

Long-term care: How to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities

Discussion Paper

Heinz Rothgang
Centre for Social Policy Research (ZeS),
University of Bremen

Karsten Engelke
Institute for Health and Medical Law (IGMR),
University of Bremen

I. Introduction

Demographic changes challenge EU countries in various perspectives and in various ways. As the numbers of older people rise in Europe, the importance of long-term care (=LTC) in terms of numbers of users and expenditures can be expected to grow. The Netherlands has approached this challenge as early as 1968 with its Exceptional Medical Expenses Act (AWBZ), a role model for addressing needs and changes in the population derived from the need for non-medical care. As part of the attempt to continuously improve care provision and respective funding, the Netherlands has initiated a peer review on the question how to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities. This discussion paper aims to stimulate respective discussions by illustrating the common demographic challenges and discussing certain responses to it. Throughout this discussion paper, a comparative, mostly European perspective will be taken, and answers from several countries will be presented and analysed.

1. Content of this discussion paper

The scope of this paper will be restricted to addressing the most important questions concerning the three sub-themes discussed in this Peer Review, namely: financial sustainability with respect to collective and individual arrangements and public and private responsibilities (sub II); the LTC system's boundaries (sub III); and securing sustainable and skilled supply of care workers (sub IV). Finally, a quick glance at the common European discussion within in the framework of the Open Method of Coordination (OMC) will round up this necessarily restricted discussion of the complex and intertwined challenges which arise from the need for long-term care in the Member States.

This discussion paper will only deal with formal care. Informal care, i.e. care performed by informal and mostly unpaid carers (e.g. family members or friends), plays an important role in many European countries, but is not examined in this Peer Review. The same applies for the issue of migrant carers. Accordingly, the vast sector of care-avoiding and care-assisting benefits like subsidised housing or support in the household by low-level employees is not examined. The same is true for the aspect of quality of care, which is not specifically looked at in this Peer Review.

2. Demographic challenges

The need of long-term care is a social risk which is easily underestimated if only the prevalence rate for any given point in time, rather than the life-long risk is considered. German data e.g. show that there is a 50 % chance to need long-term care in the course of a person's life.¹

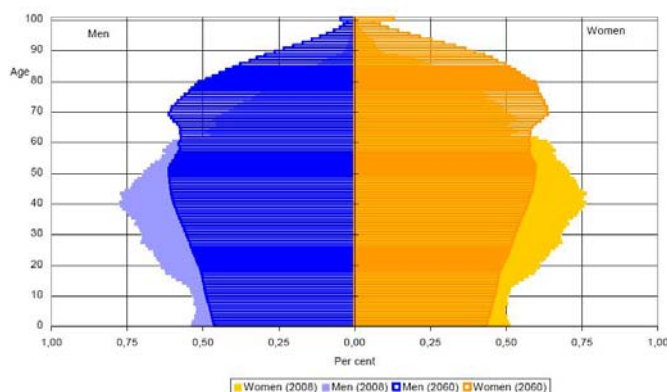


Diagram 1: Population projection 2008 – 2060

(Source: Green paper on the European Workforce for Health, COM (2008) 725, p. 6)

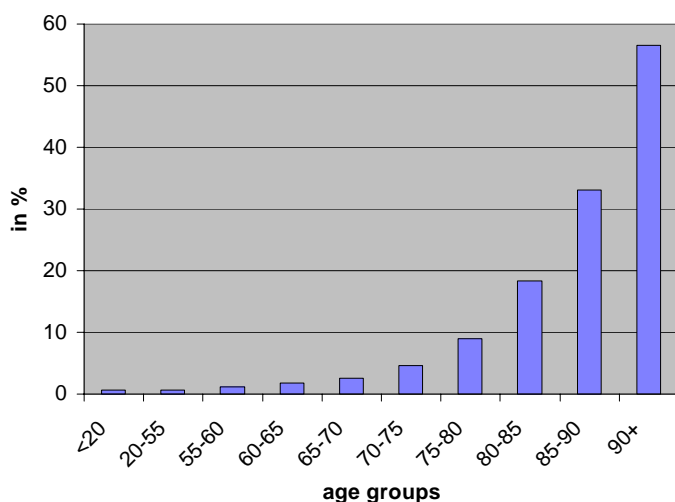


Diagram 2: Dependency rates in Germany's Social LTCI

The growth in the number of older people, however, does not necessarily transform into a proportional growth in the number of dependent people as naïve projections which just combine age-

For the future the relevance of long-term care will grow as the number of elderly citizens will increase dramatically, in absolute numbers but also in relation to people younger than 65 years. This is the result of the baby boom generation approaching retirement, but also of falling mortality rates, resulting in an increase of life expectancy of 2.5 years per decade,² and low fertility rates.³ The OECD estimates that by 2030 on average 20 % of the population will be aged 65 years and older in OECD countries and this share will rise to 25.2 % by 2050.⁴ Compared to a 13.8% in 2005 this is a 83 % rise.

More dramatically, the share of people aged 85 and older, will grow the fastest and double from 1.5 % in 2005 to 3 % in 2030. This percentage will rise to 5.2 % by 2050, representing a 242 % growth when compared with the figures for 2005.⁵ The "oldest old" face the most severe disabilities and has therefore the greatest demand for long-term care.⁶ Diagramm 2 illustrates this with data from Germany's Social LTCI insurance. The growth in numbers in this group therefore is of highest relevance for predicting the future number of dependent people.

¹ Rothgang, Borchert, Müller, Unger (2008) p. 102. Correspondingly, in the US, the chance for a person who reaches the age of 65 years of being admitted to a nursing home prior to death is 43 % on average (Norton (2000) p. 959.)

² Com (2008) 725 p. 5.

³ Norton (2000) p. 983; OECD (2007) p. 11.

⁴ See OECD (2007) p. 11 and Table 2.1 on p. 13.

⁵ See Table 2.2 in OECD (2007) on p. 14.

⁶ OECD (2007) p. 11.

specific prevalence rates with demographic projections suggest. The compression of morbidity may lead to decreasing age specific prevalence rates. The amount of the effect is, however, still unclear.⁷

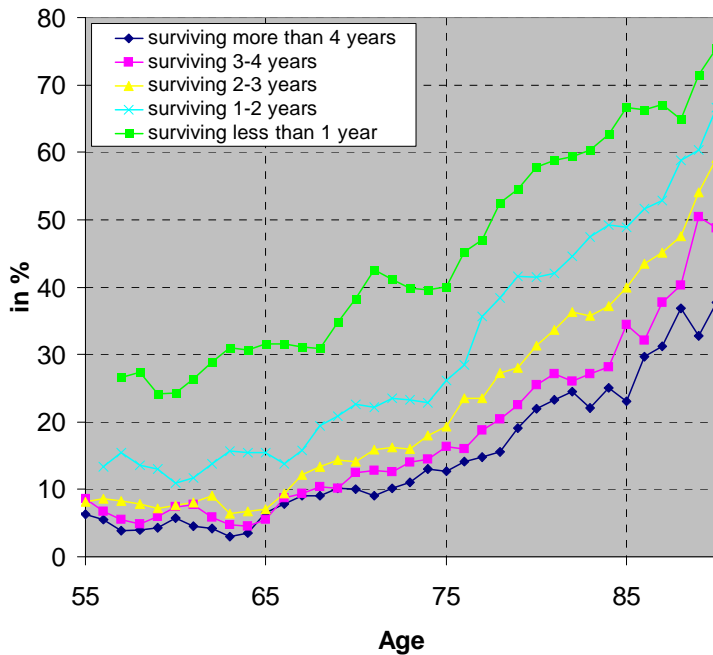


Diagram 3: Prevalence rates for need of long-term care according to age and proximity to death in Germany

Source: Rothgang (2007)

Moreover, the need of long-term care also depends on the proximity to death. Diagram 3 contains respective figures for Germany. The curves represent prevalence rates for a certain cohort according to age and proximity to death. As the diagram reveals prevalence rates are influenced by both, the age (as all curves show a positive slope), but also by proximity to death (as for all ages the prevalence rate is higher for those who are closer to death).⁸ As life expectancy grows, in each age bracket the share of people who are close to death is declining. Consequently, the age-specific prevalence rates, which can be conceived as weighted mean of age-specific prevalence rates according to proximity to death, are going to decline if the latter is taken into account.

Respective projections for Germany, for example, show that the growth in the number of dependent people is reduced by about one third if proximity to death and growing life expectancy are taken into account.⁹ Nevertheless, it remains valid that there will be a considerable growth in the number of people in need of long-term care.

II. Financing of long-term care

1. Issues

LTC is expensive and could strain the financial resources of individuals beyond affordability. They would then suffer from inadequate care or fall back on a social welfare scheme as a last resort particularly for institutional care. In order to guarantee that everyone in need for care will receive appropriate care and also to limit expenses on social welfare, numerous European countries have reacted by creating new or modifying existing financing arrangements for long-term care, but the different approaches vary in accordance with national traditions and specific challenges. While

⁷ See Jacobzone et al. 2008, Jacobzone 1999, OECD 2007.

⁸ Norton (2000) supports these findings and quotes several approving studies on p. 985.

⁹ See also Comas-Herrera et al. 2006 and OECD 2007 for projections with constant and declining age-specific dependency rates.

liberal and social democratic countries¹⁰ with a National Health Service tend to integrate services into the existing system, conservative welfare states of Bismarckian type rather create a new (insurance) scheme as in Austria, Germany, Luxembourg, Netherlands, but also in Japan.

Table 1: LTC Spending: Projection results for AWG reference scenario

	Projected spending as % of gross domestic product (GDP)						Growth rate (in % of base) 2004-2050
	2004	2010	2020	2030	2040	2050	
BE	0.9	0.9	1.1	1.3	1.6	1.8	100
DK	1.1	1.1	1.2	1.8	2.0	2.2	100
DE*	1.0	1.0	1.2	1.4	1.6	2.0	100
ES	0.5	0.5	0.5	0.5	0.6	0.8	60
IE	0.6	0.6	0.6	0.7	0.9	1.2	100
IT	1.5	1.5	1.6	1.7	1.9	2.2	47
LU	0.9	1.0	1.0	1.1	1.3	1.5	50
NL	0.5	0.5	0.5	0.8	0.9	1.1	120
AT	0.6	0.7	0.8	1.0	1.2	1.5	114
FI	1.7	1.9	2.1	3.0	3.4	3.5	84
SE	3.8	3.7	3.7	4.9	5.2	5.5	49
UK	1,0	1,0	1,1	1,3	1,5	1,8	80
CZ	0.3	0.3	0.4	0.5	0.6	0.7	133
LT	0.5	0.6	0.6	0.6	0.7	0.9	50
LV	0.4	0.4	0.5	0.5	0.6	0.7	75
MT	0.9	0.9	0.9	1.0	1.1	1.1	22
PL	0.1	0.1	0.1	0.1	0.2	0.2	100
SK	0.7	0.8	0.7	0.9	1.1	1.3	63
SI	0.9	1.1	1.3	1.5	1.9	2.2	100
<i>FR, EL, PT, CY, EE, HU</i>	No data						
EU25	0.9	0.9	0.9	1.1	1.3	1.5	67
EU15	0.9	0.9	1	1.1	1.3	1.5	67
EU10	0.2	0.3	0.3	0.3	0.4	0.5	67

Source: Table HC-P15

DG ECFIN calculation

Note: EU25, EU15 and EU10 – average weighted GDP

DE*: According to a special AWG scenario for DE the projected share of expenditure remains stable if the benefits rise in line with general inflation. The recent LTC reform Act includes a provision that authorizes the federal government to adapt benefits to the development of consumer prices, but the increase must not exceed gross wage rises.

Source: European Commission 2006: 162.

One of the major issues for any system now is to provide sufficient resources, but also to keep expenditure affordable for the national economy. Therefore it is useful, first, to identify the amount of resources spent on LTC at the moment and, second, to get an idea about future developments. Starting with the former we already face a huge data problem. As there is no common definition of long-term care and respective long-term care expenditures, there are huge differences between certain sources. Respective comparative figures for several EU countries are provided by EUROSTAT, the OECD and the European Commission. Unfortunately, these figures differ considerably. For the Netherlands, for example, EUROSTAT calculates LTC spending of 1.24 % of

¹⁰ The terms social democratic, liberal, and conservative welfare states refer to Esping-Andersen's work which has heavily influenced comparative welfare state research (see Esping-Andersen 1990).

GDP for 2004,¹¹ while a joint Report of the Economic Policy Committee and the Directorate General for Economic and Financial Affairs of the European Commission (DG ECFIN) speaks of 0.5 % of GDP for the same year (table 1). The OECD Health Project, finally, gives an even higher number for the Netherlands: 1.44 for the year of 2000.¹² Thus EUROSTAT figures are almost 2.5 times and OECD figures almost thrice as high as those from the European Commission.¹³

For future projections several factors have to be considered, as the development of age-related dependency ratios, care arrangements and unit costs, but also the macro economic performance of the respective country. The EPC Working group on Ageing Populations (AWG) has undertaken a major exercise in this, distinguishing several scenarios. Table 1 gives the reference scenario which is considered as the most likely scenario. According to these data, in 2004 EU countries spend between 0.1 to 3.8 % of their GDP on long-term care. With 3.8 % of GDP Sweden spends more than twice as much as Finland, which has the second highest number. All shares are expected to rise severely until 2050. The AWG reference scenario projection shown in the table indicates an average increase in the EU25 group of 66.7 % in the period from 2010 to 2050. With an overall growth of 120 % the figure for the Netherlands is clearly above average, second only to the growth rate for the Czech Republic. With the growth of financing needs in mind we can now discuss the options available for financing long-term care. These projections raise two issues: First, whether (and how) LTC spending can be controlled and second how these expenses can be financed. We now turn to the latter.

2. Policy options to finance long-term care

Generally speaking, there are four different potential sources of funding for social benefits:¹⁴

- (1) out-of-pocket-payments coming from private savings;
- (2) (voluntary or mandatory) private insurance with risk-related premiums, with or without public subsidies or transfers;
- (3) social insurance with income related contributions;
- (4) tax-based public systems with or without means-testing.

Each of them has certain advantages and disadvantages. In the following sections we therefore briefly discuss, which role each of these options should play.

Out-of-pocket payments

As mentioned earlier, the LTC risk is as high as 50 %. In view of the fact that LTC costs could amount to a sum that no reasonable person would save solely for this purpose and that most people would not have any chance to save during their lifetime, out-of-pocket payments cannot be regarded as the financial backbone of a LTC system. If no mandatory insurance system or

¹¹ EUROSTAT data according to data corresponding to the new set of indicators, as agreed on by the Social Protection Committee in May 2008, table HC-P13, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/data_health_en.xls (visited 2009/01/31).

¹² OECD 2005: 26.

¹³ One reason for the huge differences is the fact that EC figures are based on a common definition of LTC, necessary for projections, while OECD and EUROSTAT data is based on national accounts, relevant for current budgets.

¹⁴ See e.g. Wittenberg, Sandhu, Knapp (2002) p. 234/5.

National Health Service is in place the predominant role of a social welfare scheme is expected to follow. Limited co-payments on the other hand may play a role to prevent moral hazard.

Private insurance

Voluntary private insurance policies do not sell well. In Germany, for example, only about 300,000 private insurance policies have been sold before mandatory LTC insurance was introduced (Hau-schild 1994: 13). Demand is particularly low if there is a social welfare scheme as a last resort, which is true for all EU countries. The problem of the uninsured can only be resolved if private insurance is mandatory. In this case, however, it must be amended by tax-based subsidies for those, who cannot afford the premiums and – most likely – by premium caps particularly for the old-aged. If regulated this way a mandatory private insurance system, however, comes close to a social insurance system.

One major difference remains: private insurance systems are normally at least partly funded, while social insurance systems follow the pay-as-you-go (PAYGO) principle. If a new mandatory insurance is to be introduced as a funded system, those people who are most urgently in need of benefits are effectively excluded from contracting with insurance companies due to the high premiums necessary to cover the costs arising in the near future. If premiums for the old-aged are set at a lower level this implies that insurance companies can only grant small, insufficient benefits. Funded systems therefore need some decades until sufficient funds are accumulated to contribute noticeably to LTC financing. If a new system shall be introduced to bring instant relief for the people in need of long-term care and the older cohorts, only the pay-as-you-go system works. Furthermore, a system solely based on private insurance would have difficulties to respond to fluctuating incomes and unemployment, which result in reduced financial resources and hence inability to pay premiums. An OECD report has identified further problems on the side of the insurers, because of complex and unpredictable actuarial issues surrounding premium calculations as well as difficulties in maintaining a diverse insured population over time.¹⁵

In reality, private insurance can be found in several systems, but mostly not as the primary solution for the problems which arise from the challenges faced by citizens in need of LTC.¹⁶ In most systems where private substitutional LTC insurance is used as a means to finance LTC expenditures, this option is only open for those whose earnings are beyond a certain threshold under which social insurance is mandatory, i.e. combination with social insurance for those who are less well off.¹⁷ Private insurance companies may also offer supplemental policies, which are rarely sold. Such an insurance market exists for example in Sweden, Germany and the U.S.¹⁸

Social insurance

Social insurance systems with income-related contributions following the PAYGO principle are an option for a basic system to finance LTC as they meet most of the concerns raised against private insurance. First, income-related contributions guarantee affordability for individuals without premium subsidies. Second, a contribution-based social insurance system can be implemented al-

¹⁵ Colombo, Tapay (2004) p. 26.

¹⁶ See Merlis (2004) p. 10.

¹⁷ Merlis, (2004) p. 10.

¹⁸ Merlis (2004) p. 10.

most ad hoc as the contributions of the current generation of contributors finance the benefits of the current generation of beneficiaries. This “contract of generations” enables policy makers to implement a social insurance system immediately. The “price” for this advantage, however, is the implicit debt created by the introduction of the system and transferred from one generation to another. Moreover, PAYGO systems are vulnerable to demographic ageing, though the greying of society also affects funded systems via the capital market.

But social insurance systems have their own problems, as the example of current difficulties in Germany demonstrates. In Germany, contributions are levied on salaries and wages (as well as pensions and unemployment benefits derived from earnings) up to a certain ceiling. Since the wage ratio, i.e. the share of GDP attributed to the factor labour, has been declining, the sum of contributory income grows slower than GDP causing fiscal problems for health and LTC insurance. Moreover, this system raises distributional concerns as income coming from different sources is treated differently (horizontal inequality) and income above the income ceiling does not increase contributions (vertical inequality). Moreover, the reliance on earnings alone produces negative effects on the labour market, i.e. disincentives to work on the one hand and incentives to substitute labour by capital on the other hand.

In order to avoid such problems the base for contributions should be as broad as possible, including the entire population and all kinds of income as it is normal for income taxation. Additionally the existence of an absolute income ceiling for contributions should be reconsidered. In some countries the building of a supplementary demographic reserve as an additional tool is considered (see also practice example). Since an additional supplementary private system will cause new boundaries between systems with the necessity to manage the interface, the accumulation of funds within the social insurance system seems appropriate. In this case, however, institutional rules must be implemented to protect accumulated funds against premature dissolving.

Practice Example Belgium: the “Silver Fund”¹⁹

As a reaction to demographic projections indicating a sharp increase in public spending on benefits for elder citizens after retirement of the “baby boom generation”, Belgium set up the “Silver Fund” in 2001 to alleviate the financial burdens, while adhering to the goal of debt reduction and consolidation of public spending. Funding comes from both government surpluses and exceptional revenues (e.g. due to UMTS license sales). The Fund may only invest in specially issued government bonds so that its activities cannot interfere with operations on the financial market. The Fund is embedded into a special institutional process which monitors the estimated budgetary costs of an ageing society and issues recommendations on the amount of funding to the Silver Fund itself. For these purposes the Committee on Ageing has been created. The reserves accumulated in the Fund will later be used to (partly) cover the budgetary costs of population ageing.

Tax-based public systems

Apart from social insurance systems tax-based public systems may serve as basis for LTC financing. They may either be means-tested or not. Tax-based public systems are predominantly

¹⁹ For a general description see NBB (2003) p. 2 and Mestheneos, Triantafillou (2005) p. 19.

used in southern Member States, but also in Scandinavian countries. In Sweden, for example, local authorities provide services virtually free of charge, tax-financed and not means-tested. The total public expenditure on LTC for elderly amounts to 3.2 % GDP.²⁰ As Sweden has the highest spending from all EU countries (see Table 1), the government tries to contain expenditure by concentrating care on the most severe cases.²¹ Tax-financed benefits may also be given as cash allowances as the “Pflegegeld” in Austria demonstrates, which is not means-tested. In England, a dual system provides nursing benefits to some individuals in need of care by the NHS and some social care by local authorities. The latter benefits are means-tested.²² Countries with social insurance systems also use means-tested benefits systems to cover cases which do not meet the statutory requirements for social insurance benefits. Germany, for example, provides benefits through the means-tested social welfare system, operated by local authorities.

As social insurance systems, tax-based systems follow the PAYGO principle which allows granting immediate benefits. They may differ from social insurance with respect to distribution and sustainability. Generally speaking, means-tested benefits as the basis system may lead to under-provision of care services and destroy incentives for individual provision. They should therefore rather serve as a last resort than as the basis of the system. As taxes do not create legal claims for benefits they may be more difficult to collect than contributions. Social benefit entitlements, whether financed through contributions or tax, are protected under the property protection clause of the European Convention on Human Rights. Nevertheless, the close relation between contribution and entitlement may be regarded as an additional protection. While contributions to a social insurance system cannot be spent for different purposes thus guaranteeing a certain financial basis, tax revenues are subject to a wide range of different budget policy considerations. As has been the case in the past in some countries, fiscal crises may therefore reduce available funds below a sensible level. In order to prevent this and guarantee a certain stability of funding over time, earmarked taxes could be an option.

3. Recommendations

Long-term care systems can only be financed in a sustainable way by a mandatory kind of system, whether insurance- or tax-based. Financed via the pay-as-you-go principle such a system can be implemented virtually ad hoc. Social insurance systems should cover the entire population and not provide exit options for those who are better off in terms of income. Moreover, contributions should be levied on all kinds of income and not on wages and salaries alone. Means-tested tax-financed benefits may only serve as a last resort. If taxed-based benefits form the backbone of a LTC system they should not be means-tested. In order to guarantee sufficient funding for LTC ear-marked taxes may be considered, while small out-of-pocket co-payments may serve as a means against ex post moral hazard. Contribution- and tax-based systems are affected by demographic change. Supplementary funding, i.e. the creation of a demographic reserve, within a public system may be used to transfer some future burden into the present.

²⁰ Karlsson, Mayhew, Rickayzen (2007) p. 108.

²¹ Karlsson, Mayhew, Rickayzen (2007), p. 111.

²² Karlsson, Mayhew, Rickayzen, Health Policy 80 (2007), p. 111. Social care is not means-tested in Scotland.

III. Boundaries of the LTC system

1. Issues

Clear boundaries - but integration of services

Clear boundaries of a LTC system are necessary in order to control the cost development. The Netherlands, for example, has envisaged a huge rise of expenses in its AWBZ system, which is partly due to unclear boundaries.²³ On the other hand strict boundaries may endanger the provision of integrated care and rather produce disruptions in the chain of treatment. In its report on long-term care for older people the OECD therefore asks for “bringing services together: towards a continuum of care”.²⁴ In order to reach this goal, either institutional linkages between separate subsystems or at least individual case and care managements structures are necessary. Countries with a separate and narrow LTCl system (e.g. Austria and Germany) rather tend to discuss the dangers of insufficient integration, but also some countries without a separate system do (e.g. Belgium and Estonia). Countries with an encompassing system as the Netherlands on the other hand rather ask for clearer boundaries of the system in order to control costs. Boundaries in this respect relate to both, the entitlement to benefits and the definition of long-term care benefits.

Entitlement to Long-Term Care Benefits

Until recently, the need of long-term care was not considered as a social risk in its own right. EC Regulation 1408/71, for example, had no section on long-term care. In the case Molenaar (C-160/96) the European Court of Justice therefore subsumed LTC under healthcare, thus reflecting the difficulties to distinguish them. Today most national legal frameworks define “the need of long-term care” with respect to the inability to perform (basic) activities of daily living (ADLs) and instrumental activities of daily living (IADLs) without external help for an extended period of time.²⁵ Definitions, thresholds, and assessment criteria, however, differ widely between countries.

Practice Example Germany: the “MDK”

The German Medical Service of the health insurance (*Medizinischer Dienst der Krankenversicherung*, MDK) serves as a “gatekeeper” to the LTC system. One of the statutory functions of this service is to examine everyone who applies for LTC benefits in the social security system according to a defined set of criteria. The MDK is regarded as a neutral professional body employing doctors and nurses for a wide range of purposes in the field of healthcare and long-term care. The neutrality of the results is secured by the institutional framework the MDK is embedded in: It is an independent public body sustained by the cooperation of the sickness funds on federal state level. The sickness funds have the statutory duty to equip the MDK with the necessary financial resources. With respect to LTC the MDK examines whether applicants for LTC benefits meet the required criteria and are thus entitled to benefits. A similar system exists in the Netherlands with the CIZ as an independent organisation responsible for determining what care is required.²⁶

²³ Ministry of Health, Welfare and Sport (2009).

²⁴ OECD 2005: chapter 2.

²⁵ Huber (2007) p. 6.

²⁶ See Netherlands Host Country Report p. 5.

Apart from the definition of criteria for entitlement another question arises: Who shall do the assessment? This refers to whether doctors or nurses or any other profession are mostly qualified, but also to the organisation that does the assessment. As is well-known from healthcare, supply-side induced moral hazard may occur if the providers of care do the assessment. Giving the assessment to the funding agencies, on the other hand may produce too strict assessments. Using an independent body with professional ethos at arms-length to funding agencies, as is the case in the Netherlands and Germany, therefore seems to be the best option.

Definition of Long-Term Care Benefits

The question of boundaries relates to the entitlement to care, but also to the kind of care that falls under long-term care as distinguished from health services and social care. So, nursing care as part of a hospital stay generally falls under healthcare and respective financing arrangements. When provided in nursing homes or in the community, basic nursing care rather falls under long-term care and respective financing. When nursing care comes close to medical treatment (e.g. intravenous injections) or when extensive nursing care in a private household avoids a hospital stay, this may, however, be different. Social care for people in need of long-term care may or may not be part of the healthcare system. In the UK, for example, a Royal Commission demanded that social care in nursing homes should be financed through the NHS²⁷ – a recommendation that has thereafter been followed in Scotland, but not in England, Wales and Northern Ireland.²⁸

Difficult boundaries: Germany and the UK

In Germany, elementary care related to activities of daily living (*“Grundpflege”*) and care services to secure the success of medical interventions (*“Behandlungspflege”*) are distinguished. While the former is part of long-term care, the latter is part of healthcare. As all LTC expenditures are commonly financed by all LTC funds, but healthcare expenditures fall back on the respective fund alone, there are strong incentives for funds to use a broad definition of elementary care. This has led to numerous lawsuits in order to clarify boundaries.

In the UK, either the NHS or the local authorities are responsible for providing long-term care to individuals. The concept of “primary care needs” has been developed to assign certain conditions to one of the potentially responsible authorities. Where a person’s primary need is a health need, the NHS is responsible for providing for all needs, including accommodation, if part of the overall need, and thus these people are eligible for NHS Continuing Healthcare. The decision as to whether this is the case should look at the totality of the relevant needs.²⁹ Precaution has been taken to prevent a “gap” in the provision of care, because the NHS cannot bind the local authorities to its decision that care should be provided by the local authorities’ social service scheme.

In the U.K., a coordinated assessment procedure has been implemented, whereas Germany follows on a voluntary basis a case-management-approach through specialised coordination offices. This new approach accompanies the traditional duty of public insurance companies and local authorities to advise persons in need.

²⁷ Royal Commission on Long-term Care (1999).

²⁸ Comas-Herrera et al. (2003).

²⁹ DoH (2007) p. 12.

Whether certain services are included into the healthcare system, the long-term care system or the social care system may have huge distributional effects, e.g. when healthcare is free of charge at the point of delivery, while social care is means-tested. Moreover, cost control may be difficult if uncapped social services are provided free of charge, as these softer services and the respected needs are more difficult to define. In order to avoid disintegrated care, however, clear definitions of the benefits included into each system and mechanism to integrate benefits from different subsystems are needed – given that there are different subsystems.

2. Policy options for cost control

As already mentioned, criteria and procedures for the entitlement for long-term benefits and the definition of LTC benefits as distinguished from healthcare and social care are important issues in the pursuit of cost control. There are, however, more instruments, which have to be mentioned.

Fixed thresholds of age or time of residence

Some countries have enacted minimum age requirements or a minimum time of residence in the country for entitlement to LTC benefits. Japan has set a minimum age of 40 years, France demands the applicant to have reached an age of 60 years to be eligible for receiving benefits from the LTC scheme (*Allocation Personnalisée d'Autonomie*, APA). A separate regime exists for persons below 60 years which offers benefits in kind.³⁰

“Waiting times”

Several countries demand that a person who wants to apply for benefits has to fulfil a “waiting time”, that is a minimum time of paying contributions to the LTC benefits system or having taken residence (and thus paying taxes) a certain time before filing the application. Germany, for example, demands that applicants must have been insured for at least five years in a period of 10 years prior to the date of applying for benefits, although this rule has been changed recently to a minimum of 2 years of insurance in a 10-year-period before filing an application. The Netherlands has restricted the entitlement to benefits for new residents regarding certain types of inpatient health care covered by the AWBZ. The individual is not entitled to these kinds of benefits for a period of twelve months after having taken residence in the Netherlands if the care in question was already indicated at this time or if the person’s health condition foreshadowed need for care within six months.³¹ Waiting times also exist in tax-based Scandinavian systems.

Amount of benefits

LTC expenditure depends heavily on the amount of benefits people in need of long-term care are entitled to. A closed catalogue of benefits will result in a smaller amount of expenditure than a broad definition of claims with unclear boundaries. In particular it is important whether all neces-

³⁰ De Roo, Chambaud and Güntert (2004) p. 284.

³¹ Netherlands Host Country Report p. 5.

sary services are included into entitlements or whether capped benefits are granted. If the latter is the case, the adjustment procedure is of utmost importance. So, in Germany until 2008 the capped and nominally fixed benefits have not been adjusted for almost one and a half decades. This has added considerably to fiscal stability but has also led to a decreasing purchasing power of LTC benefits.

Care Arrangements

The fiscal burden of long-term care for an economy also depends on care arrangements. Generally speaking, informal care causes lower costs for the public purse or insurance systems. As opportunity costs of informal care are normally not accounted for this thus not necessarily mean that such arrangements are more efficient for society from a welfare economics point of view.

Income threshold

Means-tested systems set an income threshold above which no benefits are provided. This threshold may force individuals to invest all of their savings and fortune in required care services before they can ask for benefits. The UK, for example, has set this threshold at £ 22,500.³² Means-tests are a very effective means of cost-containment. They are however not advisable for the base system (see above).

System of remuneration

Finally, the system of remuneration has to be mentioned which co-determines prices for LTC services. Service prices may directly influence the expenditures of a LTC system if benefits are defined in terms of certain amounts of services. If there are capped benefits or budgets they indirectly influence expenses through the need to adjust benefits respectively.

3. Recommendations

As the above discussion has demonstrated, there are several options to control the expenditures of a public long-term care system with boundaries being just one element among others. With respect to boundaries, first, a definition of entitlement is needed. For this, all countries more or less refer to ADL / iADL scales. Special attention has to be paid to the procedure in which need for LTC is assessed and decided upon. This should be carried out by an independent organisation, staffed with medical and nursery personnel, in accordance with scientific standards. Also clear demarcations between LTC on the one hand and healthcare as well as social care on the other hand are needed. Demarcation, however, must not prevent continuous care. So, case and care management arrangements might be necessary to overcome gaps in the chain of services that might otherwise open up.

³² See UK response to the questionnaire to peer countries, answer to question 1.2.

IV. Sustainable and professional care workers

1. Issues

Approximately 70 % of the healthcare budgets in the EU are spent on salaries and other charges related directly to the employment of healthcare professionals.³³ Something similar is true for formal long-term care. With respect to expenditure of public LTC system formal care is clearly dominant: An OECD study estimates that in OECD countries between 55 % and 85 % of public LTC spending is on institutional care alone,³⁴ but also in community care most of the funds are spent on formal care. The picture is different when the amount of care-giving is considered.³⁵ In most countries informal care-giving is the backbone of LTC. Since it is not (or only partly) publicly financed the amount of informal care-giving is not reflected properly in expenditure data.

In Europe, different social protection philosophies can be identified: In northern countries, there is a conception of LTC as a social right at any person's disposal, while in southern countries a social protection philosophy dominates that offers services only in cases where social networks are absent or overloaded and the financial means of the person in need do not suffice to pay for private care arrangements.³⁶ Accordingly, the mix between formal and informal care-giving differs widely among EU countries.

Demand and supply of professional care workers

Due to demographic change the number of people in need of long-term care is going to increase. The demand formal care can even be expected to grow faster as the family care potential per dependent person is expected to decrease.³⁷ On the other hand, younger cohorts are smaller in numbers. Assuming constant recruitment patterns for professional care workers and constant average length of stay in the job, the supply of professional care workers is therefore going to decrease. Organising sustainable long-term care thus refers not only to the provision of sufficient financial resources but also to measures against a shortage of professional care workers, which is likely to occur, unless active measures are taken to increase the workforce in this area.

Gender aspects

More women than men are working as care professionals. According to a survey by a German public healthcare insurer 87 % of the employees in the care sector are female. An Austrian study says that, depending on the employer, only 3 – 8 % of care-workers in the field of long-term-care are male.³⁸ According to this study, the reason may be a difference in the intrinsic motivation between men and women: Women are much more attracted by a social, caring motivation, and by the prospect of working with other people and giving care and assistance. Men, on the other hand, are primarily attracted by job perspectives.

³³ Green Paper on the European Workforce for Health, COM (2008) 725, p. 3.

³⁴ OECD 2005: 29.

³⁵ See e.g. Döhner et al. (200) to get an impression about the amount of informal care-giving.

³⁶ De Roo, Chambaud, Güntert (2004) p. 284.

³⁷ See e.g. Blinker, Klie (2001) for respective projections for Germany.

³⁸ Reidl, Schaffer, Woitech (2006) p. 27.

(<http://www.gendernow.at/downloads/Bericht%20Chancengleichheit%20im%20Pflegebereich.pdf>, visited 2009/01/05).

The American philosopher Martha Nussbaum hints that there may be an inner connection with the European-protestant concept of worth which is closely tied to a career and success in it.³⁹ This is much more problematic for family carer whose professional career is negatively affected, which may lead to a lack of respect by others, a lack of self-respect and to health problems like depression or related psycho-somatic illnesses. But professional care-givers are also subject to this perception of care as a not fully respectable profession.

Health situation of care professionals

A German study established in 2004 that the number of days a care professional was missing due to illness, amounting to 21.3 days as compared to the average of 17.7 days over all industries. Additionally, each case of illness lasted on average 14.1 days, compared to 11.8 days on average for all industries. The employees in residential care homes showed an increased likelihood for illnesses of 0.6 percentage points compared to employees in community care settings.⁴⁰ The study also shows that care workers are much more prone to psychological illnesses than the average employee: 5.9 %, compared to 3.9 %, suffered from mental illnesses which led to inability to work for the time concerned. The study found that care workers became ill with depressive syndromes and burnout more frequently than the average.⁴¹

2. Policy options

The projected shortage of care workers follows from developments on the supply and the demand side. Therefore, strategies to counter this development can also tackle both sides of the market. Reducing the number of people in need of long-term care via prevention would clearly be one way to reduce demand. But also with a given number of people in need of long-term care, support for family care-giving and support for the voluntary sector both decrease the demand for professional care workers. As this peer review is not about ways to support family care-givers the related issues will not be discussed here. Nevertheless it seems obvious that the support of family care-giving must be a necessary element of any effective strategy.

Turning to the supply side two strategies can be identified which once again reinforce each other. First, an efficiency strategy could lean on the stratification of the workforce: Academically trained professionals rather work as organiser and manager of the care sector, while less qualified workers are doing "hands on"-jobs. As a result, more demand can be met with fewer personnel. Stratifying care-work may even make it more attractive for different parts of the work-force. Even so, in order to increase supply the attractiveness of care-work must be increased, which, generally speaking depends on payment, career opportunities, but also soft factors as work satisfaction and recognition of the profession. Policies to increase job attractiveness also have to take into account the specific gender balance in the field and the health situation of care workers as they influence chances to recruit and retain care workers.

Enhancing career opportunities – recognizing the profession

³⁹ Nussbaum (2002) p. 37.

⁴⁰ Badura et al (2004).

⁴¹ Badura et al (2004).

A structural obstacle for recruiting qualified personnel seems to be the widespread notion that caring for others is only a “second degree” career. Especially men are prone to this view. Studies suggest that this widespread notion cannot easily be changed by rises in payment. Some evidence suggests that the nursing BSc degree in the U.K. might lead to a change in the perception of the profession itself, as well as in the perception of third parties like employers and the public.⁴² There are, however, also fears: So it is suspected that nursing may develop into a mere health-care executive profession while losing the compassionate and caring aspect of nursing, and the degree opportunity might lead to the selection of individuals who are not primarily interested in caring, but in acquiring higher academic or management qualifications and positions.⁴³

Practice example: U.K.

The NHS Next Stage Review,⁴⁴ delivered by Lord Darzi on behalf of the Department of Health, emphasises among other aspects the crucial importance of high quality workplaces. But instead of focusing on medical material or good equipment, Lord Darzi’s starting point is the feeling of frustration which many professional carers encounter at work. This feeling may arise from the tendency to put perceived interests of the organization first, either by employers or cooperating institutions. Furthermore, he emphasises the importance of common values, which shall most importantly encompass respect for the patients and their dignity on the one hand, and for each member of the care-providing process on the other hand. In addition, Lord Darzi stresses the vital role of compassion for the cared-for. To implement these goals, all staff shall be provided with well-designed, rewarding jobs, including support and opportunities for personal development, access to appropriate training, line management support, active engagement in the decision-making process, individually and through representatives. Each staff member shall have the opportunity to put forward ways to deliver better care, measured by set quality goals. Staff satisfaction shall become a quality indicator in the annual evaluation of the NHS system. Only after having put forward all this, Lord Darzi demands that all staff should have easy and sufficient access to all necessary tools, and a knowledge portal could assist them.

Obviously, staff satisfaction plays an important role in the NHS review process. Interestingly, this does not primarily depend on money, but on respect, personal opportunities, valuable work. These aspects have been stressed by Martha Nussbaum, and they play a central role in diverse comparable settings.

Lord Darzi recommends clearer roles for care-workers and clearer rules concerning moving between the pathways of care. It should be possible for care professionals to switch to another profession in the care sector without starting from scratch. Skills and expertise shall be defined for each of these roles, and career pathways should be developed. It is important to keep in mind that care professionals can walk these pathways only during their working hours or in their free time. Hence it should be possible to fulfill the requirements for another role by completing modularised training units. Training for improving the quality of care by updating and developing skills should be designed in the same way.

⁴² See Wood (2008).

⁴³ Wood (2008) p. 26.

⁴⁴ DoH (2008).

Payment

Interestingly, in most of the high-income countries, the question of payment does not appear to play the most important role. Some evidence suggests, however, that the height of salaries is still insufficient in some low- and middle-income countries. Informal payments do not seem to be uncommon there.⁴⁵ In those cases rises in salary may be unavoidable, but attention should be paid to whether other factors may be relevant to improve work satisfaction.

Surveys from the U.S. support this view: While for many care professionals the level of wages is not the pivotal reason when deciding for the job, low wages are a barrier for recruiting more care professionals.⁴⁶

3. Recommendations

In order to avoid a labour force shortage in long-term care it is essential to focus on both the demand and the supply side. Support for family care giving and the evolution of mixed care arrangements, where formal care-givers, informal care-givers and people from the voluntary sector work together and find respective roles are essential to limit the demand on formal care. On the supply side both the recruitment but also the retaining of care-workers must be improved.

The recruitment of professional care workers can be facilitated through a rise in salaries, but the height of wages is neither the sole nor the predominant factor for most care workers' choice of profession. This means that "soft" aspects also have to be focused on. An initiative aimed at male youths should be started to challenge the traditional role model-based perception of care work. The NHS Next Steps report shows a lot of measures to foster respect and sense of worth with regard to care work. These aspects are of vital importance to attract qualified and compassionate professionals. A diversified approach to care and nursing home staff is recommended:

- Academically trained professionals should organise and manage the care sector, and every care worker should have the opportunity to qualify for this kind of training. Highly qualified personnel should primarily perform highly demanding tasks and delegate less responsible duties.
- "Hands on"-jobs should be performed by workers which need not necessarily have had highly-qualified training. The level of training and formal qualification should be adapted to the position in hierarchy, and a lack of formal qualification could be compensated by qualified supervisors.
- A central role should be attributed to voluntary care workers with a compassionate approach and minimal training for elementary care work and assistance to activities like spending quality time, leaving home for short walks, participating in social life.

These means should aim at fostering an integrated approach to work satisfaction.

⁴⁵ Dubois, McKee, Nolte (2006), p. 141.

⁴⁶ Harmuth (2002) p. 89.

V. Overview: Landmarks of the OMC in the field of long-term care

According to the Nice European Council in 2000, the fight against social exclusion should be led by a multi-dimensional approach called the Open Method of Coordination – OMC. It should include activities related to employment policy, social protection and other factors like housing, education, health, information & communications, mobility, security & justice, leisure and culture. The Council document stresses the importance of a coordinated effort using other sectors and strands of help in difficult life settings. In the course of this programme, the view has been expanded to other social protection and assistance schemes at national level like healthcare and long-term care.

The Lisbon Strategy and COM (2005) 706

This communication aims at the implementation of the Lisbon strategy in the field of social inclusion. Its title “working together, working better” shows the chosen perspective: improvements in the field of social life and social justice shall foster the implementation of a common market by enhancing the situation of labour forces in the Member States. This seems surprising due to the fact that persons receiving long-term care may never again participate in the labor market. But all social protection systems have to be financed by the current working population; hence the improvement of social protection also assists the improvement of the Member States’ economic situation. The Member States and the European Commission have also acknowledged at an early stage that a sustainable financial situation regarding social protection systems is vital for the long-term success of European economies. Thirdly, all social protection systems constitute economic sectors with an increasing demand for qualified services.

Objectives for the strand of healthcare and long-term care have been developed which comprise, inter alia, guaranteed access for all to adequate health and long-term care. Inequities in access to care and in health outcomes shall be addressed and reduced. But these provisions need to remain affordable and sustainable through appropriate incentives for users and providers, good governance and coordination between care systems and institutions.

The Brussels European Council of March 2006 adopted these Commission proposals and approved the Social Agenda (COM (2005) 33).

COM (2008) 42: Proposal for the joint report 2008 - Assessment of OMC and future developments

The Commission reaffirms the aims set in the 2005/2006 process and declares they shall remain guidelines for the next period until 2011. The European Social Fund's budget for 2007-2013 includes EUR 10 billion which shall be spent directly on the social inclusion priority.

In the strand of long-term care the communication stresses the rising need for long-term care and the commitment of Member States to increasing access to quality services. Furthermore, the Communication emphasises the need to strike the right balance between public and private responsibilities and formal and informal care. Provision in a residential or community setting is pre-

ferred to institutional care. The Communication also calls for improved care coordination and ensuring support for informal carers.

The OMC itself shall be reformed as well. A shift to a more context- and process-oriented approach shall take place, including the identification of unsuccessful policies. The Commission proposes a more integrative use of all available instruments to support the OMC implementation, e.g. PROGRESS. This shall be accompanied by a strengthened monitoring of policymaking, a reinforced analytical framework including a social impact assessment as a central tool and the continuous involvement of stakeholders, including local authorities.

Bibliography

Badura B., Schellschmidt H., Vetter Ch. (Hg.) (2004): Fehlzeitenreport 2004. Schwerpunktthema: Gesundheitsmanagement in Krankenhäusern und Pflegeeinrichtungen. Berlin: Springer.

Blinkert B., Klie Th. (2003): Zukünftige Entwicklung des Verhältnisses von professioneller und häuslicher Pflege bei differierenden Arrangements und privaten Ressourcen bis zum Jahr 2050, in: Enquete Kommission „Demographischer Wandel“ des Deutschen Bundestags (Hg.): Herausforderungen unserer älter werdenden Gesellschaft an den einzelnen und die Politik. Studienprogramm. Heidelberg: R.V. Decker.

Colombo F., Tapay N. (2004): Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems (OECD Health Working Papers No. 15, 2004)

Comas-Herrera A., Wittenberg R, Pickard L (2003): Long-term care for older people in United Kingdom 76-88, in: Comas-Herrera, Adelina / Wittenberg, Raphael (eds.): European Study of Long-Term Care Expenditure: Investigating the sensitivity of projections of future long-term care expenditure in Germany, Spain, Italy and the United Kingdom to changes in assumptions about demography, dependency, informal care, formal care and unit costs. Report to the Directorate General for Employment and Social Affairs of the European Commission. PSSRU Discussion Paper 1840. LSE: London. 24-42.

URL: http://ec.europa.eu/employment_social/social_situation/docs/european_study_long_term_care_en.pdf.

De Roo A., Chambaud L., Güntert B. (2004): Long-term care in social health insurance systems in Saltman, R., Busse, R. and Figueras, J. (ed.): Social health insurance systems in western Europe Buckingham: Open University Press

DoH (2007): Department of Health: The National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, June 2007

DoH (2008): Department of Health: High Quality Care For All. NHS Next Stage Review Final Report, June 2008

Esping-Andersen, G. (1990): The Three Worlds of Welfare Capitalism. Cambridge: Polity Press.

European Commission (2006): The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050) Report prepared by the Economic Policy Committee and the European Commission (DG ECFIN). Special Report No. 1.

http://europa.eu.int/comm/economy_finance/epc/epc_publications_en.htm

http://europa.eu.int/comm/economy_finance/publications/eespecialreports_en.htm

Harmuth S. (2002): The Direct Care Workforce Crisis in Long-Term Care, in NCMJ Vol. 63 (2002) pp. 87 – 94

Hauschild R. (1994): Vorschläge und Konzeptionen, in: Bundesarbeitsblatt, 45. Jg., Heft 8/9. Schwerpunktthema: Die neue Pflegeversicherung, 12-21.

Huber M. (2007): Synthesis Report on “The future of Social Services of General Interest”, Belgium

Jacobzone S., Cambois E., Chaplain E., Robine J.M. (1998): The Health of Older Persons in OECD Countries: Is It Improving Fast Enough to Compensate for Population Ageing? Labour Market and Social Policy Occasional Papers No. 37. Paris: OECD.

Jacobzone, S. (1999): Ageing and Care for Frail Elderly Persons: An Overview of International Perspectives. Labour Market and Social Policy Occasional Papers No. 38. Paris: OECD

Karlsson M., Mayhew L., Rickayzen B. (2007): Long term care financing in four OECD countries: Fiscal burden and distributive effects, in *Health Policy* 80 (2007), pp. 107 – 134

Karlsson M., Mayhew L., Plumb R., Rickayzen B. (2004): An International Comparison of Long-Term Care Arrangements. An Investigation into the Equity, Efficiency and Sustainability of the Long-Term Care Systems in Germany, Japan, Sweden, the United Kingdom and the United States (April 26, 2004)

Lamura, G.; Döhner, H. / Kofahl, Christopher (eds.) (2008): Family Cares of Older People in Europe. A Six-Country Comparative Study. Münster: Lit-Verlag

Merlis M. (2004): Long-Term Care Financing: Models and Issues, Report prepared for the National Academy of Social Insurance Study Panel on Long-Term Care (April 30, 2004)

Mestheneos E., Triantafillou J. and the EUROFAMCARE group (2005): Supporting Family Carers of Older People in Europe – the Pan-European Background. Münster: Lit.

Ministry of Health, Welfare and Sport (2009): Long-term care in the Netherlands: The Exceptional Medical Expenses Act. Host Country Report. Peer Review: Long-term care: How to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities. The Netherlands, 10-11 February 2009.

NBB (2003): National Bank of Belgium, Belgium Prime News No. 20 (June 2003)

Norton E. (2000): Long-Term Care, in Culyer and Newhouse, *Handbook of Health Economics* Vol. 1 B Amsterdam: Elsevier

Nussbaum M. (2002): Long-Term Care and Social Justice: A Challenge to Conventional Ideas of the Social Contract, in WHO, *Ethical Choices in Long-Term Care: What does Justice Require?* WHO Series, pp. 31 – 65

OECD (2005): *The OECD Health Project: Long-Term Care for Older People*. Paris: OECD

OECD (2007): *Trends in Severe Disability Among Elderly People*. DELSA/HEA/WD/HWP (2007)

Reidl S., Schaffer N., Woitech B. (2006): „gendernow“ study: Chancengleichheit im Pflegebereich, Vienna 2006

Rothgang H. (2007): Aging Society, Demographic Change, and Economic Implications for Germany's Long-Term Care System, presentation held at the AARP US/German Dialogue on Long-Term Care 29-31 October 2007, Washington DC

Rothgang H., Borchert L., Müller R., Unger R. (2008): GEK-Pflegereport 2008. Medizinische Versorgung in Pflegeheimen [GEK Long-term Care Report 2008: Medical care in nursing homes] St. Augustin: Asgard

Royal Commission on Long Term Care (1999): *With Respect to Old Age*. Cm 4192. London: The Stationery Office.

WIdO (=Wissenschaftliches Institut der AOK) (2004): *Fehlzeitenreport 2004*. Bonn: AOK-Verlag

Wittenberg R., Sandhu B., Knapp M. (2002): Funding long-term care: the public and private options, in Mossialos E., Dixon A., Figueras J., Kutzin J. (ed.): *Funding health care: options for Europe* Buckingham: Open University Press

Wood V. (2008): *Nurses in Society: starting the debate*. Oral evidence gathering, by Victoria Wood, Lala & Wood Market Research Consultants, on behalf of the National Nursing Research Unit, King's College London, June 2008