to expand narrow coalitions into broader and more inclusive alliances.

Overall, because demand-side coalitions tend to be fragmented and electoral returns are limited, governments generally favor low-risk compromises over paradigmatic policy shifts. This process of layering often results in complex—and at times internally inconsistent—policy mixes. It is the interaction between *puzzling* and *powering* that creates the conditions under which the dominant coalition can operate within institutional constraints and policy legacies, thereby generating strategic political exchange. This constitutes the central hypothesis of the thesis, which—challenging Power Resources Theory—argues that, although ideological preferences are relatively settled, they are mobilised strategically rather than mechanically translated into policy outcomes.

These predictive mechanisms can be summarized as follows. Functional pressures create the background conditions for reform, while institutional legacies shape both the constraints and opportunities for action and orient the cognitive frames of the actors involved. Actual policy change, however, depends on the ability to construct coalitions that reconcile vested interests and ideas. Cleavage activation plays a crucial role in this process by broadening otherwise narrow coalitions. By linking long-term care to salient political conflicts, it facilitates alliance-building both within and across governing coalitions. Operating under conditions of risk aversion, governments are therefore most likely to adopt reforms when such coalitions effectively reduce the political costs of action.

This Conclusion is structured into five sections. Section 2 revisits the three country cases, applying the theoretical mechanisms identified in the thesis to explain their respective trajectories of long-term care reform. Section 3 broadens the scope by situating these findings within the Southern European model, first by reflecting on the post-reform dynamics in Spain and Portugal, and then by offering a more general assessment of the Southern European welfare constellation. Section 4 develops the potential for inference, both across countries and across social policy domains, highlighting the broader analytical payoffs of the political exchange perspective. Finally, Section 5 outlines the main limitations of the study and suggests avenues for future research in the field.

2. Back to the Theory: Applying Main Theoretical Mechanisms to Empirical Cases

This section revisits the theoretical mechanisms outlined in Chapter 4 and, in comparative perspective, takes stock of the empirical findings presented in Chapters 5-8. Section 1.1 focuses on functional pressures and contextual factors, while Section 1.2 turns to institutional determinants. The following part examines ideational drivers, and Section 1.4 concludes with what Chapter 4 identified as the core mechanism in the reform of long-term care policies—the so-called *smoking gun* in the process-tracing analysis—namely, the compensatory and strategic political exchange among the actors, *i.e.*, coalitions, involved in the decision-making process.

2.1. Functional Pressures and Contextual Factors

In the period preceding the adoption of comprehensive reforms, LTC policies in Spain, Italy, and Portugal were shaped by a convergence of demographic, social, and institutional pressures that increasingly strained existing care arrangements. Across all three Southern European countries, population ageing emerged as the most significant functional driver of change. Beyond the general increase in the older population, each country experienced a rapid expansion of the “oldest old” cohort, whose higher incidence of chronic illness and functional limitations translated into growing and more complex care needs.

In Spain, the population aged 80 and over expanded sharply during the 1990s and early 2000s, altering the age structure and intensifying demand for both residential and community-based services. Italy followed a similar trajectory, with the absolute number of individuals aged 80+ more than doubling over the course of two decades. Portugal, although experiencing these trends slightly later, faced comparable demographic pressures, particularly reflected in rising dependency ratios in rural areas. Together, these developments revealed a structural imbalance: while the demand for formal long-term care increased substantially, existing policy frameworks continued to rely heavily on family provision, thereby widening the gap between demographic needs and institutional capacity.

Changes in family structures and labour markets further intensified these pressures. In all three countries, the traditional reliance on unpaid female carers became increasingly untenable. Rising

female labour market participation highlighted the contradiction between economic modernization and persistent expectations of intra-household caregiving. In Spain, this contradiction was particularly visible in public debates on work-life reconciliation, which framed women's employment as incompatible with residual public support for dependent relatives. In Italy, the family remained the backbone of LTC provision, but as more women entered the labour force and fertility rates declined, the capacity of households to absorb care demands weakened significantly. Portugal shared this structural dependence on family care, compounded by high rates of out-migration in rural areas that left older adults without close kin support. In each case, the erosion of the family-based care model transformed what had been considered a private issue into a matter of public concern, pressing governments to confront the sustainability of systems rooted in familialism.

Contextual factors further amplified these functional stresses and shaped the political urgency of reform. In Spain, the Europeanization of social policy discourse—particularly through the Lisbon Strategy and references to the Nordic model—provided reform advocates with normative benchmarks and legitimacy. Media scandals concerning mortality in residential homes gave these pressures public visibility, transforming latent imbalances into politically salient crises. In Italy, the COVID-19 pandemic became the decisive contextual shock that exposed the vulnerabilities of a system excessively reliant on families and fragmented between health and social competences. The concentration of mortality in residential facilities and the inadequacy of home-based services revealed systemic fragilities that could no longer be ignored. Portugal's contextual drivers were more structural than episodic: Rural depopulation, infrastructural deficits, and uneven access to EU funds created a geography of provision that privileged coastal and metropolitan areas while leaving interior districts underserved. The governance model, heavily dependent on nonprofit providers, further entrenched inequalities by linking coverage to the strength of local associative networks rather than objective indicators of need.

The three countries shared a common structural pressure: Rapidly growing demand for long-term care clashed with systems designed for a different social reality. Functional pressures associated with demographic ageing, rising prevalence of disability, and declining availability of unpaid care interacted with contextual dynamics such as European integration, fiscal crises, pandemics, and territorial disparities. The interaction of these forces destabilized the pre-existing *equilibrium* and opened windows of opportunity for reform.

Contextual shocks and structural conditions, however, differentiated the timing and scope of policy responses. The functional-contextual mechanism alone is insufficient to account for the outcomes of reform, and, above all, to explain why, on the one hand, Italy did not experience the same policy dynamics as Spain and Portugal in 2006—despite facing similar pressures—and, on the other, why, even in the presence of strong functional and contextual drivers, the trajectory of reform subsequently shifted.

2.2. Institutional Legacy and Opening of a Gate

While functional pressures set the stage for reform, institutional legacies decisively shaped the trajectories of LTC policies in Southern Europe. Institutions did not merely mediate reform; they created path-dependent *equilibria*, entrenched vested interests, and uneven opportunity structures for change. The comparative analysis highlights three clusters of institutional traits: The weight of cash-based benefits as functional equivalents to LTC, the structuring role of decentralization and multi-level governance, and the corporatist reliance on private non-profit providers.

Cash transfers and path dependence. In all three countries, the early introduction of universal cash benefits for frailty created powerful legacies that shaped subsequent LTC developments. Italy's *Indennità di accompagnamento*, introduced in 1980 as a disability allowance, rapidly expanded into the main pillar of care provision for dependent older people. Its unconditional and universal design produced a strong constituency of beneficiaries, reinforced by disability associations such as ANMIC and the activism of courts that broadened eligibility. The IdA became the path-dependent cornerstone of Italian LTC, crowding out investment in services and providing regional and municipal authorities with a politically convenient alternative to costly infrastructures. Spain followed a similar trajectory with the *Subsidio de Ayuda a Tercera Persona* and later non-contributory benefits administered by INSERSO, which played a residual but symbolically significant role in addressing dependency. In Portugal, the *Complemento de Dependência* (1999) reinforced the same pattern, extending modest cash support to pensioners with certified needs. Across the three countries, these measures illustrate how early policy choices established a durable cash-based *equilibrium*, defended by vested interests of recipients, families, and political actors.

Unlike Spain and Portugal, from its early inception the Italian *Indennità di Accompagnamento* played a distinct role in shaping the distributive composition of LTC expenditure in Italy. As a universalistic cash benefit designed to support families' freedom of choice, the scheme came to absorb more than 80 percent of total LTC spending. By contrast, in Spain and Portugal cash transfers remained selective and residual components of LTC provision. In Italy, however, the prominence of the allowance contributed to a progressive saturation—and eventual hypertrophy—of public LTC expenditure centered on monetary transfers.

Moreover, as highlighted by literature (see Costa, 2013), the *Indennità di Accompagnamento* has functioned as a *de facto* functional equivalent of a minimum income scheme, in a context where Italy lacked a comprehensive guaranteed minimum income for much of the period under analysis. As such, the benefit partially compensated for shortcomings in anti-poverty policies, operating not only as a care-related instrument but also as a form of income support for households. By contrast, as demonstrated in the empirical chapters, Spanish trade unions' opposition to the

introduction of a non-contributory scheme for dependent individuals, together with the expansion of non-profit service provision in Portugal, has constrained the emergence of a strong and organised constituency in support of cash-based benefits.

Vertical and horizontal institutional fragmentation. Spain represents the most radical case of vertical fragmentation. The 1978 Constitution and the subsequent consolidation of the *Estado de las Autonomías* devolved extensive social policy competences to the Comunidades Autónomas. Each region developed its own eligibility criteria, service mix, and financing arrangements, resulting in pronounced territorial disparities. National coordination efforts—such as the *Plan Gerontológico* (1990) and the *Acuerdo Marco* (1992)—proved largely ineffective, as the Comunidades Autónomas operated as powerful veto players. Even the landmark 2006 Dependency Law, while formally establishing a national entitlement, was adopted only after protracted intergovernmental bargaining and ultimately preserved wide margins of regional discretion in implementation.

Italy followed a parallel trajectory. Vertically, the creation of the *Servizio Sanitario Nazionale* in 1978 established universal healthcare at the national level, while the 2001 constitutional reform (Title V) reassigned social assistance to regional competence, further entrenching the functional division of responsibilities. Health services came under the authority of regional governments and were administered through local health agencies (ASL), whereas municipalities retained responsibility for social care. The State-Regions Conference institutionalised regional veto power, subjecting instruments such as the *Fondo per le Non Autosufficienze* to sustained intergovernmental bargaining and territorial differentiation. Horizontally, competences were split between the Ministry of Health and the Ministry of Labour and Social Policies, generating coordination problems comparable to those observed in Spain.

Portugal, at first glance, appears less fragmented, since its regions lack constitutional autonomy, and the central state retains primary responsibility for welfare design. Yet fragmentation arose in subtler forms. Horizontally, competencies were split between the Ministry of Health and the Ministry of Labour and Social Solidarity, often producing overlap and weak coordination. Vertically, while there were no regional veto players comparable to Spain or Italy, the role of municipalities and provinces in implementing social programs introduced another layer of dispersion. Local authorities were frequently charged with administering services in partnership with non-state actors, particularly the *Misericórdias* and IPSS, creating a *de facto* patchwork of provision. Thus, even in a centralized polity, implementation was territorially uneven, with strong dependence on local institutional and provider capacities.

The three cases demonstrate how both vertical and horizontal fragmentation constrained the development of coherent LTC systems. Vertical decentralization empowered subnational governments as veto players in Spain and Italy, while local-level dependence in Portugal produced territorially uneven outcomes. Horizontally, the coexistence of multiple ministries and

administrative silos created rivalries and coordination failures across the three countries. In all cases, fragmentation acted as a structural brake, making comprehensive reform politically costly and administratively complex.

Actors' vested interests. These institutional *equilibria* were not static legacies but actively defended configurations. In Italy, families, recipients, and associations mobilized to preserve the *Indennità di Accompagnamento*, while regional and municipal authorities had little incentive to push for a national legislative framework in the presence of a national but regionally allocated Fund—the *Fondo per le Non Autosufficienze*—leaving discretion at the national level. In Spain, CC.AA. fiercely guarded their competences, adapting the Dependency Law to local priorities and resisting harmonization. Provider networks entrenched at the regional level also acted as vested interests, slowing adaptation to national standards. In Portugal, the *Misericórdias* and IPSS maintained privileged access to funding and governance, ensuring that reforms reinforced their centrality rather than creating new actors. Similarly, the *Ordem dos Medicos* and actors linked to the Ministry of Health fought to preserve autonomy and discretion in the delivery of geriatric and medical care.

Across the three countries, vested interests transformed institutional legacies into sources of resistance, channeling reforms into incremental layering, selective conversion, or negotiated compromises, acting as a cognitive frame for social and political actors.

Cognitive frames as institutional filters. In Italy, dependency was historically understood as a form of invalidity, a cognitive frame rooted in post-war conditions and in the large number of war veterans and workers with recognized disabilities. The *Indennità di Accompagnamento* not only institutionalized a specific distributive mechanism but also entrenched this understanding in law and administrative practice, reinforcing the notion that frailty should be addressed primarily through monetary compensation rather than service provision. This compensatory logic, widespread in post-war welfare systems, was supported by the mobilization of associations representing disabled individuals and war veterans seeking financial and medical protection. Alongside this framing, a particular conception of the family emerged, positioning households as the main providers of care and consolidating the central role of informal caregiving within the Italian welfare model.

In Spain, the family likewise remained the primary *locus* of care, while decentralization progressively made territorial inequalities more visible. For much of the period, long-term care continued to be framed as a selective and residual form of social assistance. Over time, however, this interpretation gave way to a gradual reframing of dependency as a matter of social rights, culminating in the 2006 Dependency Law. The post-authoritarian democratization process fostered a renewed vision of welfare and expanded debate over the recognition of subjective social rights. This shift was reinforced by the polarization of political competition between the center-right Partido Popular and the center-left PSOE. Such polarization generated a mutually

reinforcing dynamic of powering—through issue politicization and electoral competition—and puzzling, understood as the collective construction and refinement of policy ideas. Together, these processes enabled the formation of a credible exchange between social and political actors, laying the groundwork for comprehensive reform.

In Portugal, intergenerational solidarity and the charitable *ethos* of the *Misericórdias* framed care as both a family responsibility and a civic mission, later hybridized with market-oriented logics as outsourcing and accreditation expanded. As in Italy, a medicalized and hospital-centered narrative prevailed, with policy attention largely focused on strengthening the NHS. These frames were not merely cultural residues but became embedded in institutional arrangements, including eligibility rules, financing structures, and administrative divisions. In this way, cognitive frames shaped reform trajectories by channeling resources toward established solutions and stabilizing coalitions around familiar policy instruments. At the same time, they functioned as institutional filters that reinforced path dependence while offering discursive entry points for incremental and politically affordable innovation.

Opening of a gate. Although institutional legacies often acted as constraints—producing lock-in effects through entrenched constituencies and high fixed costs—they could also operate as enabling devices. On the institutional level, in Spain, the dense network of regional services and allowances developed prior to 2006 not only entrenched territorial disparities but also rendered them politically visible. Precisely because each *Comunidad Autónoma* had developed its own arrangements, inequalities became increasingly salient and were reframed as violations of social rights, generating pressure for a national entitlement. Over time, the strategic position of regional governments evolved. Initially acting as veto players defending their prerogatives, several *Comunidades Autónomas* came to view participation in a national framework as an opportunity to secure additional resources, consolidate their role in welfare provision, and institutionalize their influence within intergovernmental negotiations. In this sense, decentralization functioned simultaneously as a constraint and as an institutional gate.

In Italy, the *Indennità di Accompagnamento* represented a paradigmatic lock-in mechanism, yet its universalistic design and broad legitimacy also provided a normative foundation for incremental innovations, such as the Fondo per le Non Autosufficienze. More recently, institutional resistance appeared to soften in the context of Law 33/2023. The existence of a national framework recognizing a subjective right to long-term care (Law 328/2000), together with earlier debates on essential levels of social benefits in the field of poverty (Law 117/2017), created the conditions for normative and administrative restructuring of the sector. However, this episode should be understood as a *weak precedent*, underscoring how, in the absence of complementary structural conditions—such as credible forms of political exchange—efforts to pursue transformative strategies are unlikely to succeed.

Similarly, in Portugal, the entrenched role of the *Misericórdias* and other non-profit providers (IPSS), while limiting systemic alternatives, offered a pre-existing organizational infrastructure through which the *Rede Nacional de Cuidados Continuados Integrados* could be rapidly expanded. Taken together, these cases show that institutional legacies in Southern Europe were not purely constraining. When strategically activated by political actors, they also functioned as institutional gates, enabling reform pathways within otherwise rigid and path-dependent systems.

Having identified the institutional window that enabled the opening of a reform opportunity, it is nevertheless clear from the empirical chapters that the opening of an institutional gate must be traced back to political dynamics operating on both the supply and demand sides of socio-political mobilization (see onwards). On the supply side, political parties perceive an opportunity to reposition themselves around a social policy issue, drawing on a specific ideational configuration shaped through processes of *puzzling*. On the demand side, the aggregation of representative organisations should be treated as an endogenous variable: it depends on how these actors organise, which alliances they form, and the types of compensations they are able to negotiate.

2.3. Puzzling: Ideational Drivers as Vehicles in Actors' Positioning

Ideational approaches to welfare state transformation highlight how actors discursively construct problems and legitimate solutions. In the field of LTC ideas mattered not only because they offered new interpretative lenses, but because they operated as coalition magnets and vehicles of legitimacy in contexts marked by institutional inertia. Yet, the Southern European cases reveal striking divergences in how such ideas were mobilized.

In Spain, long-term care reform was discursively anchored in a social investment paradigm centred on growth and equity. The *Libro Blanco de la Dependencia* (2004-2005) reframed dependency as a new social risk and explicitly positioned it as the “fourth pillar of the welfare state.” Drawing on European benchmarks and the language of modernisation, the PSOE government under Zapatero successfully portrayed the 2006 Dependency Law as a democratising milestone. The EU social investment paradigm was selectively appropriated to legitimise the reform both as a mechanism of de-familialisation and as a source of employment creation in the care sector (“white jobs”).

This discursive framing proved particularly attractive to trade unions, which were increasingly confronted with a changing electorate and a transforming labour-force base. More broadly, it facilitated the mobilisation of a heterogeneous coalition comprising trade unions advocating female labour market participation and the professionalisation of care, regional governments seeking additional resources and greater autonomy in service provision, and social organisations demanding recognition for caregivers and stronger protections for people with disabilities and dependency. The *Comunidades Autónomas*, initially positioned as veto players, were gradually

transformed into conditional supporters through the promise of enhanced legitimacy, shared ownership of the reform, and more stable funding arrangements.

As discussed earlier, these developments were supported by a growing orientation toward puzzling, largely driven by an intensification of powering. Heightened inter-party competition encouraged actors to reorient policy ideas toward solutions perceived as governable and adaptable within existing institutional contexts—such as established competencies and peer policies—while simultaneously making them more appealing to an evolving electorate. In this sense, politicization and collective problem-solving operated in tandem, reinforcing one another in the lead-up to reform.

Italy diverged sharply from the Spanish trajectory. The decision-making process between 2020 and 2024 produced an unprecedented coexistence of ideas within the Italian welfare state, unfolding across three partially overlapping policy arenas, each advancing a distinct interpretation of long-term care and non-self-sufficiency.

The first arena developed within the Ministry of Health through the Paglia Commission, where non-self-sufficiency was framed primarily as an issue of personal dignity and quality of ageing. Emphasis was placed on proximity-based and home-based care, alongside a critique of institutionalization, particularly residential facilities. Rather than focusing on policy instruments or financial resources, this arena promoted a cultural redefinition of ageing and care.

A second arena emerged within the Ministry of Labour and Social Policies through the Turco Commission. Here, the starting point was the social services system. The Commission focused on service standards, essential levels of social benefits, and the strengthening of local administrative capacity, in continuity with the National Plan for Non-Self-Sufficiency and the framework established by Law 328/2000. The aim was to make public provision more structured and territorially homogeneous, without directly challenging the centrality of cash transfers.

The third arena was represented by the *Patto per un nuovo welfare sulla non autosufficienza*, which articulated a broader and more systemic vision. The *Patto* sought to integrate cash benefits, services, and institutional arrangements within a single framework, explicitly addressing the long-standing fragmentation between social and health care. From this perspective, non-self-sufficiency was conceptualized as a distinct social risk requiring dedicated governance structures and policy instruments, rather than as a marginal extension of existing policies.

Each arena thus advanced a different problem definition. Policy learning did not take place within a unified or consensual framework but emerged through the coexistence, overlap, and occasional tension among competing interpretations. The resulting reform design reflects an aggregation of heterogeneous objectives, held together less by a coherent paradigm than by an exceptional alignment of political and institutional circumstances.

In practice, however, the case shows that the conditions which had enabled a partial convergence of ideas under the Draghi government largely dissipated with the transition to the Meloni government. The return of competitive political dynamics—combined with an increasingly crowded policy agenda and a turnover in ministerial administrative staff who had previously followed the reform—undermined the fragile equilibrium that had supported ideational alignment. As a result, dynamics of convergence gave way to renewed fragmentation. Consequently, the three policy arenas left many of the pre-existing ambiguities unresolved. Under these circumstances, the only viable strategy for the Patto was to invest in technical expertise and evidence-based knowledge, alongside internal coordination efforts aimed at identifying a minimal common denominator: the enactment of Italy’s first long-term care reform and the formal recognition of non-self-sufficiency as a distinct social risk, separate from disability and invalidity.

Finally, in Portugal, for a long time, long-term care had been addressed mainly through family care and charitable provision, especially by the *Misericórdias* and other non-profit organizations (IPSS). Instead of reframing long-term care as a new social right, policymakers in the early 2000s introduced the concept of *cuidados continuados integrados* (integrated long-term care). This approach framed dependency primarily as a problem of coordination between health and social services, rather than as a matter of entitlement. Crucially, the idea of “integration” was intentionally broad and ambiguous. The Socialist Party used it to signal modernization and system reform; the centre-right parties (PSD and CDS) accepted it because it was compatible with subsidiarity and a limited role for the state; left-wing parties (i.e. BE), in turn, interpreted it as a first step toward more universal provision. This ambiguity made it possible to build a wide—though relatively shallow—political consensus.

Thanks to this flexible framing, the RNCCI was created in 2006. Its development followed an incremental logic: instead of radically transforming the welfare system, the reform expanded care provision step by step, embedding new arrangements within existing corporatist and non-profit networks. As a result, the reform consolidated the central role of the non-profit sector rather than replacing it with a fully state-centred model.

The three cases demonstrate that ideas matter not merely because they redefine policy problems, but because they shape the political conditions under which reform becomes possible, governable, and durable. The comparison shows that ideational change is most transformative when it simultaneously performs three functions: it provides a compelling normative justification, operates as a coalition-building device, and offers a credible template for institutional design. Spain represents the clearest case in which these elements aligned, as ideas contributed to the construction of an institutional context in which non-intervention became increasingly costly.

Ideas, however, are not sufficient drivers of policy change in themselves. What ultimately matters is how they are mobilised: how they are framed, strategically deployed to assemble coalitions, and aligned with institutional constraints and political incentives. It is this political use of ideas—

rather than their substantive content alone—that constitutes the central explanatory insight of this thesis.

2.4. Actors' Interest and Strategic Political Exchange in the LTC Sector

While ideational approaches emphasise puzzling and discursive reframing, evidence from the three cases demonstrates that puzzling is always embedded in powering. Coalitions mobilise around strategically activated cleavages and issue linkages, and reform trajectories emerge from negotiated compensations between the supply and demand sides of policy change.

Spain most clearly illustrates the conditions under which a pro-public coalition was able to seize a window of opportunity and reframe long-term care as a universal social right. Led by the PSOE and supported by trade unions (UGT, CC.OO.), advocacy organisations such as CERMI, and progressive regional governments including Andalusia and Catalonia, this coalition linked dependency to broader frames of social investment, employment creation, and work-life balance. Through this discursive strategy, a traditionally low-salience policy domain was transformed into a high-reform-potential arena. The publication of the *Libro Blanco de la Dependencia* and the subsequent *Acuerdo sobre la Dependencia* institutionalised this reframing, providing focal points for a broad reformist front anchored in the symbolic definition of long-term care as the “fourth pillar” of the welfare state. The initial political exchange was set in motion by the PSOE, driven by the need to reposition itself as the agent of social completion following the Partido Popular’s accession to power in 1996. The demand side was then strategically aggregated through *puzzling*, drawing on ideational resources that had already been present since the early 1990s and that were mobilised to structure claims, align actors, and render reform both intelligible and politically actionable.

Yet the reform did not represent a unilateral victory for the universalist coalition. Rather, it materialised through a complex political exchange that reconciled divergent interests across multiple cleavages. Along the territorial cleavage, a pro-family coalition—anchored in the Partido Popular and conservative regional executives—secured extensive regional autonomy through the Consejo Territorial, which institutionalised co-governance and preserved discretion over financing and implementation. Along the state-market cleavage, a pro-market coalition—led by employer associations (CEOE and sectoral business federations) and private providers—obtained guarantees of a pluralistic system of provision and, crucially, the inclusion of an unconditional cash-for-care benefit. Initially conceived as an exceptional instrument, this benefit rapidly became central, particularly in regions with limited-service infrastructures, thereby embedding familist and market logics within the new policy framework.

The resulting settlement was hybrid and layered. While it proclaimed universality and professionalisation, it simultaneously preserved structural reliance on unpaid family care and private provision. Trade unions epitomised the paradox of this exchange. Longstanding advocates

of de-familialisation and the formalisation of care, they ultimately accepted cash benefits and the recognition of informal caregiving as the pragmatic price of consensus, securing in return the historic breakthrough of long-term care as a legally enforceable social right and the inclusion of informal caregivers within the Social Security system.

This trajectory speaks directly to Hypothesis 2. A pro-public coalition at a critical juncture was able to engineer a path departure, but only by embedding rights recognition within a compromise that accommodated entrenched familist and market actors. The Spanish case thus demonstrates that transformative reforms in fragmented welfare states are rarely the outcome of unilateral victories; rather, they emerge from the interplay of discursive innovation and strategic concessions, producing layered institutional hybrids that simultaneously advance—and constrain—the universalist agenda.

Italy illustrates a different configuration of coalition dynamics, where reform did not result from the linear triumph of a pro-public front but from the sequencing of two distinct coalition seasons under shifting political circumstances. The first unfolded under the Draghi government, when the COVID-19 crisis and the EU's Recovery and Resilience Facility created an unprecedented window for reform. Within this context, an unusual advocacy coalition—the *Patto per un Nuovo Welfare per la Non Autosufficienza*—brought together trade unions, third-sector organisations, scientific associations, and providers into a broad, time-limited alliance. By translating fragmented demands into a coherent blueprint centred on universality, integration, and the recognition of caregiving, the Patto raised the political salience of LTC and provided technical inputs that shaped the drafting of the Delegated Law. Complementary arenas such as the Turco Commission (institutional, incremental, constrained by veto players) and the Paglia Commission (normative, proximity-based, weakly institutionalised) reinforced this dynamic, producing overlapping but distinct reform visions. The October 2022 draft law embodied a composite compromise: Technically rigorous, normatively ambitious, but politically ambiguous.

The second season began with the alternation to the Meloni government, which re-politicised LTC reform and fractured the consensus. Law 33/2023 institutionalised a *Sistema Nazionale per la Non Autosufficienza*, a unified assessment system, and the principle of a *Prestazione Universale*, but remained deliberately vague. Parliamentary debates reactivated entrenched cleavages. On the family-state axis, the governing right reaffirmed familist primacy and resisted caregiver rights, while progressive actors advocated de-familialisation. On the state-periphery axis, the government centralised governance through CIPA, sidelining regional co-governance, while opposition parties and regional authorities protested. On the cash-services axis, conservatives and centrists upheld flexible cash transfers, while unions and left parties promoted service-based, community-oriented models. Legislative Decree 29/2024 ultimately diluted earlier ambitions, confirming the persistence of a cash-centred and family-dependent equilibrium.

The contrast between these two coalition seasons is analytically significant. The Draghi phase showed that, under exceptional conditions, a broad but fragile coalition could articulate a reformist agenda and achieve symbolic breakthroughs. The Meloni phase revealed how quickly that alignment dissolved once supranational pressure waned and internal fragmentation resurfaced, leaving reform to be channelled through partisan cleavages and “fiscal prudence”. This trajectory illustrates that in Italy, unlike Spain, a pro-public coalition was able to open the reform agenda but not to sustain a decisive path departure. Reform was continuously reshaped by shifting coalitional logics: First through exceptional, cross-partisan consensus constrained by internal fragmentation; then through partisan polarisation along entrenched ideological and territorial divides. The Italian case shows that the aggregation of demand, in the absence of sustained and coordinated *puzzling* and of genuine politicisation of the issue (issue ownership), is insufficient to generate policy change. Moreover, rather than fostering convergence, this condition reinforces the internal fragmentation of demand.

Portugal represents a distinct equilibrium, consistent with Hypothesis 3: selective expansion. Long-term care reform was articulated through the creation of the Rede Nacional de Cuidados Continuados Integrados (RNCCI) in 2006, which institutionalised “integration,” “continuity,” and “prevention” as its guiding frames. These ideas were promoted primarily by pro-public actors—particularly primary care clinicians, segments of the Ministry of Health, and health administrators—but they did not translate into the recognition of a universal social right. Instead, reform was shaped by the interaction of two structurally entrenched coalitions.

On the pro-market side, hospitals, the Ordem dos Médicos, and the Federação Nacional dos Médicos defended medical primacy and hierarchical authority, ensuring that integration unfolded under hospital- and physician-led governance structures. On the pro-family side, the Misericórdias and Instituições Particulares de Solidariedade Social (IPSS) leveraged their dense organisational presence and historical legitimacy to secure long-term contracts, stable tariffs, and the consolidation of their dominant role in service provision.

The PS majority government after 2005 framed the RNCCI as a managerial innovation compatible with EMU constraints: a mechanism to relieve hospital congestion, strengthen primary care, and signal reform capacity without creating a costly universal pillar. The PSD and CDS-PP accepted this logic through the lenses of fiscal prudence and regulated pluralism, while the BE and CDU—unsuccessfully—advocated a rights-based approach that would have expanded public provision, limited co-payments, and advanced de-familialisation. In this low-salience policy environment, distributive conflict remained largely confined to elite bargaining, and no broad pro-public coalition emerged capable of linking long-term care to gender equality or social citizenship.

The political exchange underpinning Decreto-Lei 101/2006 thus reconciled the particularistic, elite-driven, demands of each coalition. Hospitals and physicians preserved clinical authority and professional prerogatives; NGOs secured recognition as an indispensable partner, accompanied by

long-term financing guarantees; and the government obtained a reform that enhanced coordination and visibility without jeopardising fiscal stability. Families, however, remained the primary providers of care: the *Complemento por Dependência* continued as a residual and selective benefit, and defamilialisation failed to advance.

Across the three cases, three cross-cutting insights emerge.

First, long-term care reforms were shaped less by exogenous functional pressures than by the strategic activation of political cleavages and issue linkages. These frames helped recast long-term care as a politically salient issue. Yet framing alone was insufficient: ideas became consequential only when embedded in coalitions willing to engage in political exchange and mutual concessions.

Second, the *familism of the left* emerges as a recurrent and underexplored theme. Even coalitions formally committed to public provision (PSOE, PD, trade unions) repeatedly accepted compromises that preserved or reinforced family-based care arrangements. Across cases, ideological universalism was consistently moderated by pragmatic familism, revealing the limits of rights-based discourse when confronted with fiscal, electoral, and organizational constraints.

Third, political exchange and compensatory logics are central to explaining reform outcomes. Reforms advanced only insofar as costs and benefits were redistributed across coalition partners. In Spain, universalism was accepted alongside cash allowances and regional discretion; in Italy, institutional architecture was conceded without stable financing and later diluted into experimental measures; in Portugal, integration was conceded without expanding entitlements, thereby preserving clinical and provider interests.

In theoretical terms, these trajectories confirm that ideational approaches are crucial for understanding how long-term care problems are framed and how reform coalitions are mobilised, yet puzzling cannot be analytically separated from powering. Spain and Portugal experienced partial shifts in long-term care governance, largely driven by centre-left parties (PSOE and PS), which acted as reform protagonists by promoting service expansion, integration, and the professionalisation of care. These reforms, however, remain institutionally bounded and fiscally fragile, and were highly sensitive to economic cycles and budgetary constraints.

Italy, by contrast, emerges as laggard cases in the LTC domain. In Italy, the centre-left was frequently internally divided and only intermittently in government, while centre-right actors largely acted as antagonists to structural reforms, resulting in a fragmented and limited development of services and a persistent reliance on cash-based, familist arrangements.

3. Insights for the Southern European Model

This section revisits some of the key insights of the research by applying them to the Southern European model (Ferrera, 1996). Section 3.1 traces post-reform dynamics in Spain and Portugal, while Section 3.2 reflects on the extent to which the Southern European model has been transcended or reshaped through these reforms.

3.1. Application of Mechanisms to Post-Reform Trajectories in Spain and Portugal

Spain's and Portugal's post-2006 trajectories demonstrate that the durability of LTC reforms is not the outcome of functional inevitability, but of their continuous re-embedding within shifting political exchanges shaped by partisan alternation, territorial conflict, and sectoral coalitions. In Spain, the Ley de Dependencia was enacted at a critical juncture marked by a strong pro-public coalition—PSOE in government, supported by UGT, CC.OO., CERMI, and progressive *Comunidades Autónomas*—which strategically activated cleavages to reframe dependency as the “fourth pillar” of the welfare state. Its adoption, however, depended on compensatory bargains: the *Partido Popular* and conservative regions secured autonomy through the *Consejo Territorial*, while employer associations and private providers obtained pluralism and unconditional cash allowances.

The Eurozone crisis and the PP governments (2011-2015) reactivated the particularistic-universalism cleavage. Through decree-laws, benefits were curtailed, user co-payments expanded, and Social Security credits for informal carers abolished, shifting power toward budgetary actors and conservative executives and relegating unions and advocacy groups to a defensive position. With the PSOE's return to government (2015-2019), the balance partially shifted back: caregiver contributions were reinstated, teleassistance expanded, and central transfers increased. Yet these measures unfolded within a decentralised framework that enabled progressive regions to expand provision while allowing conservative ones to slow implementation, thereby reactivating the centralisation-autonomy cleavage. The COVID-19 pandemic constituted another moment of politicisation. Sánchez's left coalition government, supported by *Unidas Podemos* and EU recovery funds, reframed dependency as a matter of dignity and safety, advancing the *Plan de Choque* and the 2024-2030 deinstitutionalisation strategy. Still, these initiatives were again mediated by bargains with pro-market providers and conservative regions resistant to costly structural change.

Portugal followed a parallel but distinct trajectory. The creation of the RNCCI in 2006 was framed by Socialist governments as a modernisation strategy centred on integration, prevention, and continuity of care. Politically, however, it rested on exchanges that preserved medical primacy (hospitals, Ordem dos Médicos, FNAM) and corporatist pluralism (*Misericórdias* and IPSS), while the PSD and CDS accepted the arrangement as fiscally prudent and compatible with subsidiarity.

The initial expansion phase (2006-2012) reflected this compromise, until the Eurozone crisis reactivated fiscal restraint under PSD-led governments and slowed growth.

Subsequent phases extended coverage—into palliative care, paediatric LTC, and mental health—primarily through layering rather than transformation. New services were incorporated under hospital-led governance and non-profit provision, reinforcing existing bargains. The consolidation phase (2018-2022), under alternating Socialist and centre-right governments, incrementally expanded capacity but entrenched territorial asymmetries and reliance on non-profit providers. While COVID-19 reframed LTC in terms of systemic resilience, it left the underlying corporatist settlement intact. The RNCCI 2030 Strategy reflects this duality: discursive renewal linking LTC to European modernisation and digitalisation, alongside continuity in political exchange, with hospitals retaining governance primacy and IPSS/Misericórdias securing long-term contracts under persistent fiscal constraints.

These trajectories show that in both Spain and Portugal the endurance of LTC reforms has depended on partisan alternation and the repeated activation of territorial, fiscal, and state-market cleavages, managed through compensatory bargains with entrenched familist and corporatist actors. Expansionary phases—Spain in 2006 and post-COVID, Portugal in 2006—were possible when progressive governments successfully reframed dependency and assembled broad coalitions through concessions. Retrenchment followed when conservative governments reconfigured these exchanges under austerity, underscoring that LTC reform remains a politically contingent and continuously negotiated settlement rather than a linear path of expansion.

3.2. A Reflection on Southern European Model

A reflection on whether and how the Southern European welfare model is being transcended must engage not only with policy instruments—such as defamilization, de-commodification, work-life balance, and professionalization—but also with the ideational and partisan architectures that continue to structure LTC politics. Ferrera (1996) famously described the Southern model as characterized by strong familialism, fragmented stratification, weak state capacity, and a central reliance on cash transfers. In his recent reassessment (Ferrera, 2025), however, this configuration is reinterpreted through the lens of recalibration and hybridization in the context of Europe's ongoing "polycrisis." While the core features of the Southern model have not disappeared, they have evolved into a more complex and internally differentiated configuration, in which enduring constraints coexist with new opportunities generated by EU-driven convergence, strengthened administrative capacities, and emerging social risks. The Southern model should therefore no longer be understood as a static or deficient regime, but rather as a dynamic family of welfare states whose shared legacies—familial solidarity, segmented labour markets, and partial stateness—continue to shape reform trajectories under pressures such as population ageing, digitalization, and the green transition.

Four reflections follow.

With regard to defamilisation, Spain, Italy, and Portugal all display some movement, but largely within persistent familist boundaries. In Spain, the 2006 Dependency Law was framed by the PSOE and its allies as a new “fourth pillar” of the welfare state, linking long-term care to social rights and gender equality. Conservative actors, however, emphasised family autonomy and fiscal restraint, preserving the central role of cash-for-care benefits and broad regional discretion. In Italy, centre-left actors promoted reforms aimed at service integration and more standardised access, yet consistently avoided challenging the *Indennità di accompagnamento*, the cornerstone of the familist LTC system. Reform was thus framed as support for families rather than as a substitution of family care through public provision. In Portugal, the RNCCI strengthened coordination and continuity of care, but family responsibility remained embedded through the dominant role of IPSS and *Misericórdias* and the absence of a universal entitlement. Overall, defamilisation advanced more at the level of discourse than of institutional change. Across the three cases, familist frames, entrenched policy legacies, and coalitional vetoes limited reform to incremental adjustments rather than structural transformation.

Second, with regard to the decommodification of care, cash transfers remain a central policy instrument in Spain and Italy, and to a lesser extent in Portugal, where a monetary benefit to support care is also introduced through different institutional arrangements. Beyond the general reliance on cash benefits typical of Southern European welfare regimes, in the Spanish case these transfers performed a specifically strategic function. They served on the one hand, to accommodate the preferences of conservative parties and employer organizations and, on the other, to temporarily compensate for the structural shortage of care services. Thus, beyond partisan and ideological considerations, cash transfers functioned as a pragmatic device to sustain a service-poor system and to enhance the overall governability of long-term care policies.

Third, work-life balance entered LTC discourse largely through processes of Europeanization, feminist advocacy, and the diffusion of the social investment paradigm. Left and centre-left actors (PSOE, PD, PS) mobilized this frame to argue that formal services and caregiver recognition were essential to reconcile employment and family responsibilities, particularly for women. Christian-Democratic and liberal actors, by contrast, reframed work-life balance as a matter of flexibility, family choice, and fiscal neutrality, favouring cash allowances, tax incentives, and family-centred rhetoric. Italy exemplifies this tension: while the *Patto* emphasized the liberation of women’s caregiving time as a contribution to gender equality in the labour market, the Meloni government’s 2024 decree diluted structural commitments and reinstated fiscally neutral, family-oriented measures.

Finally, partisan competition and cleavage structures continue to filter the scope and direction of reform. The capacity to generate political conflict around welfare reform—rather than relying on episodic crises alone—emerges as a key mechanism for rendering LTC politically visible and

contestable. In Spain and Portugal, the rise of new left and radical-left actors (such as Podemos and the Bloco de Esquerda) contributed to the polarization of debate and re-centred claims around social rights and welfare expansion. In Italy, by contrast, a comparable dynamic has largely been absent. The lack of sustained partisan competition over LTC has contributed to policy inertia, with no strong political actor consistently advancing an alternative vision of care beyond fragmented or sectoral demands. In this context, civil society organizations have often stepped in to fill the gap between citizens and political institutions, constructing broad, purpose-driven coalitions—such as the Patto per la non autosufficienza and the Alleanza contro la povertà—to compensate for the absence of a clear political entrepreneur. While these coalitions have proven effective in agenda-setting, their capacity to generate durable institutional transformation remains structurally constrained in the absence of sustained partisan conflict.

4. Potential for Inference Over Policies and Countries

The analysis of long-term care reform yields broader insights into the politics of social policy change. Major reforms rarely arise from functional pressures or programmatic design alone. Rather, they emerge through compensatory political exchanges, in which reformist elites expand political space by linking new social risks to resonant normative frames, yet secure enactment only by trading concessions across entrenched political cleavages.

This mechanism is not specific to long-term care. In healthcare, the construction of universal systems required bargains with medical associations and private providers, embedding corporatist delegation within policy frameworks formally centred on social rights. In family policy, the expansion of childcare services and parental leave has typically been accompanied by the preservation of cash benefits or tax allowances, accommodating pro-family constituencies. Across these domains, the decisive “smoking gun” of reform is not the policy blueprint itself, but the political exchange through which costs and benefits are redistributed among families, markets, and public authorities.

Crucially, political cleavages are not mechanically inherited; they are strategically activated. Actors selectively mobilise frames, recombining them into bargains. Welfare politics thus hinges less on fixed partisan preferences than on the capacity of political elites to reframe issues and engineer coalitional settlements. Comparative evidence also clarifies the scope conditions under which compensatory exchange becomes most visible: limited state capacity, multiple veto points, and the presence of entrenched familial, professional, or territorial actors endowed with durable legitimacy.

When extended beyond Southern Europe, the same mechanism is evident across Continental welfare states, albeit calibrated to different power configurations. Germany’s *Pflegeversicherung* (1994) emerged from a bargain between the CDU/CSU, which defended family care and private

insurance, and SPD-union actors, who secured a universal insurance pillar. Austria's *Pflegegeld* (1993) reflected a grand-coalition compromise: Social Democrats obtained a universal entitlement, while Christian Democrats safeguarded subsidiarity and family primacy through cash allowances, entrenching a path-dependent cash-based equilibrium. France's *Allocation personnalisée d'autonomie* (2001) illustrates a territorial bargain, whereby the Jospin government proclaimed a universal right while delegating financing and implementation to *départements*, preserving local discretion and fiscal containment. Variation in outcomes thus reflects differences in coalitional balance rather than differences in the underlying causal mechanism.

This interpretation is further reinforced by counterfactual reasoning. Had Spanish reformers in 2006 insisted on a “pure” universalist design—rejecting unconditional cash benefits and refusing the institutionalisation of territorial co-governance through the *Consejo Territorial*—the reform would almost certainly have failed. Conservative regions would have mobilised vetoes, employer associations would have opposed service monopolisation, and the Partido Popular would have withheld support, resulting either in postponement or in a minimalist outcome resembling Italy's pre-2020 trajectory. Similarly, in Germany, absent the CDU's ability to claim symbolic and distributive gains through the *Pflegegeld* allowance, the SPD's insurance proposal would likely have been blocked as fiscally unsustainable and politically overreaching.

These counterfactuals underscore the core argument of the thesis: path departure in long-term care does not result from the unilateral imposition of universalist reforms, but from reformers' capacity to compensate entrenched actors through selective concessions. Where such exchanges succeed, reform takes the form of hybrid compromise; where they fail, reform stalls or reverts to marginal adjustments. The institutional outcomes observed—bounded universalism in Spain and France, cash-based continuity in Austria and Italy, corporatist integration in Portugal and Germany—are therefore not deviations from an ideal model, but the predictable products of compensatory political exchange operating under distinct power configurations.

5. Future Research and Limitations

This study has sought to disentangle the politics of LTC in Southern Europe by focusing on the interplay between coalitional dynamics, discursive frames, and institutional legacies. While the analysis provides a fine-grained account of how political exchange operated across Spain, Italy, and Portugal, it necessarily faces several limitations that suggest avenues for future research. Here are three main points of discussion.

First, the scope of generalization. Although the core mechanism appears as the smoking gun across Southern Europe and resonates with Continental European experiences (Germany, Austria, France), the explanatory leverage of this framework remains to be systematically tested in other contexts. In particular, the Nordic countries—where de-familization is more advanced and universalistic principles are deeply institutionalized—may reveal different compensatory logics.

Similarly, Eastern European states, characterized by low fiscal capacity and strong reliance on informal care, may rely less on coalition-building among organized actors and more on external conditionalities (e.g., EU funds, demographic pressures). Future comparative research should investigate whether the same mechanisms apply, or whether alternative dynamics predominate.

Second, the level of analysis. The focus here has been primarily on national-level bargaining among parties, unions, employer organizations, provider associations, and civil-society coalitions. Yet much of LTC politics unfolds at subnational and local levels, particularly in decentralized systems such as Spain and Italy, or in corporatist arrangements like Portugal's. Regional executives, municipal governments, and local provider networks often act as crucial veto players or reform enablers. A more systematic multi-level analysis—possibly integrating network analysis or process-tracing of local implementation—would refine our understanding of how vertical and horizontal fragmentation mediates political exchange.

Third, measurement and operationalization. The analysis has highlighted the role of ideational drivers—such as rights-based frames, familist discourses, or social investment paradigms—but measuring their causal weight relative to material interests remains challenging. Process-tracing and elite interviews provide valuable insights, but more systematic discourse analysis, coupled with survey data on public attitudes, could clarify how ideas circulate between elites and mass constituencies. This would also help to explain why LTC, despite its growing social relevance, often remains a “low-salience” policy field compared to pensions, health care, or minimum income.

LIST OF INTERVIEWS

Spain (10/2024 - 05/2025)

Interview No.	Date	Affiliation
ES1	08.10.2024	Academic Expert, Department of Social Policy, University of Barcelona
ES2	16.10.2024	Former Cabinet Member, Ministry of Social Rights
ES3	22.10.2024	Employer Representative, Spanish Confederation of Employers (CEOE)
ES4	24.10.2024	Academic Expert, Institute for Labour Studies, Autonomous University of Barcelona
ES5	25.10.2024	Academic Expert, Autonomous University of Barcelona; Former Regional Legislator, Catalan Parliament (2003-2010)
ES6	04.11.2024	Director, IMSERSO, 2023-present
ES7	05.11.2024	Union Representative, Public Policy Department, Workers' Commissions (CC.OO.)
ES8	05.11.2024	Union Representative, Public Policy Department, Workers' Commissions (CC.OO.)
ES9	06.11.2024	Academic Expert and LTC Consultant, Department of Social Policy, University of Alcalá
ES10	12.11.2024	President, Fundación Pílares; Former President, Spanish Society of Geriatrics and Gerontology (SEGG)
ES11	13.11.2024	President, Spanish Committee of Representatives of People with Disabilities (CERMI)
ES12	19.11.2024	Union Representative, Social Rights Department, General Workers' Union (UGT)
ES13	22.11.2024	LTC Consultant, Association of Directors and Managers of Social Services
ES14	22.11.2024	President, Association of Directors and Managers of Social Services
ES15	22.11.2024	Former Director, IMSERSO (2019-2023)
ES16	05.12.2024	Public Official, Agency for Social Services and Dependency, Regional Government of Andalusia
ES17	14.02.2025	Former PSOE Minister, Ministry of Labour and Social Affairs (2004-2008)
ES18	15.04.2025	Former Director of Cabinet, Ministry of Employment and Social Security (2011-2015); Secretary of State for Employment (2015-2018)
ES19	05.05.2025	Public Official, Directorate General for Social Rights, Regional Government of Asturias

Italy (11/2023 - 01/2025)

Interview No.	Date	Affiliation
IT1	16.11.2023	Expert - Ministerial Commission, Ministry of Labor and Social Policy
IT2	26.11.2023	Expert - Ministerial Commission, Ministry of Health
IT3	15.01.2024	Welfare and Health Secretariat, Democratic Party (PD)
IT4	19.01.2024	Expert - Itinerari Previdenziali
IT5	11.06.2024	Representative, ANASTE
IT6	10.06.2024	Representative, Conference of Regional Health Authorities and Healthcare Management (CARD)
IT7	13.06.2024	Representative, Italian Federation of Pensioners (FNP CGIL)
IT8	14.06.2024	Representative, Alzheimer Uniti
IT9	21.06.2024	Representative, CNA
IT10	21.06.2024	Representative, La Bottega del Possibile
IT11	26.06.2024	Representative, Assindatcolf
IT12	28.06.2024	Representative, Italian Society of Hospital and Community Geriatrics (SIGOT)
IT13	03.07.2024	Representative, Legacoop
IT14	08.07.2024	Representative, ANAP/CUPLA
IT15	08.07.2024	Representative, ANAP/CUPLA
IT16	08.07.2024	Representative, ARIS
IT17	10.07.2024	Representative, Italian Amyotrophic Lateral Sclerosis Association (AISLA)
IT18	12.07.2024	Representative, Diaconia Valdese
IT19	15.07.2024	Representative, FederCentri
IT20	23.07.2024	Representative, UNEBA
IT21	24.07.2024	Representative, Professional Order of Social Workers (CNOAS)
IT22	30.07.2024	Representative, Italian Society of Gerontology and Geriatrics (SIGG)
IT23	31.07.2024	Former Administrative Director, Ministry of Labour and Social Policies
IT24	01.08.2024	Representative, Federsolidarietà
IT25	01.08.2024	Representative, Italian Federation of Mutual Aid Societies (FIMIV)
IT26	01.08.2024	Representative, Italian Federation of Mutual Aid Societies (FIMIV)
IT27	21.08.2024	Representative, Fondazione Promozione Sociale
IT28	18.09.2024	Administrative Director, Ministry of Disabilities
IT29	20.09.2024	Representative, Cittadinanzattiva
IT30	04.10.2024	Expert - Federsanità Toscana

IT31	08.10.2024	Expert - IRCCS INRCA
IT32	09.10.2024	Expert - Fondazione Don Gnocchi
IT33	14.10.2024	Advisor, Office of the Prime Minister (Draghi Government)
IT34	16.10.2024	Expert - ARS
IT35	16.10.2024	Secretary General, Cittadinanzattiva; Former Head of Technical Secretariat, Ministry of Health (Draghi Government)
IT36	23.10.2024	Representative, Italian General Confederation of Labour - Pensioners' Union (SPI CGIL)
IT37	08.11.2024	Expert - Social Services Agency "Ambito 9", Jesi
IT38	23.01.2025	Patto's Coordinator

Portugal (03/2025 - 05/2025)

Interview No.	Date	Affiliation
PT1	14.03.2025	Academic Expert, Centre for Administration and Public Policies, Universidade de Lisboa
PT2	17.03.2025	Academic Expert, Department of Social Work, Universidade de Lisboa
PT3	05.05.2025	Legal Counsel, Integrated Continuing Care Directorate, Santa Casa da Misericórdia de Lisboa
PT4	21.05.2025	Department Coordinator, Cooperativa António Sérgio para a Economia Social

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