Peer Review
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2011

Closing the Gap — in Search for Ways to Deal with Expanding Care Needs and Limited Resources

Stockholm , 20 - 21 October 2011

Synthesis Report

European Commission

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Stockholm , 20 — 21 October 2011

Synthesis Report

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Executive summary

This paper summarises findings of a Peer Review held in Stockholm on 20–21 October 2011, 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. The stakeholders represented were Caritas Europa and AGE Platform Europe. Taking part for the European Commission were officials from DG Employment, Social Affairs and Inclusion.

Increasing shares of older people and changing societal models and labour markets will result in a considerable gap between the demand for, and supply of, health and social care for the elderly unless major changes in the care system can be achieved. On the demand side, the Swedish approach to closing this gap builds on prevention, measures to increase self-sufficiency and reduce functional dependency. The supply side is to be strengthened by the development and support of the work force, as well as support for informal carers. Increased efforts in data collection, evaluation, and broader use of technological solutions, including those based on ICT are expected to increase efficiency and the quality of service provision. The discussions at the Peer Review supported this approach and highlighted the importance of a renewed mind-set which embraces a more holistic approach. Estimates for Sweden suggest that bridging the forecast gap in the provision of long-term care and financing could play a part in achieving four of the five Europe 2020 targets (75% employment rate, 3% investment in R&D, reduced share of early school leavers and reducing people at risk of poverty and social exclusion).

A. Policy context at the European level

Currently, **no common European model** for provision or financing of long-term care (LTC) is identifiable. At the national level, there are differences in the importance of informal care and support for this, the shares of public as against private finance and provision of care, the role of cash benefits as opposed to benefits in kind, and different degrees of generosity and accessibility of care systems. National systems with similar characteristics can be grouped according to the main variables chosen and the scope of the systems under consideration, (see e.g. Kraus et al. 2010, Esping-Andersen 1990). There are, however, some common **challenges** that all care systems for the elderly in Europe will face during the coming decades.

The European population is **ageing**, albeit to differing degrees in different Member States. The European Commission estimates the share of public spending for LTC in GDP will increase from 1.2% (EU27, 2007) to 2.4% (2060, reference scenario; see European Commission 2009). A number of changes in societal models, such as declining family size, changing residential patterns and increasing female participation in the labour market will affect possibilities for informal care provision, while later generations might approach services with higher expectations regarding service levels and quality. Currently, 1–2% of the total workforce is employed in LTC in developed countries. Existing projections for European countries suggest that this share will increase considerably during the next half century, with limits on its expansion coming from the supply rather than the demand side. Without effective counter measures, these developments will create a gap in care provision. This calls for efficient strategies to delay the need for care while increasing the workforce and its productivity.

Care for older people is highly **labour** intensive. In most countries it is characterised as low-paid, low-status but very demanding work. There is wide dispersion of wages and working conditions both between and within countries, e.g. between the public and the private sector or between home care and nursing home care. Consequently, work in elderly care in many countries is subject to high turnover rates and/or recruitment problems (Simonazzi 2009, Fujisawa, Colombo 2009, OECD 2011).

In many European countries the workforce in this sector is predominantly female, older than the average and with larger shares of low-skilled, foreign-born, and part-time workers than in other sectors. Additionally, in several countries migrant workers with uncertain economic and legal prospects, working mostly as domestic help make up a considerable number of care workers (Simonazzi 2009, Fujisawa, Colombo 2009, Geerts 2011).

Three strategies to secure the availability of future LTC workers emerge from the literature (OECD 2011):

1. improve recruitment efforts from new as well as traditional pools;
2. increase the retention of successfully recruited LTC workers, by improving wages levels and working conditions in the care sector;
3. look for ways of increasing the productivity of care workers.

According to economic theory five **financing models** for LTC systems can be outlined (Wittenberg et al. 2002, Fernandez et al 2009). First, there are private systems with or without government subsidies, but these place considerable financial burdens on individual care recipients and their families and show a tendency for unmet need to arise; they are usually not considered to reach the standards aspired to by European social policy. Of the remaining options, simply the provision of a safety net can place a large financial burden on the population and requires considerable administrative effort to steer resources to those with the greatest need in order to limit the demand on public budgets. The expenditure entailed by universal funding systems is usually higher than that of safety net systems, largely due to defined entitlements. Universal funding systems cover the entire population and should foster equality and social cohesion, ensuring that everyone who meets the needs criteria can access services regardless of their income or wealth. Funding is typically progressive and relies on a combination of earmarked contributions and payroll taxes. Often user charges play a role with certain services. In social insurance systems of this type, total expenditure is typically needs driven rather than budget constrained, while tax-funded systems can impose constraints on expenditure and eligibility criteria more easily. Progressive universal funding systems are attempts to combine advantages of both types. Entitlement, therefore, covers the entire

population, but means-testing ensures that individuals in the most financial need receive the largest amount of public support, so reducing demands on public expenditure. The effects on social cohesion are greater and the stigma effects less than in the case of safety net systems.

B. The situation in Sweden

Sweden is currently among the Member States with the largest share of population of 80 or more. Projections show that in the next 30 years, the highest growth in population in Sweden will occur among people aged 65 and over. In international comparisons the Swedish LTC system stands out as being very generous and as providing a high level of formal care which is financed primarily by public rather than private money. There is an increasing role of informal care, with considerable support for informal carers.

Over the past 15 years, Sweden has experienced a fall in the need for help among the older population while the incidence of health problems has increased; it is therefore unlikely that the declining need for help can be explained by improving health. The more likely explanation is that better housing standards and better access to assistive technology have made it easier for people to manage without help.

A key way of reducing the demands for care is by improving the possibilities for the elderly to stay living in their own home, which can be fostered by introducing **intelligent and user-friendly technical support**. The Swedish view is that LTC is a very promising area for efficiency-enhancing technologies. Over a period of six years, the Swedish Government has supported the development of products and services which can assist older people and their carers in their everyday lives. The initiative will continue until 2012 and supports 130 projects in the period 2007–2012. The programme builds upon a "24-hour perspective" which aims at keeping people independent in as many everyday functions as possible for as long as possible. A special focus is placed on designs which take account of the special requirements which many older people have (e.g. diminished eyesight).

A **tax credit for household services** is also designed to help the elderly stay in their own homes. The tax credit makes household services up to 50% cheaper. It is most commonly taken up by women aged 85 and over.

Demographic and medico-economic models identify leverage effects, and a reduction in morbidity should be a major objective of policy-makers (see LEV Project).

The Swedish Government has decided on an initiative for **active and healthy ageing**. Local authorities are encouraged to cooperate with NGOs to undertake health promotion activities. In addition, health coaches are intended to support individuals with minor health problems to adopt a healthier lifestyle.

As elderly care is highly labour intensive, skills and good organisation as well as good practice in caring are critical for efficient and high quality care. The present shift towards more private home-based care provision changes the demands placed on staff working in this setting. The Swedish Government is therefore financing a four-year **education initiative** to improve the competence of staff without formal education. There are national criteria for the content which courses need to include. Municipalities are incentivised to procure education courses through a bonus scheme.

New legislation in 2011 established the tenets of elderly care by stipulating **national core values** for the dignified care of the elderly; this initiative applies to both public and private providers. According to the national core values, elderly care shall promote participation, the feeling of well-being and choice. The Act on **Free Choice** Systems, introduced in 2009, aims at facilitating market entry for private providers and therefore at encouraging competition based on quality. It is up to municipalities to introduce choice into the system; a third of people receiving home help already live in a municipality where this is the case.

The National Board of Health and Welfare cooperates with municipalities and county councils to develop **open comparison** and public performance reports on health care and social services. Surveys of service providers and users together with official statistics are used to build a wide range of indicators of quality which can be used to illustrate how municipalities and county councils are performing in different aspects. This provides useful information for prospective service users as well as for politicians seeking to improve the quality of local services and it can raise the awareness of staff about quality of care. Additionally, two **quality registers** for elderly care have been developed building on modern IT solutions and enabling participating providers to compare their own results over time and with those of others. But for the time being, registers concentrate more on health care indicators

than on social care. The introduction of a performance-based grant system has increased the input to registers dramatically and improved the coverage and quality of data. The next step is to promote the use of the registers for local improvements in quality by strengthening analytical capacity at the local level.

In cooperation with stakeholders, the Swedish government has drawn up an **eHealth strategy** to ensure efficient and effective use of information and communication technology (ICT) in order to promote safer, more accessible and efficient health and elderly care services. Development of a common approach and nationally established guidelines and solutions are necessary and call for collaboration of all actors in the health and care sector.

C. Policies and experience in peer countries and stakeholder contributions

In compliance with the Europe 2020 strategy, the **Bulgarian** government adopted a National Reform Programme (2011–2015) in 2011, translating European targets into national targets tailored to Bulgarian challenges. This programme includes the sub-target of reducing the number of people aged 65 and over and at risk of poverty by 52,000. This is to be achieved through a combination of measures: developing a national concept for active life, the creation of a network of LTC services, and reform to increase the adequacy of pensions. Bulgarian activities to protect public health follow three general approaches: educating and informing the people, combating diseases, and health protection. A noteworthy national prevention programme aims at limiting osteoporosis (2006–2010). The programme includes changes in reimbursement rates of the national health insurance fund, training programmes for densitometry staff along with a random community screening of 2500 Bulgarian women, and an epidemiological survey (of 2000 women) to investigate the prevalence of disease and risk factors among women of 50 and over. Currently, a second national programme against osteoporosis as well as a national concept for active ageing is in preparation. The Bulgarian Red-Cross in cooperation with relevant ministries have started to implement a project called "Home care towards independent and dignified life" (October 2011–March 2015), which is one of the measures aimed at improving quality and developing a home care sector.

A scheme to improve the quality and effectiveness of social work is currently being implemented. It builds, among other things, on improved cooperation and interaction between institutions as well as vocational training and the upgrading of personal qualifications and skills. With respect to informal care, a recent scheme enables an unemployed family member to work, after training, as a personal or social assistant to another member of the family with disabilities for a minimal payment (including social insurance contributions). Part of the scheme also enables non-relatives to act as carers. The Bulgarian long-term care system is in the process of being refocused from mainly institutional to more community and home-based as more services of the latter kind are introduced. The number of private

providers has gradually increased. Moreover, better cooperation between health and social services has been identified as one of the priority areas for the next few years. Decentralisation of financing accompanied by the introduction of some unified standards is aimed at increasing the provision of services by the private sector, so increasing quality and choice for clients.

In **Cyprus**, elderly care is provided by public as well as private institutions, but is concentrated more on therapy than on prevention. In 2004, the Council of Ministers took the decision to develop and implement a 10 -year Action Plan for the development of health care services for the elderly. Five priority areas, including health promotion and prevention, were chosen, but since 2005 there has been only a partial implementation of the plan. Due to the economic crisis, revisions, the selection of different priorities (e.g. use of e-Health and more targeted approach) and consequently a reallocation of resources are under way. In order to foster care provision at home, there is continuous development and investment in community nursing. Training of employees in the private sector, however, is not organised on a regular basis. There is no public provision of short-term care or aftercare.

The system in **Denmark** has a number of characteristics in common with the Swedish system, with home care being at the core of elderly care. Municipalities are obliged to offer personal care and assistance, but also support for necessary practical work in the home, regardless of the recipient's type of accommodation. User charges can be applied only to users of temporary home-care, with the charge per hour depending on income. Since 2003, there has had to be a choice offered between public and private provision of home-care services. In contrast to Sweden, Danish municipalities are obliged to establish arrangements to make this choice effective.

In recent years, several projects have focused on enhancing the monitoring of the quality of services. Elderly care was chosen as the first focus area for a project to improve, simplify and secure more coherent documentation on central areas of public service, initiated by the Danish Government and the association of Danish municipalities. Since 2008, this monthly data collection has covered 7 indicators of effects and 16 background indicators on elderly care. The initiators of this project are also responsible for an annual national

survey of satisfaction among recipients of help, covering satisfaction with the quality of services, with carers and with the stability of help. Additionally, municipalities need to employ such surveys systematically in their management and development and are encouraged to publish results. The tools to carry out comparable surveys have been developed and tested and are available to be used by municipalities. Moreover, a national system of means of monitoring quality in elderly care has been developed.

Preventative and health-promoting efforts are made at both national and local levels. 90% of Danish municipalities offer training as an alternative to conventional, more compensatory home-care services in line with a focus on rehabilitation. One of the best known models is the ambient assisted living programme in Fredericia municipality, which focuses on everyday rehabilitation and reports positive outcomes for participants as well as public finances. The two main initiatives to increase the productivity of the workforce concerned are flexible task performance and task relocation between health and elderly care and a focus on welfare technology. The latter programme covers all public services (not only social services) and was allocated EUR 400 million (DKK 3 billion) for the 2009–2015 period. Ten demonstration projects in respect of elderly care have been funded; tests and evaluations in cooperation with the National Board of Social Services focus on the impact on services and the working environment but also on productivity and economic benefits.

As in several other EU12 Member States, in **Estonia** the care system for the elderly is divided between social care (care homes, home care services, and day care centres) which is financed by local governments, and health care (including home and inpatient nursing care, and geriatric care) which is financed by the national insurance fund. In addition to low service and capacity levels overall, differences in the financial capacity of local governments, the lack of integration between the two sectors and the absence of a standardised needs assessment framework are seen as problems. Expected increases in life expectancy, and consequently in the relative number of older people, will presumably aggravate these problems. Current discussions are centred on whether or not the local government should remain responsible for financing, organising and providing these services. As many municipalities

have small populations, some local governments do not offer all the services which, in theory, they are legally obliged to supply. It seems that the scarcity of (human) capacity and not so much the provision of appropriate training is seen as the main challenge, even though better and standardised systems for assessing needs and services remain on the agenda.

German long-term care insurance is a "pay-as-you-go" system and is almost entirely financed by contributions and premiums. For the public part, uniform contributions of 1.95% of wages (2.2% for those without children) are charged, subject to an income ceiling. The entire population is covered but persons with high income may opt into the private system. Three levels of need for care are defined which then determine the level of benefits granted. Benefits are therefore independent of age, income or wealth. All insurance benefits are capped, the aim being to provide coverage for basic LTC needs, but not all LTC expenses. The basic principle governing LTC insurance is "rehabilitation before care giving, care giving at home before institutional care". This principle is understood as the preventative approach. Given the fact that the overall population is already declining while the share of older people is rising, Germany has already started to gain experience with practices of attracting and retaining LTC workers such as recruitment from specific target groups and measures to improve job status. The latter includes a variety of measures such as developing national curricula, new job categories and a minimum wage.

Informal care plays a significant role. Several measures to support informal care providers are in place; a reform in 2008 introduced additional measures such as improved counselling and support and provided the possibility for unpaid leave for up to six months.

Since the introduction of LTC insurance, the number of professional home-care services has expanded significantly, with the share of private services growing even more and the average number of clients per institution increasing. The 2008 reform included an increase of the contribution rate, but this is not expected to ensure the long-term financial sustainability of the LTC system. Measures to avoid additional demand (like preventative home visits in Denmark), measures to improve cooperation between types of care providers (LTC — health care, nursing home — home care), and last

but not least continued, and increased, efforts to attract and retain human resources are also deemed necessary.

In **Luxembourg**, LTC insurance has been an element of compulsory social security since 1998. It is financed from contributions (1.4% of the income of active and retired people alike), and supplemented by a state contribution (30–35% of total LTC expenditure) and a contribution from the electricity industry. A care plan is drawn up according to the dependency level, specifying the services the person concerned is entitled to. All the services are fully covered by LTC insurance. Those who need it are entitled to assistance with Activities of Daily Living (ADLs) and, depending on the level of care needs, with household tasks and other support including from an informal carer. For those living at home, LTC insurance covers help and care provided by a care network (a professional service under contract with LTC insurance, which may also cover health care as well as LTC) or by a semi-stationary centre, or is used to cover pension contributions for informal carers who are not yet in receipt of a pension.

The 2010 health care reform is aimed at improving the quality of service as well as reducing demand for health and LTC service. Improving the links, communication and cooperation between the actors concerned is seen as a major challenge. In this vein, a national e-Health plan (eSanté) was adopted which is going to support multiple projects; the first two of which involve radiological imaging and laboratory analysis. Luxembourg is trying to respond to future challenges by introducing new ways of delivering health services, putting health professionals and their continuing training and vocational education at the centre of efforts.

As regards human resources, Luxembourg is in a somewhat different situation to other European countries. As wages are above those of neighbouring countries, it has been easy to attract non-resident workers, resulting in a large share of migrant workers in LTC, even though there are sometimes language problems. It is hoped that these problems will be overcome soon as several care providers, including the largest (SHD), are working on implementing a software system for managing care data, including a multi-user application which can be customised for different user groups and combined with a multi-language user interface. This software is intended to produce a number

of benefits but will require additional training for the workforce.
To ensure financial viability in the short term, government contributions will be adjusted. In the long-term, a revision of the legislation concerned is planned for 2013.

Slovenia currently lacks an integrated system for LTC, with measures scattered over several areas (health, pensions, disability, and social assistance). Cash benefits and residential care are organised centrally while home care services are provided at the local level. New legislation is in preparation.

Home care services are less developed. A somewhat larger share of those aged 65 and over receive LTC in an institutional setting than the EU average. There is already considerable excess demand for services, especially for residential care places, and more increases are expected as demographic trends unwind. Funding for LTC comes from both public (75%; from compulsory social insurance and taxes) and private (25%) sources. Some 31% from public funds is paid in cash in the form of various benefits, e.g. municipalities can provide some compensation for the loss of income of informal family carers. Benefits in kind are means-tested.

The **AGE Platform Europe** stresses that an adequate level of investment in health promotion and disease prevention over the life cycle — as well as the mainstreaming of health in all policies — are needed. For effective disease prevention, training of healthcare professionals and their knowledge of geriatric issues is crucial. Increased efforts to form an age-friendly environment can be beneficial in several ways. They can prevent accidents and social isolation with potentially positive side effects for mental health, as well as reducing levels of dependency and possibly extending the duration of active labour market participation.

AGE Platform Europe confirms the importance of measures like (European recognised) training, certification, continuing support programmes, and improved payments and working conditions to increase the status of formal carers. The development of more flexible (e.g. family friendly) working hours, better protection of the health of carers and new job profiles and qualifications (enabling inter alia increased mobility between care sectors)

may also increase the attractiveness of jobs in the care sector for national and migrant workers alike. Introducing ICT and assistive technology could help attract more younger and male care workers.

For informal carers, AGE believes there is a need for EU legislation to ensure carers are entitled to leave, to better enable them to balance paid work and informal care. Current developments are underlining this need. The increasing age at which families are started means future generations of informal carers will be affected at younger ages than current informal carers, and the economic crisis and resulting shortages in public budgets will leave more older people living at home with greater and more complex needs. Adequate provision of child and innovative eldercare is viewed as a prerequisite to reaching the 75% employment rate required in the Europe 2020 Strategy. With regard to the quality of care, AGE points to the voluntary European Framework for Long-term Care (WeDO Project), which encompasses quality of care as well as quality of work.

Caritas Europa draws attention to migration issues. In spite of the large share of foreign-born LTC workers in many European countries, legal channels for migration into the EU are limited and/or complicated and give preference to highly skilled workers, which only to a limited extent is in line with the projected needs in the LTC sector. Migrants from poorer EU regions often end up working illegally, especially in informal domestic settings, despite their right to free movement and to work in another EU country. These issues should be addressed through policy intervention with an overall strategy aimed at improving access to the labour market, recognition of qualifications, recruitment and increased retention of LTC workers. Caritas Europa regards recent Swedish rules in this regard as an important step forward, and recommends regulating transnational recruitment agencies in order to eliminate abuse and trafficking of workers. In a similar vein, eliminating precarious working conditions represents an important step towards improving recruitment and increasing retention of workers. This aspect is particularly important in the domestic sector.

With regard to informal carers, Caritas Europa also underlines the need to establish an entitlement to leave to protect carers from the risk of

unemployment and of reduced income both during their working lives and retirement.

Furthermore, Caritas Europa sees favouring non-profit care providers over for-profit ones as a means of improving the quality of care, given the principles governing the different segments of the market. There seems to be a potential, however, for non-profit providers to benefit from more business-like processes, such as modern human resource management procedures or work organisation. Any measures to strengthen financial sustainability need to support different income groups according to their means, i.e. the lowest income quintile should be a priority to receive social transfers.

D. Discussions at the Peer Review meeting

The discussions during the meeting focussed on enhancing **efficiency** 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, the contribution of stakeholders** to the care system and **technological support** for the elderly. The **Swedish approach** received much support and encouragement, especially its focus on prevention, quality care and an age-friendly society rather than on optimal financing of an isolated LTC system. However, the position of countries differs because of different starting points and different historical developments. The tradition of a large and active role for the government is established in Sweden. But such a large role may be less popular in countries with a different history and the general public may be reluctant to put most or all regulation, monitoring and provision of personal care into the hands of national authorities. Differences in peoples' attitudes and trust towards public authorities need to be taken into account when assessing what other countries can learn from the Swedish approach.

A topic of lively discussion was **prevention**. The presentation on this topic highlighted, among other things, the beneficial effects of an active lifestyle and the need for prevention to start early on, when a person is in his/her 40s. Peers from several countries presented programmes or initiatives. For example, Germany intends to implement a strategy focused on workplaces in SMEs, Luxembourg is planning a diabetes prevention scheme for the young, and Bulgaria outlined a priority programme in 2011 for those aged 65 and over at risk of poverty. The following issues were raised in the discussion which followed:

- Rehabilitation is also possible in old age. This seems not to be sufficiently understood and therefore leads to higher than necessary dependency.

- Prevention can often involve long timespans, which can make it a costly procedure. Studies on the cost-effectiveness of existing measures are needed.

- Several low-cost measures exist already, e.g. to reduce the risk of falls, which can often be the starting point for later dependency. There are examples of positive experience from France where automatic lighting has been used to prevent falls during the night.

- Active ageing can be supported by a variety of different measures, such as special areas in public places (compare the attitude to common gymnastics of the elderly in China and playgrounds for children around the world), later retirement (paid work provides motivation, which is one of the most important prerequisites for activity), and projects to link the old and the young (for example in a Slovenian project young people from schools support older people in the use of IT).

A recurrent topic in discussion was that we need a **change of mind-set**. We need to remind ourselves of the capabilities and resources of the senior generation. (Severe) need for care or support is concentrated in a small share of a large population group, while large numbers of older people still can enjoy reasonably good health. Therefore, there will also be a growing number of relatively healthy people, and already today much more informal care is being provided by people of the same age (mostly spouses or partners) than by younger family members. More focus on the capabilities — not just the needs (and associated costs) — of the older generation would be appropriate in the care discussion. For example different forms of networking (from cafés for seniors to informal senior ICT communities) represent an under-utilised resource. As examples of possible preventative measures show, a limited focus on the "core" LTC sector encompasses only some of the potential improvements and would not lead to the age-friendly society desired. The European Commission emphasised the role LTC could play in providing employment opportunities and as a possible way into the labour market for those with low levels of formal education in particular.

The current and future care **workforce** was another recurrent topic. The discussion confirmed the impression that informal care will continue to predominate in many countries, despite the fact that declining family size, an increase in the age of starting families and rising retirement ages all increase the difficulty of balancing informal care and employment. A number

of support measures, including the education of informal carers, need to receive much more attention.

During the discussion there was a consensus that major improvements in job quality in the care sector (pay, reputation, education, and working conditions) are needed in a number of countries. Education will remain a key issue not only in Sweden but in many other countries. Indeed, various education programmes are already underway (e.g. in Bulgaria for family carers, in Germany, where there is a 3-year training programme, and in Slovenia, where programmes focus on different age groups). Legislation may also come into play here. In addition, in some countries the role of illegal (mostly migrant) workers is significant, especially in terms of domestic care provision, and will need to be addressed by a proper labour migration policy.

There was, however, more open-ended discussion on two topics. First, the role of part-time employment: is its extension desirable in order to recruit otherwise unavailable workers, or is current part-time work a "waste" which can be avoided by switching more workers into full-time employment? The second topic concerned qualifications for low-skill care workers: how much skilled versus unskilled labour will be needed, and how much education or training is sufficient to provide quality care in respect of more basic tasks?

The problems of insufficient availability of relevant **data** gave rise to call for more comprehensive, comparable and efficient data collection programmes, typically as part of an eHealth initiative. Due to the large gaps in information suitable for evaluations and forecasts, there still seems to be significant room — and a need for — further work, including proper dissemination of results on what works under what circumstances and what does not.

A general feature of the discussions was the **close interrelationship between several key issues**, which affirms repeated calls for a holistic approach. For example:

- better education for the (nursing) workforce has the potential to increase not only the quality of care, but also the retention of staff; both may contribute to reducing the cost of care;

- active ageing can lessen the need for care, but may also increase the ability for older people themselves to provide care and so contribute to closing the gap in human resources;

- a more widespread application of technical aids (simple mechanical aids as well as ICT use) can improve the efficiency of care, as well as increase recruitment from non-traditional pools of potential labour, e.g. younger and male workers.

E. Conclusions and key lessons

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

- Micro-simulations based on administrative data — as in the Swedish case — 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 alternative strategies to reduce or close the gap.

- Estimations for Sweden found that no single instrument is capable of closing the gap and that concentrating on alternative financing forms offers particularly limited prospects. But the estimations also show that a combination of smaller but systematic measures can close the gap, including through improvements in productivity (both capital substitution and better organisation), efficiency, healthy ageing, the recruitment, retention and training of carers, the ability of frail elderly people to manage their disabilities well enough to live independent lives with the help of assistive technologies etc.

- A clear **order of preferences** is needed when choosing possible ways of closing the gap between future care needs and scarce resources:

  - Efforts should be made first to **improve the effectiveness of existing systems**. There is still some slack in them, due to the organisation of work in the past or insufficient use of technical equipment and ICT, for instance. In some Member States, like Sweden, models have shown that with a small increase in productivity, existing systems have the capacity to meet the needs of the population without increasing medical expenditure as a share of GDP (see conclusions of LEV Project).

  - 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**.
- **Cutting services** or **increasing user charges** should be considered as a last option.

- **Preventive measures** are urgently needed in order to reduce the incidence of diseases, which are predicted to become the major challenge as regards keeping down health care costs. There are currently only a few **prevention implementation studies** to guide selection of the most efficient ways of reducing risk factors. Prevention needs to be implemented at different stages of life, depending on the current health profiles of the different age groups in the existing population. Focus on pathologies must be designed accordingly. However, it seems that achieving full efficiency requires prevention plans to **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 and corresponding increases in long-term care needs. It should, however, be borne in mind that **prevention also generates costs** and there are still not many studies on these.

- 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 widely.

- 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 to support decision-making. Evaluations need to focus on specific pathologies, in connection with a specific technique or strategy. Low-cost techniques or strategies could be promoted more specifically in the context of a budget crisis.

- **Possible resources** of which more use could be made in elderly care:

  - The **supply of formal and informal carers** could be significantly enlarged through the involvement of older people 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 possibly some training, many more resourceful people aged 65 and over 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 number of resourceful people in this group could be **incorporated into the waged care workforce**. In this case, **more flexible arrangements for combining other income with pensions** as well as **for part-time work** would be required since few people above pensionable age can be expected to work a 40-hour week.

  - **Patients as providers** are a further potential resource. More modern techniques should be used to make use of patients' own capacity to tackle their care needs and manage autonomous lives in spite of frailties and disabilities. This also involves **empowering patients** wherever possible. If people — such as diabetics — get used to the idea of taking responsibility for some of their care needs themselves at a younger age, it will be easier to continue this later on.

  - Obviously, the relevance of these approaches will vary from one country to another.

- Even when making better use of the above mentioned resources, **informal care** will continue to play a major role in elderly care. Probable developments on the labour market will increase the need for efficient support to informal carers, particularly those who are employed.

- There is a **need to raise the prestige of the caring profession** as a whole. This could also help to attract more men into the 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**.

- **Developing and supporting age-friendly environments** is also important, not only as a means of limiting or avoiding possible costs but also of better providing for the full integration of elderly people into society. If gains in life expectancy were to make us define the age corresponding to the notions of "old" and "retirement age" 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 now and in the future.

- A **change of mind-set** towards elderly care will be needed, involving a **holistic approach**. Rather than being seen as a burden, older people should be valued for their **wealth of experience and as potential resources**. In this respect, on-going experience and projects focusing on intra-generational (i.e. between older people) and inter-generational solidarity (i.e. between older people and other age groups) should be valued and used to demonstrate the benefits that society can gain from the contribution of older people.

- 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** and increased demand for services may pose even greater challenges, than those arising from demographic or health-related needs per se. Governments must be **transparent**

and honest with the public about this issue. They must make clear what can realistically be achieved in the future and what cannot. They must also explain the costs involved.

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

- **Preparing for population ageing** is seen as one of the most challenging issues in the Europe 2020 strategy. Across the EU there is risk that changing demographic dependency rates might affect public budgets to such an extent that they undermine the potential for economic growth. The challenge will be to reform social systems and practice including long-term care in a way that minimises such risk while simultaneously maintaining, or even improving, social standards.

- Member States' **ability to close the gap** between expanding needs and limited or declining resources for long-term care constitutes a major element of their capability of **responding adequately to the challenges posed by an ageing population**.

- Finding ways to close this gap is an important part of adapting European societies to make the most of the **opportunities of the new demographics** including the changes in needs and in the pattern of demand for goods and services which will form the basis of much 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 share of early school-leavers, 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 particularly relevant in terms of developing the capability of Member States to close LTC need gaps. The combined focus on prevention and raising the effectiveness and efficiency of caring systems through innovative organisation and assistive technologies puts this squarely at the centre of efforts to close the gap. One challenge for the EIP is to get the balance right so that prevention and support for autonomous living receives sufficient attention and enough resources *vis-à-vis* 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 that elderly care should not give rise to poverty (for care receivers or care providers) and that poverty should not exclude anyone from care.

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

- Closing the gap in long-term care is also linked in important ways with the **employment target**. Women in particular (and especially those in middle age) are subject to under-employment in many Member States. Long-term care can be seen as a **motor for jobs** which could provide a considerable share of the unskilled and semi-skilled jobs we will need in the future. This could be particularly useful for vulnerable groups, 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 if they have low levels of education or outdated qualifications. But if long-term care is to function effectively as a motor for jobs, **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 skill levels. In addition to new jobs in the care area itself, new jobs in supply sectors like assistive technology are also to be expected.

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Papers produced for the Peer Review

Discussion paper, peer country comments papers and stakeholder contributions available at:

http://www.peer-review-social-inclusion.eu/peer-reviews/2011/closing-the-gap

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Closing the gap - in search for ways to deal with expanding care needs and limited resources

Host country: **Sweden**

Peer countries: **Bulgaria, Cyprus, Denmark, Estonia, Germany, Luxembourg, Slovenia**

Stakeholders: **AGE, Caritas**

Across Europe, countries are confronted with the challenge of how to care for an ageing population with limited resources. This challenge has become even more acute as the tightening constraints on public expenditure in the aftermath of the financial crisis and the recession which accompanied it reinforce the effect of demographic trends. Although countries have quite different systems of care, there is a common need to find ways to limit the demand for care whilst at the same time ensuring access to good quality care for all those that need it without putting unsustainable stress on public resources. The purpose of this Peer Review is to stimulate debate and ideas which will help develop a strategy to assist this process.

In Sweden, a report on "The future need for care" investigated the logistics involved in maintaining a high-level of health care for the elderly in the context of heightening demand and no corresponding increase in resources. While in principle it is possible to cater for higher demand, the extent of demographic change makes prompt action across a variety of areas absolutely crucial. Governments need to explore new ways to reduce demand by increasing years of healthy life and at the same time improve the cost-effectiveness of service delivery, both of which require making good use of technical and medical developments, such as by developing mobile services so that older people do not need to travel to receive care.