CHALLENGES IN LONG-TERM CARE IN EUROPE

By: Slavina Spasova, Rita Baeten and Bart Vanhercke

Summary: This article describes the national provision of long-term care (LTC) in 35 European countries, with a focus on arrangements for older people. It points to the four main challenges common to all countries: 1) access and adequacy of LTC provision, 2) quality of formal home care as well as residential services, 3) employment of informal carers, and 4) financial sustainability of the national systems. Since all European countries will continue to face significant LTC system challenges, a series of recommendations are presented to help overcome these.

Keywords: *Long-term care services for older people, Home Care, Deinstitutionalisation, Informal care*

Slavina Spasova is a Researcher, **Rita Baeten** is a Senior Policy Analyst and **Bart Vanhercke** is the Director at the European Social Observatory, Brussels, Belgium. Email: spasova@ose.be

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Introduction

Long-term care (LTC) is considered an 'invisible social welfare scheme'[1] for two reasons. First, in most European countries, LTC financing and provision involve a mix of intertwined health care and social care. Second, LTC relies heavily on unpaid 'invisible' care provided by relatives, mostly women, whose social rights are still only a side-issue for social protection systems. At the same time, LTC is gaining visibility in policy discourse and reforms at both national and European Union (EU) level. Emphasis has been placed on the development of home-based and community-based care, including in the proclaimed European Pillar of Social Rights (EPSR).*

This article draws on a recent Synthesis Report from the European Social Policy Network (ESPN) on *Challenges in Long-term care in Europe,*[2] which provides a comparative analysis of reports drafted by national ESPN experts in 35 European countries. The report showed that issues related to LTC are gaining visibility in European countries, in a context of population ageing and changing labour and family patterns. Indeed, as a result of women's increasing participation in the labour market, and the rise in pensionable ages, the pool of informal carers, in particular for older people, is shrinking. At the same time, LTC demand will continue to increase with population ageing. The percentage of EU citizens aged 80+ is projected to increase from 4.9% to 13% over the period 2016–2070.[3]

In this context, national social protection systems face four main challenges with regard to LTC for older people:

1) **access and adequacy** linked to the underdevelopment of publicly funded formal LTC services and a lack of complementarity between formal and informal LTC;

* Principle 18 of the EPSR states that 'Everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services'.

Box 1: Official Country Abbreviations

EU countries	
AT	Austria
BE	Belgium
BG	Bulgaria
GR	Croatia
CY	Cyprus
CZ	Czech Republic
DK	Denmark
EE	Estonia
FI	Finland
FR	France
DE	Germany
EL	Greece
HU	Hungary
IE	Ireland
ET	Italy
LV	Latvia
LT	Lithuania
LU	Luxembourg
MT	Malta
NL	The Netherlands
PL	Poland
PT	Portugal
RO	Romania
SK	Slovakia
SI	Slovenia
ES	Spain
SE	Sweden
UK	United Kingdom

Non-EU countries covered by ESPN	
MK	Former Yugoslav Republic of Macedonia
IS	Iceland
LI	Liechtenstein
NO	Norway
RS	Serbia
CH	Switzerland
TR	Turkey

2) **quality of care**, which is at risk due to the significant increase in demand and lack of quality control in many countries;

3) **employment of carers**, women in particular, who are often informal carers and may need to quit their jobs due to caring responsibilities;

4) **financial sustainability challenge**, linked to population ageing and increasing public spending on LTC.

How easy is it to access LTC services and how affordable are they?

First, access to and affordability of services can be hindered by the fragmentation of LTC. In general, LTC provision and funding are split horizontally and vertically, i.e. between health care and social care as well as between territorial entities. Fragmentation of provision between health care services and social services often leads to a lack of coordination between entities, which in turn affects waiting periods and administrative procedures (e.g. in BG, CY, CZ, EE, FR, LT, LV, RS, SI, UK).† In addition, regional responsibilities for LTC have resulted in disparities in LTC provision in many countries.

Second and more importantly, there are access issues related to the underdevelopment of formal services, both for home care and community-based LTC and residential care. One of the main solutions proposed in national policy making and EU discourse is to develop access to home-based services in order to enable older people to live independently at home as long as possible. However, the availability and affordability of home-based services is a significant issue in most EU countries. This discourse has been coupled with an emphasis on replacing residential care with community and home-based care, or in other words, de-institutionalisation, in several countries. Nevertheless, the picture is far from clear-cut in this respect and several trends can be observed.

With regard to home care, there is a clear divide between European countries. Home and community-based services are most developed in the Nordic countries (DK, FI, IS, NO, SE) and some Continental European countries (e.g. AT, BE, DE, FR, LU, NL). By contrast, those in need of LTC in Southern (e.g. CY, EL, ES, MT, PT), Eastern European countries (e.g. BG, CZ, EE, LV, LT, MK, PL, RO, RS, SI, SK) and the UK face insufficient availability of home care provision, or provision often targeted at persons with a high degree of dependency.

As for residential care, the long-term outcome of the (de-)institutionalisation process is mixed (**see Figure 1**).

In Nordic countries, a significant process of de-institutionalisation can be observed, and emphasis has been placed on the development of home care. At the same time, the Nordic countries still have among the highest percentages of LTC recipients in residential facilities.[5] The situation is similar in some Continental European countries, even though a bit less straightforward.‡

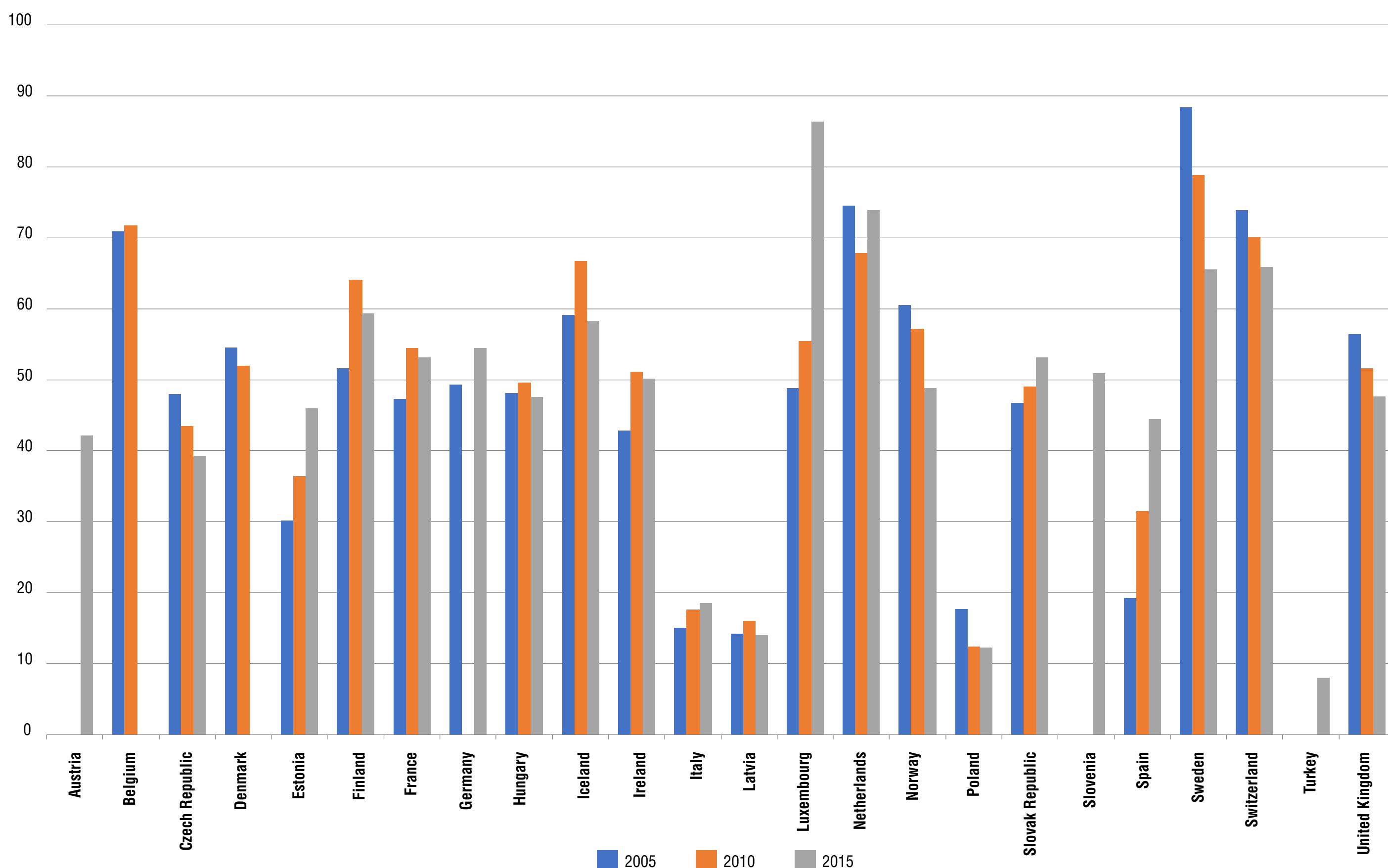
In Southern Europe (e.g. ES, IT, PT), however, there is a clear trend towards increasing the number of LTC beds for people aged 65+, due to changes in labour market structure (more women working), increase in the pensionable age and changes in the family structure (and norms). In Eastern Europe, the reasons for increasing demand and shrinking supply of care are very similar, but the situation concerning residential care supply is less obvious. In some countries there has been a slight but steady fall in the number of residential beds since the 2000s (e.g. LV), while in other countries there has been a certain increase in the number of residential beds (e.g. BG, EE, LT, RO). In both Southern and Eastern Europe, demand strongly exceeds supply for both institutional and home care provision.

Access to LTC is also hindered by issues related to adequacy of care. Adequacy is extremely difficult to measure, as very few

† Countries which have developed along similar lines are listed in brackets (the lists are not necessarily exhaustive) see also the 35 ESPN national experts' report.[2] The list of country abbreviations can be found in Box 1.

‡ With regard to people receiving formal (paid) LTC in institutions (other than hospitals). LTC institutions refer to nursing and residential care facilities which provide accommodation and LTC as a package.

Figure 1: Beds in residential long-term care facilities per 1000 population aged 65 and over, (2005, 2010, 2015)



Source: OECD. Ref.[4]

Note: Residential LTC facilities comprise establishments primarily engaged in providing residential LTC that combines nursing, supervisory or other types of care as required by the residents. Excluded from the indicator: hospital beds reserved for LTC and beds in residential settings such as adapted housing that can be considered as the individual's home.

countries have indicators or surveys to do so. We considered care as "adequate" if it provides sufficient and affordable social protection to cover the existing needs for LTC care. Sufficiency and affordability of LTC has been assessed according to the national context and is based on the limited data available. Affordability has been hampered by budget cuts in LTC provision in many countries (e.g. DK, IE, UK). In other countries, it has or may become an issue because of a strong long-term trend towards privatisation and marketisation of LTC and the rapid growth of a commercial sector (e.g. BE, DE, DE, FI, LT, RO, UK). Finally, affordable care may be an issue because of the above-mentioned fragmentation of care financing and provision.

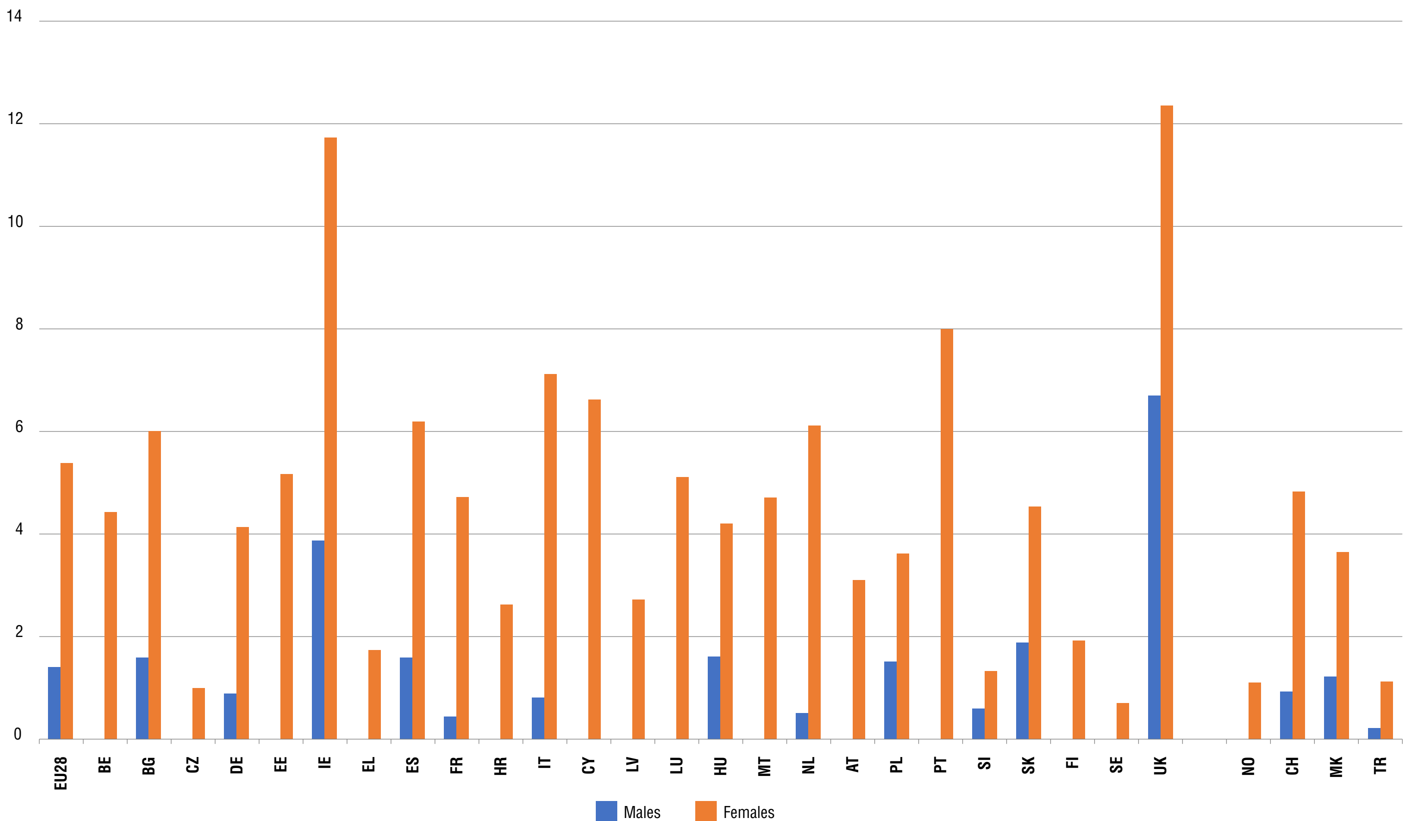
The quality of LTC: a long road ahead

The quality of LTC is key to maintaining and improving the quality of life of frail older people, both in residential and home care settings. However, the requirements in place vary substantially according to the type of care, i.e. residential care or home care. Whereas the home care sector remains mostly unregulated, residential care is governed by stricter requirements. These quality control measures seem to be a first step to ensuring quality commitment, but in some countries there are problems in implementation due to limited resources, a lack of qualified inspectors and/or a lack of transparency in the process.

Again, with regard to quality standards, there is a clear geographical divide between Nordic countries and, to some extent, Southern and Eastern European states. The former have developed indicators and there is general satisfaction with the quality of care (e.g. DK), while Southern and Eastern European countries often lack well-developed measurement tools, and care quality is considered problematic. Many aspects of quality are not covered by existing national indicators.

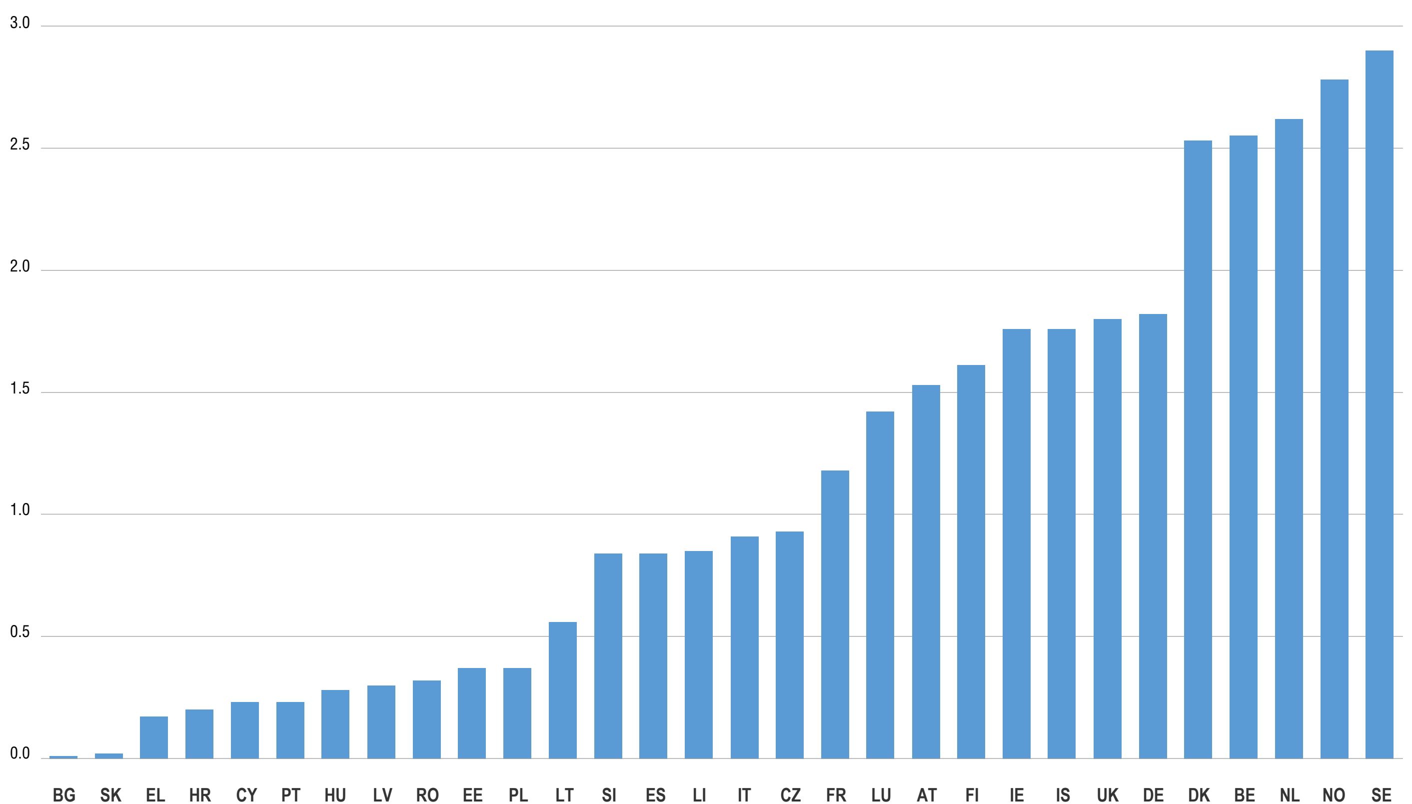
The quality of jobs and working conditions in the care sector also play a role in this context. The attractiveness of the sector remains low, as it is often depicted negatively, due to poor working conditions and job precariousness (low income, lack of training, high workload and high levels of stress). This leads to a severe shortage of qualified professionals.

Figure 2: Percentage of inactive men and women (aged 50–64) not working on the grounds that they are looking after children or incapacitated adults (2016)



Source: Eurostat, Ref.[6]

Figure 3: Long-term care expenditure (health) as a percentage of GDP, 2015



Source: Eurostat, Ref.[8]

Working and caring: can they (really) be combined?

There is a high incidence of informal care in most European countries. An informal carer is a person who provides care, in principle unpaid, to the care-dependent older person, not on a professional or formal employment basis and in general a person with whom the care-dependent has a social relationship. Family responsibilities for parents are even enshrined in law in some countries (e.g. HU, LV, LT). The main reasons for the high incidence of informal LTC are the shortage of accessible formal LTC facilities, the poor quality of LTC, the non-affordability of LTC, and, finally, the traditional model of intergenerational and family relations.

It is difficult to estimate the number of informal carers for older people. Data from the Labour Force Survey (LFS) show that looking after children or incapacitated adults was the main reason for inactivity for 5.4% of inactive women aged 50–64 years old in 2016 in the EU. The equivalent percentage for men was 1.4%. With figures of respectively 11.7 % (compared with 3.9% for men) and 12.3% (compared with 6.7% for men), Ireland and the UK have the highest shares of female inactivity on the grounds of care (**see Figure 2**).

It should be noted that migrants play a specific role in informal care provision, as families frequently rely on them to assist with care tasks for older people. However, there are frequent issues with regard to their qualifications and working conditions (e.g. irregular contracts, low social protection coverage etc.)

The financial sustainability of LTC provision: the unknown equation

Public expenditure on LTC as a percentage of Gross Domestic Product (GDP) has been increasing over the past 20 years in European countries, and is expected to grow by 70% – from 1.6% to 2.7% of GDP – between 2016 and 2070, due to population ageing. However, projections vary widely between countries. Nordic countries and Eastern countries are expected to spend generously on LTC.[7] Currently, Nordic and Continental countries are among the leaders in expenditure on LTC (e.g. SE 2.90%, NL 2.62%, BE 2.55%, DK 2.53%) while Eastern European countries score the lowest values at around 0.3% (e.g. BG 0.01%) in 2015 (**see Figure 3**).

Looking into the different challenges facing national LTC systems, financial sustainability may be made more difficult by several issues. It may be affected by fragmentation of care due to a lack of coordination between health and social care entities. An absence of clear financial strategies by the territorial entities responsible for LTC may also lead to unpredictable LTC spending.

The high incidence of informal LTC is one of the main factors accounting for the financial sustainability of the current LTC

Box 2: Recommendations

Access to and affordability of LTC

1. The development of home-based services should go hand in hand with strong prevention and rehabilitation policies, to ensure that people can continue to live for as long as possible in their own home if they so wish. Home care should be available to all persons with LTC needs and not only to the most care-dependent older people.
2. While prioritising home care over residential care, countries should avoid policies which reduce the supply of residential institutions without providing sufficient home-based services. An appropriate national policy mix should be found, which provides sufficient residential care facilities. Planning of the number of care places should be based on an objective assessment of the population's needs, adapted to the regional situation.

Quality of care

3. Countries should apply stricter standards to the various providers, and above all should extend the scope of services offered to cover home care. Effective checks on and supervision of the quality of care should be reinforced.
4. Member States should agree on a common set of indicators to assess the quality of LTC. To do so, a major step forward would be to reach an agreement on a common EU definition of quality of care.

Informal carers and domestic workers

5. Where cash benefits are provided, payment should be made subject to proof that it is used to pay for care. If cash benefits are used to recruit domestic workers, this recruitment should be made conditional upon a formal employment contract with the care worker. If the cash benefit is used to compensate the informal carer, the involvement of the carer should be defined in a multidisciplinary care plan.
6. Stronger support for informal carers should include: (1) improved social (security) rights for informal carers; (2) providing adequate training, upskilling and recognition of skills; (3) enhanced possibilities to remain in the labour market (e.g. part-time carers' allowances, flexible arrangements) and to return to it later.

Financial Sustainability of LTC

7. Countries should aim to gather and update evidence and data on sustainability in order to plan the funding of the LTC policy mix (benefits and services).
8. More effective and cost-efficient measures should include an even stronger emphasis on rehabilitation and social investments (e.g. in prevention strategies, innovative technologies and social services).

systems in many European countries. In Portugal, the work performed by informal carers is estimated at over 2% of GDP (while formal care is estimated at 0.2%).

Looking forward: recent reforms and debates

LTC provisions have been subject to reforms in most European countries over the past ten years (2008–2018). Three broad trends can be identified: first, the readjustment of the LTC policy mix and namely the move away from residential care towards home care and community-care; second, measures addressing financial sustainability (most often introducing budgetary restrictions), in particular during the crisis period (e.g. DK, ES, PT, IE, UK); and third, reforms aimed at improving the access and affordability of provisions, including increased LTC funding, improving eligibility conditions and benefit levels, tackling interinstitutional and territorial LTC fragmentation, and recognition and improvement of the status of informal carers (e.g. AT, FR, CZ, PT, PL).

Recommendations

The challenges listed above require solutions. Our main recommendations are listed in **Box 2**. For a more exhaustive discussion of the policy recommendations, see Spasova *et al.* 2018.[2]

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