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The Netherlands 11 – 12.02.09

Synthesis Report

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

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Long-Term Care: How to Organise Affordable, Sustainable Long-Term Care given the Constraints of Collective versus Individual Arrangements and Responsibilities

In cooperation with the Ministry of Health, Welfare and Sport

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Executive Summary

Like many other EU countries, the Netherlands is confronted with the challenge of containing the growing burden of long-term care (LTC) and ensuring it remains affordable. This is particularly important in such economically challenging times as these. The Dutch government has therefore opened a public debate about the future of its long-term care system and initiated a Peer Review on the subject, considering it important to share, compare and exchange views with other EU Member States.

The aim of the Peer Review meeting on long-term care policies was to examine how best to organise affordable and sustainable long-term care, given the constraints of collective versus individual arrangements and responsibilities. It took place on 10–11 February 2009 in The Hague, the Netherlands. The event was held within the framework of the European Commission's Peer Review programme on Social Protection and Social Inclusion, and was hosted by the Dutch Ministry of Health, Welfare and Sport.

Together with the host country participants, representatives from ten peer countries took part, namely: Austria, Belgium, Estonia, Germany, Hungary, Poland, Romania, Slovenia, Sweden and the United Kingdom. European stakeholder groups were represented by AGE — the European Older People's Platform — and the EASPD — the European Association of Service Providers for Persons with Disabilities. Also present were representatives from the European Commission's Directorate-General for Employment, Social Affairs and Equal Opportunities, and a thematic expert from the University of Bremen in Germany.

The Peer Review discussions were structured around three central questions, identified by the host country as key in ensuring that long-term care remains not only affordable but also sustainable, accessible and of good quality. These questions were as follows:

1) On financing: "How can a balance be established between collective and individual arrangements and responsibilities, so that individuals can have the option of both being involved in collective arrangements (through co-payments or personal budgets) and

having local authorities help them cope independently with long-term care?"

2) Regarding boundaries between different care systems: "Where can the boundaries between long-term healthcare and related facilities, such as subsidised housing or domestic help, be drawn so that people are aware of what services they are entitled to and so that decisions on provision are made in a fair and transparent way?"

3) As regards the labour force and the availability of qualified staff in long-term care: "How can the correct balance be achieved between supply and demand, taking demographic and labour market factors into account?" This question also covered the issue of the migration of care workers within the European Union.

In addition to these questions, the Peer Review discussed the effects of the current financial and economic crisis on the LTC sector.

In the course of the discussions, some areas of common understanding were reached on the following issues:

- On financing: It was considered that private insurance in the form of out-of-pocket payments cannot form the backbone of the system as, if it is risk-related, it will preclude universal care provision and, if it is compulsory for all, it will de facto become a form of social insurance. It was therefore considered that an LTC system requires substantial public financing, either in the form of social insurance or of a tax-based system.

- Regarding boundaries between systems: Though the necessity for clear boundaries between systems in order to control costs was acknowledged, there was even higher consensus that boundaries could end up obstructing the provision of integrated care, which was regarded as both desirable and necessary.

- As regards the labour force: Measures on the demand and supply sides were viewed as necessary to prevent a future shortage of care workers. Migration of care workers between Members States was not seen as the best or the only solution at a European level.

I. Introduction

The Peer Review meeting on long-term care policies, aimed at examining how best to organise affordable and sustainable long-term care, given the constraints of collective versus individual arrangements and responsibilities, took place on 10–11 February 2009 in The Hague, the Netherlands, as part of the process of Peer Reviews in Social Protection and Social Inclusion and Assessment in Social Inclusion. The event was hosted by the Dutch Ministry of Health, Welfare and Sport.

Together with the host country participants, representatives from ten peer countries took part, namely: Austria, Belgium, Estonia, Germany, Hungary, Poland, Romania, Slovenia, Sweden and the United Kingdom. European stakeholder groups were represented by AGE — the European Older People's Platform — and the EASPD — the European Association of Service Providers for Persons with Disabilities. Also present were representatives from the European Commission's Directorate-General for Employment, Social Affairs and Equal Opportunities, and a thematic expert from the University of Bremen in Germany.

This Synthesis Report documents the discussions that took place during the meeting. It follows the structure of the Peer Review and its accompanying questionnaire, and builds on the discussion paper that served as a thematic background paper to the Review.

The discussion was structured around the three sub-themes that had been placed on the table by the host country:

1) On financing: "How can a balance be established between collective and individual arrangements and responsibilities, so that individuals can have the option of both being involved in collective arrangements (through co-payments or personal budgets) and having local authorities help them cope independently with long-term care?"

2) Regarding boundaries between different care systems: "Where can the boundaries between long-term healthcare and related

facilities, such as subsidised housing or domestic help, be drawn so that people are aware of what services they are entitled to and so that decisions on provision are made in a fair and transparent way?"

3) As regards the labour force and the availability of qualified staff in long-term care: "How can the correct balance be achieved between supply and demand, taking demographic and labour market factors into account?" This question also covered the issue of the migration of care workers within the European Union.

However, in the course of the debate, a new issue emerged, namely that of the current financial and economic crisis. Both the short-term and long-term effects of the crisis on long-term care in the respective Member States were thus also discussed.

Each of the four above-mentioned issues is dealt with in more detail in section V of this report. Prior to that, some background information on the demographic challenge (section II), as well as on the policy and situation in the host country (section III) and in the peer countries (section IV), is provided. The conclusions then summarise the major lessons learnt.

II. Background: the demographic challenge

The demand for long-term care is, of course, age-related and, with the EU Member States' increasingly 'greying' population, the number of people in need of long-term care will inevitably grow. According to the OECD, the share of the 'oldest old', i.e. those aged 85 or more, is expected to double from 1.5 % of the population to 3.0 % between 2005 and 2030. In 2050, this figure is expected to stand at 5.2 %, which is more than three times as high as today. Since the 'oldest old' face the highest risk of dependency, this gives a flavour of what is to be expected in terms of numbers of people in need of long-term care. While the repercussions of this emerging trend may be tempered by decreasing age-specific dependency rates, there can nevertheless be no doubt that the demographic change will lead to higher demands on long-term care.

What's more, the demand for long-term care (LTC) can easily be underestimated if one only looks at the prevalence rate at a given point in time rather than at the lifelong risk. German data, for example, shows that even under a fairly narrow definition of long-term care, there is a 50 % chance that a person will need LTC during his or her lifetime. This figure is confirmed by US data.[1] Long-term care therefore represents a social risk of huge relevance for everyone, and protection against this risk should, by consequence, be considered a prerogative of the welfare state in all EU countries.

The discussion on how best to organise affordable and sustainable long-term care is thus of utmost political and social relevance and many questions surrounding this issue need answering: How can we guarantee a sufficient supply of future carers? Where do we find sufficient and sustainable funding? How can spending on long-term care be controlled and stay affordable?

1 The Peer Review discussion paper provides a more in-depth discussion on this issue and on the effects of demographic change on LTC. This paper is available at: http://www.peer-review-social-inclusion.eu/peer-reviews/2008/how-to-organise-affordable-sustainable-long-term-care-given-the-constraints-of-collective-versus-individual-arrangements-and-responsibilities/discussion-paper.

III. Policy and situation in the host country: the Netherlands

The situation in host country the Netherlands served as a starting point for the Review.[2] With a population of 17 million, the Netherlands has an average life expectancy of 78 years.

Within the Netherlands' legal framework, three instruments are relevant to the long-term care system: the Cure Insurance Act (ZVW), covering medical services, the Exceptional Medical Expenses Act (AWBZ), which covers people suffering from serious long-term illnesses or disorders, and the Social Support Act (WMO), which is run by local authorities.

The Exceptional Medical Expenses Act (AWBZ) was introduced in 1967. It establishes a national insurance scheme within which everyone meeting the criteria defined in the legislation is automatically insured and obliged to pay a statutory contribution, irrespective of whether they plan to use the services or not. The scheme is funded by means of these premiums, as well as state subsidies and personal contributions from care recipients. The insurance covers institutional care (nursing homes or homes for the elderly), as well as home care for the frail elderly, disabled people and people with chronic psychiatric disorders.

Today some 3.6% of the Dutch population (588,000 people) qualify for long-term care under the AWBZ. However, over the past ten years, the cost of the AWBZ — and therefore of premiums — has increased significantly. An individual with an average income now pays a monthly AWBZ premium of € 320.

This hike in costs can only be partially explained by demographic developments and by the rising number of older people requiring long-term care. Indeed, AWBZ expenses have also been growing much faster than expenses related to the Cure Insurance Act (ZVW) for medical services. This has led to some

2 The LTC policy in the Netherlands is summarised in the host country paper available at http://www.peer-review-social-inclusion.eu/peer-reviews/2008/how-to-organise-affordable-sustainable-long-term-care-given-the-constraints-of-collective-versus-individual-arrangements-and-responsibilities/host-country-report.

concern that costs that should actually be covered by the ZVW are actually being shifted towards the AWBZ, thereby unfairly increasing the financial burden of the LTC system.

The questions of sustainability, solidarity and clear boundaries between systems are therefore crucial in the Dutch discussion. Changes aimed at ensuring that long-term care remains accessible, of high quality and affordable are already underway. Measures include redefining the types of care people are entitled to and ensuring the system is more efficient (namely with the introduction of a 'personal budgets' scheme, in which individuals receive a specific allowance that they can spend on the services they choose). These measures are expected to save € 800 billion by 2010. However, despite these efforts, the cost of the Exceptional Medical Expenses Act is still expected increase by 3 % due to demographic change, and expenditure is likely to rise from € 21 billion in 2008 to € 23 billion in 2012.

IV. Policy and situation in peer countries[3]

The way a country responds to the challenges of ensuring a sustainable LTC system depends significantly on the structure of its welfare state. The following section therefore provides an analysis of the peer countries' situations and of their policies towards the issues raised by the host country. Countries have been grouped according to the typology of their care systems.

1. Traditional social insurance systems: Germany, Austria, Belgium

While the social insurance systems of Germany, Belgium and Austria are comparable in many respects, the three countries have all come up with different solutions for providing long-term care.

a) Financing

Different sources of financing are used in all three countries: In Germany a specific mandatory LTC insurance was introduced in the mid-1990s. However, this insurance does not cover all costs incurred and an additional share has to be financed out-of-pocket or by taxed finances and means-tested social assistance. Austria's "Pflegegeldgesetz" was introduced even earlier than the German scheme. Under Austrian law, tax-financed cash benefits are reserved for extramural care only, while public financing of intramural care relies on social assistance. In Belgium, long-term healthcare is part of the mandatory social health insurance and a loss of autonomy will trigger an entitlement either to some cash allowances that are charged to the federal budget ("palliative care allowance", "intervention for incontinence material", "chronic illness allowance") or to some social care and services that are charged to the budgets of the Communities and Regions.

3 This overview is based on the country reports written in response to the questionnaire drafted by the host country (see: http://www.peer-review-social-inclusion.eu/peer-reviews/2008/how-to-organise-affordable-sustainable-long-term-care-given-the-constraints-of-collective-versus-individual-arrangements-and-responsibilities).

Thus, none of these three countries relies solely on contributions to social insurance for the public financing of their LTC systems and all of them have some provision for out-of-pocket payments.

b) System boundaries

All three countries describe the boundary between long-term care and other care systems as troublesome in one way or another. The Belgian country report underlines the huge fragmentation of the national LTC system, which creates a lot of gaps and uncertainties concerning the coverage of specific needs. The differentiation between healthcare benefits is regarded as a particular problem. The Austrian report points out that hospitals are being used as *de facto* alternatives to nursing homes in some cases. In Belgium, certain types of hospital services have in fact been introduced into the LTC system intentionally to avoid this kind of situation. In Germany, the discussion relating to boundaries between healthcare and long-term care focuses more particularly on the issue of medical devices used in nursing homes and on the distinction between basic care (financed by LTC insurance) and medical care (financed by health insurance).

None of the country reports provide a clear set of rules or criteria that would enable a differentiation between different types of care. In fact, all three country report highlight the disadvantages of establishing clear, distinct boundaries, namely when it comes to integrating the separate kinds of care provided to elderly people. It has in fact been observed that the clearer the differentiation between healthcare and long-term care, the more difficult it becomes to provide integrated care. Hence Germany, for example, endeavours to provide both kinds of services through integrated LTC support centres and mandatory counselling.

c) Labour force

All three countries report a growing demand for nursing personnel in both residential and at-home care. They expect a shortage of personnel in the near future unless measures are taken to recruit more professionals. Only Belgium describes the current situation slightly more optimistically, while

Austria reports that an increasing number of open jobs in the care sector are being covered by foreign-trained nurses.

On the other hand, the countries note that several factors could modify the number of care professionals needed to provide quality care to each person in need. Indeed, Austria points out that developments in future quality standards, policies and technology, as well as in the expectations of care receivers and their families, will determine the level of qualified care work needed. In Germany, attempts are being made to expand the area of formal care so as to minimise the gap between the supply and demand of care workers. Belgium has introduced the concept of 'care assistants', i.e. care workers in charge of supporting nurses, as a recognised healthcare profession. Moreover, the country has paid special attention to improving the working environment, as well as relations with care receivers and work satisfaction, through improved support for informal care, special social agreements and the possibility for care assistants to become nurses. Nurses now have improved job perspectives as well, as they may take training courses or acquire a bachelor's degree whilst keeping their wages. Austria has also taken measures to improve job mobility and hierarchical mobility.

2. The Scandinavian model: Sweden

a) Financing

Almost 96 % of LTC spending in Sweden is financed by taxation at the municipal level. The services available within this system are delivered equally to all but it is possible to buy additional services from LTC providers. The Swedish report nevertheless points out that, in a working LTC system, there should be no need to buy additional services because all needs should be covered by the municipal services. On the other hand, co-payments are common to many municipalities on the condition that care receivers are wealthy enough to afford contributions to the costs of LTC.

b) System boundaries

The Swedish system differentiates between healthcare and long-term care. The two systems are managed by separate administrative levels. While Sweden favours clear distinctions, it recognises that assistance is needed to prevent fragmentation and to bypass the disadvantages resulting from this structure. In line with this thinking, the country has introduced 'pilots' to help care receivers to navigate through the systems.

c) Labour force

Sweden reports no current problems concerning care personnel, but it does expect a shortage in about 10 years time due to retirements and a demographic shrink in the available workforce. Hence, competition for competent staff can be expected. Sweden has recently started to develop strategies aimed at acquiring competent personnel in sufficient numbers. A report addressing this question was published at the end of 2008. Key requirements for attracting competent staff include establishing a minimum level of qualifications, possibilities for care workers to develop their skills and improved career opportunities. Moreover, Sweden intends to start education on long-term care in school.

3. The UK's National Health Service[4]

a) Financing

In England, long-term care services are tax-financed. Applications are processed according to an assessment of the person's needs and include a means test, which limits the state's contribution to the costs of care according to the service user's personal capital, including savings, investments and property.

If care receivers have estimated assets above the threshold of £ 22,500 (around € 26,570), they will be required to pay the full cost of their care

4 Since there are distinct institutional arrangements in different parts of the United Kingdom the description rather refers to England.

expenses and will not be entitled to state support, regardless of their level of need.

What's more, decisions about levels of care funding are taken locally, which means that two people with identical needs could end up receiving different levels of care and services, depending on the community they live in. A national framework for defining levels of care exists in an attempt to minimise differences related only to residence.

The needs assessment also considers whether informal care is available to the applicant.

b) System boundaries

A basic distinction is made between healthcare and social care. Healthcare services are part of tax-financed National Health Service (NHS) services, while social care is provided by local authorities. Medical treatment within the NHS is, by and large, provided free of charge at the point of delivery and without any means-testing. Social care, however, is means-tested. Hence these systems have to be kept distinct. Long-term care is neither completely part of the former nor the latter. The precise boundaries are under review.

c) Labour force

The UK country report notes that, in April 2007, the overall turnover rate for all categories of social care staff was 19.3 %, with 25.9 % in domiciliary care. Such high turnover rates indicate a staffing problem. Indeed, human resources studies indicate that a turnover of 15 % represents a problem, while one over 20 % can act as a major deterrent to a quality service. This is especially important in a sector such as LTC, where relationships are vitally important and the tasks are personal and intimate. The report also cites vacancy rates as high as 5.9 %.

The UK is attempting to increase the attractiveness of long-term care work by addressing fees, staff's remuneration and contracting, but also by improving working conditions, training and career opportunities. In June 2008, the Department of Health, in partnership with several stakeholders, published an interim statement relating to the UK's workforce strategy development,

entitled: "Putting People First — Working to Make it Happen". Moreover, each year, the Department of Health runs a recruitment campaign for the social care sector, to raise awareness of social care work and to encourage people to find out about local employment opportunities.

In 2008–09, the Department of Health spent £ 290 million on the training and development of an adult social care workforce. Furthermore, the National Skills Academy will set up a programme to train and further qualify social care workers.

4. New EU Member States: Poland, Slovenia, Hungary, Estonia, Romania

Healthcare systems in these five countries are mainly or solely based on insurance. However, as is often the case in insurance-based systems, tax revenues are sometimes used to complement premiums, seeing as the services covered by the system are of general interest. Hungary, for example, has a mixed insurance system combined with additional tax financing.

As regards long-term care, none of these countries has a distinct insurance scheme in place. Formal LTC-related services are rather provided as part of other social security schemes. In Poland, care duties are traditionally attributed to family members and relatives, with social assistance as a last resort.

a) Financing

The way LTC services are financed depends on the system the specific service is attributed to. Some services are financed from national state budgets, some from community or county budgets, some from insurance payments. Social service systems are primarily based on tax financing, while healthcare is covered by insurance systems. Contributions and co-payments by care receivers, as well as means-tests, are common to each of the five nations' systems.

b) System boundaries

All countries report problems arising from the administration of LTC services by distinct care systems. In Slovenia, there is a strict separation between nursing homes and at-home care. The country points out that, in cases where care services are provided at home, healthcare and social care providers currently work separately and without cooperation, sometimes even in contradiction to each other. Poland also underlines the difficulties related with maintaining distinct systems of care provision. It is currently seeking to enhance cooperation between the institutions that provide services in different care sectors so as to improve the situation of care receivers and reduce inefficiencies. Estonia also highlights huge difficulties in changing from nursing care services to other kinds of care provision and vice versa. As a solution to this problem, it is currently developing integrated care concepts to support closer links between long-term care services and other related services.

c) Labour force

Estonia, Romania and Slovenia all report notable to severe problems with the supply of qualified care personnel. In Hungary and Poland, such pressures on supply are not felt at the moment but they are expected to arise in the near future. As is reported by Poland and Romania, the reasons for an increased pressure on supply are basically the same in all countries: a decrease in unemployment, combined with rising wages, which leads to an increased demand for care services and workers. Slovenia also emphasises this growing demand for care services, while Estonia points out that care jobs receive too little recognition and social reward, and that wages in the sector are too low to compensate for this.

Solutions proposed by these countries mainly include improving working conditions and, especially, strengthening at-home care by family members.

5. Stakeholders' point of view

AGE, the European Older People's Platform, and EASPD, the European Association of Service Providers for Persons with Disabilities, both submitted statements and participated in the Peer Review process.

First and foremost, **AGE** underlined the importance of adopting a holistic point of view, which takes into account the interests and perspectives of all generations, when it comes to LTC. In terms of financing, the organisation emphasised that, for both care receivers and care providers, the most important question is not actually the source of financing, but rather the impact that these sources have on issues such as accessibility, affordability and quality of care. AGE namely expressed scepticism about shifting responsibility for LTC to the individual because the impact of such reforms is not known. In particular, vulnerable groups, like older women without strong family support or migrants with little or no employment records, could suffer from such changes in the LTC environment. AGE therefore recommended that LTC services be universally accessible, regardless of age, income, health condition or employment record.

The organisation also criticised the distinctions that are sometimes made between LTC and medical care systems. Although the group acknowledged that boundaries between systems may be necessary, it warned that these could also lead to obstacles in the nursing and care-giving process. Moreover, boundaries surrounding LTC systems could provoke a change in balance between collective and individual responsibilities. Hence, AGE recommended that the Commission carry out an impact assessment of the reforms implemented in some Member States to shift part of the dependency risks to the individual.

Concerning the issue of qualified personnel, AGE pointed out that most workers in the LTC system are unable to find another job and this is why they work as care givers. It urged Member States to make the profession more attractive by implementing better working conditions. New technologies could contribute to this objective, while also reducing the number of workers needed to provide high-quality care. The EU should use EU financial

instruments like the Structural Funds and the European Social Fund for this purpose.

The **EASPD** emphasised the importance of maintaining a 'value perspective' when it comes to LTC and stressed the concept of 'desirable care'. From this perspective, support towards activating people with disabilities emerges as more important than just providing pure care and a key aim is to enable people to be independent from LTC services. To achieve this aim, the organisation believes assessment methods should be reviewed on the basis of best practice analyses. Reforms should take into account comparable needs, as well as cultural, religious and ethnic factors. Family members, relatives and neighbours should be integrated in the needs assessment and into the service provision. A wide range of services should be offered to avoid 'one-fits-all' solutions that simply do not work. Moreover, the group pointed to extensive variations in eligibility criteria between, and sometimes even within, Member States. It recommended the establishment of managed care systems to minimise the disadvantages related to fragmented social security systems. Concerning the issue of qualified personnel, the EASPD recommended improving the status of workers and their working conditions.

6. Common problems; common solutions

The analysis of the peer country reports reveals that virtually all countries suffer from comparable problems and challenges, irrespective of the type of system chosen to provide long-term care. This finding enables and facilitates a common exchange of ideas at the European level and strengthens the very idea of the European Peer Review process itself.

The peer country reports nevertheless demonstrate that some problems arise from specific national constitutional or legislative choices or from specific circumstances that several Member States share. Austria, for example, reported considerable difficulties with its distinct federal and provincial competences. Similar problems arise in other countries with a high degree of devolution.

V. Lessons learned

1. Labour force

Due to demographic change, the number of people in need of long-term care is set to increase. The demand for formal care is expected to grow at an even faster pace as the family care potential per dependent person decreases. At the same time, the downsizing of the younger cohorts of the population is likely to lead to a reduction in the supply of professional care workers, if one assumes constant recruitment patterns and constant average length of stay in the job.

Though the timeframe differs from one country to another, this general trend is consistent in all Member States examined. Even if there is no labour shortage at the moment, the combination of the above trends can be expected to create future labour shortages in long-term care. The issue of organising sustainable long-term care thus refers not only to the ability to provide sufficient financial resources, but also to the adoption of measures against the shortage of professional care workers.

To prevent a labour shortage in the realm of long-term care, both the demand and supply sides can be influenced. During the meeting, participants intensively discussed strategies from both these sides.

With respect to the *demand side*:

First of all, *prevention* could slow down the growth in the number of people needing long-term care. This includes all measures aimed at encouraging a healthy lifestyle and creating a healthy surrounding, as well as those specifically and directly influencing the need for LTC. During the Peer Review, the UK 'reablement scheme' was discussed as an example of a specific measure serving this purpose successfully. 'Reablement' courses help older people to regain their skills and their confidence in their ability to care for themselves. These courses are relatively short and intensive, and have been found to reduce the demand for long-term care significantly. Nevertheless,

it should be noted that effects were measured after six weeks and that it is thus not yet clear how long the effects of reablement last.

A second important aspect on the demand side is the availability of *informal care* for those in need of long-term care, alongside professional care. Among Member States, the balance between formal an informal care varies significantly. Generally speaking, Nordic countries with a social democratic welfare state model rely rather more on formal care, as do liberal welfare states. Informal care plays a much bigger role in the conservative welfare states with a Bismarckian tradition and an even greater one in Mediterranean countries. For the former, family care and voluntary work could therefore provide an option to exonerate the formal care system. However, those relying more on informal care will have to cope with an ever decreasing capacity and willingness of families to care. In any case, there can be no doubt that the support provided by family care, which still remains the backbone of LTC provision in most countries, is an important strategy to complement formal care-giving and thereby reduce the demand on formal LTC services.

With respect to the *supply side*:

Two strategies were identified in the course of the presentations and discussions: firstly, improving productivity and, secondly, enlarging the workforce in the area of formal long-term care-giving.

The basic notion is that even the given labour force could satisfy increased demands on long-term care if *productivity were improved*. Such improvements could result from innovations in work routines, such as more efficient task allocation or job differentiation. They may also derive from advances in information and communication technologies (ICT) or from new medical instruments. Inventions such as the recently developed Japanese suit that enables women to lift greater weights, or technologies that enable at-distance caring could play a big role in the future.

Strategies to *enlarge the workforce* active in care-giving can be distinguished according to the moments they address within an employee's life-course. Strategies may aim to:

- get more people in;
- increase average working hours per week;
- make workers stay on until retirement and pension, and;
- make staff work after reaching the legal pension age.

First of all, to boost *recruitment*, targeted campaigns aimed at youngsters provide a potentially useful instrument, as does specialised funding for education. Indeed, up to now the share of men taking up education in the field of care work remains small. To counter this, new campaigns could be oriented towards different target groups, such as young men. Moreover, providing students in care institutions with practical learning and work experience may help to improve the image of the sector. In short, there appears to be scope for increased head-hunting and career marketing in the care-giving sector, as is done in the Netherlands.

Secondly, *raising the average number of working hours per week* can help to close the gap between a growing labour demand and a declining labour supply. Currently, part-time work is widespread in the care-giving sector and, while promoting lighter working schedules has in general proven a successful strategy in countering unemployment, a reverse strategy aimed at reducing part-time work is needed in times of labour shortage. This could be achieved by offering longer, but more flexible, work schedules for those with children or older relatives. However, efforts to increase working hours must be flanked by parallel efforts to improve childcare infrastructure.

Finally, it is important to *minimise the number of drop-outs from care working* and, even, to encourage care workers to continue *working after reaching the current legal pension age*. With respect to the latter, the elevation of the minimum pension age that is taking place in some Member States could prove helpful.

Generally speaking, all attempts to recruit a higher share of the total labour force, to increase working hours and to minimise drop-outs have one thing in common: they rely on attempts to improve the appeal of

professional care-giving. The attractiveness of care provision depends not least on the social recognition of the profession, but also on factors such as work pressure, career opportunities, including the possibility of obtaining academic qualifications, and — of course — payment. Though a wide variety of measures could contribute to enhancing the profession's allure, nearly all of them would generate additional expenditure one way or another. Nevertheless, Peer Review participants agreed that there was a real need to take active measures to improve the attractiveness of care-giving in order to avoid prospective labour force shortages.

During discussions with respect to demand and supply-side strategies, a new issue emerged as a source of intense debate, namely that of the *migration of care-givers* from Eastern to Western Europe. For example, a substantial share of care workers trained in Romania and Hungary migrate to Western European countries for better paid jobs after finishing their training. This phenomenon further exacerbates shortages in their home countries. It was pointed out that measures aimed at putting a stop to this specific kind of 'brain drain' can be taken by both sending and receiving countries. Representatives from the Dutch government, for example, stated that the Netherlands had declined to attract foreign care workers, particularly since most people in the Netherlands want to be cared for by people who live near them and speak their own language. For receiving countries, foreign care workers are particularly attractive when they work for much lower wages. Regulating the working conditions for migrants therefore represents an effective means of limiting the brain drain. On the side of the exporting countries, the provision of career chances for care workers in their home countries is a very effective means to limit migration, as highlighted in a current Austrian study on the matter. Another useful strategy could be to put in place an education system where studies are charged to the student and financed by loans that could be written of once the individual has completed a certain period of work in the country of education.

Of course, in the short run, the current financial and economic crisis might eclipse the issue of long-term labour shortage in care-giving. Indeed, as unemployment rises, recruitment problems will appear to fade away and the return of emigrants to their home countries might relieve labour

shortages there. Nevertheless, this should not serve as a reason to stop the reflection on how to prevent a future labour shortage, as the economic crisis — hopefully — will not last forever.

2. Public-private mixes in funding long-term care

As established, changes in demography are likely to cause an increase in the number of people in need of long-term care. Moreover, as the dependency ratio rises, informal care will come under growing pressure and, in the long run, formal care will suffer from labour shortages that can only be surmounted with the adoption of certain measures creating additional expenditure (see section V.1). There can therefore be no doubt regarding the need for increased financial resources for long-term care in the future.

Generally speaking, there are four potential sources for these revenues:

(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.

With respect to these options, it was agreed that there is no one-size-fits-all solution. Member States have different traditions and have built up their welfare state in different ways. Any system of LTC financing therefore has to take into account the existing institutional arrangements and the constraints related to them.

Nevertheless, there was also remarkable consensus on the following notions:

a) that the goals of universal coverage of the population and of equal access to long-term care services are essential, and;

b) that these goals cannot be reached through a private system alone and require some form of public financing — be it via some kind of social insurance or via a tax-based system.

Indeed, with LTC expenditures sometimes extending to sums that no reasonable person would ever put aside solely for this purpose — and that most people would never have the chance to save during their entire lifetime — individual savings in the form of *out-of-pocket payments* cannot be regarded as the financial backbone of an LTC system. Limited co-payments could play a role, if only to prevent moral hazard, although abuse of the system is in any case unlikely when it comes to benefits in kind, which very few people would appreciate unless they really needed them.

Voluntary private insurance is generally only taken up by a minority of people and cannot therefore serve as a basic financing system for LTC either. Demand is particularly low where a social welfare scheme exists as a last resort — which is the case within the EU. What's more, risk-related private insurance premium tends to be too expensive for older people, people in bad health and people with little income. That is why the problem of the uninsured can only be resolved by making private insurance *mandatory*. However, if this is done, the system must be bolstered by tax-based subsidies for those who cannot afford the premiums and — most likely — by the introduction of premium caps, particularly for the old-aged. However, if regulated in this fashion, a mandatory private insurance system will come close to becoming a social insurance system.

The meeting therefore concluded that private insurance cannot form the backbone of the system. Indeed, if it is voluntary and risk-related it excludes universal coverage and, if it mandatory, it is necessarily accompanied by certain regulation relating to subsidies and/or premium caps, thus making it resemble a form of social insurance. LTC financing systems that combine universal coverage, equal access and sufficient funding therefore require either a social insurance or a tax-funded system.

Social insurance systems with income-related contributions, based on a pay-as-you-go (PAYGO) principle, were identified as an option for the basic financing of an LTC system, as they meet most of the concerns raised against

private insurance. Firstly, by resorting to income-related contributions, such systems guarantee affordability for individuals without the need for premium subsidies. They can therefore be extended to the whole population, enabling universal coverage and equal access to benefits. Secondly, contribution-based social insurance systems can be implemented almost ad hoc as the payments made by the current generation of contributors will finance the benefits of the current generation of beneficiaries. This "contract of generations" enables policymakers to implement social insurance systems immediately.

The "price" to pay for this advantage, however, is the creation of an implicit debt, generated by the introduction of the system and transferred from one generation to the next. What's more, if contributions are levied on salaries and wages alone and 'good risks' are allowed to opt out of the system — as is currently the case in Germany — the system can comprise other problems. Indeed, if the wage ratio — i.e. the contribution of the factor labour to overall GDP — declines, the amount of contributory income will grow slower than GDP, causing fiscal problems for LTC insurance. Moreover, such a system raises distributional questions, as income coming from different sources is treated differently (horizontal inequality) and income above a certain income ceiling does not increase contributions (vertical inequality). In order to avoid such problems, the base for contributions should be as broad as possible, including the entire population, as well as all types of income, as is the case for income taxation. Additionally, the existence of an absolute income ceiling for contributions should be reconsidered.

Apart from social insurance systems, *public taxes* may serve as basis for LTC financing. Like social insurance systems, tax-based systems follow the PAYGO principle, which means benefits can be granted immediately. On the other hand, taxed-based systems differ from social insurance with respect to distribution and sustainability. Generally speaking, systems providing for means-tested benefits may lead to an under-provision of care services and destroy incentives for individual provision. Means-tested benefits should therefore rather be a last resort, rather than the basis of the system. In terms of sustainability, because taxes do not create legal claims for benefits, they may be more difficult to collect than contributions. Also, while contributions

to a social insurance system guarantee a certain financial basis for LTC as they cannot be spent for different purposes, tax revenues are subject to a wide range of different budget policy considerations. As has been the case in some countries in the past, fiscal crises may therefore reduce available funds below a reasonable level. In order to prevent this and guarantee a certain stability of funding over time, earmarked taxes could be an option.

Empirically, when moving towards a public system for long-term care funding, countries that already have a national health service tend to try to integrate long-term care services into the existing system, while countries with insurance schemes tend to create a new system, as it is not so easy to establish new benefits within an existing insurance. With respect to compatibility with overall welfare state arrangements, this appears plausible. The most important being — and this is confirmed by the conclusions of the Peer Review — that there is at least *some* form of public system.

3. Long-term care system boundaries

During the last decade, the Netherlands has recorded a huge rise in expenditure related to expenditure under the AWBZ (Exceptional Medical Expenses Act). It is felt that this development is partly due to unclear boundaries, which have resulted in all kinds of additional services being covered by the AWBZ. The host country therefore raised the question of how best to draw crystal clear boundaries that ensure that every insured person knows what he or she is entitled to and that prevent an explosion of costs due to the utilisation of services that the system has not been created for.

While participants acknowledged the need for clear boundaries in order to control costs, there was, on the other hand, considerable concern that strict boundaries could endanger the provision of integrated care and produce disruptions in the chain of treatment. A recent report by the OECD on long-term care for older people, for example, calls for services to be brought together with a view to creating "a continuum of care".[5] The dangers of insufficient integration were not only highlighted by countries with separate

5 See the OECD Health Project: Long-Term Care for Older People. Paris: OECD, 2005.

and narrow LTC systems themselves (e.g. Austria and Germany), but also by some countries without separate systems (e.g. Belgium and Estonia).

The question of whether integrated care systems providing both health and long-term care might provide a better solution was therefore debated.[6] In such a system, the question of boundaries would become irrelevant and fragmentation between different systems would be overcome. On the other hand, there was concern that an integrated system could further increase the dominance of the medical over the nursing profession in long-term care provision. An over-medicalisation of long-term care could indeed lead to an oversight of certain issues crucial for the sustainable provision of long-term care, such as informal care. Moreover, with so many funding problems surrounding the whole of the healthcare sector, there would be a danger that money would be siphoned away from long-term care towards other types of medical care.

There was a lot of interest in the Dutch scheme of 'personal budgets', in which individuals receive a specific, independently assessed, allowance, which they can spend on the services they choose. Similar models also exist in other countries, although the details differ. For example, in a corresponding German experiment, beneficiaries are not allowed to pass the budget to their children, while in the Netherlands they may do so. In the UK, a randomised trial has been carried out to assess the impacts of the personal budget, revealing that it works well with the younger population, but not so well with older people. Several questions are still the subject of intense discussion with regard to this system: Can the budget be used for family members? Are there specific training courses for carers? How can quality be secured? And, in general, how much control is useful and how much trust is necessary?

Returning to the original issue of controlling costs by better defining LTC boundaries, the dangers of excluding certain otherwise necessary and useful services were discussed. For example, in the Netherlands and England, the implementation of clearer boundaries has led to domestic care

6 See also the Council of Europe report on Integrated Social Service Delivery (http://www.coe.int/t/dg3/socialpolicies/socialrights/default_en.asp and http://www.coe.int/t/dg3/socialpolicies/socialrights/source/IntegratedsocialservicesinEurope-Guidelines.doc)

being excluded from collective care arrangements. What's more, while LTC in principle covers groups such as disabled children, there is a tendency to neglect their needs in an agenda ever more driven by demographic change. By redefining needs and tightening criteria, authorities may make it harder to obtain services, especially for the less articulate and people with language problems. Fragmented systems are furthermore in constant danger of producing suboptimal care arrangements because they enable one institution to shift costs to another. In Poland, for example, until 2004, residential care homes were funded by the state, while home services were financed by local authorities. As a result, local authorities put people into homes to reduce their own expenditures, even though residential care was often neither necessary, nor cheaper from a societal point of view. Since 2004, local authorities have had to co-finance residential care, leading to a rise of 10,000 in the number of people living at home, between 2004 and 2007.

In order to control costs, other policy options exist, such as the introduction of fixed-age thresholds, waiting times, caps on the amounts of benefits, minimum periods of residence in the country before people are entitled to LTC benefits, and so on. Thus, a more precise definition of an LTC system's boundaries offers just one means among others. Due to this, the debate focused less on how to control expenditures by sharpening the demarcations between LTC and related benefits, and more on how to erode boundaries that obstruct integrated care.

4. Effects of the economic crisis

It is obvious that the current financial and economic crisis will also have effects on long-term care provision. As nobody is able to predict how long the crisis will last, it is important to distinguish between potential short, medium, and long-term effects.

Regarding the problem of recruiting care workers, several participants noted that, in the short-term, the economic crisis may lead to an increase in people looking for jobs in the care sector as other forms of employment become scarcer. In this respect, the crisis could actually help the LTC sector. This

effect might, however, be reversed once the economy recovers. Therefore, attempts to increase the attractiveness of care-work should be maintained even if it would appear there is no short- term need to do so.

With respect to financing, on the other hand, the economic crisis will severely harm long-term care provision, particularly if it lasts for a long time. Several participants in the Peer Review already point to consequences in their countries, while others predict similar effects soon:

- In the *Netherlands*, the financial crisis is accelerating the debate on where to draw the line between services that should be covered by care insurance and normal living expenses (e.g. accommodation). A working group in the Dutch Ministry of Finance has put this issue on the agenda of the review of the future sustainability of the LTC system. It is widely expected that there will be cuts in public spending that will affect LTC.

- In *Austria*, the local authorities responsible for LTC report tightening budgets and are asking for assistance from the Austrian federal state. The budget for 2009–2010 is under discussion and, due to the crisis, there are doubts as to whether a new plan, in which the state was to subsidise services, will be put into effect. The outlook for this year and the following is not good.

- If the crisis lasts for a long time, it will weaken opportunities to enlarge social protection and, in *Belgium*, social policy will become more difficult. Subsidising early retirement will, for example, become unaffordable in future. Belgium's recently introduced voucher system, under which vouchers can be exchanged for home help (covering 80% of total cost), will not be affordable in the future either. However, with the system already having been taken up by some 600,000 people over the past five years (indeed, the vouchers are not means-tested or taxable, which makes them even more beneficial for people on higher incomes), cut-backs will not be easy.

- In *Poland*, the government has put € 9 million into a 'social solidarity fund' to help local authorities provide services. Taxes have been

lowered this year so it will be impossible to find extra resources for LTC.

- The national budget in *Hungary* is in bad condition, largely due to tax evasion. Out of 10 million people, only 4 million pay tax, among which just 1 million contribute as much as 90% of the country's tax revenue. The government is taking steps to counter this problem and, if they are successful, there may be no need to cut spending. Charges are already high and thus cannot be increased.

- *Romania* has not felt the full impact of the crisis yet. The minimum wage has increased and the state is continuing to subsidise NGOs. Child allowances, which are based on parents' income and funded by the state, have been substantially increased. The health system continues to reimburse up to 90% of the cost of medicines.

While the consequences of the crisis are still felt differently in the various Member States, there was nevertheless a joint concern that the social consensus on how best to emerge from the crisis might be fragile, making it important to defend the integrity of people's rights. Otherwise the crisis might lead to an acceptance of cuts in social protection.

VI. Conclusions

With respect to the key issues addressed during this Peer Review, the most notable conclusions agreed upon by participants included the following points:

Though at the moment, *labour-force shortages in long-term care* are only visible in some countries, future shortages are likely all around. In order to prevent this development, measures should target both the supply and demand sides. On the one hand, prevention and better healthcare, as well as targeted rehabilitation efforts, can serve to reduce the demand for long-term care. Boosting the role of family care and enhancing the role played by the voluntary sector can also play a crucial part in ensuring the sustainability of long-term care arrangements. On the other hand, it will also be necessary to work on the supply side by raising productivity, getting more people into care work and keeping them there. It was generally agreed that care work suffers from an image problem and that measures are needed to make it more attractive, especially among young people. Among others, policies should focus on boosting social recognition of the profession, improving career opportunities and pay, and reducing pressure on workers. Encouraging the migration of nursing personnel between Member States may exacerbate shortages in the 'sending' state and should not therefore be regarded as the only solution on the European level.

With respect to *financing*, it was agreed that there is no one-size-fits-all solution. However, there was consensus in favour of universal coverage and equal access as major goals for LTC systems. The meeting took the overall view that, given these goals, private insurance cannot serve as the system's backbone. Indeed, if private insurance is risk-related, it excludes universal care provision, and, if it is compulsory, it thereby becomes a form of social insurance. Participants therefore agreed that an LTC system needs substantial public financing, either in the form of social insurance or through a tax-based system. Since means-testing is in force in some countries and rejected in others, its role remained contested.

Though the need for *clear boundaries* between systems was acknowledged as a means of controlling costs, there was even higher consensus that

boundaries may obstruct the provision of integrated care, which is essential for people in need of long-term care. In most countries, therefore, specific steps are being taken to ensure a more integrated care provision — the Dutch 'personal budget' scheme being one of the most interesting schemes underway.

As an additional issue, the economic crisis was discussed, with participants pointing out that, while in the short run, the crisis may help to overcome labour market shortages, in the long run, it poses a serious threat to the sustainable funding of LTC — particularly in countries without a specific LTC system, where budgets risk being siphoned away by other types of medical services.

http://www.peer-review-social-inclusion.eu

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

Host country: **The Netherlands**

Peer countries: **Austria, Belgium, Estonia, Germany, Hungary, Poland, Romania, Slovenia, Sweden, United Kingdom**

In the Netherlands (as in many EU countries) the question of how to keep long-term care affordable is a burning issue. For such care to be not only affordable but sustainable, accessible and of good quality requires a number of conditions to be met:

- There needs to be a careful balance between collective and individual arrangements and responsibilities which is not easy to achieve Individuals can be involved in collective arrangements (through co-payments; or personal budgets) while local authorities can help people cope independently with long-term care.
- Clear boundaries need to be drawn between long-term care and related schemes like subsidised housing or home-help, so people are aware of what services they are entitled to and how this is decided.
- Qualified personnel are as important as funding being available, while balancing supply and demand needs to take account of demographic and, labour market factors.

In the Netherlands, a public debate is underway about the future of the long-term care system and in these challenging times, the government considers it important to reflect, compare and exchange views with other governments in the EU.