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Closing the Gap – in search of ways to deal with expanding care needs and limited resources

Short Report

On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Closing the Gap – in search of ways to deal with expanding care needs and limited resources

Held in Stockholm on 20-21 October 2011, the Peer Review was hosted by the Swedish Ministry of Health and Social Affairs. In addition to the host country, seven peer countries were represented: Bulgaria, Cyprus, Denmark, Estonia, Germany, Luxembourg and Slovenia. Represented as stakeholders were Caritas Europa and AGE Platform Europe. Taking part for the European Commission were representatives of DG Employment, Social Affairs and Inclusion.

1. The policy under review

More than 18% of the Swedish population, or about 1.7m people, are aged 65 or above. The number of those aged over 80 is projected to double between 2010 and 2060. While the health of older people has not improved in Sweden over the past 15 years, demand for help has actually decreased. This is probably due to better housing standards and improved access to assistive technology. Over the next ten years, the increase in demand for care will be quite modest, as many pensioners will still be in the 65-70 age group. Care needs will rise more rapidly after that, as the number of those aged 80 and above increases.

Elderly care at the municipal level cost SEK 88bn (about EUR 9.6bn) in 2008, mainly funded by municipal taxes. About 4% of the costs are financed by charges. Per person, care in special accommodation is almost twice as costly as care in ordinary housing. However, more than 94% of elderly people in Sweden live in their own homes, either with or without home help. If county-level provisions (hospital and outpatient services) are included, the total cost of elderly care in Sweden doubles to about SEK 160bn (EUR 17.4bn). By 2050, elderly care costs are expected to rise by around 70% and health care costs by 30%. A shortage of around 65,000 full-time equivalent staff is expected in Sweden's care services by 2030.

Sweden intends to continue providing good-quality, universally available elderly care. In view of the demographic pressures, some additional measures will need to be taken, while others that have proved their worth will be continued:

- **Longer working lives** will help to strengthen the financing of the welfare system. Young people should, in practice, enter the labour market earlier and fewer people should leave it prematurely. There are already signs of a trend towards later retirement. The average age at which people retire in Sweden (if they are in the workforce at the age of 50) was estimated at 63.2 in 2009 – the highest since the early 1980s.

- The Swedish government is to launch an **initiative for active and healthy ageing.** The National Institute of Public Health will produce a guidance document for local authority and NGO cooperation on health promotion activities. Health coaches will help individuals with minor health problems to adopt healthier lifestyles.

- **Improved access** for older people can help to contain care costs and make it easier for them to continue living in their own homes. **Housing adaptation allowances** are provided by the municipalities to improve the accessibility of people's homes (about 75,000 grants in 2008, costing SEK 959m – EUR 104m). Modern **assistive devices** are being strongly promoted. Introduced in the early 1980s, the multifunctional **wheeled walker** is currently used by some 250,000 people. Sweden's **Technology for the Elderly programme** is supporting more than

130 different projects in the period 2007-2012, at a cost of SEK 22m (EUR 2.4m) per year. New technologies currently being introduced include a **digital social alarm,** a **mobile alarm with built-in GPS location, locks that carers can open with their mobile phones,** an **automatic pill dispenser** and various **domotics** applications to make living at home safer and easier. The **Giraff,** an Internet-linked communications centre on motorised wheels, is now being installed in the homes of interested older people. It enables frequent virtual visits by family, friends and carers.

- A **tax credit for household services** was introduced in 2007. In effect, this means that the end-user pays only 50% of the cost of home helps and other services. This has made household services available to a wider range of users. In the first half of 2011, more than 11,000 firms were providing home-based services to 257,000 people.
- The Swedish government is financing a four-year education initiative to **improve competences among care staff** who lack formal qualifications. The aim is both to raise the basic level of competence and to meet the demand for more specialised skills.
- **Ethical principles** that must permeate all elderly care, by both public and private providers, were built into Sweden's Social Services Act in January 2011. They emphasise privacy and physical integrity, autonomy, individualised services and participation, quality services and respectful treatment.
- **Open comparisons and public performance reports** on health care and social services are being developed. The aim is to promote local and national discussions on quality and efficiency through peer pressure, greater transparency and political accountability. Two **quality registers** for elderly care contain a number of indicators, e.g. on fall injuries, care-related infections, malnutrition and experiences of pain. To motivate care providers to register, the government has introduced a **performance-based grant system.**
- Sweden's **eHealth strategy** includes the efficient and effective use of **ICT** in elderly care.

2. Key issues and lessons learned

The discussions during the meeting focussed on **efficiency enhancement** within the current care systems in EU Member States, particularly through **prevention strategies, evaluation** and **data collection**, as well as on **workforce development and support, stakeholders' contribution** to the care system and **technological support** for the elderly**.**

A number of **key lessons** emerged from the discussions:

- Micro-simulations based on administrative data - as in the Swedish case - can allow Member States to estimate the probable size of the future care gap. Such scenario building would also allow policy makers to test the relative importance of functionally alternative strategies to reduce or close the gap.
- The Swedes found that no single instrument is capable of closing the gap and that alternative financing forms hold out particularly limited prospects. But they noted that closing the gap would be perfectly possible provided there is a combined effect of smaller but systematic improvements in productivity (both capital substitution and better organisation), efficiency, healthy ageing, the recruitment, retention and training of carers, the ability of frail

older people to manage their disabilities well enough to live independent lives thanks to assistive technologies etc. (see end of LEV project report[1] for full list of variables).

- A clear **order of preferences** is needed when choosing possible ways of closing the gap between future care needs and scarce resources:
  - Efforts should first be made to **improve the efficacy of existing systems.** There is still some slack within them, due for instance to historical work organisation, or insufficient use of technical equipment and ICT.
  - At the same time, efforts should be made to **reduce the demand for services** through **increased prevention and health promotion** efforts.
  - **Modern support techniques** should be utilised more fully in order to improve the **self-sufficiency of older people** in need of care.
  - Only then should we think about **increasing public expenditure on long-term care.**
  - Only as a last resort should we think about **cutting services** or **increasing user charges.**
- **Preventive measures** are urgently needed to reduce the incidence of diseases, which otherwise are predicted to become the major challenge in health care costs. There are currently only a few **prevention implementation studies** to guide selection of the most efficient way to reduce risk factors. Prevention needs to be implemented at different stages of life, depending on current health profiles of the different age groups in the existing population. Focus on pathologies must be designed accordingly. However, it is absolutely clear that, in order to be fully efficient, prevention plans should **start in middle age** in order to encompass the major groups at risk. It is also essential to act on relevant risk factors (diabetes, hypertension, obesity, etc.) to avoid further deterioration of health status and corresponding long-term care needs. It should be borne in mind that **prevention also generates costs.**
- We have only a small window of opportunity before the **demographic effects** of ageing are fully felt. So we need to **collect more evidence now** and **disseminate** the results on a very broad basis.
- **Developing and supporting age-friendly environments** is also an important point to underline, not only to limit or avoid possible costs but also to improve full integration of elderly people into society.
- The **cost-efficiency dimension** of existing projects (especially local and community-based) and also **technologies that meet long-term care needs** should be brought forward as a support for decision-making. "Efficiency" can be understood primarily as the reduction of specific pathologic episodes or prevalence, in connection with a specific technique or strategy. Low-cost techniques or strategies could be promoted more specifically, in a context of budget crisis.

[1] The future need for care: Results from the LEV project, Government Offices of Sweden, 2010: http://www.sweden.gov.se/content/1/c6/15/36/57/d30b0968.pdf

- **Possible resources** of which more use could be made in elderly care:
  - The **supply of formal and informal carers** could be significantly enlarged through older people's involvement in care work, which could be made into one major form of **Active Ageing.**
  - The role of **voluntary work** is important at a time when a large share of the 65+ population is still healthy. With public support and maybe some training, many more resourceful people 65+ could be enticed to help older and frailer elderly people on a voluntary basis.
  - Some retirees (especially women) struggle with low pension levels and could use an extra source of income. Perhaps, with some training, a significant share of resourceful people in this group could be **incorporated into the waged care workforce. More flexible arrangements for combining other income with pension** as well as **for part-time work** would be required since few people above pensionable age could be expected to work a 40-hour week.
  - **Healthy and Active Ageing** could help to **contain the need for care**. Participatory involvement is likely impact positively on mental and physical health. Public health initiatives focussed on nutrition, physical exercise and mental stimulation – aimed specifically at retirees as they age – can be helpful.
  - **Patients as providers** are a further potential resource. More modern techniques should be used to make use of patients' own capacities to tackle their care needs and manage autonomous lives amid frailties and some disabilities. This also involves **empowering patients** wherever possible. If people – such as diabetics - get used to the idea of tackling some of their care needs themselves at a younger age, it will be easier to continue later on.
  - Obviously, the relevance of these approaches will vary from one country to another.
- A **change of mindset** towards elderly care will be needed, involving a **holistic approach**. Rather than being seen as a burden, it should be recognised that older people represent a **wealth of experience and potential resources** that should be put to good use. In that respect, ongoing experiences and projects focusing on intra-generational (i.e. between elderly people) and inter-generational solidarity (i.e. between elderly people and other age groups) should be supported and presented to demonstrate the benefits that society can gain from elderly people's commitment.
- If with gains in life expectancy the age corresponding to the notions of "old" and "retirement-age" became defined by distance from death (average life expectancy) instead of from birth (chronological age) we could better understand how old age is being redefined by the rising average age of the population in this and coming decades.
- There is a **need to raise the prestige of the caring profession** as a whole. This could, furthermore, also help to attract more men into this profession.
- **Education** is vital to the **quality of care.** However, there are still **inconsistencies between the content of education for care work and the demands made of employees** in everyday work situations. Continuing education and career development are incentives for **staff retention.** There are also strong indications that education helps to **contain costs.**

- Countries have to strike a **balance between national consistency and local responsibility for provision**. The right level of government for financing, organising, planning and providing services is still an issue in several Member States.
- **Rising expectations** may pose even greater challenges, in the form of increased demands for services, than might be supposed from the demographic or health-related needs per se.
- Governments must be **transparent and honest** with the public about this issue. They must make it clear what can be achieved in future and what (probably) cannot. They must also state what the costs will be.

3. Contribution of the Peer Review to the objectives of the Europe 2020 Strategy

- **Preparing for population ageing** is seen as one of the challenging issues in the Europe 2020 strategy. The challenge will be to implement those reforms of retirement and pension practices and of health and long-term care systems that are necessary to avoid the risk that changing demographic dependency rates will affect economic dependency rates so much that this will destabilise public finances and seriously undermine the potential for economic growth.
- Member States' **ability to close the gap** between expanding needs and limited or declining resources in long-term care forms an important part of their capability to **respond adequately to the challenge from ageing**, in particular the rapid growth of the oldest cohorts in the population.
- Finding ways to close the gap is an important part of adapting European societies to the **opportunities of new demographics** including the changes in needs and the composition of demand for goods and services which will form the basis for future economic activity.
- Thus, the long-term care gap issue has links to **four of the five Europe 2020 targets** (75% employment rate, 3% investment in R&D, reducing the percentage of the cohort without education and training, reducing people at risk of poverty and social exclusion) and **six of the seven flagship initiatives**.
- In terms of the need for **research and product development** it links to the 'Innovation Union', the 'Digital agenda for Europe' and the 'Industrial policy for the globalisation era'. In terms of **employment, skills and social inclusion** it links to the 'Agenda for New Skills and Jobs', 'Youth on the move' and the 'European platform against poverty'.
- The Innovation Union **European Innovation Pilot (EIP) on Active and Healthy Ageing** is of high relevance for the development of LTC need gap closing capabilities of Member States. The combined focus on prevention and strategies to raise the effectiveness and efficiency of caring systems through improvements and deployment of innovative organisation and assistive technologies puts this squarely at the centre of gap closing efforts. One challenge for this EIP is to get the balance right so that prevention and support for autonomous living receives sufficient attention and enough resources compared to care therapies.
- The EU's Europe 2020 strategy for growth does not contain a specific section on **social protection**. However, this issue is indirectly covered by the strategy's strong commitment to

reducing poverty. Amongst other things, this means both that elderly care should not give rise to poverty and that poverty should not exclude anyone from care.

- Long-term care reform can help to **reduce poverty risks.** Becoming dependent on long-term care is a major poverty risk if co-payments or user charges are involved, as is the case in many EU countries. If the focus is on keeping older people in a position to manage their own lives, this poverty trap can be reduced. This entails effective **prevention strategies** and appropriate **means of support.**

- Closing the gap in long-term care also connects in important ways with the **employment target**. Women, notably those of middle age, are particularly subject to underemployment in many Member States. Long-term care can be seen as a **job motor** which could provide a considerable share of the un- and semiskilled jobs we will need in the future. This could be particularly useful for groups of special concern in the labour market context such as early school leavers and drop-outs from training. For **young people,** work in long-term care could be a low threshold way of entering the job market. It might also provide employment opportunities for **middle-aged** and **older people** who currently have difficulty in finding jobs – especially those with low levels of education or outdated qualifications. But if long-term care is to function effectively as a job motor, **easy access to training** will be required. Some **reorganisation of care work** may also be needed in order to match a **particular skills mix**, encompassing both highly qualified carers and those with lower skills levels.