**Long-Term Care in Post-Industrial Countries**

Larry Polivka

This chapter addresses long-term care (LTC) systems in the U.S. and Europe for older and younger persons with serious physical or cognitive impairments they need assistance with on a day-to-day basis. This assistance could be provided in their own homes or an out of home residential programs, usually a nursing home or assisted living residence. Here I describe and analyze what I think are the major differences between the selected European programs and the U.S. state programs while noting the considerable variance among the states in the U.S. and the countries in Europe. I also describe the major LTC policy trends in the U.S. and Europe, emphasizing the trends that will most likely deepen the differences in LTC policy and practice between the U.S. and Europe. The major trend in the U.S. is the neoliberalization of publicly supported LTC services through Health Maintenance Organizations (HMOs) administered by ~~through~~ managed (MLTC) programs. As the following section of the paper describes, this trend has accelerated over the last 10 years and distanced LTC programs in the U.S. from European countries with the exception of the U.K. As noted by Clotworthy (Part VI), this does not mean that the countries of Europe have been immune from the encroachment of neoliberal, corporate oriented models of LTC administration and funding.

The chapter is divided into three sections beginning with an overview of the development of community based LTC services across the U.S. and changes over the last several years in the way these services are funded and administered. The second section is a description of current LTC systems across several European countries and what appear the most significant changes over the last decade. The third section is an analysis of how changes in the role of the state in the U.S. and Europe have affected the relationship between the public and private in the

administration of LTC services. This section draws on Wolfgang Streeck's theory of the "Consolidation State" to show how changes in the role of the state have led to neoliberal LTC policies, especially privatization, that are fundamentally changing the character of LTC services in the U.S., and to a much lesser extent so far, in Europe.

**PUBLIC LONG-TERM CARE IN THE U.S.**

Publicly funded LTC services in the U.S. are largely administered at the state level and funded through both state and federally funded Medicaid programs. Medicaid has been available since 1966 and the principle funder of nursing home care since the 1970s.

The Medicaid LTC program consisted of institutional (nursing home) care almost entirely until the mid-1980s when states began to use Home and Community Based Services (HCBS) allowed under a new waiver program established by Congress in 1981. The waiver allowed the states to use funds that would have otherwise gone for nursing home care to fund alternative in-home and community residential services. The HCBS Medicaid program grew slowly from the 1980s through the 1990s and then more rapidly after 2000. The services were largely administered through the non-profit aging services network which had been established under the Older Americans Act of 1966 as part of the Johnson Administration's Great Society initiative to expand the New Deal (Polivka and Zayac 2008).

By 2000, several states had very substantially reduced their dependence on nursing homes for the delivery of LTC through the expansion of Medicaid waiver funded HCBS programs. Within a decade almost half the states were serving over half of their Medicaid LTC beneficiaries in the community leading to a reduction of the nursing home population from 1.6 million in 2000 to 1.4 million by 2010 (Polivka and Zayac 2008). These numbers were clear evidence of the non-profit Aging Network's (AN) capacity to decisively shift LTC from nursing

home domination to a far more balanced and more efficient LTC systems. These systems ~~are~~ increasingly feature in-home and community residential care that elderly and younger disabled persons greatly preferred to nursing home placement (Polivka and Luo 2017). This demonstrated capacity to reduce nursing home use and to serve LTC recipients more cost effectively in the community did not go unnoticed by insurance companies looking to expand their HMO participation in the Medicaid program from an acute care orientation to managed to LTC.

According to Carroll Estes this expansion is now occurring for two major reasons (2014). First corporate insurers and managed care organizations were historically skeptical that Medicaid supported LTC services could be made profitable. Factors included relatively low funding levels, the complicated trajectories of care for people with LTC needs and a lack of potential for achieving increased efficiencies in LTC services and the profits that greater efficiency could generate. This perception, however, changed when it became evident that community based non-profit organizations were successfully diverting impaired persons from nursing homes to less expensive community based programs, which reduced costs and generated savings, some or all of which could be converted to profits under corporate administration of the Medicaid LTC system. The second reason identified by Estes is the emergence of the neoliberal, pro-corporate ideology that emerged in the 1980s and became dominant at both the federal and state government levels by the end of the Clinton Administration. This ideology claimed that by outsourcing pubic programs to the private sector (privatization) governments would be able to take advantage of free markets and light regulation to save money for taxpayers and improve the quality of services in competitive market environments. This ideology has proven durable even in the absence of much documented evidence to support it.

Over 30 years of experience and research findings have demonstrated that the non-profit Aging Network (AN), with its service delivery and case management capacities and comparatively low costs, could build and administer the infrastructure for HCBS programs and create well balanced LTC systems much less dependent on expensive home care. These capacities, which were built over a 30-year period and largely funded through Medicaid waivers, are amply documented in comprehensive and comparative analyses of state LTC systems conducted by AARP between 2011 and 2017 (Reinhard, et. al. 2017).

These reports show that many states have dramatically transformed their LTC systems over the last three decades with the use of Medicaid waiver funds largely administered by non-profit AN's and their non-profit organizations in states across the country. The reports identify the top 10 LTC states by ranking their performance in five sets of criteria covering such measures as access to care, quality of care, costs, etc. All 10 of the top ranked states in 2017 have strong ANs and other non-profit participants in their HCBS systems; none of them are administered by corporate HMO's in managed long-term care (MLTC) systems. In fact, two states (Iowa and Kansas) that were ranked in the top 10 in 2011, fell into the third quintile by 2017 following the implementation of HMO administered MLTC programs after 2012 (Reinhard, et. al 2017).

Documentation, however, of the non-profit sector's ability to create and administer cost effective community based LTC systems has not been sufficient to keep them from being replaced in a growing number of states by HMO administered or MLTC programs. In the absence of supportive empirical evidence, the principle rationale offered by proponents of the corporate MLTC model is essentially ideological. They make the neoliberal case for corporate management of the Medicaid LTC program by claiming that as competing organizations in a free market for publicly funded LTC services, they will be incentivized to achieve the kinds of

efficiencies the non-profit sector cannot, allowing them to cut or at least contain costs and generate profits without undermining access to care or its quality (Polivka and Zayak, 2008). This ideology-based rationale is barely plausible. The non-profit AN organizations in most of the states have administered their Medicaid LTC programs efficiently over the last 25 years as shown in the AARP state LTC reports and it strains credulity to argue that for-profit corporations could provide services in MLTC programs at a lower cost without limiting access and quality of services (Polivka and Luo 2017).

In the three states that have made the most aggressive efforts to change from a non-profit aging network AN administered LTC program to a corporate MLTC program, the results demonstrate the failings of privatization. Florida, which began its MLTC program in 2013, now has over 60,000 people on its wait list for Medicaid LTC services (Polivka-West 2017). Furthermore, evaluations of the Florida program have shown that the program is not reducing costs for Medicaid LTC services compared to the previous AN administered LTC program, which was a major part of the original neoliberal rationale for the programs which claimed that market driven efficiencies would inevitably reduce costs (Polivka-West, 2017). Instead, the HMO's insist that they are underfunded and will need substantial increases to continue participating in the program (Chang 2015).

The HMOs in Iowa and Kansas have made similar claims about inadequate funding. These claims raised the question of whether Medicaid will ever have enough funding to meet the financial demands of the for-profit HMO's. If not, policy makers will be forced to let the HMOs limit access and quality of services in order to ensure profitability and keep the HMOs in the Medicaid LTC program. The HMO's would seem to have an advantage over policy makers in states like Kansas, Iowa and Florida where the AN capacity to run the Medicaid HCBS programs they built before the HMO's were given control, have likely eroded to the point that returning the

program to their administration is not feasible absent an expensive rebuilding effort. This means that these and other states adopting the corporate MLTC model in Medicaid do not have enough political leverage to hold the HMOs accountable for the delivery of cost effective services to enough beneficiaries to keep wait lists from growing as rapidly as they have in Florida. This may not, however, be a politically sustainable situation and public resistance generated by media accounts of denied or poor quality services could force policy makers to pay the HMO's substantially more, further undermining the cost reduction part of the rationale for the corporate MLTC model.

The failure of policy makers in these and other states moving toward corporate Medicaid LTC to anticipate and better prepare for these developments reflects their deep affinity for neoliberal ideology and its application to public policy. It also reflects the power of health care corporations at the Federal and state levels to use the neoliberal ideology to transform the Medicaid program and create profit making opportunities with their managed care programs. This transformation was largely complete in the acute care part of the Medicaid program in most states by 2015 and is now under way in LTC in a growing number of states.

The Trump Administration and the Republican led Congress and policy makers in many states, however, have placed a high priority on cutting or sharply restricting growth in Medicaid. If they are successful in achieving these priorities the budget for Medicaid LTC could be tightened substantially over the next decade putting HMO profitability in the Medicaid programs under growing pressure and increasing the probability that the corporate HMO's will abandon the Medicaid program, especially the LTC part of the program. Such a threat would leave policy makers with a harsh dilemma; either raise Medicaid spending to pay the HMOs what they want or allow the LTC program to deteriorate even as the need for LTC services is set to double in the U.S. over the next 20 years (Polivka and Luo 2017).

For profit HMO's are likely to continue expanding their presence in Medicaid funded LTC programs across the states over the next several years. Does this mean that HMO's are on a path to eventually control public LTC resources in all states? We think a more likely scenario is that several more states will adopt the HMO managed LTC model, but that several others will not or only in some partial, hybrid form. State public LTC programs are likely to become more varied in the future than they are today (Kwak and Polivka 2014). In some states;

- The HMO managed LTC model has clearly taken root and isn't likely to be dislodged. In these states the HMO MLTC infrastructure is established and the AN has either become a limited player in HCBS LTC or was never a major LTC player (Arizona, Texas, Florida and New Mexico).
- In states where the AN has become a well-organized and relatively sophisticated manager of HCBS programs the HMO administered model is not likely to become dominant, or at least not to the extent that HMO's would displace and marginalize AN organizations as major LTC players (Oregon, Washington, Wisconsin, Vermont, Maine , and a few other states).
- In the other states, mixed models of LTC, versions of which already exist in some states, are likely to emerge over the next decade (Massachusetts, Minnesota, and Ohio). These models could provide opportunities for partnerships between corporate HMO's and AN organizations.

**LONG TERM CARE IN EUROPE**

Many European countries have far more extensive and comprehensive systems of LTC services than the U.S. as a whole in terms of total spending. European countries spend 1-4% of

their GDP on publicly supported LTC compared to less than 1% in the U.S (OECD-2017). These higher funding levels have allowed several countries, especially the Scandinavian nations, Germany and France, to develop largely univerisal LTC entitlement programs that provide the kind and level of community LTC services that are available to residents of only a very small number of states with model public LTC systems in the U.S (OECD-2017). Even in these U.S. programs, however, access is limited by means tests that allows only low income citizens with little wealth to receive LTC services (Reaves and Musumeci 2015).

The LTC systems of Europe essentially fall into three clusters of countries (Kroger and Bagnato 2017):

- The northern cluster make up mostly of Scandinavia is characterized by high public spending on LTC, relatively low family responsibility and universialistic programs.
- The central cluster, which is made up of Germany, France, Austria and Belgium, has average spending levels and family responsibility or what is often referred to as familization of care. Germany, France and Spain have implemented substantial universial LTC programs (cash for care of some form) since 1996.
- The southern and eastern clusters (Italy, Spain, Portugal, Poland, CR, Hungary, and Slovenia) have low LTC spending levels, high family responsibility (familization) and residual models of LTC with few if any features of universialism. That is, LTC programs in the southern and eastern clusters of countries tend to be means tested (eligibility determined by financial status) and relatively limited in the kinds and amounts of services available (means-tested and limited scope programs).

The Netherlands and Sweden have administered the most extensive public LTC systems in Europe for several years and spends the greatest share of its GDP on LTC than any other

country (3.7% and 3.2%). Other European countries in the southern and eastern clusters spend far less of their GDP in LTC, usually between .05 and 1.5% (OECD-2017). There is "some" indication of limited convergence in LTC policy and practice across Europe with countries like Sweden moving toward increased reliance on family members for providing LTC assistance and the lower spending countries increasing their spending levels and reducing reliance on families for LTC support (Kroger and Bagnato 2017).

These converging trends may be driven by the large growth in the older population requiring LTC in virtually all European countries and the U.S., which is pushing up spending in the low expenditure countries and raising concerns in the high expenditure countries that they can't afford to spend much more and may need increasing family involvement (familization of care) in providing and paying for services provided to family members (Campbell et. al-2016). The economic crisis and austerity budget policies following the 2008 financial collapse is lending a sense of urgency to all of these concerns. Greater reliance on family members, however, is limited in both the high and low expenditure and familization countries by the declining availability of family and other informal caregivers across Europe—an emerging universal challenge across the developed world (Gori et. al 2016).

Policy convergence across Europe can lead to either progressive reform (more spending for HCBS) or retrenchment (cuts, familization and privatization), depending in large measure on whether austerity budgets continue to hold sway, the extent to which LTC becomes a stronger "social right" and the EU moves toward the Social Europe Model (Fernandes and Rinaldi 2016).

Compared to the U.S., only modest neoliberal market oriented policy trends have emerged in the northern (universial) and central (mixed) cluster LTC programs, mostly in the form of greater consumer choice and competition among providers and growth of for-profit providers. In some countries administration of LTC services has been shifted to local entities

and eligibility criteria tightened. These market oriented policy changes are often justified by the concept of New Public Management (NPM), a neoliberal administrative theory supporting marketization of services and greater consumer choice among services and providers (Pavolini and Ranci 2013).

These expansion, retrenchment and program modification policies have had a varying impact on access to LTC, the quality of working conditions for caregivers and on the extent of reliance on familization of care. In the more universial models, which have more funding to begin with, cost containment is becoming a co-equal priority with meeting rising LTC needs, and a focus of rationing based on assessed need and service targeting, has begun to emerge under the neoliberal rationale of "choice creation." (Ranci and Pavolin 2013).

In the residual model countries (southern/eastern clusters), fiscal pressures from other policy areas (education, pensions, health care) have had a restraining influence on LTC spending and slowed movement toward more universal programs since the economic crisis and austerity budgeting began. Overall, the movement toward universalism has slowed or halted in the residual model countries and some limited retrenchment has occurred in the countries with universial models of LTC (Carrera et. al 2013).

In many European countries the caregiving workforce has grown for several years and work conditions have deteriorated. Worker autonomy, independent judgement and discretion have declined in both universial and residual model countries. A tendency toward the greater uniformity and standardization of work (routinization and quantification of tasks) has emerged. The expansion of home care services creates the potential for familization by the blending of paid home care staff with unpaid family care or care by other informal caregivers (Meagher and Szebehely 2013).

Overall, the conditions of care provision across Europe have become poorer in-countries where the number of underqualified, inadequately supervised and underpaid care workers has grown. In such cases care provision standards are reduced and indifferently monitored and familization of care increases. These trends appear to be much less developed in the northern European countries where workers are still better trained and remunerated them in the U.S., the U.K. and the southern European countries (Greve 2017; Clotworthy Part VI).

Although most of the European countries have implemented some form of neoliberal (privatized) LTC over the last 20 years, few seem to have become as committed as the U.S. has to the for-profit privatization of their publicly funded LTC systems. In fact, the systems generally recognized as the most extensive and effective, such as those in the Scandinavian countries, Germany, France and the Netherlands, have so far kept their public LTC systems largely intact. Germany has a comprehensive system of payments to LTC recipients and their caregivers that is consistent with the neoliberal principle of giving consumers the resources to make their own decision about the kind of care they prefer (Nadash et. al 2018). This program of consumer directed care, however, has not opened the door to significant corporate participation in the German LTC system. (Polivka and Luo 2017). This does not mean, however, that privatization and other neoliberal policy initiatives have not made significant in-roads in several European countries with the most developed public LTC programs. According to Anttonen and Karsio (2017) these in-roads are occurring through marketization which has advanced…

> "through two avenues, outsourcing of services and free choice models. Although the Nordic principle of care as a social right remains more or less untouched, the increasing involvement of for-profit companies in service provision and the expanding free choice model are changing the welfare state ethos. The principles

> of universalism, inclusiveness and equality are threatened by the logics of profit making and free choice. First, the more the access to public care services is dependent on individual choices and resources, whether money or the ability to make rational informed choices, the further the principles of inclusiveness and equality are undermined. Secondly, as private for-profit companies strive for profit in the area of social and health services, the integrity of the welfare state system is compromised. Advocates of marketization argue that profit making and its implications can be regulated by state, but as research shows, this is not always the case, and regulation has many unintended consequences.

The country where neoliberal LTC policies are most comparable to those unfolding in the U.S. is Britain which has been attempting to privatize its LTC services for the past several years (Glendinning-2017; Humber 2017). A major characteristic of this privatization initiative is the extent to which LTC services, both in home and residentially based care, are being financialized at a rapid rate and in the face of deteriorating financial conditions of care providers across the country. Private equity firms and hedge funds now have major stakes in the British social care system as provider firms have used loans and investments to expand their service capacities and, increasingly, to stay in business as their debt burdens grow and both the public and private sources of revenue fail to keep pace (Garside-2017; Freytas-Tamura 2018).

Debt levels in the British residential care sector are very high and the shares of several large residential care firms are officially rated as junk bonds, or sub-investment grade. In 2013 over 700 companies had liabilities worth more than assets. The National Care Association has stated that a quarter of independent sector care providers are at serious risk of being forced out of the market due to their unmanageable debt levels and lack of government funding which will

cause the loss of 40 thousand beds in the independent care market (Freytas-Tamura 2018). Humber notes that;

> "The shortage of available beds in the care sector has a knock-on effect in hospitals which are increasingly having to retain patients who would be discharged if a place in a community setting could be found. This so-called "bed blocking" crisis is an expression of the broader problems in the social care sector, and a direct consequence of the marketization of services. Buyouts, bond issues, refinancing and other corporate and ownership strategies make the residential care sector very difficult for local authorities to monitor or control, even if they wanted to. Left to the anarchy of sector organizations competing for scarce resources and needing to make a profit from them, with their buildings rented from multinational corporate conglomerates beyond the reach of local control, the system bumps along in crisis mode and will continue to do so" (Humber 2017).

The British Government is attempting to address the growing social care crisis caused by a rapidly growing population of people with LTC needs and insufficient public resources to meet them by supporting the development of increasingly larger corporate health care systems with responsibilities for both social and health care services. This policy solution for the failure of the market in social care with a large number of individual providers, is to…

> "Encourage their replacement by a smaller number of much larger ones stretching across the traditional health and social care divide… and to transform -local authorities from provider to purchaser, begun in the 1980s, the final step away

from any notion of democratic accountability for social care provision" (Humber 2017).

Britain is arguably the leading example of how fragile the claims of neoliberal policy advocates have proven to be in practice. Increasingly it appears that the British Government will have to "bail-out" a number of large care home companies who cannot meet their debt payments. This will put increased pressure on the states capacity to meet current care needs with no real plans for how the large increases in the need for such services over the next 10 years will be met. The expanding involvement of investment firms in LTC services in the U.S. could well create the kind of funding and quality issues there that now confront Britain (Rau 2018).

## CORPORATE HEALTH CARE AND THE CONSOLIDATION STATE

The increasing for-profit corporate control of the U.S. health care system described in the following sections, including the huge public programs Medicare and Medicaid, demonstrates the extent to which the political center has shifted to the right over the last 40 years and how much control the U.S. corporate health sector exercises over the Federal Government and many governments at the state level. Health care is now the largest sector of the U.S. economy at over 18% of the GDP (Petty-2014). The sector is set to continue to grow rapidly with the aging of the population, increasing acquisitions and mergers that facilitate the growth of monopoly control, and with advances in the effectiveness of care through science and technology. These trends will enhance the power of corporate health and increase its leverage over health care policy at the Federal and state levels. The blurring of boundaries between the corporate health sector and government has been occurring since the 1980s, but accelerated after the implementation of the Medicare Advantage and the Part D Medicare drug programs in 2006 and then surged with the implementation of the Affordable Care Act (ACA) in 2014 (Geyman 2017).

The neoliberal irony here is that as the Federal health care programs, Medicare and Medicaid, grew at unprecedented rates after 2006, Federal and state government control over these programs declined as the power of corporate health grew. The costs of these programs for the Federal and state governments are increasing faster than any other major parts of their budgets but substantive policy and operational control of them is shifting to the corporate sector. This trend is consistent with what Wolfgang Streeck calls the Hayekian Consolidation State or what might also be referred to as the neoliberal corporate state: a state with the organizing mission to serve the interests of the most powerful corporate actors through privatization, deregulation, shifting taxes from the wealthy to workers and providing corporate bailouts as needed (Streeck 2016).

Streeck's concept of the Hayekian Consolidation State is based on Frederick Hayek's advocacy for a large state role in protecting the interests of capital against public policies favorable to the interests of the larger public. The Consolidation State is designed to serve corporate interests by containing public debt, much of which was generated in recent years by government efforts to bring the financial crisis and the Great Recession under control. This also ensures that taxes on wealthy households and corporate profits are kept low and not increased to reduce deficits and pay for interest on the debt (Streeck 2016).

The Consolidation State increasingly functions less like a sovereign institution and more like a corporate firm. According to Streeck this means that the fundamental mission of the state under neoliberalism is to protect financial markets from democracy rather than the New Deal or social democratic state mission of protecting democracy from the market. This emerged in the U.S. in the 1980s, as an unprecedented experiment involving the massive privatization of programs created to protect individuals against a range of social risks, to provide health care and

education, and to build and administer physical infrastructures. The Consolidation State has become the vehicle for the sweeping commodification of the public sector (Streeck 2016).

As austerity budgets gradually reduce funding for public investments in both the physical and social infrastructures, governments increasingly rely on private sector firms to administer formerly public services.

> "While typically subject to regulation, private providers are likely soon to become powerful players in the political arena where they will ally with the upwardly mobile middle class and its liberal-conservative parties. The evolving connections of the new firms with the government, often taking the form of a revolving-door exchange of personnel, and their campaign contributions will further cement the shift from a redistributive towards a neoliberal state that abandons to civil society and the market its responsibility to provide for social equity and social cohesion (Streeck, 2016)."

The corporate health part of the Consolidation State is not consistent with the kinds of austerity budgets and tax policies that has been constructed by corporate elites to achieve over the past 30 years. Privatization of other services such as education, welfare and housing has almost invariably been associated with stagnant or reduced budgets at the federal and state levels. This has not, however, been the case, as a rule, with health care budgets, especially Medicare and Medicaid both of which have increased steadily and at rates well above the consumer price index (CPI) for decades. These budgets will in all probability increase at an even higher rate for the next several years with corporate health interests exercising even greater fiscal influence than in the past as their role in both programs becomes more dominant.

This neoliberal privatization within an austerity policy regime for health care will be substantially more challenging politically to implement compared to the other policy domains (education, welfare, etc.). But, the magnitude of the gap between demand (costs) and availablea revenues is likely to create an unprecedented fiscal crisis of the state necessitating at least an attempt to implement the "British option;" that is to privatize the programs as fast as possible while reducing funding. This is precisely what the former Speaker of the House Paul Ryan has proposed for the Medicare program by converting it into vouchers to subsidize the purchase of private insurance and for the Medicaid program by converting it into a capped block grant to the states program. The effort to make these changes has been made more urgent by the huge 2017 tax cut legislation, which will increase the deficit by $1.5 trillion over 10 years and by the largest defense budget ($715 billion) in several years.

## CONCLUSION

The health care system in the U.S. has grown enormously over the last several decades and is now the largest industry in the U.S. economy at about 18% of the GDP. This growth has occurred in both the private and public sector of the health care system as corporate health firms and the Medicare, Medicaid and Veterans Administration programs have grown rapidly since 1980.

Even though the public sector programs have more than doubled in costs and persons served over the last 20 years, corporate health firms, mainly a few big insurance companies, have increasingly gained control of these programs through contracts with the federal and state governments to administer about one third of the Medicare program (Medicare Advantage), over 75% of the Medicaid program through HMOs for both acute and long term care and a growing share of the VA health care program (Gordon 2018). The community-based portion of the LTC

Medicaid program had, historically, been administered through the non-profit Aging Network at the state and local levels. This began to change very rapidly, however, 10 years ago when corporate health firms, mainly large insurance companies, began to administer managed LTC programs through HMOs under contracts with a growing number of state governments (Polivka and Luo-2017). The ACA (Obamacare) actually accelerated this shift in the Medicaid program to greater corporate control by encouraging the expansion of contracts with corporate health firms, while simultaneously increasing the population receiving health insurance. This means that very substantial increases in public health care funding have resulted in a significantly more corporate controlled health care system, especially in Long Term Care, than existed before implementation of the ACA in 2014.

These changes in U.S. health care and LTC policy, funding and administration have also contributed to a widening gap between LTC in the U.S. and in most European countries. The extensive for-profit privatization of public LTC in the U.S. over the last decade has diminished the role of the public sector in LTC well beyond the comparatively minor shifts in the European LTC programs toward privatization (marketization) during this period. Policy makers in several European countries have introduced various forms (competitive bidding, consumer choice, more for-profit providers, etc.) of more privatized LTC programs. Yet, no country has contracted out their entire public LTC system to proprietary health care firms with minimal provisions for accountability as several states have done in the U.S. This growing divergence in models of LTC is qualitatively increasing differences between the U.S. and Europe in how policy makers fund and administer programs.

The U.S. has historically had a substantially smaller public LTC System with much lower funding levels than northern and central European countries. This difference in capacity has continued to the present with the U.S. spending far less as a percentage of GDP (.05%) than

many European countries which spend 2% to 3.7% of GDP. This longstanding difference in LTC funding is now just one major difference among others as the U.S. has moved rapidly in recent years toward full scale privatization through corporate administration of LTC programs and private equity investments in LTC programs. The U.K. is the only European country that has matched the U.S. in its efforts to privatize its LTC programs.

These trends in the direction of greater corporate control of public LTC systems in the U.S. and the U.K., are consistent with Wolfgang Streeck's concept of the Consolidation State in the neoliberal political economies of the U.S. and most European countries. This is designed to serve the interests of capital, especially finance capital by implementing austerity budgets, maintaining a regime of low taxes on wealth, prioritizing the financing of state deficits and debt and privatizing as many profitable public services and assets as possible. The mission of the Consolidation State is to protect capital from the democratically determined interests of the public rather than protecting the public and democracy from capital.

As the Consolidation State tightens its grip on the entire public sector, the precarity of later life is likely to grow as the already extensive privatization of health and long term care services is expanded and the original purpose to serve the sick and frail as effectively as possible is threatened by the pursuit of corporate profits through commodification of the need for care. Other functions of the Consolidation State, such as austerity budgets and cuts in regulations are also threatening the well-being of the elderly and increasing their exposure to a precarious late life.

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