Adequate social protection for long-term care needs in an ageing society

Report jointly prepared by the Social Protection Committee and the European Commission

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Luxembourg: Publications Office of the European Union, 2014

ISBN 978-92-79-39283-2 - doi:10.2767/32352 (print)
ISBN 978-92-79-39282-5 - doi:10.2767/32147 (online)

Printed in Luxembourg

PRINTED ON ELEMENTAL CHLORINE-FREE BLEACHED PAPER (ECF)

PREFACE BY THE WORKING GROUP ON AGE OF THE SOCIAL PROTECTION COMMITTEE DEALING WITH LONG-TERM CARE

Fully aware of the vast differences between the Member States of the European Union (EU) when it comes to demography, economy, traditions and the development of systems for Long Term Care (LTC), the Social Protection Committee Working Group on Ageing (SPC-WG-AGE) is trying to find common ground for cooperation and action.

The group acknowledges that there is no one-size-fits-all solution to cope with the increasing demands caused by the ageing of our societies. At the same time the group is convinced that there is much value in mutual learning between Member States and that exiting evidence about innovative approaches to social protection against long-term care risks demonstrate that it is possible to contain the growth in needs, make care more efficient and ensure dignity in care if action is taken based on best available knowledge. Several different approaches may have to be taken at the same time and with different emphasis in different Member States.

The aim of this report is:

- to reiterate the case for social protection against the risk of LTC needs;
- to identify existing evidence about possible ways to contain and address present and future demands;
- to identify where there is lack of knowledge and need for further evidence;
- to give examples of good practices around the EU that could be considered also in other Member States;
- to suggest to the SPC where policy action could be taken to increase EU support to the efforts of Member States.

The aim of this report is not:

- to change the primary responsibility of Member States for the provision of LTC;
- to increase the burden of reporting on Member States.

As a basis for the report the SPC-WG-AGE has used knowledge gained during a number of meetings where experts and stakeholders from a wide range of Member States and organisations have presented their view and expertise. Recent statistics, Peer Reviews, Commission papers, joint work with the OECD and project reports have also fed into the draft report.

Clearly this report cannot claim to hold all facts, and certainly not all answers, but to our knowledge this is the first common EU Member State effort taking on this broad, and in our opinion necessary, view in the long-term care area.

Hopefully, it will lead to a good discussion within the SPC and in single Member States and stimulate further cooperation between EU Member States in the LTC field.

Niclas Jacobson – Chair of the SPC Working Group on Age dealing with long-term care

ACKNOWLEDGEMENTS

This report has been prepared by the European Commission services of Directorate General for Employment, Social Affairs and Inclusion (Directorate D. Europe 2020: Social Policies, led by Director Lieve Fransen, Unit D3: Social Protection, headed by Ralf Jacob) in collaboration with the Member States delegates in the Social Protection Committee's (SPC, chaired by Tom Dominique) Working Group on Ageing Issues[1] (SPC-WG-AGE, chaired by Niclas Jacobsson) and the SPC Indicators Subgroup (ISG, chaired by Volker Schmidt and Rudi Van Dam). The report was adopted by the SPC on 20 May 2014 and its Key Messages were endorsed by the Council on 19 June 2014.

In Unit D3, Arnaud Senn as secretary to the SPC-WG-AGE has been responsible for most of the research and drafting of analytical contributions to the report from which external consultants Clive Tucker and Caroline Macready developed the draft manuscript. Initial drafts for the country profiles by independent experts in the ASISP network were reviewed by Member State officials. The manuscript and the country profiles evolved further through contributions from Sven Matzke and Fritz von Nordheim. Audronė Balkytė has been responsible for the data work and the graphical editing of the manuscript.

The report uses projections of the budgetary impact of ageing population in the Member States of the European Union (EU) from the 2012 Ageing Report. Other data used in the report are provided by Eurostat, Member States and the OECD.

[1] The full list of delegates to the SPC-WG-AGE working on long-term care can be found in Annex 2.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

KEY MESSAGES

1. In our ageing societies, a rapidly increasing proportion of Europeans can expect to reach an age in which they are at risk of becoming frail and developing multi-morbidity conditions requiring both medical and social care on a continuing basis. EU citizens aged 65 can expect less than half of their remaining years to be free from conditions affecting their ability to manage daily living activities. The risk of needing long-term care (LTC) rises steeply from the age of 80. Our ability to manage it will have major implications for the wellbeing of ageing Europeans and for public expenditure.

Social protection against the risk of long-term care dependency is needed for equity and efficiency reasons

2. Dependency on LTC is a significant health-related economic and social risk for individuals and for their families. Often social care needs are not covered as comprehensively as the health care needs of LTC dependant people with the primary responsibility of obtaining the required care shifted to the dependent persons and their relatives.

3. With little to no social protection against the risk of needing LTC, the living conditions of the dependent will hinge on his/her means and the family's ability and willingness to provide or pay for care. This may have negative impacts both on equity, as some families will be much more affected than others, and on overall economic performance, as relatives may need to withdraw from employment to provide informal care. In addition, neither the quality nor the efficiency of informal care can be guaranteed.

A large and widening gap between the need for and the supply of long-term care is likely to develop

4. Long-term care will face three major, related and simultaneous challenges: (a) a *huge increase in need*. Over the next five decades the number of Europeans aged over 80 requiring LTC is expected to triple; (b) a threat to the *supply of long term carers* from the decline in the number of people of working age and from social changes making it less likely for families to provide in the future the same level of informal care as they do today; and (c) the pressure that rapid growth in demand, and the expectations of the "baby boom" generation, will place on ensuring *care quality*.

5. Thus there are solid equity and efficiency reasons for Member States to establish social protection against the risk of LTC dependency, and for ensuring adequate access to affordable quality care, as well as support to informal carers, including through a better recognition of care duties in labour law and corporate practice. Member States, who are responsible for LTC provision, can collaborate on achieving these aims with the support of the EU including through mutual learning.

Closing this gap requires proactive approaches to contain the growth in needs and to meet them in the most efficient way

6. There is a need for Member States to move *from a reactive to an increasingly proactive policy approach* seeking both to prevent the loss of autonomy and thus reduce care demand, and to boost efficient, cost-effective care provision in homecare and in residential institutions. Facing these challenges requires both short term solutions, such as improving

LTC delivery through better use of existing human, financial and technical resources - and longer term approaches such as containing the needs through prevention and rehabilitation policies on central, regional and local level.

7. The main elements of the proactive response to social protection against LTC dependency include measures aimed at: *preventing* people from becoming dependent on care, by promoting healthy life styles, tackling the major causes of dependence and promoting *age-friendly* environments in homes and neighbourhoods through design for all ; early *detection of frailty*; *rehabilitation and re-enablement* for those whose health and fitness have been impaired to restore their ability to live independently; realising the *full potential of technology* to help older people remain at home, to *raise the productivity of care services* and to compensate for the decline in the number of carers; *fully integrating* the health care and social elements of LTC provision; enhancing *support for informal carers* and making it easier for them to *reconcile employment and care* responsibilities; and using the potential of the NGO sector in providing care services.

There are many examples of good proactive practices: a more systematic assessment of what works and what is most cost-effective will add further value

8. Several Member States are already experimenting with innovative and proactive approaches. Analysis shows that many of these can help prevent or postpone the onset of frailty and morbidity and halt or even reverse a further deterioration of health and well-being. Importantly proactive approaches combining re-enablement and smart assistive technologies can raise and maintain frail older people's capacity for independent living, including through elements of self-care. Assistive technologies are cost-effective and when used in existing delivery frameworks, they can improve the quality of life of recipients while saving working time and resources.

9. Thus, the investment in the development of these approaches can contribute to tackling ageing related challenges in LTC. However, to enhance the possibilities of mutual learning, a more solid knowledge base is needed on what works and what is most effective, including when seeking to design mechanisms for sustainable financing of LTC services.

Adequate social protection against LTC dependency is a major aspect of gender equality in old age as well as in working age

10. LTC is an issue that affects men and women differently. Women have a higher life expectancy and greater morbidity in old age than men, so most LTC recipients are women. The vast majority of informal and formal carers are also women. In countries with extensive formal provision for LTC, care work generates significant labour market opportunities for women in particular. By contrast, informal care duties, if not accompanied by appropriate support services; can represent an impediment to female labour force participation.

11. Responding to the challenges of a great increase in the number of people 80+ also offers important opportunities. Meeting the care needs of a growing population of older people, notably women, is an essential part of what is often called "Silver Economy". Many more jobs for women and men could be created in the LTC sector, notably where formal services are least available, and as result of the rising demand for goods and services for older people, including assistive technology.

Given the diversity of LTC policies there is scope for better mutual learning and for a common European knowledge base

12. Differences between Member States in the way LTC needs evolve and services are provided are larger than in any other area of social protection offering possibilities for knowledge transfer for example through peer reviews and mutual advantages from sharing some of the cost of research and development at EU level.

13. The EU can help by facilitating the exchange of best practices, by researching and testing new solutions and fostering technical and social innovation. The European Innovation Partnership for Active and Healthy Ageing has been established for that purpose. Moreover, the EU can improve its support by developing better ways of exchanging knowledge about the costs, benefits and quality of LTC. Yet LTC-related activities at EU level need to be better coordinated and linked up such as through the improved cooperation between the SPC and the WPPHSL[2].

There is a need to further clarify the common objective of adequate social protection against LTC dependency and to set out how EU support for the LTC efforts of Member States can be enhanced including through better collaboration between ministers of health and ministers of social affairs

14. The Social Protection Committee, which has developed common objectives for Member States in social protection, including long-term care, has a key role to play in the further development of collaboration on this. A crucial step would be to develop a better understanding of the effectiveness and efficiency of current LTC provisions in the Member States and improving the portfolio of indicators to assess progress in relation to the common objectives of access, quality and affordability.

15. For this to be possible, a number of data and knowledge issues need to be resolved: the main surveys on income and living conditions and on the labour force (i.e. EU-SILC and LFS) could be adjusted to better highlight the social and employment challenges posed by dependency and the demand for and supply of LTC; a better overview on the legal and administrative aspects of LTC policies in Member States could be developed, as well as methodologies for comparing LTC provisions to which people are entitled in typical cases of need; data on social protection spending on LTC could also be collected as a separate function in ESSPROS.

16. These activities at the EU level aim at making mutual learning more effective in the context of the Open Method of Coordination. The responsibility for designing LTC systems and securing their financing remains fully with the Member States.

[2] The Council Working Party on Public Health at Senior Level

1. INTRODUCTION

The European Union (EU) is facing unprecedented demographic changes. Europeans are living longer and healthier lives, although large gaps in health remain between different social groups, countries as well as regions.. Life expectancy is increasing at the rate of 2-3 months every year. This is a very positive trend. However, an ageing population, combined with lower birth rates, changing family structures and migration, creates a number of challenges. As the big generations of baby-boomers are swelling the ranks of the retired the working age population will increasingly be formed by the smaller cohorts of baby-busters. In the light of these challenges it is important, both at EU and national level, to review and adapt at national level existing policies, including long-term care services for frail older people. With the further ageing of the big cohorts a major challenge will be to meet the needs of a fast-growing number of older people at risk of suffering from frailty and physical and mental disability while keeping cost affordable and avoiding to endanger the stability of public finances. Even as some of these older people will come to need residential care, many others – if given the right support in time – can continue to live fairly independently at home and enjoy a good quality of life.

Responding to these challenges also offers opportunities. Meeting the needs of a growing population of older people, and supporting what is often referred to as the "*Silver Economy*", could potentially create many more jobs in the long-term care sector and much greater demand for a wide range of older-age-related goods and services, including assistive technology.

Long-Term Care (LTC) encompasses a range of services and support for people who are dependent over a long period of time on help with their daily living. This need is usually the result of disability caused by frailty and various health problems and therefore may affect people of all ages. But the great majority of the recipients of long-term care are older people.

Increasingly long-term care in the EU will be facing three major, related and simultaneous challenges. The first is a huge increase in need. Over the next five decades the number of Europeans aged over 80 and at risk of needing LTC is expected to treble. The second is the threat to the supply of long term carers from the decline in the number of people of working age, and from social changes which make it less likely in the future that families will provide the informal, home-based care on which the great majority of older people now rely. The third is the pressure that rapid growth in demand, and the expectations of the “baby boom” generation, will place on care quality, enforcement of care standards and on public expenditure.

There is a real risk that current arrangements for long-term care across the EU will be overwhelmed by this three-fold challenge and a major gap between needs and available services will develop.

This report examines what can be done to help Member States reduce the risk that such a gap emerges and ensure that adequate provisions for long-term care needs can be organised in a sustainable way even at the height of population ageing.

There are more pronounced differences between Member States in the way long-term care is provided than in any other aspect of social protection. There are significant differences in the way it is delivered and the way it is financed. In nearly all Member States, non-professional family care plays a major role, but the extent to which this is complemented by formal, publicly provided care varies widely. Still, while there is no one-size-fits-all policy solutions population

ageing confronts countries with many similar challenges. Moreover, the diversity in evolution and approaches to LTC also implies that possibilities for knowledge transfer between Member States are particularly large.

LTC is an issue that affects men and women very differently. Older women have a higher life expectancy and greater morbidity in old age than men, so most LTC recipients are women. Moreover, the vast majority of both informal and formal carers are women. Formal LTC is a labour intensive sector offering employment opportunities with a relatively low skill threshold and moderate to low pay. In Member States which make extensive formal provision for LTC, care work generates significant labour market opportunities for women in particular, removing barriers and generating jobs for them. By contrast, informal care duties can represent an impediment to female labour force participation.

As a strand of social protection, long-term care provision is a Member State responsibility. While EU countries set their own level of ambition in LTC provision, they have also agreed, in the context of the Open Method of Coordination, the following three common objectives:

- *Guarantee access for all to adequate health and long-term care and ensure that the need for care does not lead to poverty and financial dependency. Address inequities in access to care and in health outcomes.*

- *Promote quality in health and long-term care and adapt care to the changing needs and preferences of society and individuals, notably by establishing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients.*

- *Ensure that adequate and high quality health and long-term care remains affordable and sustainable by promoting healthy and active life styles, good human resources for the care sector and a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and institutions.*

The Annual Growth Survey 2014[3] stressed that "there is a widespread need to strengthen the efficiency and financial sustainability of social protection systems (…) while enhancing their effectiveness and adequacy in meeting social needs and ensuring essential social safety nets". In 2013 seven Member States received a country-specific recommendation requesting them to improve the cost-effectiveness of their LTC systems.

For this report, the WG-AGE took as its starting point the Commission Staff Working Document Long-term care in ageing societies - Challenges and policy options", which formed part of the Social Investment Package adopted in Feb. 2013. Following on from the case this document presented for social investments in preventive and enabling forms of social protection against LTC dependency The Working Group has examined the extent to which innovative approaches to LTC can be used to tackle the challenges. A major part of deliberations took the form of seminars with Member State experts and decision-makers.

[3] Annual Growth Survey 2014/EU Commission
http://ec.europa.eu/europe2020/pdf/2014/ags2014_en.pdf

The report highlights two key arguments:

(1) There are solid equity and efficiency reasons reasons for Member States to establish social protection against the risk of LTC dependency, and to provide adequate access to affordable quality care. In accordance with the Treaty on European Union, Member States with the support of the EU should cooperate closely to achieve these aims, notably in the framework of the Open Method of Coordination.

(2) If the challenges to present LTC arrangements resulting from population ageing are to be tackled constructively and the rise in public expenditure contained, Member States need to move from a primarily reactive to an increasingly proactive policy approach, which seeks both to reduce care demand and to boost efficient, cost-effective care provision. Care arrangements should be strengthened and relatives with care duties should get the support they need. Europe can help by exchanging best practices, pooling the cost of researching and testing new solutions and fostering technical and social innovation.

This report sets out in Chapter 2 the current picture of LTC in the EU, the case for adequate social protection against LTC dependency and why it is important to develop a common understanding of adequacy, affordability and quality. In Chapter 3 it assesses the scale of current and future challenges to LTC in the EU, and seeks to identify ways of meeting these challenges. Chapter 4, focuses on 'Closing the Gap' and suggests priorities for action by Member States, including:

- preventing people from becoming dependent on care from others, by promoting healthy life styles and tackling the major causes of dependence;
- improving understanding and awareness of the pathway from health to frailty and disability, and identifying risk factors at an early stage;
- improving arrangements for rehabilitating people whose health and fitness are impaired;
- making cost-effective use of technology to remove obstacles to independent living;
- creating more age-friendly environments to facilitate independent living of people with impaired health; and
- improving the efficiency of long-term care services, by ensuring better care coordination, raising the productivity of services, improving recruitment and retention in the long-term care workforce, improving support for family carers and making it easier for them to reconcile family and care responsibilities.

The report's concluding Chapter 5 suggests how the EU can improve its support for Member States, including through developing better ways of exchanging knowledge on the costs, benefits, outcomes and quality of LTC and its different components, and sharing results across the EU.

2. LONG TERM CARE: THE CURRENT SITUATION

This chapter sets out what is known about long-term care in EU Member States at present. It covers needs for care, how those needs are provided for, the resources allocated to care, and the extent of social protection against the risks of becoming dependent on long-term care.

2.1. Long-term care: what it means and who needs it

Long-term care (LTC) is defined as a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care. The daily living activities for which help is needed may be the self-care activities that a person must perform every day (Activities of Daily Living, or ADLs, such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions) or may be related to independent living (Instrumental Activities of Daily Living, or IADLs, such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone).

People of all ages may become dependent on LTC. However, the risks of dependency for children, young people and adults of working age are low compared to the risks for people at the upper end of the age spectrum, and are falling as the proportion of people below retirement age shrinks. The demographic situation and prospects are discussed further in Chapter 3. Therefore policy makers need to focus particular attention on the risks of LTC dependency in old age.

In old age, people often become frail and develop multi-morbidity conditions, which cause them to need both medical care and social care on a continuing basis. In 2009, taking men and women together, EU citizens aged 65 could expect less than half of their remaining years to be free from conditions affecting their ability to manage daily living activities (see Table 1).

Table 1. Life expectancy and healthy life expectancy at 65 in the EU-27 in 2009, by gender

	Total years life expectancy at 65, men	Healthy years life expectancy at 65, men	Percentage of healthy years life expectancy at 65, men	Total years life expectancy at 65, women	Healthy years life expectancy at 65, women	Percentage of healthy years life expectancy at 65, women
EU-27	16.5	8.4	51.0%	20.1	8.6	42.7%

Source: Eurostat Statistics Database; Joint Action European Health and Life Expectancy Information System (JA EHLEIS). http://dx.doi.org/10.1787/888932702936

Moreover, the risk of becoming dependent on LTC rises steeply from the age of 80. Population ageing, resulting from rising life expectancy and the ageing of large cohorts of baby-boomers, will greatly expand the number and proportion of people at risk over coming decades.

Without access to quality LTC, the affected person's wellbeing, dignity, health or even survival may be endangered. Also, the cost of purchasing LTC services can put a serious strain on, and often exceed, the regular income of the person in need. Thus for individuals and their families, being dependent on LTC represents a significant health-related economic risk, comparable to the need for expensive medical treatment.

Social protection systems, whether based on direct provision of services or social insurance or both, pool costs and risks so that safety for all can be obtained. In the area of health, people in Europe can usually expect most of the cost of their care to be covered by social protection systems, regardless of their own financial situation. Yet in most countries, long-term social care is regarded and treated differently from health care, even though the conditions that cause people to need it are health-related. LTC is not covered by the same collective protection as health care, or not in the same way or to the same extent. Often, the primary responsibility for financing LTC remains with the people in need of care and their families. Likewise, the responsibility for providing care falls first on relatives, especially spouses or partners, children and grandchildren. Several Member States provide social protection for LTC only as a safety net for individuals without any means of funding their own care or any relatives on whom caring responsibilities can be placed.

In societies where needs for LTC are inadequately supported by social protection systems and care is left to kin and chance, many problems arise.

- Individuals and families meeting the cost of professional care face a substantial reduction in disposable income. Just two hours care every day can cost more than many people's pension, while institutional care could cost a multiple of the average pension.
- Those paying for care, and family carers who have to give up or cut back paid employment, may suffer severe economic strain and risk falling into poverty.
- As relatives reduce working hours or drop out of the labour market to provide informal care this will also have a negative impact on labour supply and the economy.
- In addition to the loss of income (both current and future, if pension rights accrual is also affected), family carers may be exposed to a heavy workload and social isolation.
- In systems where the dependent person is expected to use up not only their entire income but also assets to pay for LTC before the social protection system intervenes, descendants may lose their inheritance.
- Relying on relatives to provide care, regardless of suitability, training or motivation, can be economically inefficient as a way of allocating people to caring jobs, delivering care and ensuring quality standards.
- Unsatisfactory or poor-quality LTC can cause (or fail to prevent) a wide range of further problems. For dependent individuals, these can include a poorer quality of life, additional health problems, pain, abuse or mistreatment, loss of dignity and autonomy, and early institutionalisation. The state may well see extra, avoidable costs falling on the health service and other public services.

If these problems are to be avoided in the European Union, each Member State needs to consider whether its current systems offer an adequate level of social protection to support LTC, now and into the foreseeable future, when – as the next Chapter explains – numbers of the needy will be larger and the challenges of meeting their needs greater. Whatever the LTC delivery model, there is a strong case for supporting family carers at different levels: legal, institutional, financial and organisational, and for making sure that satisfactory social protection and quality standards are met.

At EU level Member States should seek to clarify the level of social protection that is to be considered ‘adequate’, and should discuss how it can be measured and monitored. This report is intended to serve as a basis for future discussions in the Social Protection Committee.

2.2. How is long-term care provided across Member States?

The comparative information currently available on LTC in EU Member States is patchy. It does not give a clear and systematic picture of the public support people can expect for themselves and their relatives when they become dependent. Reasons for this patchiness include: the many differences between the systems of different countries; the lack of common definitions of LTC and its constituents parts of health and social care and the borderline between them[4]; and the difficulties inherent in LTC quality measurement. The absence of comparable data is not surprising. Member States have each developed their own systems, in accordance with their perceived needs, social traditions, culture and financial means. Each State has collected the data that they feel they need for their system to operate, or that is generated as a by-product of it. Until recently, attempts to seek comparable information or harmonise data in this area have been few and limited.

As a result, the picture of existing provision for LTC in Member States presented below is far from complete. It draws on previous work by the European Commission, and on OECD health statistics[5] both of which are hampered by the inability of several Member States to provide comparable data on LTC. OECD information covers only those EU Member States also in membership of OECD. However, OECD data is used in this report where it is available for a later year than European data or gives an additional perspective.

The information available leaves no doubt that there is great diversity in Member States' arrangements for LTC. The way in which long-term care is treated in the social protection systems of EU Member States varies greatly, notably in the relative weight assigned to formal and informal care. There is also marked diversity in the way formal care is organised (e.g. by public, for-profit or NGO providers), financed (e.g. via general taxation, obligatory social security, voluntary private insurance or out-of-pocket payments) and delivered (e.g. as home care or institutional care). The publication *Long-Term Care in Europe,*[6] based on the EU-funded INTERLINKS project, observed that in general, in Northern European countries the state is expected to take responsibility for paying for LTC, while in Southern and Eastern European countries the family is considered to be in charge. Their levels of spending on long-term care vary accordingly. The OECD publication *Help Wanted*[7] notes that Sweden, Finland, Denmark and the Benelux countries allocate relatively more resources to LTC than the OECD average and more than could be expected given the share of their populations aged over 80, whereas Portugal, Hungary, Slovakia, Poland and Spain allocate significantly less.

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[4] In several Member States the health and the social aspects of LTC are organized by different ministries and/or provided by different levels of government authorities: while regional authorities may be responsible for the health components local or municipal government often cover the social aspects.

[5] OECD (2013), *Health at a Glance 2013: OECD Indicators*, OECD Publishing. http://dx.doi.org/10.1787/health_glance-2013-en

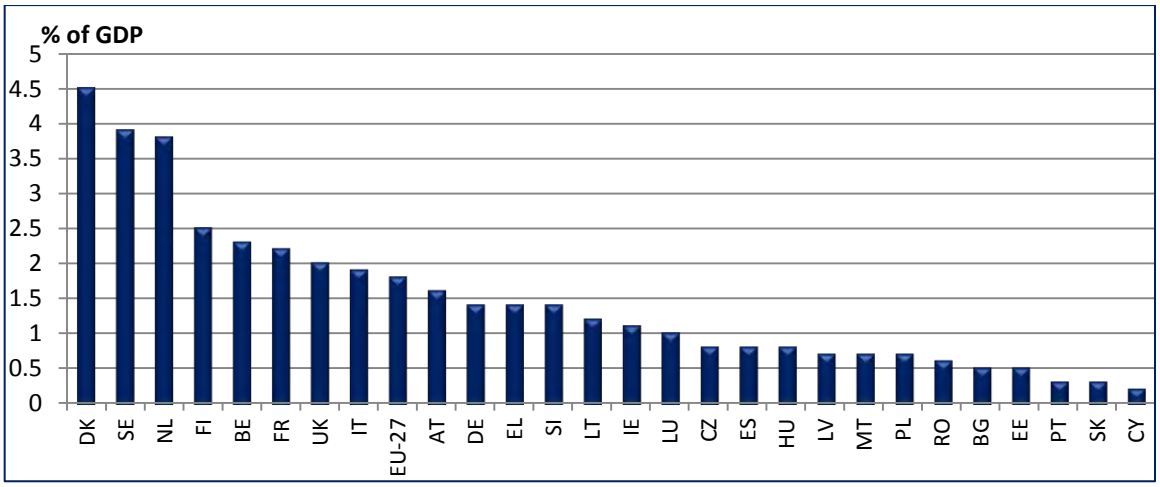
[6] Kai Leichsenring, Jenny Billings and Henk Nies (2013) *Long-term care in Europe - Improving policy and practice.* - Basingstoke: Palgrave Macmillan- http://interlinks.euro.centre.org/project/reports

[7] Colombo, F. *et al.* (2011), *Help Wanted? Providing and Paying for Long-Term Care*, OECD Health Policy Studies, OECD Publishing. *http://dx.doi.org/10.1787/9789264097759-en*

2.3. How are resources allocated to long-term care in Member States?

Figure 1 indicates each Member State's public expenditure on long-term care as a percentage of GDP in 2010. The percentages in Figure 1 were estimated for the European Commission's 2012 Ageing Report,[8] for the purpose of the 'scenario' projections of expenditure through to 2060 described towards the end of Chapter 3; however, the preferred source data (System of Health Account-SHA) was available for only 15 of the EU27, introducing extra uncertainties into projections for the other 12.[9] On this analysis, Member States' public spending ranged from 4.5% of GDP in Denmark (estimate particularly uncertain because preferred data is not available) to 0.2% in Cyprus; the average for the EU27 was 1.8% of GDP.

Figure 1. Public expenditure on long-term care as percentage of GDP in 2010, all ages



Source: based on data from The 2012 Ageing Report (for an explanation of the input data see p. 226)

Table 2, from OECD health statistics, records total expenditure on health and social LTC in 17 U countries, ranging from 3.7% of GDP in the Netherlands and 3.6% in Sweden to 0.0% of GDP in Greece. Denmark, having no comparable data for social LTC, is ranked 3rd by OECD; but (as in Figure 2.1) Finland ranks 4th, Belgium 5th and France 6th.

[8] European Commission (DG ECFIN) — Economic Policy Committee (AWG), 2012, 'The 2012 Ageing Report — Economic and budgetary projections for the 27 EU Member States (2010-2060). http://ec.europa.eu/economy_finance/publications/european_economy/2012/pdf/ee-2012-2_en.pdf

[9] In case SHA data are not available, ESSPROS data is used for proxying the full spending of both in-kind and cash the institutional and/or home care components for the respective Member States. Cash benefits for LTC are calculated using data from ESSPROS for cash benefits from some sub-categories of disability and old-age functions.Ibid., Underlying Assumptions and Projection Methodologies, Annex 8.2

Table 2. Long-term care public expenditure (health and social components), as share of GDP, 2011

Member States	Health LTC	Social LTC	Total
Netherlands	2.7	1.0	3.7
Sweden	0.7	2.9	3.6
Denmark	2.4	:	2.4
Finland	0.7	1.4	2.1
Belgium	2.0	:	2.0
France	1.2	0.5	1.8
Austria	1.2	:	1.2
Luxembourg	1.1	0.1	1.2
Slovenia	0.7	0.2	1.0
Germany	1.0	:	1.0
Spain	0.6	0.1	0.7
Poland	0.4	0.0	0.4
Czech Republic	0.3	:	0.3
Hungary	0.2	:	0.2
Estonia	0.2	:	0.2
Portugal	0.2	:	0.2
Greece	0.0	:	0.0

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

In Table 2 social LTC spending, where shown, ranges from 2.9% in Sweden (where it outstrips health LTC spending by a considerable margin, as it does in Finland) to 0.0% in Poland. Where no figure is given for social LTC this may be because it is not collected, or because it is lumped in with health LTC; but the countries lowest in the table for health LTC spending may not be spending much on social LTC either.

The proportion of LTC costs covered by social protection arrangements in any given Member State will depend on two things: comprehensiveness (is support available for all, some or only a few types of care?) and eligibility (is support available to all, some or only a few needy residents?). The authors of Help Wanted compared selected OECD countries' LTC support arrangements for comprehensiveness and eligibility, using figures from 2008 or earlier. Sweden, the Netherlands, Denmark, Norway, Finland and France appeared in the 'high comprehensiveness, high eligibility' quadrant. In the 'low comprehensiveness, high eligibility' quadrant were Austria and the Czech Republic (which with marginally higher eligibility would have joined France in the 'high C, high E' quadrant). Belgium was in the 'high comprehensiveness, low eligibility' quadrant. Slovenia combined an average comprehensiveness rating with low eligibility. In the 'low comprehensiveness, low eligibility' quadrant were Hungary (comprehensiveness particularly low), Poland (with the most limited eligibility of any EU country shown) and the Slovak Republic (low on both counts).

Table 3 shows that the costs of LTC in EU Member States are met from diverse sources. Some countries draw on the general budget, some on social security or insurance funds, many draw on both to varying degrees.

Table 3 furthermore shows that the great majority of care costs were met from the general government budget in Sweden, Denmark and Austria. Sweden's government met 99% of all costs, leaving 1% to be paid by private households; in Denmark the split was 90%/10%. Austria's split was 81% government, 2% other sources, 17% private. Also, countries vary widely in the percentage of costs remaining to be met out-of-pocket by private households (though the figures on this may not be as reliable as others in the table).

Table 3. Long-term care expenditures by sources of funding, 2007

Country	General government (excl. social security)	Social security funds	Private insurance	Private households out-of-pocket exp.	Other	Non-profit institutions serving households	Corporations (other than health insurance)
Portugal	**2.0**	**51.4**	1.1	**45.4**		0.0	0.0
Germany	**12.5**	**54.7**	1.7	**30.4**	0.7	0.6	0.1
Spain	**61.7**	**10.2**	0.0	**28.1**		0.0	0.0
Slovenia	**18.3**	**57.1**	0.5	**24.0**		0.0	0.0
Austria	**81.1**	**0.7**	0.0	**17.1**	1.0	1.0	0.0
Finland	**77.2**	**7.6**	0.0	**14.2**	1.0	1.0	0.0
Estonia	**48.2**	**39.3**	0.1	**12.4**	0.0	0.0	0.0
Denmark	**89.6**	**0.0**	0.0	**10.4**		0.0	0.0
Hungary	**60.1**	**30.2**	0.9	**2.4**	6.4	6.4	0.0
Sweden	**99.2**	**0.0**	0.0	**0.8**		0.0	0.0
France	**44.8**	**54.4**	0.4	**0.4**		0.0	0.0
Poland	**43.1**	**49.2**	0.0	**0.3**	7.4	7.4	0.0
Belgium	**31.4**	**58.7**	9.8	**0.2**		0.0	0.0
Czech Republic	**30.5**	**69.5**	0.0	**0.0**		0.0	0.0
Netherlands	**9.5**	**90.4**	0.0	**0.0**	0.1	0.0	0.1

Source: OECD Health System Accounts 2010, cited in Help Wanted page 231
Note: countries ranked by decreasing share of out-of-pocket spending

Finland, Spain and Estonia met more care costs from the general government budget than from any other source, but social security funds contributed importantly too. In Finland the split was 77% government, 8% social security funds, 3% other, 14% private. In Spain, the split was 62% government, 10% social security funds, 28% private. In Estonia, the split was 48% government, 39% social security funds, 12% private. By contrast, social security funds met more than half of all care costs in the Netherlands (90%), the Czech Republic (70%), Belgium (58%), Slovenia (57%), Germany (55%), France (54%) and Portugal (51%). Some of these countries (the Netherlands, the Czech Republic, Belgium, France) added in significant general government funding, so that the cost falling on private households was nothing, or less than 1%. But in Slovenia, Germany and Portugal, despite some government contribution, private households still had to meet 24% of costs, 30% of costs and 45% of costs respectively.

Many – but not all - EU countries saw significant growth in spending on health and social LTC over the period 2005-2011. Real terms annual growth was 14.4% in Portugal, 9.1% in Estonia and 6.9% in the Czech Republic (albeit from low bases). Spending in Belgium and Poland also grew more than the OECD average of 4.8%. At the other end of the scale, Hungary's spending shrank by 1.1% annually in real terms, and annual growth in Sweden, Germany, Denmark and the Netherlands ranged from 2.2-3.1% (albeit from high bases).

2.4. Scale of need for long-term care in Member States

Table 4 shows, for 21 EU countries, the percentages of the population whose daily activities are limited by health problems or disability. These percentages give some indication of the relative numbers requiring LTC in different Member States, though should be treated with caution as people's assessment of their health is subjective and can be affected by cultural factors; translation issues may also affect responses.

Table 4. Limitations in daily activities, population aged 65-74 and 75+, European countries, 2011

Country	65-74 years			75 years and over		
	Limited to some extent	Limited strongly	Total	Limited to some extent	Limited strongly	Total
Sweden	12.2	8.4	20.6	18.0	14.6	32.6
Denmark	18.5	7.9	26.4	24.3	11.8	36.1
Luxembourg	21.4	9.8	31.2	27.2	20.0	47.2
Ireland	24.0	9.2	33.2	30.1	16.8	46.9
United Kingdom	20.3	15.8	36.1	23.5	22.7	46.2
Czech Republic	29.2	8.9	38.1	42.1	20.7	62.8
France	25.3	13.3	38.6	34.7	29.2	63.9
Belgium	26.9	11.8	38.7	32.3	24.9	57.2
Netherlands	32.9	7.0	39.9	40.1	14.8	54.9
Spain	33.3	7.8	41.1	43.8	20.1	63.9
Greece	24.6	16.8	41.4	36.5	32.7	69.2
Finland	31.9	12.9	44.8	42.9	23.7	66.6
Austria	30.9	14.7	45.6	32.7	35.0	67.7
Poland	30.7	15.0	45.7	35.6	27.8	63.4
Italy	36.1	14.5	50.6	43.0	31.0	74.0
Germany	38.2	14.8	53.0	45.1	27.0	72.1
Hungary	39.1	14.9	54.0	43.7	30.1	73.8
Portugal	37.3	17.7	55.0	40.6	31.7	72.3
Slovenia	31.6	26.6	58.2	36.8	35.4	72.2
Estonia	43.2	15.6	58.8	44.0	33.3	77.3
Slovak Republic	48.4	25.0	73.4	44.2	44.7	88.9

Source: Eurostat database 2013, based on the EU Statistics on Income and Living Conditions survey (EU-SILC)

According to these figures, the lowest percentage of over-75s whose daily activities are limited is found in Sweden (32.6%), one of the biggest LTC spenders in the EU; conversely, several of the lowest-spending countries, such as Portugal, Estonia and Hungary, have very high percentages. The highest percentage, nearly 90%, is found in the Slovak Republic, which also has by far the highest percentage of needy among those aged 65-74.

Table 5. Population aged 65 years and over receiving long-term care, 2011 (or nearest year)

Member States	Institutions	Home	Total
Netherlands	6.4	12.7	19.1
Denmark	4.3	12.4**	16.7
Sweden	4.9	11.4	16.3
Czech Republic	2.2*	10.9*	13.1
Luxembourg	5.3	7.7	13.0
Finland	4.9	7.4	12.3
Germany	3.9	7.8	11.7
France	4.3**	6.9**	11.2
Hungary	3.0	8.2	11.2
Spain	1.7	5.5	7.2
Slovenia	5.0	1.7	6.7
Estonia	2.0	4.4	6.4
Italy	:	4.1	4.1
Ireland	3.7	:	3.7
Slovak Republic	3.2	:	3.2
Poland	0.8	:	0.8

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.
*Note: * - 2009; ** - 2010; : - not available.*

Table 5 shows, for 16 EU countries, the percentage of the population receiving care in institutions, at home and in total. LTC recipients are defined as people receiving long-term care by paid providers, including non-professionals receiving cash payments under a social programme. They also include recipients of cash benefits such as consumer choice programmes, care allowances or other social benefits granted with the primary goal of supporting people with long-term care needs.

The highest total percentages of long-term care recipients are seen in the Netherlands, Denmark and Sweden, which all make relatively generous financial provision for LTC; but the Czech Republic[10], which spends relatively little, has the next highest percentage. Hungary also combines a relatively high percentage of care recipients with relatively low spending.

2.5. Who are the carers?

The differences between Member States in public expenditure on long-term care mainly reflect differences in the estimated coverage of formal systems of institutional care and home care. Long-term care in institutions is primarily[11] provided by formal care workers who are paid and work under contract. Home care may be paid and/or formally contracted, but in many EU countries tends to be unpaid; if so, it is described as informal or family care. In most European countries informal caregivers provide a great deal of the LTC for older people. Even in countries with a well-developed supply of formal LTC, using narrow definitions of informal carers, the number of informal caregivers is estimated to be at least twice as big as the formal care workforce.

Formal and informal care can be substitutes or complements, depending on the type of care and needs. Some EU Member States report little home care and also seem to have relatively limited ability to respond to demand for institutional care. Some countries like Denmark, Lithuania, the Netherlands and Sweden show relatively impressive coverage rates in both types of provision. A few rely

[10] The number of LTC recipients in Czech Republic refers to recipients of the care allowance.
[11] Some Member States also use volunteers to assist the professional work-force in care homes.

predominantly on one or the other. In 2010, the UK, Greece, Ireland, Luxembourg, Austria, Germany, France and Italy seemed to rely more on home care; institutional coverage rates were relatively higher, though moderate overall, in countries like Bulgaria and Slovenia.

The number of care workers is a good indication of the size of the formal long-term care sector. In 2008, long-term care workers represented only 0.3% of the total working-age population in the Czech and Slovak Republics, but 3.6% in Sweden and 2.9% in Norway and Denmark.[12] Even though most care recipients are cared for at home, the majority of formal care workers work in institutions where care intensity is much higher than at home.[13]

On average across the OECD, nearly 30% of formal care workers are nurses, while the other 70% are personal care workers, who may have different titles in different countries. There are wide variations in their qualifications and responsibilities. Whereas nurses generally have at least three years of training, many countries have no standard or minimum requirements for personal carers, though some organise training programmes. In several countries, most of the care workers lack a LTC-related qualification, particularly if they work in home care.

Foreign-born workers often play an important role, making up some 70% of LTC workers in Italy.[14]At present, wages in the long-term care sector are generally low and working conditions not particularly attractive.

An important feature of the formal long-term care sector is that most LTC workers are women (over 90% in Denmark, the Czech Republic, Ireland, the Slovak Republic, the Netherlands and Sweden); they are often middle-aged and/or work part-time.[15] And the demand for healthcare workers is strong and growing, which may encourage some improvement in the working conditions. According to the September 2013 edition of the European Vacancy Monitor,[16] personal care workers in health services were number 1 in the top 25 growth occupations in Europe, when comparing the fourth quarter of 2012 with the same quarter in 2011. It seems likely that the provision of health and social care will be an important and growing source of jobs, particularly for women, into the future.

Table 6 shows (paid) long-term care workers as a proportion of the over-65s in 15 EU countries. Nordic and Northern European countries Sweden, the Netherlands, Denmark and Estonia make the most use of paid carers. In the Netherlands and Denmark these carers are mainly in institutions where more intensive support is generally given, but in Estonia and Sweden, paid care is often provided in people's homes. The greatest involvement of formal care workers is found in those Member States where LTC is comprehensively financed from general tax revenue, organised as a public service and delivered by trained public sector workers. This then becomes an individual right, as in Denmark and Sweden.

Sweden has nearly one paid care worker for every 8 people aged 65 and over. At the lower end of Table 6 are 6 countries with at most one paid care worker for every 40 people aged 65 and over.

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[12] Triantafillou J. et al, 2010, Informal care in LTC — European Overview Paper, INTERLINKS report
[13] Ibid.
[14] Figures in this paragraph are from OECD (2013), *Health at a Glance 2013: OECD Indicators*, OECD Publishing. The data for Germany exclude elderly care nurses ("Altenpflegefachkräfte") and persons declared to social security systems as caregivers, resulting in a substantial under-estimation.
[15] Ibid
[16] European Vacancy Monitor - Issue No. 10 / September 2013 (29/08/2013)
http://ec.europa.eu/social/main.jsp?catId=737&langId=en&pubId=7643

Table 6. Long-term care workers as share of population aged 65 and over, 2011 (or nearest year)

Member States	Institutions	Home	Total
Sweden[1]	12.2		12.2
Netherlands	6.5	4.4	10.9
Denmark	6.4 (2008)	2.9 (2009)	9.3
Estonia	0.6	5.9	6.5
Spain[1]	4.3		4.3
Germany	2.7	1.3	4.0
Ireland	1.5	1.7	3.2
Finland	3.0 (2005)		3.0
Austria	2.8 (2006)		2.8
Slovenia	2.5		2.5
Czech Republic	1.6 (2009)	0.8 (2009)	2.4
Hungary	1.4	1.0	2.4
France	1.6 (2007)		1.6
Slovak Republic[1]	1.6		1.6
Italy	1.1 (2005)		1.1

Source: OECD Health Statistics 2013,http://dx.doi.org/10.1787/health-data-en.
Note: [1]It is not possible to distinguish between LTC workers in institutions and at home.

Several Member States experience difficulties in recruiting LTC workers. A Peer Review organised in Berlin on 23-24 October 2013 discussed the use of migrant workers to bridge this gap. Major challenges in this regard are to ensure that such international recruitment drives benefit both the host country and the sending country, and to discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.[17] Also, live-in care workers recruited directly by families are covered by the ILO Domestic Workers Convention (N° 189), which sets out requirements concerning decent work, human rights, social protection and working conditions for domestic workers.[18]

The World Bank has recently suggested tackling the problem of brain drain by setting up global training partnerships to increase the availability and quality of health care workers globally, and also to bring a true added value to sending countries (who would otherwise suffer from brain drain). This would involve setting up training centres in migrant-sending countries (such as North African countries) that offer training programmes matching the standards of highly developed countries.

Germany is trying to implement some of these strategies in 'triple win programmes' targeted on non-EU countries. The triple win consists in allowing countries of origin to build up a better-skilled health workforce; Germany to increase the number of medical staff and improve social diversity; and students to gain job opportunities and enhance their skills. Partnerships exist with Serbia, Bosnia, the Philippines, Tunisia and Vietnam, and there are plans for schemes with Morocco and India.

[17] See WHO Global Code of Practice on the International Recruitment of Health Personnel http://www.who.int/hrh/migration/code/practice/en/
[18] ILO Convention signed in 2011, entered into force 05 Sept. 2013 http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C189

2.6. Informal carers

Formal care workers, though not highly paid, necessarily cost more than informal unpaid carers provided that economic opportunity costs are not taking into account. The Member States with the highest numbers of paid care workers also tend to be the Member States spending the highest proportions of GDP on long-term care. Affordability is one reason why many Member States prefer to rely on informal, usually unpaid family carers, but there are others. As reported by EU surveys, a noticeable number of older people, asked what type of care they prefer, choose home care by a relative.[19] Also, many European countries have strong cultural traditions of family caring. While family solidarity has great social value in itself, the reliance on informal family care in many countries suggests that dependence on long-term social care is not perceived as a risk requiring social protection in the same way as, for instance, sickness or acute ill-health.

An informal or family carer can be described as someone "who provides help to someone with a chronic illness, disability or other long-term health or support need, outside a professional or formal framework".[20] Estimates of the number of informal carers vary, depending on variables such as the type of caring tasks or the minimum number of hours spent in caring. The report of the second European Quality of Life Survey showed that in the EU27, 3% of people stated that they care for an elderly or disabled relative several times a week, 4% provided care once or twice a week and 8% did this less than once a week.[21]

Most informal carers are women, but the proportions of women are a little lower than in formal care: 71% in Hungary; 66-64% in Estonia, Italy, Poland, Portugal, Spain, Sweden and the Czech Republic; 62-60% in France, Austria, Germany, Slovenia and Belgium; 58-57% in the Netherlands and the UK; and 54% in Denmark. Over 90% of people providing regular informal care have a family relationship with the people they care for. Informal carers are typically spouses, middle-aged daughters or daughters-in-law.

Table 7 shows the percentage of the over-50 population providing informal (usually unpaid) care to family, friends or people in their social network in 16 EU countries. Of the countries shown Belgium at 20.6% has the highest percentage of informal carers aged 50+ followed by Italy (which has the fewest paid LTC carers) and the UK. The lowest percentage of informal carers is found in Denmark, with Sweden (the country with the most paid carers) and Poland only a little higher. On average across OECD countries, 66% of informal carers provide daily care, the rest weekly care. However there is a wide variation between countries in the intensity of caregiving. In Portugal, Spain, Italy, Poland and Slovenia, where there is a strong tradition of family caring, at least 3 in 4 informal carers report caring on a daily basis; but in Sweden and Denmark where more caring is done by paid LTC workers, the proportion of informal carers providing daily care is much lower.

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[19] See *Health and long-term care in the European Union (Special Eurobarometer 283),* European Commission 2007 http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

[20] Glendinning, et al (2009b) '*Care provision within families and its socio-economic impact on care providers across the European Union'*, Research Works, 2009–05, York, Social Policy Research Unit, University of York.

[21] Second European Quality of Life Survey – Overview – Anderson et al. 2009
http://www.eurofound.europa.eu/pubdocs/2008/52/en/1/EF0852EN.pdf
http://www.eurofound.europa.eu/publications/htmlfiles/ef0902.htm

Table 7. Percentage of population aged 50+ reported to be informal carers, 2010

Member State	Percentage
Belgium	20.62
Italy	19.66
United Kingdom	18.19
Czech Republic	17.66
Estonia	17.46
Netherlands	16.92
Hungary	16.15
Austria	16.10
France	15.98
Germany	15.65
Portugal	15.64
Slovenia	14.56
Spain	14.18
Poland	12.84
Sweden	12.30
Denmark	11.78

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

Women are more likely than men to have to assume care responsibilities for elderly family members with LTC needs and are thus far more likely to reduce their working hours in the formal economy. As highlighted in the Joint Employment Report 2014[22], in several Member States the underdevelopment of formal LTC provision remains a major impediment to female employment and growth, and limits carers' protection against dependency in old age. In many other Member States, while the problems may be less acute, it is still true to say that women's chances of labour market participation are disproportionately and undesirably reduced by caring responsibilities, particularly in middle age. Even though there is a clear correlation between female labour force participation rates, notably at ages 55-64, and the extent of access to LTC provision, there is nothing in this field similar to the EU's Barcelona objectives/targets for child-care. Nor is there any monitoring at EU level of progress in coverage, access and affordability, as there is for the Barcelona targets. Some of the agreed indicators for labour market participation and for work-life balance which have been developed within the Joint Assessment Framework[23] to cover the impact of child-care may also be useful in relation to LTC care duties.

Estimates suggest that the economic value of unpaid informal care as a percentage of the overall cost of long-term care in EU Member States ranges from 50% to 90%.[24] It has also been calculated that, depending on the methodology applied, the total value of unpaid family caregiving ranges between 20.1% and 36.8% of EU GDP.[25] However, with this economic value come some serious costs and disadvantages.

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[22] Draft Joint Employment Report accompanying the Communication from the Commission on Annual Growth Survey 2014 http://ec.europa.eu/europe2020/pdf/2014/jer2014_en.pdf

[23] Joint Assessment Framework - European Council document - 16984/10 26; Nov. 2010 "*Foundations and structures for a Joint Assessment Framework (JAF)*" The JAF is a common analytical framework developed at EU level to monitor the 3 strands of social protection. http://www.ec.europa.eu/social/BlobServlet?docId=6440&langId=en

[24] Triantafillou J. et al, 2010, Informal care in LTC — European Overview Paper, INTERLINKS report http://interlinks.euro.centre.org/project/reports

[25] Giannelli et al. "*GDP and the value of Family Caretaking: How much does Europe care*?" 2010/ http://ftp.iza.org/dp5046.pdf

First, there are economic opportunity costs. Informal carers may not be able to find or stay in other formal work, and so may pay little or nothing in taxes and social contributions. Informal carers, and especially women, have been found to be at higher risk of poverty, reflecting a weaker attachment to the labour force and hence the accrual of lower pension entitlements. Viitanen (2005,[26]), in a study of 13 EU countries,[27] found that single women with care responsibilities for older people incur a greater risk of old–age poverty. Intensive carers tend to have lower income than non-intensive carers: 60% of them are in the first and second income quintiles compared to 40% of non-intensive carers. Unless there is good access to formal care support and policies enabling people to combine work and family responsibilities, as in some Northern European countries, care can entail substantial economic sacrifice; informal carers may be forced to cut down their working time or leave paid employment altogether. Obligations to look after elderly relatives can also cause poverty when informal carers reach pensionable age, unless arrangements have been made to help them to reconcile family and care responsibilities and (as in Germany and Slovakia, for example) to build up pension rights.

Secondly, there can be costs to the health and wellbeing of family carers themselves. Informal carers can be under considerable stress as they try to balance work and family duties, and most have received no training in caring for the elderly. The prevalence of mental health problems among informal carers is 20% higher than among non-carers (Colombo et al., 2011[28]), and particularly high for people who provide very intensive care (more than 20 hours per week) – see Figure 2. Depressive disorders, anxiety, anger and hostility are frequently associated with heavier caring duties.

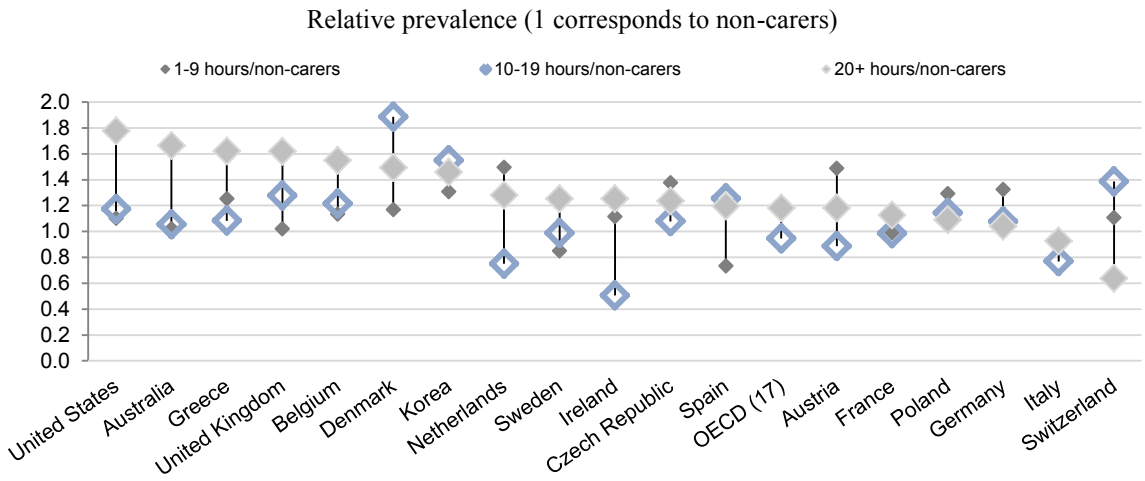
Research has also found various adverse effects on physical health, as caregivers are less likely than others to meet their own health needs. This can result in harmful habits and lifestyles (smoking, inadequate food or sleep habits) and failure to take preventive health measures (such as medical consultations). And thirdly, countries which rely predominantly on informal carers are likely to find it significantly more difficult to guarantee equality of access to care, because not all needy people have family members able or willing to be carers. They are likely also to find it difficult to ensure good-quality long-term care, unless comprehensive systems are put in place to give family carers the same training, supervision, guidance and support as employed carers.

[26] Viitanen," *Informal Elderly Elderly care and female labour force participation across Europe*" ENEPRI Research Report N°13 – July 2005 http://www.enepri.org/files/Reviser/enepri-tarja.pdf

[27] Austria, Belgium, Denmark, the UK, Germany, the Netherlands, Luxembourg, France, Ireland, Italy, Greece, Spain and Portugal

[28] Colombo, F. et al (2011), *Help Wanted? Providing and Paying for Long-Term Care, OECD Health Policy Studies; OECD Publishing. Chap 3 p98.* http://dx.doi.org/10.1787/9789264097759-en

Figure 2. Mental health problems depend on the intensity of caring



Source: OECD estimates. Colombo et al., 2011
Note: Numbers presented correspond to the relative prevalence of mental health problems among carers by intensity of caring with respect to non-carers. Samples include persons aged 50 years and above (with the exception of Korea where 45 and older are considered). The United States includes care provided to parents only. The following years are considered for each country: 2005-07 for Australia; 1991-2007 for the United Kingdom; 2004-06 for other European countries; 2005 for Korea and 1996-2006 for the United States.

One type of care that is half-way between formal and informal care involves the family hiring someone unrelated - possibly as a live-in carer - if families are unable or unwilling to provide care themselves, or if formal services are unavailable or unaffordable. Then family members need not miss out on job opportunities; indeed, they are likely to have paid employment to pay for the live-in carer. However, as this approach tends to involve undeclared work (often by illegal immigrants) there are indirect costs in taxes foregone, while the hired carers are underpaid and forego social and labour law protection.

2.7. Information needs and data gaps

As the foregoing analysis shows, Member States in their LTC provisions have very different approaches to the balance between health care and social care; between paid care and family care; between institutional and home care; to the comprehensiveness of care programs and eligibility for support; and to the mix of public, private and insurance financing. These differences can complicate the tasks of collecting and comparing data on LTC. There are still issues regarding data comparability on LTC issues, especially regarding coverage (routine data collection not yet available for all Member States on all topics). Data are also scarce on quality, care outcomes, value for public money and care sector productivity. The following paragraphs will give an overview on existing data sources. Data on Long Term Care are collected primarily by the System of Health Accounts (SHA) and the European System of Social Protection Statistics (ESSPROS).

In the *System of Health Account (SHA)* both SHA 1.0 and SHA 2011 have a separate category (HC.3 Long-term care (health)) for reporting the expenditures and financing related to LTC. These expenditures are further subdivided based on the mode of provision as follows (SHA 2011 sub-categories):

HC.3.1 Inpatient long-term care (health)
HC.3.2 Day long-term care (health)

HC.3.3 Outpatient long-term care (health)
HC.3.4 Home-based long-term care (health)

SHA also collects data in three 2-dimensional Tables, each one combining 2 of the 3 available dimensions (health care functions, health care providers and health care financing agents). This means that LTC expenditure data can be further broken down by health care providers, as well as health care financing agents.

Over the last years, important work has been undertaken by Eurostat to better define the boundaries of LTC and improve the reporting, especially to accurately split the health component of LTC (which should be reported under HC.3) from the social one29. To allow faster and easier acccess to LTC data, Eurostat also publishes a separate Table for LTC on its online database30. Based on close cooperation with Member States Eurostat has addressed an important number of areas that are of interest to policy makers (e.g. Out-of-pocket payments) and is now finalizing a legal act on health care expenditure and financing, which will contribute significantly towards data for all countries being available on a regular basis and in a timely manner. It will also contribute to better data on LTC in terms of methodology and data quality (consistency and comparability).

The *European system of integrated social protection statistics – ESSPROS* - can provide a coherent comparison between European countries of social benefits to households and their financing, based on the concept of social protection, or the coverage of precisely defined risks. It records the receipts and the expenditure of the organizations or schemes involved in social protection, and can provide decision-makers with quantitative data (social protection receipts and expenditures by schemes) and qualitative data (metadata by scheme and detailed benefit). ESSPROS can also provide them with interesting retrospective view as it already has a long historical background.

ESSPROS does not define a self-standing and separate "Long Term Care" function. Still it can give various data and information related to Long-Term Care. Among the different functions covered, one called "Old Age function" covers important topics (see table below and for further details the ESSPROS Manual[31]): cash benefits (related to pension) and benefits in kind (accommodation and assistance).

However, it must be born in mind that ESSPROS, as its name suggests, is focused on Social Protection schemes, and therefore can exclusively provide information, if a topic is already covered by a social protection scheme, but cannot provide information on topics for which no social protection coverage exists.

The impact of LTC needs on informal carers and relatives could conceivably be measured through the *EU survey on income and living conditions (EU-SILC)* and the *EU Labour Force Survey (LFS)*. In the former, questions about dependency and long-term care needs in households or of close relatives (e.g. elderly parents not living in the same household) could yield information on how such dependency impacts people's living conditions, notably in the absence of strong social protection arrangements. If questions on informal care obligations in the LFS were more specific on whether these involved children or older people they could provide

[29] An in-depth description of this issue can be found in pages 88-95 of the SHA 2011 manual: http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/publication?p_product_code=KS-30-11-270
[30] http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha_ltc&lang=en
[31] http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/publication?p_product_code=KS-RA-07-027

valuable information on the employment impact of dependency and hence on the potential benefits, in terms of higher activity rates (particularly of women) resulting from better access to affordable professional LTC services.

Finally, the *Mutual Information System on Social Protection (MISSOC),* which was established to promote a continuous exchange of qualitative information on social protection legislation among the Member States, gives an overview of LTC coverage and benefits available, from a legal regulatory point of view. But its comparability needs to be further improved, notably as far as applicable means tests are concerned.

Better EU statistics require agreed, clear definitions of LTC concepts. An Inter-institutional Working Group, set up in 2012, steered by the Institute of Macroeconomic Analysis and Development, the Slovenian Social Protection Institute and the Slovenian Statistical Office, has focused on information and data collection needs in the field of LTC - starting from the SHA framework and working in close cooperation with international institutions. Its final contribution will be to prepare guidelines designed to improve identification, comparability, collection and recording of LTC data items. There is a need for further cooperation between this Group and Member States.

A major step towards more comparable information on risks of dependency and social protection against dependency risks in Member States could come from a new Commission/OECD two-year joint project on "Measuring effective social protection in Long-Term Care". This project, which has started in January 2014, will focus on measuring whether LTC services and systems intended to help LTC recipients live a life in dignity are adequate for the purpose. It will develop a methodology for cross-country comparisons of social protection systems against the risk of needing long-term care on the basis of 'typical cases' with clearly defined care needs. For these cases, the costs of the required care can be assessed, and the extent to which such needs are covered by social protection arrangements can be estimated. The result of this project would be a tool similar to the theoretical replacement rates in the area of pensions.

Valuable statistical information may be available from other sources too. For example, the *Survey of Health, Ageing and Retirement in Europe (SHARE)* is a multidisciplinary longitudinal survey of people aged 50-plus, conducted in many EU countries. As it covers health, dependency, healthcare use, social support, formal and informal long-term care, as well as income, wealth and many other socio-economic variables, it allows in-depth analysis of many of the issues mentioned in this report. Extending SHARE to all EU countries, and enlarging the sample size, would make this database even more useful, and complement EU-SILC and the LFS.[32]

There is a a discussion on the question of developing agreed datasets and indicators which will enable informed judgments to be made about the most effective approaches to delivering LTC in Member States. The extent of the predicted increase in demand, growing demands for public accountability, and the high and rising expectations of older people for high-quality long-term care, make it imperative to monitor what works and what does not. Agreed datasets and indicators will help Member States to find a common understanding on adequate long-term care provision, and to monitor progress towards achieving national and EU-wide goals of social protection for people in need.

[32] See http://www.share-project.org for further information.

In conclusion, there is a need to address statistical gaps in the coverage of LTC in EU databases. It will obviously remain Member States' responsibility to ensure adequate supply and quality of long-term care services and to safeguard the dignity and fundamental rights of frail elderly people. The European Commission can help in two ways: first, it can help by clarifying common objectives of adequate social protection against LTC dependency risks. Secondly, it can help to build up a base of statistical data and agreed indicators for exchanging knowledge about progress towards the goals and standards,. However, this will require major multi-annual investment in collecting and ensuring the comparability of data, both quantitative and qualitative.

2.8. Is there adequate social protection for people needing long-term care?

Social protection for LTC aims to ensure that people with special long term care needs (i.e. due to frailty, ill health or disability) can get the goods and services they need for a life of dignity, and will not fall into poverty.

To establish whether their current social protection is adequate, Member States need to ask themselves two questions:

- Do people dependent on LTC get the help they need?
- Is this achieved without impoverishing the person needing help or their family?

Answering these questions involves considering

- whether (and how much) help and care is available to people who suffer from a decreased self-care capacity (including a loss of autonomy) and become dependent on LTC;
- whether this care (which may include non-institutional care such as tailor-made support for independent living) is of sufficient quality;
- whether and what help is available to family carers; and
- what degree of means-testing is applied before the social protection system will bear the costs of care.

The above questions focus on quantity and financing of care, but LTC quality and impact are also important, and growing in importance. People dependent on LTC will not feel that they are getting the care they need if what is offered is ineffective or of poor quality or not the sort of help they want. This can also have implications for the protection of fundamental rights and the dignity of people in need of care. Moreover, the requirement for public accountability can be expected to grow. As the cost of LTC rises and absorbs a greater share of countries' GDP, governments will increasingly feel the need to show tangible benefits for extra investment.

The OECD and EC report *A Good Life in Old Age*[33] highlighted both the importance and the difficulty of ensuring that LTC is of good quality, i.e. ensuring that it maintains and where possible improves the functional and health outcomes of frail, chronically ill and physically disabled old people. The report notes a consensus that good quality care has three critical components. It is effective and ensures the patient's safety; it is centred on and responsive to their

[33] OECD/European Commission (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care,* OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/9789264194564-en

needs and wishes; and it is co-ordinated with other services they use. Therefore 'adequacy' assessment should include asking the following questions about impact and quality.

- How effectively do LTC services deliver good outcomes for users and prevent avoidable adverse events or deteriorating health?
- To what extent are users' fundamental rights respected?
- To what extent are users' wishes and preferences taken into account when care decisions are made?
- How do those dependent on LTC rate their quality of life and satisfaction with LTC services?
- Are LTC services well integrated with other services used by those dependent on LTC (e.g. health services)?
- Do LTC services offer good value for public money?

With the support of the European Commission's Daphne III Programme, AGE worked a project with a network of 11 partner organisations to develop - A **European Charter** on the rights of older people in need of Long-Term Care[34]. This Charter focused on people and women in particular, who are dependent on a family member or carer, or are need of long-term care or assistance. - An Accompanying Guide or 'toolkit' addressing each of the rights expressed in the Charter, explaining what they concretely mean and how they can be enforced. This European Charter can be seen as first step towards better identification of actual situation and needs of LTC recipients. Based on this approach, the EU-supported WEDO project[35] (Wellbeing and Dignity of Older People) has brought an important contribution to the definition of quality standards with the *European Quality Framework for Long-Term Care Services*,[36] defining key principles to improve the quality of LTC for elderly people.

This Framework is based on a pragmatic approach and reflects the large diversity of existing practices across the EU. But it also reflects, key agreed principles, paving the way for a more adequate LTC delivery. One of the corner stone of this document is the **recipient's empowerment**, especially in the definition of his own needs. In that respect, the principles developed in this European Quality Framework can be seen as inspirational point for a better implementation of LTC services.

Recently the Committee of Ministers of the Council of Europe adopted a *Recommendation on the promotion of human rights of older persons*,[37] reaffirming the rights of older people and recommending a range of measures to be taken by Member States. The Council of Europe in practice endorsed underpinning principles of such documents as the Framework mentioned above. The Recommendation of the Council of Europe was inspired by existing initiatives especially WE DO documents, and WE DO project promoters were involved in the drafting of the official statement of the Council of Europe. In that respect, the statement can be seen as a logical development but also as a political support towards better enforcement of recipients' rights.

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[34] http://www.age-platform.eu/images/stories/22204_AGE_charte_europeenne_EN_v4.pdf
[35] http://www.wedo-partnership.eu/
[36] http://wedo.tttp.eu/european-quality-framework-long-term-care-services
[37] https://wcd.coe.int/ViewDoc.jsp?id=2162283&Site=COE&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383

The text covers the major challenges faced by older people: discrimination issues; autonomy and participation; protection from violence and abuse; social protection and employment; care; and the administration of justice.

3. THE CHALLENGES FACING LONG-TERM CARE SYSTEMS

This Chapter describes the immense challenges facing LTC provision and social protection for LTC over the next decades where population ageing will entail that:

- The number of older people will grow rapidly, generating major growth in demand for long-term care.
- The percentage of the very old will grow particularly rapidly, changing the nature and increasing the scale of dependency on long-term care for age-specific conditions.
- The supply of potential carers, both formal and informal, will shrink.
- The growing population of older people dependent on care services will have higher expectations than previous generations of receiving good-quality care, responsive to their wishes.
- Governments will find it increasingly difficult to make sufficient public provision for long-term care needs within tight public budgets as demand rises and as the supply of informal carers shrinks.
- Demands for public accountability for care spending will increase, as will pressures on the care sector to improve productivity and deliver more for less.

3.1. Growing demand for LTC

Population ageing is universal across EU Member States. All EU countries will see major increases in the proportions of their populations aged 65+ and 80+. People are living longer, and the baby-boom cohorts are joining the ranks of the elderly. According to the latest Eurostat Population Projections the number of people aged 80+, and their population share, is set to increase in all EU countries until 2060, though the increase will be especially pronounced from 2030 to 2040. For those aged 65+, the highest increase is expected in 2020 to 2030 (Table 8).

Table 8. Projected changes in number of people 65+ and 80 + in EU27, 2008-2060, millions

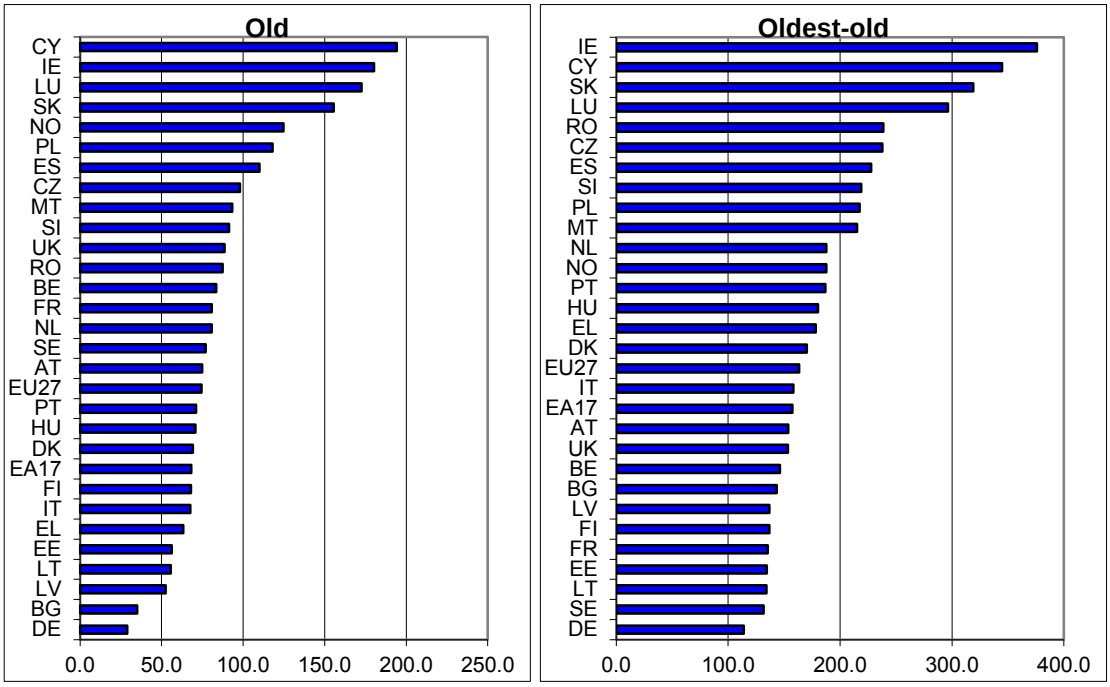
EU-27	2008	2010	2020	2030	2040	2050	2060	% change (2008-2060)
65+	84,6	87	103,7	123,5	143,1	149,9	152,7	80.5%
Of which: 80+	21,8	23,3	29,7	36,6	48,8	57,5	62,2	185,4%

Source: 2010 EUROPOP

In 2060 (see Figure 3), the share of the population aged 65 or more is projected to range from 22% in Ireland and 25% in the United Kingdom, Belgium and Denmark to 33% in Bulgaria, Germany and Slovakia, 35% in Romania and Poland and 36% in Latvia. The share of the population aged 80 or more is projected to be 12% on average in the EU27, ranging from 9% in Ireland, Cyprus and the United Kingdom to 14% in Spain, Italy and Germany. In the 100 years since 1960, the proportion of people aged 80+ in the population will have grown at least five-fold, at most eighteen-fold, in the Member States for which data is available. Between now and 2060, the number of people aged 80+ is expected to almost triple.

The likelihood of physical or mental disability causing a person to become dependent on long-term care increases with age. Therefore, unless the prevalence of frailty and morbidity is reduced, the projected increases in the proportions of people aged 65+ and 80+ in Member State populations may be expected to lead to corresponding increases in future demand for LTC.

Figure 3. Projected percentage changes in older population groups in EU-27, 2010-2060



Source: The 2012 Ageing Report

People are said to be dependent on long-term care when they are unable to perform daily personal care tasks, or have difficulties in performing at least one Activity of Daily Living, without some help. It is not age in itself, but the health status of older people, that triggers the need for care. It is a consequence of frailty, then disability and the degree to which this causes individuals to become dependent on the assistance of others.

The relationship between disability levels and the need for, demand for and use of long-term care is not simple. Many people with some form of disability can live independently without the need for assistance or care services. Some people who appear to others to need long-term care do not seek it or are unwilling to accept it if offered. And when it comes to the legal definition of dependency, major differences can be observed between Member States.

However, it is generally accepted that older people with a severe disability are (most) in need of long-term care services. Therefore a measure of severe disability can be seen as a proxy for dependency. Table 9 shows disability rates for those aged 65+, for 2006 and 2009, by EU Member State and age band – though caution is required in making cross-country comparisons of perceived health status, because people's assessment of their health is subjective and can be affected by cultural factors.

Academic researchers do not agree on whether, as life expectancy increases, morbidity and dependency levels in old age will decrease, remain constant or increase. It remains unclear whether, and to what extent, the prevalence of disability will be affected in future decades by changes in lifestyle and improvements in the management of chronic diseases.

Table 9. Disability rates in 2006 and 2009 in EU countries, 2006 and 2009

	EU-SILC 2009					EU-SILC 2006				
	65-69	**70-74**	**75-79**	**80-84**	**85+**	**65-69**	**70-74**	**75-79**	**80-84**	**85+**
BE	10.6	14.1	15.8	21.8	27.5	12.4	15.5	17.3	25.9	26.0
BG	9.8	10.1	16.3	19.0	27.4	:	:	:	:	:
CZ	8.3	13.4	17.3	23.9	34.3	10.1	15.3	18.1	27.9	41.5
DK	8.7	7.3	12.3	18.4	19.6	:	:	:	:	:
DE	14.7	18.1	25.5	30.8	52.0	12.4	16.5	21.2	25.9	46.6
EE	13.3	18.6	28.1	35.7	41.3	19.9	25.5	36.3	41.6	56.6
IE	8.4	11.5	13.2	19.5	22.6	9.1	12.0	18.6	19.1	32.0
EL	15.0	21.4	30.7	40.1	54.2	10.9	15.0	18.4	25.4	28.7
ES	8.8	11.0	15.5	22.8	33.2	14.2	15.4	20.9	26.1	35.3
FR	12.8	17.9	24.1	35.8	45.7	8.8	14.1	16.4	28.3	34.0
IT	11.6	16.6	21.8	33.5	39.3	10.2	15.4	21.5	28.7	42.6
CY	10.7	15.0	27.1	41.7	39.0	19.6	25.9	31.0	42.3	41.6
LV	10.7	16.5	23.3	15.0	35.3	23.2	23.6	27.5	39.9	46.9
LT	14.1	14.8	21.7	31.3	41.5	19.5	27.3	33.6	41.0	55.7
LU	12.3	14.4	12.7	16.1	23.6	11.6	16.4	21.2	21.2	46.1
HU	14.4	19.8	29.7	34.4	41.5	24.6	32.7	35.9	47.0	53.6
MT	6.4	8.7	18.8	18.2	29.6	7.8	9.5	17.8	27.6	37.8
NL	8.3	9.3	12.5	14.8	20.5	11.1	9.9	18.7	23.2	32.9
AT	13.5	19.5	27.1	34.1	49.2	13.6	21.7	26.4	34.1	52.6
PL	14.9	18.2	26.0	29.5	38.6	9.8	18.4	25.4	29.2	39.9
PT	17.0	22.8	30.6	41.9	55.6	22.6	26.5	38.2	42.4	51.7
RO	10.3	20.8	24.3	31.2	36.9	:	:	:	:	:
SI	18.7	20.4	25.0	32.3	35.5	11.8	17.3	20.6	24.2	32.4
SK	24.1	29.8	43.7	55.8	63.0	24.9	34.8	42.6	52.1	56.4
FI	10.5	13.4	19.3	31.7	37.1	15.4	25.9	27.2	33.5	40.0
SE	6.5	9.5	15.7	16.1	20.3	9.8	11.6	13.6	15.2	22.3
UK	16.4	16.7	22.2	21.8	29.6	13.1	17.5	17.6	23.1	36.9

Source: Commission services (DG ECFIN), based on the EU-SILC data.

International evidence suggests that health may continue to improve, with improvements in medical knowledge and technology. Certain studies Lafortune and Balestat[38] have noted that as life expectancy increases the incidence of severe disability is postponed, leading to a reduction in the prevalence of severe disability and dependency for some age groups. Some recent papers suggest that people are living longer with less disability and fewer functional limitations. On the other hand, causes of disability and dependency, which are strongly age-related, may become more prominent. In particular, the number of people with a diagnosis of mental disease or dementia (Alzheimer's, Parkinson's disease) seems likely to increase. And there is growing concern in Europe, as in Western societies generally, about the impact of obesity, unhealthy diets and sedentary lifestyles on people's longer-term health. Lafortune and Balestat[39] have

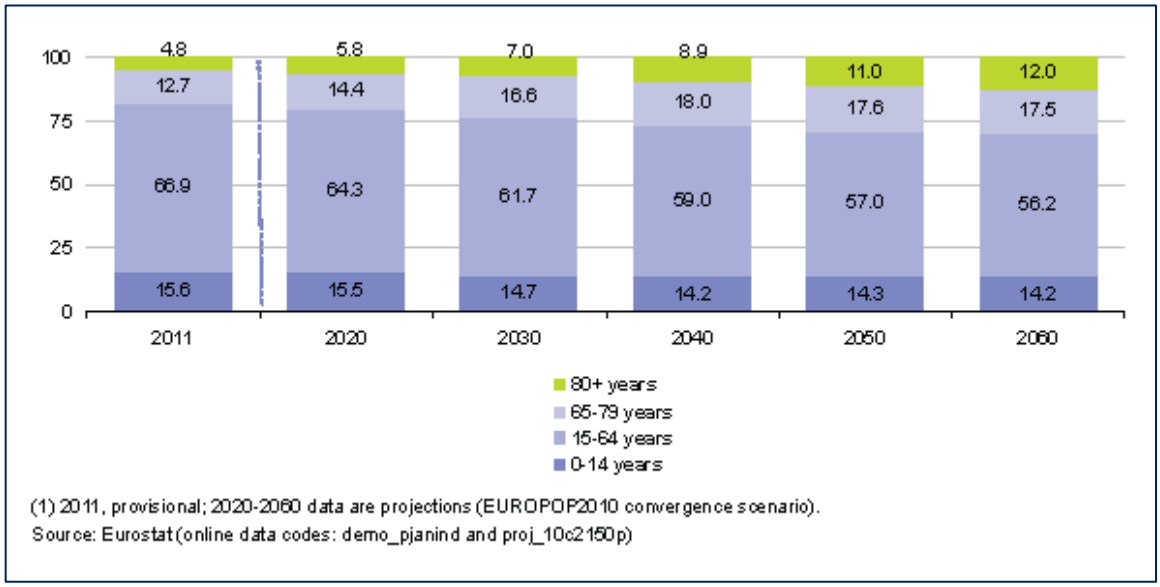
[39] OECD Health Working Papers No. 26: Trends in severe disability among elderly people: assessing the evidence in 12 OECD countries and the future implications - Gaétan Lafortune, Gaëlle Balestat, and the disability study expert group members - http://www.oecd.org/social/soc/38343783.pdf

convincingly argued that, although different trends in severe disability have been observed in different countries, the scale of the increase in the number of people over 65 is bound to lead to a rise in the number of severely disabled older people. While a decline in the prevalence of severe disability could mitigate this growth, it will not compensate for the large increase in the number of people in the age groups at risk. At this stage, the safest assumption is that the ageing of the population, driven in particular by large cohorts reaching old age, will lead to a significant increase in the number of frail older people with functional limitations and disabilities.

3.2. A dwindling supply of potential carers

Where will the carers come from to meet the potential much-increased demand for long-term care? The supply of people available to provide unpaid or paid LTC is also affected by the ageing of the European population and other demographic trends. The working age population is expected to decline steadily as a percentage of total population, as shown in Figure 4.

Figure 4. EU-27 population projections, percentages in each age band, 2011 to 2060



(1) 2011, provisional; 2020-2060 data are projections (EUROPOP2010 convergence scenario).
Source: Eurostat (online data codes: demo_pjanind and proj_10c2150p)

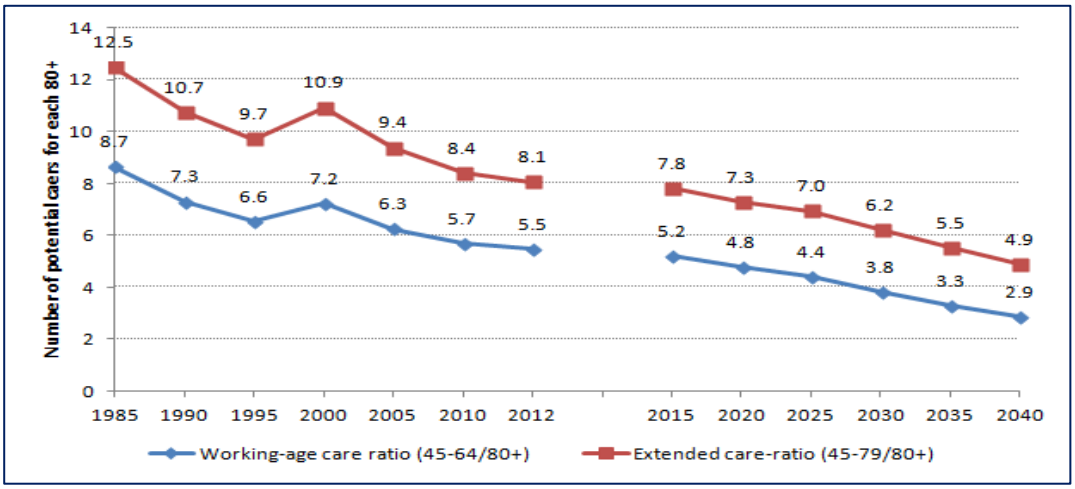
In the EU27 the population aged 65+ as a percentage of the population aged 15-64 is projected to increase from 26% in 2010 to 53% in 2060. In other words, there will be just two people aged 15 to 64 for every person aged 65 or more in 2060, compared with four in 2010. At the Member State level, the percentage will be relatively high - 60% or more - in Bulgaria, Germany, Latvia, Poland, Romania and Slovakia, and relatively low - 45% or less - in Belgium, Denmark, Ireland, Luxembourg and the United Kingdom.

These demographic trends will have serious consequences for the availability of paid carers. Intense competition for manpower will make it very difficult to attract enough extra carers to keep pace with growing care needs. Jobs in the sector may need to be made more attractive by enhancing terms and conditions. This will of course raise the unit costs of care. Manpower shortages commonly prompt greater efforts to recruit into the workforce groups which were previously economically inactive. This could draw some informal carers into the formal sector. Poland, for example, has a programme to recruit as care workers people who previously cared for family members, by accrediting the caring skills they have acquired.

Consequences for the availability of informal carers may be even more dramatic. In Europe today, the bulk of informal care is provided by people aged 45-64. Figure 5 compares

demographic trends for this age group, the 65+ age group and the 80+ age group. In 1985 there were 8.7 people aged 45-64, and 12.5 people under 80, for every person aged 80+. By 2012 there were 5.5 people aged 45-64, and 8.1 people under 80, for every person aged 80+. Projections suggest that by 2040, there will be just 2.9 people aged 45-64, and 4.9 people under 80, for every person aged 80+.

Figure 5. Changes in working age and extended care ratios for the EU-27



Source: Eurostat, Demographic Statistics and EUROPOP2010

To add to these problems of demography, the vast majority of informal carers are close family members. Therefore the potential pool of informal carers, mainly spouses and daughters or daughters-in-law,[40] will also be drained by recent changes in society which have altered family structures. In the EU-27 the marriage rate has been declining (from 7.9 marriages per 1 000 inhabitants in 1970 to 4.4 marriages per 1 000 inhabitants by 2010) and the divorce rate increasing (from 1.0 divorce per 1 000 inhabitants in 1970 to 1.9 divorces by 2009), particularly among older people. So fewer people can look to spouses for informal care. And fewer Europeans can look to their children, because they have been having fewer of them. A total fertility rate of around 2.1 live births per woman is considered to be the 'replacement level', but in the EU-27 in 2002 the total fertility rate was 1.46 live births per woman. After a slight recovery to 1.59 live births per woman by 2009, fertility rates fell again in 2010 and 2011 as recession hit.[41] Additionally, while children are tending to live with their parents for longer at the beginning of adulthood when parents' health should still be relatively good, once children move out they are tending to live further away, making daily caring impracticable.

Other recent social changes have been more helpful. Couples who do not split up are living together for longer. The gender gap in life expectancy has narrowed and is expected to narrow further. These changes make it more likely that the over-80s will be living with partners and will be able to take care of each other (where their own health permits), offsetting the impact of the unhelpful social changes – but probably only to a very limited extent.

Economic changes, too, are contributing to the squeeze on informal carer supply. More and more women are in paid work, and they are increasingly likely to be the main family breadwinner,

[40] Hubert M. et al. (2009) Facts and Figures on Long-term Care: Europe and North America, European Centre for Social Welfare Policy and Research.
[41] All figures in this paragraph come from Eurostat

restricting time and opportunity for unpaid caregiving in the home. And people will stay in the labour market for longer, as retirement ages continue to rise for both men and women.

3.3. The quality challenge

Another major challenge for EU Member States is how to improve and maintain the quality of long-term care and long-term carers.[42]

LTC quality is important for four reasons. First, unless LTC is of sufficient quality the health and well-being of recipients may be put at risk. A rapidly growing demand for care will increase the tension between the volume and the quality of care. Secondly, users of care services are increasingly demanding more voice and control over their lives. It can be safely assumed that the high expectations of the baby boom generation for life in retirement will extend to the quality of their long-term care. Thirdly, as the cost of care services keeps on growing, LTC service providers are under pressure to improve their accountability. Fourthly, governments have the responsibility to protect vulnerable older people from the risk of abuse.

The rising demand for LTC and the growing need to monitor the quality of the care being provided will inevitably focus greater attention on protecting the fundamental rights of frail older people. In June 2013 the Commission, with the Regional Office for Europe of the Office of the UN Commissioner for Human Rights, organised a conference on "Preventing Abuse and Neglect of Older People in Europe", which highlighted the added value of integrating a human rights-based approach with strategies to ensure high quality in long-term care. On 14 February 2014 the Committee of Ministers of the Council of Europe adopted a Resolution on the Promotion of Human Rights of Older Persons. The Resolution set out a number of principles with which, it recommended, national legislation and practice should comply.

More generally, good quality of LTC maintains or, when feasible, improves the functional and health outcomes of frail, the chronically ill and the physically disabled old people. Indicators of LTC quality are useful for government regulatory oversight; help providers to identify problems and adverse events in the provision of care; and can help users to make informed choices. Quality measurement needs to encompass three important dimensions:

- the effectiveness of care in safeguarding and where possible improving the health of the person cared for, and in keeping them safe from adverse incidents;
- the user experience (is the care provided attuned and responsive to the cared-for person's needs and wants? Is it well coordinated with other services they use?)
- the care recipient's quality of life.

Unfortunately, quality measurement in LTC lags some way behind quality measurement in health care. Most countries have indicators of inputs, such as staffing and care environment, but only a limited number of EU countries collect information on quality systematically. At present, the most common approach in Member States is to try to safeguard quality by controlling inputs such as labour and infrastructure, setting minimum acceptable standards and enforcing compliance. Clearly this is much easier to do for institutional care – which is where most effort is focussed – than in homes, where many more older people are being cared for and where most want to remain

[42] This section draws heavily on the report *A Good Life in Old Age? Monitoring and Improving the Quality in Long-Term Care,* published by OECD/European Commission (2013)

as long as possible. However it can be done for home care too: in Austria, for example, professional nurses make 20 000 monitoring visits a year to home carers.

In many Member States certification or accreditation of institutional facilities is either compulsory, a condition for reimbursement of care costs, or common practice. Germany, Portugal, England and France also have accreditation for home care providers. Specific regulatory protection mechanisms designed to prevent elder abuse range from ombudsman to adult guardianship systems and complaint mechanisms. Despite regulation, compliance and enforcement may not yet be adequate. However, in practice, actual efficiency of the different measures of control (especially financial and administrative sanctions) remains debateable and there is no conclusive solution on that point.

Outcomes, quality of life, choice and human dignity are the quality dimensions most often included in accreditation and standards. However, outcomes are much harder to measure than inputs and there is no consensus within Europe on the best way to do it, or the most appropriate indicators to use. Quality of life and the user experience can really only be measured using survey data. Denmark, Spain, the Netherlands and England all survey LTC user experience around issues such as consumer choice, autonomy, dignity, comfort, security, relationships and social activity. A system called ASCOF (Adult Social Care Outcomes Framework) was developed for this purpose in England, which produces a range of LTC indicators (including carer views and quality of life) nationally and by local authority area. Now Denmark, Austria, Finland, and the Netherlands are starting to use ASCOF too. Germany and Portugal also assess user experience in LTC.

One big and growing quality challenge for long-term care is how to make sure that it is attuned and responsive to older people's wishes and preferences. This must involve respecting the preference of the vast majority in all EU countries to maintain 'independent living' in their own or family homes for as long as possible. Better access to assistive technology can make this more feasible, as experience in Sweden and elsewhere has demonstrated (see Chapter 4). So can ensuring a good match between the home care and help wanted by older people living at home, and the home care and help supported in their locality. Work by Lamura et al[43] found that older people feel the need for help with domestic care, care organisation, emotional support, health care, transportation, personal care and financial support, in that order: how many LTC support systems embrace all these aspects? OECD noted in *A Good Life in Old Age*[44] that giving independent-living older people cash payments or allowances to spend as they wish, as in England and Austria, is associated with higher satisfaction and a perception of higher quality of life among users, because they feel they have choice and autonomy.

Another big challenge - which can only increase as the numbers of older people and their likelihood of having multiple complex health conditions increases - is to ensure integration of LTC with the other services used. Poor care integration or co-ordination prejudices the safety, responsiveness and effectiveness of LTC. It can lead to preventable hospital (re)admissions, or patients staying in hospital unnecessarily because social care is not in place to support them

[43] Lamura G, Mnich E, Bien B, Krevers B, McKee K, Mestheneos E, Döhner H. 2007. „Dimensions of future social service provision in the ageing societies of Europe" Advances in Gerontology 3, Vol. 20: 13 http://www.uke.de/extern/eurofamcare/publikationen.php?abs=7

[44] OECD/European Commission (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care,* OECD Health Policy Studies, OECD Publishing

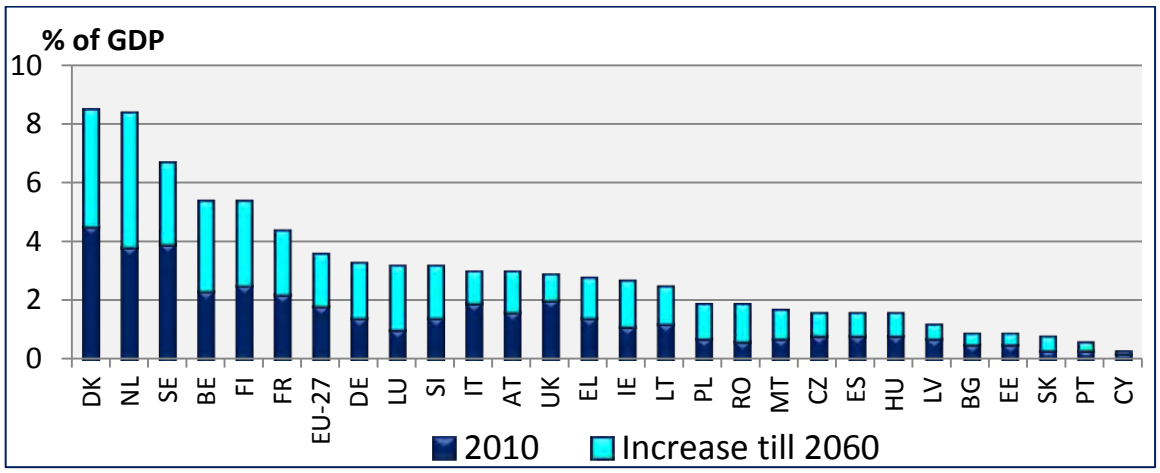
elsewhere. This is unsatisfactory, not only for the older people directly affected and their carers, but also for public budgets which have to meet extra healthcare costs.

3.4. The financing challenge

The European Commission's 2012 Ageing Report estimated that public spending on long-term health and social care in EU Member States in 2010 ranged from 4.5% of GDP in Denmark to 0.2% of GDP in Cyprus (see Figure 1).[45] As Chapter 2 mentioned, these percentages were estimated for the purpose of 'scenario' projections of expenditure through to 2060.

Figure 6 shows the EU baseline scenario projection – also described as the 'pure ageing and no policy change' scenario. This projects the future demand for long-term care by assuming that the future number of years with disability will increase in line with life expectancy, and that Member States will continue to meet LTC needs in exactly the same way and to the same extent as they do now.

Figure 6. Long-term care spending as % of GDP, Base case scenario (2010 and 2060)



Source: based on data from The 2012 Ageing Report (for an explanation of the input data see p. 226)

According to the 2012 EU baseline scenario, between 2010 and 2060 public expenditure on LTC is projected to increase by more than 90%. As Figure 3.5 illustrates, the projected increase ranges from less than 45% in the United Kingdom to around 230% in Luxembourg.[46]

Policy-makers in EU Member State may find these public expenditure projections, and the scale of increase in care provision and carer numbers that they imply, more than a little daunting. They may wonder whether their systems can take the strain, particularly if they currently rely mainly on family carers and/or recognise a need to raise LTC quality in their countries; and they may wonder where the necessary resources – human and financial – can come from.

It should be emphasised that the EU baseline scenario is just a scenario, not a forecast or a desirable outcome. Its underlying assumptions mean that the projected increases are greatest in

[45] European Commission (DG ECFIN) — Economic Policy Committee (AWG), 2012, 'The 2012 Ageing Report — Economic and budgetary projections for the 27 EU Member States (2010-2060).

[46] In Germany, according to the current legislation, benefits rise in line with the general inflation rate, the share of LTC expenditure in per cent of GDP remains therefore almost constant in the long run.

the countries which today make most use of formal and institutional care, and some of the countries now achieving the highest standards of care and social protection seem to face the biggest increases. This, however, runs counter to the policy aim within the Open Method of Coordination of bringing all countries up to adequate levels of LTC and social protection. And it is implausible that countries faced with increases at the higher end of the scale would keep their policies and practices unchanged.

The EU projection exercise also presented alternative scenarios calculating the impact of changes in (a) demography (higher life expectancy), (b) disability (assuming that all gains in life expectancy are spent in good health), (c) policy changes (Member States with underdeveloped LTC systems would expand formal in-kind services or cash benefits) and (d) unit costs (effects of a convergence in real living standards on LTC spending). However, all scenarios present a picture of a future that could be unsustainably costly and overwhelm long-term care services, unless the expected rise in the demand for those services, and hence the associated increase in public expenditure, can be mitigated. The next Chapter considers ways of achieving this, principally by improvements in the health and dependency status of elderly people.

4. CLOSING THE GAP

4.1. Policy responses needed to tackle the challenges

The challenges described in Chapter 3 create a serious risk that in coming decades, many EU Member States will not be able to meet the fast-growing demand for effective, responsive and good-quality long-term care. This will leave families to carry a heavy burden of care responsibilities alone and unsupported, and put the health, dignity and quality of life of frail older people at risk while also challenging the sustainability of the public budgets. This chapter discusses the policy responses needed to close the gap between the likely demand for, and supply of, long-term care services in the future. This gap is expected to arise mainly for the very positive reason that European life expectancy has been increasing; however, closing the gap is complicated by less positive demographic changes, such as low birth rates, changing family structures and reductions in working age populations.

Mitigating this risk across Europe will require comprehensive, effective and well-coordinated changes in current policies and practices in many, if not all, European countries. Policy-makers looking for ways of closing the gap between demand and supply should aim to see this as not just a problem, but also an opportunity: an opportunity to find solutions which work by closing other gaps too, such as the gap between the onset of frailty and the end of life, and the gap between users' expectations and the actual quality and accessibility of provision.

The capacity of people in poor health to live independently and enjoy their lives in their own homes can be enhanced by creating barrier-free, ***age-friendly and disability-friendly environments*** and responsive support services. Approaches of this kind could enable elderly people to manage without care, or with far less care than today, despite functional limitations.

Needs for care can be reduced by measures to help people live more of their older years in good health. This can be achieved through the ***prevention*** of health problems that cause dependency and through the ***rehabilitation and re-enablement*** of people who suffer from physical or mental impairments, teaching them how to cope in spite of their impairments. Member State policies should also aim to close the gap between what older people want from the care system and what they get, in terms of quality of life, care location (home or institution), care quality and responsiveness and social protection.

Before going any further into the different policy options for closing this gap, some precision on conceptual definition are required, to distinguish Prevention, Rehabilitation and Re-enablement very precisely. Table 10 gives a very precise view of the content of each concepts that will be mentioned further in the report.

Prevention and rehabilitation are well-known concepts, but re-enablement is a much more recent approach, which aims at improving a patient's autonomy when dealing with his or her own health problems. These approaches are not all common practice in all Member States, and some countries that operate them use slightly different definitions. In Denmark, for example, the concept of rehabilitation covers physical, psychological and social aspects of care, and embraces both "rehabilitation" and "re-enablement" as shown in the table below.

Table 10. Definitions of Prevention, Rehabilitation and Re-enablement concepts

Prevention	Rehabilitation	Re-enablement
Services for people with poor physical or mental health to help them avoid unplanned or unnecessary admissions to hospital or residential settings. Can include short-term emergency interventions as well as longer term low-level support.	Services for people with poor physical or mental health to help them get better.	Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.

Source: Care Services Improvement Partnership, 2007, extracted from Allen and Glasby, 2009

There have already been some promising initiatives demonstrating that all these ways of closing the long-term care gap can make a significant contribution. However, more systematic evaluation and evidence-gathering is needed, to provide policy-makers with clear guidance on setting priorities and investing scarce public money to reduce the gap as far as possible.

The ***efficiency*** of care provision can be raised through better organisation, financial incentives, quality control and re-engineering, including through the substitution of technology for labour. Securing good integration of the social and health components of LTC and continuity in care will be key. It is also important to help family carers by introducing better support services, to strengthen coordination between the formal and informal care systems. The supply and retention of formal carers can be improved by strengthening recruitment efforts, ensuring better job quality and increasing the retention of LTC workers.

Despite rising evidence about the positive impact, large scale use of the potential of *technology* and innovation for improving the productivity of long term care services is still largely unrealised, not least in the informal sector, where the need to compensate for the shortage of carers is likely to be most acute and the scope for improving the quality of care is probably greatest.

The EU Joint Research Centre- IPTS[47] has identified important good practices of technology use in LTC and will keep working on this topic and seek to develop business cases and business models related to IT solutions, based on existing experience especially the *Technolage*[48] project.

Well-known concepts such as 'ageing in place', 'continuity in care', 'care integration' 'self-care' and 'smart homes' should be part of strategies to tackle future challenges in long-term care. Ageing in place, independent living and rehabilitation can be achieved through age-friendly environments, assistive technology and appropriate provision of home help and home care.

If demand can be reduced, or at least contained, this will ease pressures on the supply of carers, and on the public budgets which pay for care services. However Member States will also want to consider ways of making limited resources (human and financial) go further, by improving efficiency and productivity in the delivery of long-term care, and hence the possibility of producing more, better care with the same or fewer resources.

[47] Joint Reseacrh Centre – IPTS : CAR-ICT and ICT AGE project - http://ipts.jrc.ec.europa.eu/ http://is.jrc.ec.europa.eu/pages/EAP/eInclusion/carers.html

[48] The Business Model Canvas Methodology: www.technolage.org

Key questions are:

- *To what extent can prevention rehabilitation and re-enablement affect the incidence and course of frailty and disability in old age?*
- *How much potential is there for raising the capacity of frail older people to manage independent living through age-friendly adaptations, smart technologies and assistive devices?*
- *To what extent can systematic efficiency improvements in care delivery, including thorough service innovation, help to deliver more and better care with the same number of carers or fewer?*

For some countries with well-developed formal long-term care, focusing on prevention, productivity and independent living will seem a logical extension of their present provision. Other countries, which have yet to develop proper social protection against LTC needs, will have to make substantial changes. If risks are to be effectively shared and individual needs guaranteed, genuine social protection programmes covering long-term care will have to be developed. This may involve shifting care from the informal to the formal sector to raise the productivity and quality of care delivery systematically. It will entail making visible the hitherto hidden cost of long-term care. But it will also offer the prospect of substantial GDP growth and higher employment rates. This way, Member States can benefit substantially from formalising and modernising their LTC provision.

4.2. Prevention

Active and healthy ageing and a determined emphasis on prevention can reduce the incidence of frailty and postpone its onset. People who are fit when they become old and who remain physically and mentally active not only have a better chance of avoiding or postponing frailties, they are often also better at managing functional decline when it occurs. Avoiding the premature erosion of physical and mental fitness and damage inflicted through wrong medication and accidents such as falls can bring large benefits, both in cost savings and in improving quality of life. It is important for prevention policies to target the main diseases/physical conditions that cause dependency. Another priority is the early detection of emerging limitations and frailties, and providing appropriate therapy, including assistive aids. A wide range of preventive measures and policies has been demonstrated to be clinically effective. Encouraging senior citizens to participate in physically and mentally stimulating activities in various settings, such as education, sport centres, volunteering organisations and day care centres, can halt the course of decline and help maintain and sharpen faculties.[49]

In many cases the need for LTC is the result of accidents - such as a fall or hip fracture, which have much more serious consequences for an older than for a younger person - or of one or more of the following medical conditions[50] which are particularly prevalent in older people.

[49] S. Rohwedder and Robert J. Willis, Mental Retirement, Journal of Economic Perspectives—Volume 24, Number 1—Winter 2010, pp. 119–138.
https://www.aeaweb.org/articles.php?doi=10.1257/jep.24.1.119

[50] See in particular: Disability profiles International Classification of Functioning, Disability and Health (ICF) WHO model - http://www.who.int/classifications/drafticfpracticalmanual.pdf

- *Arthritis*: osteoarthritis affects joints in the body, causing pain, stiffness, weakness and instability. It reduces mobility and increases the risk of falls. Dependency can arise from the effects of arthritis itself or from accidents caused by the physical weakness it induces.
- *Stroke*: this is a major cause of long-term disability. Over 50% of those who survive a stroke are still physically dependent after 6 months and at least 25% are still either moderately or severely disabled after 3 years.
- *Diabetes mellitus*: if not controlled, this has a severely detrimental effect on the heart, blood vessels, eyes, kidneys and nerves and accelerates disability from other causes.
- *Chronic obstructive pulmonary diseases (COPD)*, including chronic bronchitis, emphysema and chronic obstructive airways disease: these reduce mobility and lead to a range of distressing symptoms. In the 60-79 age group rates of COPD are almost twice as high for men as for women (primarily reflecting differences in smoking).
- *Dementia and other cognitive impairments*: these are a major cause of dependence and the more serious they become, the greater the degree of dependence. The total number of people with dementia in the EU in 2006 was estimated to be 7.3 million. Because of their greater longevity, women were almost 68% (4.9 million) of this total. The total cost in 2008 of LTC for people with dementia was estimated to be 160 billion euros (22 000 euros per dementia patient per year) of which 56% was the cost of informal care.
- *Frailty*: is a multidimensional geriatric concept referring to an increased vulnerability to stressors and with biological, physiological and psychological components. The most distressing outcome of frailty is the older person's ability to function and eventually to live independently. Thus, frailty has been shown to increase the risk for adverse health outcomes, including falls, hospitalisation, institutionalisation and mortality.

As noted in chapter 3, it is possible that the incidence of some of these conditions and diseases will be lower in the "baby boom" generations now entering retirement than in previous generations because of healthier life styles (for example, better diets and significantly reduced levels of smoking). On the other hand, trends in obesity and hypertension and the rising incidence of chronic conditions such as arthritis, diabetes and dementia may counteract the benefits of these lifestyle improvements.

Moreover, the prevalence of the disability-inducing conditions and diseases listed above increases significantly as people get older. For example, clinical symptoms of dementia usually emerge after the age of 65 and the prevalence rate increases markedly with age, as Table 11 shows. In Europe in 2009 dementia affected just 1.8% of men and 1.4% of women in the age group 65-69, but 31% of men and 47% of women over 90 were affected.

Table 11. Age and gender specific prevalence of dementia in Europe, 2009

	65-69	**70-74**	**75-79**	**80-84**	**85-89**
Europe - Males	1.8	3.2	7	14.5	20.9
Europe - Females	1.4	3.8	7.6	16.4	28.5

Source: Alzheimer Europe, 2009, reproduced in OECD Health at a Glance 2013 Figure 8.4.2

Given what is known about the specific factors which can give rise to LTC needs in older people, what could be done to reduce the future need? The answer may well lie in policies leading to reductions in morbidity, and in effective rehabilitation. The Kungsholm Project[51] in Sweden

[51] Kungsholm Project – Sweden http://www.kungsholmenproject.se/

concluded that the worldwide incidence of dementia could be significantly reduced, by addressing the risk factors to which a sizeable number of dementia cases are attributable sufficiently early in people's lives. And research by Jagger in the UK[52] demonstrated that even moderate improvements in population health can reduce the prevalence of the main chronic diseases in older people.

Understanding the risk factors for frailty is an important prerequisite for implementing programmes for early detection, prevention and management to reduce future demand of LTC. Successful prevention of frailty and functional decline requires more knowledge about the risk factors. The ability to stratify is particularly needed. Eventually it will result in better definitions of risk groups and therapies and interventions that can be offered earlier and be more tailored to individuals.

So far, few countries have developed comprehensive prevention strategies designed to reduce older people's need for LTC. However, useful elements of such strategies are already well known. Measures to ensure that people take prescribed medication, or to prevent falls which cause hip fractures, require only a small initial investment but can lead to considerable savings in care costs and enhance older people's quality of life. Policies of this kind have been successfully implemented in the UK, France and other Member States (see Boxes 1 and 2).

Box 1. The New Medicine Service: a successful program in the UK.

An experimental UK programme ("The New Medicine Service"[53]) running from 2011 to 2013 and focusing on age-related chronic conditions such as hypertension, diabetes and COPD, was designed to address the problem that 30-50% of prescribed medicines are not taken as recommended. The purpose of the programme was to test whether, through a planned series of contacts between patient and pharmacist, it would be possible to ensure that newly prescribed medicines were taken at the recommended times and in the recommended quantities. A first evaluation of the programme (by the University of Nottingham) concluded that it had positive results both in improving the health of the patients and in terms of cost efficiency: an investment of £25 per patient yielded average savings per patient of £95.

Avoiding the premature erosion of physical and mental fitness and damage inflicted through wrong medication and accidents such as falls can bring large benefits, both in cost savings and in improving quality of life. It is important for prevention policies to target the main diseases/physical conditions that cause dependency and in turn to strengthen activities and functions that prevent or delay functional decline and the onset or manifestation of frailty and disability. Another priority is the early detection of emerging limitations and frailties, and providing appropriate therapy, including assistive aids. A wide range of preventive measures and policies has been demonstrated to be clinically effective. Encouraging senior citizens to participate in physically and mentally stimulating activities in various settings, such as education, sport centres, volunteering organisations and day care centres, can halt the course of decline and help maintain and sharpen faculties.[54]

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[52] Dependency / age class: Source MAP 2030 / Carol Jagger – University of Sheffield
http://www.newdynamics.group.shef.ac.uk/map2030-modelling-ageing-populations-to-2030.html

[53] New Medical Service-UK
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215423/dh_130231.pdf
University of Nottingham: http://www.nottingham.ac.uk/~pazmjb/nms/overview-of-the-study.php

[54] S. Rohwedder and Robert J. Willis, Mental Retirement, Journal of Economic Perspectives—Volume 24, Number 1—Winter 2010, pp. 119–138.

Box 2. HAPPIER[55] – Healthy Activity & Physical Programme Innovations in Elderly Residences

HAPPIER is a transnational study co-financed by the EU PROGRESS programme that evaluates the effects of Adapted Physical Activity (APA) on active ageing in care homes. APA will be tailored to people's needs and abilities, and include programmes such as Chair Gymnastics, Fall Prevention and Alzheimer gymnastics. The project will also offer exercise sessions focused on individuals suffering from chronic illnesses like Parkinson's disease, heart conditions, Type 2 diabetes and arthritis.

HAPPIER is steered by the French Ministry of Health and conducted in four Member States (France, Ireland, Spain, Belgium) between January 2012 and March 2014. Its objective is to measure the physical, social and cognitive impact of a programme of physical activity on the residents of nursing homes and to assess the programme's contribution to the promotion of active, independent and healthy ageing. The study also aims to assess the indirect effects and contributions of such a programme on care homes and their organisation.

The experience of countries which have been active in the area of prevention suggests that key components of a successful prevention programme are:

- Identifying and targeting resources on the specific causes of dependency. Compared with other fields, the main factors which lead to the need for LTC are relatively few (the five medical conditions and diseases listed above, plus falls).
- Adopting a "life course" approach: there is, for example, a clear link between mid-life health problems and late-life health status. Early identification of people at risk of dependency means that information, advice and help can be given before the need for LTC arises. This process should begin at age 60 at the latest (earlier if possible) and continue throughout old age.
- Identifying those within the older age group who are most at risk. It is important to assess every person who reaches a specified age, as in Finland (between 60 and 70 is recommended). The process needs to take into account not only traditional clinical or public health issues but also social, cultural and geographical factors.
- Drawing up "personalised action plans" in cases where risk of becoming dependent on LTC is identified so that the most effective form of prevention can be adopted in each case. These plans should cover both medical and non-medical needs and include guidance on promoting well-being, healthy lifestyles and functional capacity as well as on preventing illness and accidents; early support for identified social or health problems; guidance on financial or other support available through social security or welfare; guidance on medical care, rehabilitation and safe pharmacotherapy; and guidance on locally available services to promote wellbeing, health, functional capacity and independent living.
- Implementing innovative organisational approaches and technical solutions that screen, identify and target frail older people for evidence-based interventions that achieve a more efficient use of resources, skills and technology, improve the health and quality of life of older people and caregivers, delay disability, slow the progression of the disease, and avoid unnecessary hospitalisation and institutional care.

[55] HAPPIER Project: Healthy Activity & Physical Program Innovations in Elderly Residences http://www.social-sante.gouv.fr/vieillissement-actif,2230/initiatives,2236/vos-initiatives-europeennes,2301/initiative-happier-healthy,14210.html

- Empowering LTC recipients in order to improve person-centred dimension of delivery but also self-management of people. This orientation enables informed choice on possible options but also a positive shift of patient role from passive recipient to active decision-maker on his/her own health and care.

Some of these elements are for example found in existing policies and practices of the Member States (e.g. France, Finland and Slovenia).

Box 3. The new French policy[56] for prevention of loss of autonomy

The main element of this emerging policy concepts are:

A Life course oriented approach: Three age groups have been identified within the elderly population (60-80+) - "young retirees", "middle-aged retirees", and "frail retirees".

A Holistic definition of frailty and subsequent needs: wide range of cultural, socio-economic, marital status, tax-related and geographical factors (e.g. residence in "at-risk-territories" for which access to care is difficult).

Collective design of policies and individualization of implementation measures: individualized care plans that go far beyond the clinical dimension are then designed and adjusted in line with changes in the actual situation of individuals.

Definition of a common data set and data exchange framework between all involved social protection institutions (*Pension funds, Health Insurance funds and other institutions*) has been set up.

Box 4. The new framework for LTC provision in Finland.

Life course approach / age threshold within the elderly population: in most municipalities people are invited to a **health check-up**, when reaching 63 (*in other municipalities, 65 or 70*). Here health personnel inform them about possible ways to stay healthy and to adopt a more healthy life style that can help halt the pace of physical and mental decline.

- LTC municipalities' duties defined very precisely: advice services that support the wellbeing, health, functional capacity and independent living of the older population.

[56] French prevention policies / Pension branch
https://www.lassuranceretraite.fr/cs/Satellite/PUBPrincipale/Retraites/Action-Sociale?packedargs=null

Box 5. SOGRAP Project in Slovenia[57]

Objective was to explore the **social gradient potential** for the reduction of health inequalities among elderly people. Small Patient groups from different social and cultural backgrounds, suffering from a small cluster of chronic diseases/conditions, have been set up with a view to measuring : self-management capacity, attitudes and capacities for mutual help and learning on all health-related topics (*information dissemination, awareness raising on lifestyles, habits, food habits, perception of health, etc*.).

- Self-management proved to be efficient for a mutually beneficial exchange of knowledge and experiences about healthy ageing.
- Lessons learned for the design of prevention policies: taking local environments (geographical, sociological) into consideration is key success factor for design of LTC delivery. In a context of health workforce shortage, the knowledge and experience of lay people can be mobilised to help promote healthy ageing and reduce care demands; primary health care and social services should seek to foster self-help groups based on the SoGraP model for elderly with LTC needs.

Box 6. European Innovation Partnership on Active and Healthy Ageing

Gathering some of the best prevention strategies from Member States is a part of the activities in the European Innovation Partnership on Active and Healthy Ageing. In its Strategic Implementation Plan[58] actions on active and healthy ageing are being developed around prevention, screening and early diagnosis; care and cure; and active ageing and independent living. The work of the Action Group on prevention of frailty[59], created in June 2012 as part of the European Innovation Partnership on Active and Healthy Ageing provides the necessary input as regards examples of innovative practices that can improve the quality of life of frail old people and help reduce the burden of inefficiency in care delivery. Activities on falls prevention addressed under the EIP Action Group on "Personalised health management: Falls prevention" are also of relevance.

4.3. Rehabilitation and re-enablement

A fall leading to a broken hip or a spell of serious illness can send an otherwise fit older person into rapid decline, requiring extensive care. UK statistics show that there are 86 000 hip fractures each year, that the average age for people suffering hip fractures is over 80, that more than 10% of those who survive a hip fracture are unable to return to their previous residence and that most of the rest experience some residual pain or disability. UK statistics also show that 25% of people who suffer a stroke move from acute care directly to institutional care, that more than 50% of those who are still alive after suffering a stroke are dependent on others for their everyday living and at least 25% are still moderately or severely disabled after 3 years.

However, rehabilitation has worked well even for the oldest old people. It is most cost-effective if provided immediately after an incident such as a fracture or stroke, before serious frailties set in. Several Member States have included rehabilitation in their long-term care approaches. As with prevention, the experience of these countries is that rehabilitation can achieve important savings as well as increase the individual's quality of life and life expectancy. Early rehabilitation not only helps the recovery of mobility but also prevents the development of pneumonia,

[57] http://www.inst-antonatrstenjaka.si/repository/Annex18d_Informational_leaflet.pdf

[58] Strategic Implementation Plan – Strategic Part: http://ec.europa.eu/research/innovationunion/pdf/active-healthy-ageing/steering-group/implementation_plan.pdf#view=fit&pagemode=none

[59] COM (2012) 83 Taking forward the Strategic Implementation Plan of the European Innovation Partnership on Active and Healthy Ageing

thrombosis and other serious medical conditions associated with immobility. Research shows that occupational therapy can counteract the decline in the ability of stroke sufferers to care for themselves and to remain mobile. Box 7 illustrates one effective approach. Unfortunately, awareness of the benefits of rehabilitation is not widespread, and it is still not practised systematically throughout the EU.

Box 7. Rehabilitation in the UK

Recently, the Department for Work and Pensions (DWP) put in place the **LinkAge Plus**[60] programme, a scheme worth £10 million to improve the wellbeing of older people through promoting stronger partnership, better information and access to services, and putting older people at the forefront of service design and delivery. The LinkAge Plus principles can be replicated in a variety of contexts. Case studies demonstrate the potential of the approach and a business case has been developed[61]. Taking falls as an example, on average, a fall resulting in a hip fracture costs around £20 000 to the taxpayer. Evidence suggests that 15 weeks of balance classes reduces the likelihood of a participant falling by around 50 per cent. This illustrative example suggests that each £1 spent on balance classes by the taxpayer in LinkAge Plus areas could yield health and social care savings of £1.35 plus benefits to the individual of around £0.90, from improved longevity and quality of life. Combining the costs and benefits of these services with a holistic approach to service delivery increases the net present value in the example to £2.65 per £1 invested.

There is clear evidence that rehabilitation can be highly beneficial in helping older people who are recovering from illness or learning to live with chronic diseases and conditions; that it can improve their ability to care for themselves; and that it can be cost-effective in terms of reducing the need for on-going support and care services. However, to achieve these outcomes, rehabilitation programmes require early and specific identification of rehabilitation needs; the provision of personalised help designed to meet individual needs; and to go beyond a clinical assessment of capabilities, focusing on enabling people to undertake the tasks of daily living and re-building their self-confidence.

Functional decline, both physical and cognitive, is not an inexorable process in frail older people, and rehabilitation could significantly improve the functional state of old people. Thus, any improvement or stabilisation of functional decline could ultimately generate huge benefits for health and long-term care systems. Evidence suggests that planned, coordinated and systematic health and social service interventions in the frail elderly population can have a significant impact on health outcomes, quality of life, patient and caregiver satisfaction, and the pattern of hospital and nursing home utilisation and cost.

Re-enablement is an interesting concept and policy that has emerged especially in Denmark[62] and in the UK, with many local authorities increasingly refocusing their traditional home care services in order to achieve more preventative and rehabilitative ends. Above all, the re-enablement approach aims to maximise independence and quality of life in older age, whilst at the same time reducing costs. It is based on the following principles: encouraging individuals to do things themselves rather than doing it for them; focusing on real practical outcomes within a

[60] Linkage Plus: https://www.gov.uk/government/collections/linkage-plus

[61] Watt, P. and Blair, I. with Davis, H. and Ritters, K. (2007). Towards a business case for LinkAge Plus. DWP Working Paper No. 42. *Not available on line / To be ordered – see address below:* https://www.gov.uk/government/organisations/department-for-work-pensions

[62] In Denmark the word rehabilitation covers physical, psychological and social aspects of care, and thus embraces both "rehabilitation" and "re-enablement.

specified timeframe; and continuous rather than one-off assessment of an individual's care needs[63]. The cost reductions come about both because re-enablement brings longer-term health benefit and because, where there is a choice between residential care and home care, home care is usually cheaper. Home care is also what most older people want. In the Special Eurobarometer survey of 2007,[64] asked how they would prefer to be assisted with long-term care if the need arose, 45% of respondents said 'in my own home by a relative', 24% said 'in my own home by a professional care service', 12% said 'in my own home by a hired carer' and 5% said 'in the home of a close family member'; in total, 86% chose some form of home care and only 8% said 'in a nursing home'.

Innovative examples worth mentioning include the Delivery Framework for Adult Rehabilitation in Scotland,[65] published in February 2007, a joint document for health and social work. It gives strategic direction and support to all health and social care services and practitioners who deliver rehabilitation or enablement services to individuals and communities. The vision underpinning the framework is the creation of a modern, effective, multi-disciplinary, multi-agency approach to rehabilitation services that are flexible and responsive in meeting the needs of individuals and communities. Based on similar principles, 149 out of 152 UK Councils have recently moved care provision onto a more re-enablement basis, in order to reduce potential health expenditure, but also to increase independence and prolong life at home.

In Denmark many municipalities have implemented a comprehensive re-enablement model, e.g. as the one described in the Box 8 below.[66] Moreover, the recent government commission on the future of home care recommended that similar approaches be applied across the country[67].

Box 8. Fredericia model[68]

Like most Danish municipalities, Fredericia operates a programme of home-based rehabilitation. Fredericia's programme has operated since 2008, and is entitled "As long as possible in one's own life". Within two days of being discharged from hospital, older people are registered and attached to an occupational therapist or physiotherapist, who assesses their needs and prepares a rehabilitation plan designed to enable them to undertake - and to gain the confidence to undertake - the normal activities of dressing, cooking, shopping etc. The aim is to enable older people to look after themselves and enhance their quality of life. Evaluation of the programme shows that a total of 4 450 hours spent on training and rehabilitation has achieved a reduction of 26 828 hours spent on home help and home care.

[63] Kerry Allen and Jon Glasby - English Report on Prevention and Rehabilitation – Sept. 2009 http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/research/interlinks-work-package-3.pdf

[64] *Health and long-term care in the European Union (Special Eurobarometer 283),* European Commission 2007 http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

[65] Delivery Framework for Adult Rehabilitation: http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/adultrehabilitation/rehabframework

[66] As mentioned above, in Denmark the word rehabilitation covers physical, psychological and social aspects of care, and embraces both "rehabilitation" and "re-enablement".

[67] http://sm.dk/publikationer/hjemmehjaelpskommissionens-rapport

[68] Frederica Model (and evaluation) - http://www.fredericia.dk/Sider/Default.aspx http://international.ucl.dk/files/2012/08/information-regarding-license-fee.pdf

4.4. Age-friendly environments: contribution to a comprehensive approach

European societies need to devote a great deal more attention in future to creating supportive, age-friendly environments and communities in which older people can live independently. In age-friendly environments, policies, services, settings and structures support and enable people to live independently and age actively.

According to the World Health Organisation, 80% of older people in developed countries now live in cities. This proportion is expected to continue to rise.[69] The circumstances of everyday living in an urban environment, the accessibility of services and facilities, their safety and security, the barriers to participation and gaps in provision are therefore all hugely important factors in determining the extent to which older people with varying needs and capacities can continue to live independent lives. However, there will be also still seniors in rural communities facing specific challenges such as the decreasing availability of informal care and public services.

The World Health Organisation (WHO) has established a Global Network of Age-Friendly Cities and Communities which share a commitment to creating physical and social urban environments which promote healthy and active ageing and a good quality of life for their older residents. The Network provides a platform for information exchange and mutual support through the sharing of experience.

The WHO's Guide to Age Friendly Cities could provide a useful starting point for a similar initiative within the EU. It draws directly on the views and experiences of older people in 33 cities worldwide (including cities in Germany, the UK and Ireland). It focuses on 8 aspects of urban living whose importance has been specifically identified by older people:

- outdoor spaces and buildings
- transport
- housing
- social participation
- respect and social inclusion
- civic participation and employment
- communication and information
- community support and health services.

The WHO Guide provides a checklist of features which can be used by cities in consulting their older citizens about the specific strengths and weaknesses of their city in providing an age-friendly environment which recognises the wide range of capacities and resources of older people; which anticipates and responds to their needs and preferences; which respects their lifestyle choices; which protects the most vulnerable; and which promotes their inclusion in and contribution to all areas of community life.

Within the *European Innovation Partnership on Active and Healthy Ageing*, an Action Group brings together regional and local authorities, European NGOs, technology providers, research centres and SMEs implementing innovative solutions to develop environments that are more age-

[69] *Global age-friendly cities: a guide,* WHO 2007.
http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf

friendly and promote an active and healthy living[70]. The Action Group works on setting up mechanisms to engage the older people and ensure their participation;

- adapting and developing principles and guidelines on age-friendly environments for the EU context;
- understanding how ICT and Service innovations can help shape supportive environments for older people and how those innovations work in their physical and social context;
- exploring new ways to promote active and healthy ageing with age friendly environments;
- running pilots to analyse integrated approaches to age-friendly urban design, housing, transport health and social services, age-friendly workplaces, ICT and smart environments.

Age-friendly environments are also designed to support the three key concepts of prevention, rehabilitation and re-enablement, discussed in the following sections. These different approaches are not mutually exclusive; they can and indeed should be combined, depending on policy strategies and people's needs, in a comprehensive approach to closing the gap between the need for and the supply of long-term care.

4.5. Improving LTC service efficiency and making best use of technology

The challenge of fast-rising demand coinciding with a shrinking number of carers, particularly in the informal sector, can be met only if more effective strategies for prevention and rehabilitation are accompanied by efforts to raise significantly the efficiency of care service delivery. There are two main ways of achieving this: more effective integration of health and social care and the much greater use of cost-effective technology.[71] To work both may require major additional training and upgrading of staff.

[70] http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/d4_action_plan.pdf#view=fit&pagemode=none

[71] Joint Reseacrh Centre – IPTS : CAR-ICT and ICT AGE project - http://ipts.jrc.ec.europa.eu/

[71] In the specific context of support to carers the EU Joint Research Centre- IPTS has identified important good practices: http://is.jrc.ec.europa.eu/pages/EAP/eInclusion/carers.html

Box 9. Closer care co-ordination/integration in four Member States[72]

In Italy GPs, and in Germany mainly nurses, act as "case managers" responsible for informing and advising older people and their families about appropriate health and long-term care and other services.

GPs in Spain and Slovakia are responsible for drawing up a health care plan and co-operating with specialists such as neurologists, gerontologists and psychiatrists in implementing it. In Spain, the Dependency Law requires a personal intervention plan based on an assessment of individual care needs leading to a discussion of services and funding between the family and a social worker.

In Scotland a new legislation[73] is close to adoption which merges the health and social budget and delivery into a single structure in order to further increase the quality and efficiency of health and social care services, which are increasingly interdependent due to the growing proportion of older people in need of LTC.

In the Emilia-Romagna region of Italy, a case manager (usually a social worker) is responsible for ensuring continuing care in cases of dementia and there are training courses for family carers which cover medical, psychological and behavioural aspects of the progression of dementia.

Links between health care and long-term social care can be weak and their full integration is rare outside a few Member States. The historically sharp distinction between health care and long-term social care is rooted in very real differences: health care, for example, is entirely professional whereas long-term social care in many countries relies heavily on family and informal carers. However, in future the key role of health care in prevention and rehabilitation will make effective coordination essential. And the traditional distinction between health and social care is likely to become increasingly blurred, as the social care sector is obliged to develop expertise in managing the medication and other treatment of long-term conditions such as dementia and diabetes. Several Member States have taken steps to encourage closer coordination/integration of health and social care services, as illustrated in Box 9, 10 and 11.

Box 10. The Buurtzog model in the Netherlands

The organisational model of Buurtzorg is for care to be delivered by small self-managed teams of (at most) 12 professional carers and to keep costs as low as possible, in part by using ICT for the organisation and registration of care. It aims to provide integrated health and social care in the home. It originated from a sense of dissatisfaction among carers themselves that the traditional organisation of care was not meeting the full range of its recipients' needs, that their own professional competences were not being fully utilised, and that they were tending to work in isolation from each other with too much time spent on overlapping bureaucratic procedures.

The Buurtzog model starts with a comprehensive assessment of each care recipient's medical, social and personal needs. This is then translated into an individual care plan specifying the care they need and the carers, formal and informal, who will supply it. The emphasis is on working with the care recipients themselves and their carers to identify the range of support they want and need to live as independently as possible. Costs are covered by the regular sources from which care homes draw their income. Satisfaction rates are high for care recipients and carers alike.

There is no single universal model for integrating health and social care, but the aim should be to ensure that the recipients of long term care and their families are empowered and supported to take an active role in the management of the care.

[72] As also outlined in the Compilation of Good Practices, Integrated Care: Action Group B3, European Innovation Partnership on Active and Healthy Ageing, November 2013 http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/gp_b3.pdf#view=fit&pagemode=none

[73] http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/About-the-Bill

Informal carers should have ready access to information from doctors, nurses and therapists about available medical services and how to use them; publicly funded home care services should act as intermediaries between professional health care services and home based informal carers; and users and carers should be involved from the outset in the assessment of needs and the allocation of tasks.

Innovative organisational approaches and technical solutions that screen, identify and target frail older people for evidence based interventions could achieve a more efficient use of resources, skills and technology, improve the health and quality of life of older people and caregivers, delay disability, slow the progression of the disease, avoid unnecessary hospitalization and institutional care and increase the sustainability of health and care systems.

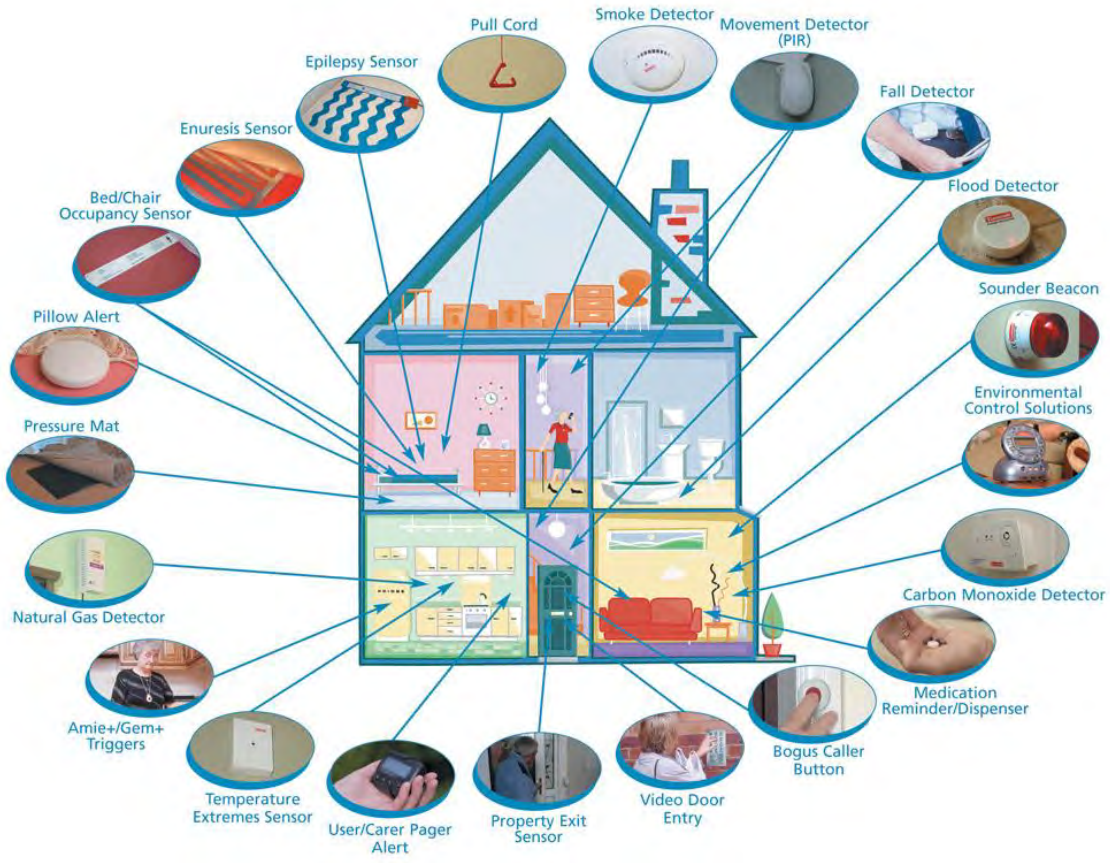
The other major source of greater efficiency in long-term care services is investment in new technology. Impairments to the health and fitness of older people need not threaten their ability to lead independent lives if they are helped to cope with them. One of the primary ways of achieving this is by investment in age-friendly adaptations of older people's private homes and in new assistive devices, including those that allow for self-monitoring, self-care and self-management. ICT can also facilitate social interaction with family and friends and allow for emotional support when people are largely confined to their homes and relatives do not live nearby. It can also allow care professionals to work more efficiently, for instance if the use of tele-medicine reduces the need for travel. Tele-monitoring has demonstrated the potentials to reduce the need for re-hospitalisation and emergency care through a better management of chronic conditions, such as chronic heart failure or respiratory diseases. Avoiding hospitalisation is in particular relevant for old and frail people, who are more likely to suffer from adverse health events in hospitals.

Box 11. Coordination of care across the delivery chain: recent Swedish initiatives

A person-centred approach to care to secure integration and continuity is seen as a political and institutional priority by the Swedish authorities. The distinctive feature of the recent reform is the comprehensive approach to coordination, which goes far beyond the delivery dimension. A four-year national plan with a 400 Mil Euro budget has been designed to improve health and social care for the elderly and strengthen policy coordination in the field of ageing. Empowerment of recipients, person-centred approaches and integrated care are key elements of the new regulatory framework which also covers information sharing, monitoring, and assessment dimensions., It further seeks to address all dimensions of coordination and integration: the technical dimension of delivery coordination between providers; the medical-legal dimension where the responsibility for coordination of the whole spectrum of health and social care has been defined in legislation; the clinical integration where guidelines cover the whole chain of care and enabling resources; the fiscal dimension: based on comprehensive concept of integration the recent reform has also enabled pooling of fiscal resources including the possibility to transfer funding between the health and the social parts of the LTC delivery chain; finally, as key element in the overall coordination efforts the data exchange system is being significantly improved to aid the planning and organisation of services: the Personal Health Record Ecosystem has been set up to improve information and data exchange between people involved in the long-term care process. As a response to current poor exchange of knowledge (even regarding basic health data or patient history), this data base was designed in a comprehensive way to capture all required information.

Pooling resources between the health and social sectors for designated care coordinators who help patients and families at these transition points is seen as one model to bridge administrative barriers. This should be performed in close connection with patient's needs. For dementia patients integrated person-centered care is seen as particularly important.

Figure 7. A Smart Home



Source: extracted from Afsarmanesh and Brielmann, Lifelink 2011

The so-called "Smart Home" in Figure 7 illustrates the possibilities of technological support for independent living. There is already a wide range of technological products to support independent living by older people in their homes. The ageing of populations across Europe and much of the globe will create a major new market for products designed to make life for older people easier and safer. Future generations entering retirement will be fully aware of the potential of ICT in their everyday lives, but technology's potential for helping care and health workers to deliver services in the home has been largely untapped.

Where electronic communication, including visual contact through Skype, can complement or replace visits to people's homes, there can be significant efficiency savings in resources, allowing formal carers and their services to be deployed more widely and more effectively. ICT can also play an important role in supporting the work of informal carers, when properly assessed and adequately used. The development of electronic networks of informal carers can be a very effective and low-cost way of spreading information on the support services available locally and nationally, and of exchanging ideas on good practice. Electronic networks can also help to alleviate the loneliness experienced by many informal carers, and encourage them to continue their valuable work. Boxes 12 and 13 describe some successful schemes.

Box 12. ACTION programme, Sweden[74]

The ACTION programme (Assisting Carers using Telematics Interventions to meet Older people's Needs) is directed towards the care of frail elderly people in their own homes. It aims to strengthen the self-management capabilities of older people and their families. By means of ICT, family carers can get on-demand support from local service centres, which are staffed with qualified professionals. The service also facilitates networking and mutual exchange between service users. It provides information, education and support to older people and their family carers via the following channels: access to an extensive information database about caring in daily life, services available and coping strategies; physical and cognitive training programmes and relaxation programmes; support and social company from other users via the integrated videophone system; support and advice from skilled care practitioners working in the call centre via the videophone system; individual and group computer education about how to use the ICT-based service; and comprehensive education, on-going supervision and a certification programme for care practitioners working in an ACTION call centre. The main outcome of this service is a strong improvement in quality of life, reduction of isolation of the patient and the carers, the improvement of carers' preparedness, and therefore reduction in the need for home help services and delayed entry to nursing homes. The service is available to carers in several municipalities at a low price.[75]

The potential for technology to help older people to live independently is self-evident, and will generate important market opportunities. However, a number of factors may hinder the achievement of its full potential. Some are inherent in the way long-term care has so far been organised, and some are the result of the relative novelty of applying technology to support care services.

First, the area where technology can make the biggest impact – informal care in the home – is the one where there is least knowledge of the technology that is available and what it can do. There is an urgent need to create channels of information to home-based family carers, via electronic networking, for example.

[74] Action Caring Project / Sweden - http://www.actioncaring.se/Eng/EngDefault.htm

[75] The Telecare Development Programme in Scotland 2006-2011, (2011) New Heaven Research. http://www.scotland.gov.uk/Publications/2010/10/27154413/0

Box 13. Telecare programme, Scotland

Telecare[76] covers a range of devices and services that use technology to enable people to live with greater independence and safety in their own homes in Scotland. Examples include devices that trigger a response from a call centre, such as falls monitors and motion sensors. The responses may range from a phone call to the person, to alerting a local carer, neighbour, the social services or the emergency services. Other examples include devices that alert the person in the home to a particular hazard, such as a water-level monitor in a bath. Other examples include tele-monitoring for chronic diseases or remote programmes supporting adherence to treatment. IT developments are continually extending the range of devices and services available and, as a result, there is much scope for Telecare to help older people with particular health and social care needs to remain in their own homes and optimise their independence and quality of life. From 2006 to 2011, Telecare involved investments of £20 million and is estimated to have saved about £80 million. Nearly half of these savings arose from avoiding care home admissions, while a similar figure arose from avoiding hospital in-patient stays. Clients and carers are referred to Telecare by social services, social workers or health professionals. The 5-year trial period achieved its aims to increase the use of Telecare in mainstream service provision, improve assessment procedures for service users, train service providers' staff to incorporate Telecare within care packages, ensure Telecare services are delivered to recognised standards, and enhance innovation in Telecare services. The Scottish government is now implementing a new Telecare/Telehealth initiative running from 2012 to 2015, called Delivering Assistive Living Lifestyles at Scale. This is intended as phase one of the wider Scottish Assisted Living Programme, which will utilise new technologies to support people with health and social care needs in their own homes.

Secondly, there is a need to link the skills of invention with those of business. Too many promising technological innovations fail to reach or stay on the market because of the lack of a sustainable business model which will ensure the availability of finance for development and provide an effective marketing and pricing strategy.

Thirdly, there is a need to link the users, carers and providers of care services with the inventors of new technology, so that knowledge of what is needed can be brought to bear on the process of innovation at the earliest possible stage. Technology can play a significant role in prevention and rehabilitation but, in the case of prevention, needs to be based on knowledge of the factors which cause dependency. In the case of rehabilitation, it needs to be flexible enough to cater for a wide range of differing skills and capabilities. Involving users and carers in the development of new technological solutions and services improves user-friendliness and significantly facilitates the uptake of the products.

Fourthly, some national arrangements for funding long-term care may be more likely than others to encourage technological investment to raise productivity. Willingness to invest may be greater where the costs of long-term care are met mainly from central government budgets and are subjected to close public scrutiny. Conversely, pressures for higher productivity and continuous improvement in value for money may be less in an insurance-based system, particularly if contributions automatically rise as needs increase.

Public policies can encourage and (where appropriate) subsidise older people and their families to pay for assistive devices which enable older people to live in their homes with reduced long-term care. There is an important role for public/private partnerships and public procurement in developing the use of technology to extend and improve home care services. But this underlines the importance of systematic cost-effectiveness analysis to assess new technological products, as in Sweden (see Box 14).

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[76] See:http://www.scotland.gov.uk/Publications/2010/10/27154413/6.

Box 14. Swedish Institute of Assistive Technology[77]

The Swedish Institute of Assistive Technology (SIAT) was created to make innovative technology more available and accessible to formal and informal carers of people of all ages. SIAT works directly with professionals, consumers and policy makers. It has a Users Council which includes representatives from organisations of people with disabilities and of older people. SIAT focuses on:

- bridging the gap between the Research and Development community and decision makers, by raising awareness and facilitating knowledge-sharing;
- supporting the evidence-based assessment of assistive technology products;
- helping companies to develop innovations;
- cooperating in particular with organisations which provide "smart home" technologies and helping them to design business models.

Similarly, the European Commission's Joint Research Centre and its Institute for Prospective Technological Studies is undertaking a project in 2013-14 to help Member States to develop long-term care strategies for using technology to promote independent living of older people, especially those who are frail. The project's main objective is to produce guidelines to help Member States and their policy-makers to: design long-term care strategies to increase the capacity of older adults for independent living, including through use of technology; identify innovations in technology-based services; and learn from others' good practice.

When evaluating the impact and cost-effectiveness of new LTC practices and technologies, a particular problem is how to put value informal care. There is no standard definition at international level. Many aspects of informal care are difficult to define and the time spent on them difficult to quantify, because they overlap with normal household activities, or involve psychological support or supervising the person cared for to avoid adverse incidents. Moreover, changes in the long term care can be of complex nature and the benefits accumulate over a longer period of time and may be intangible, such as more active participation in the society, the possibility for carers to return to the job market or preventing the burnout of informal carers. Developing a methodology for defining and assessing costs would be an important step in the development of the necessary cost-effectiveness and cost-benefit analysis.

The potential of technological innovation, both to improve the quality of long-term care and to raise the productivity of those who provide it, remains largely unrealised. Unleashing that potential and the forces of innovation is fundamental to meeting the multiple challenges which long-term care now faces across the EU.

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While first steps are being undertaken to assess the cost-effectiveness of new technologies in health and long-term care, a much wider effort is required to decide how to close the growing gap between demand and supply in the area of long-term care. A systematic assessment of cost-effectiveness and of returns on investment should cover the full range of measures presented in this chapter. This would allow policy makers to design powerful strategies for ensuring that all frail older people can get the help they need.

[77] Swedish Institute of Assistive Technology - http://www.hi.se/other-languages/english/

4.6. Supporting informal and formal carers and reinforcing the LTC work force [78]

Financial support for carers – such as allowances paid directly to carers and cash benefits paid to the care recipient – recognise and compensate carers for their effort, but targeting of support to those facing the highest health and labour market risks, and defining appropriate compensation, remains a challenge.

Carer's allowances are cash benefits providing carers income support replacing lost wages or covering expenses incurred due to caring. In the Nordic countries, the payment to carers is akin to a remuneration, offering compensation for caring efforts while representing a relatively low wage. In Ireland and United Kingdom allowances are targeted to carers with income below a set threshold, or carers who provide a minimum amount of hours of care.

While recognising the societal value of caring, carers' allowances raise difficult design issues, for example how to fix an appropriate compensation level, which offers carers a reasonable reward without discouraging labour market participation for working carers.

Means-testing and eligibility conditions, for example, may result in disincentives to work. Eligibility criteria need to be clearly spelled out, but the definition of who is the primary carer and the measurement of carer's efforts are prone to errors. Strict eligibility requirements help to avoid abuse, but can be costly to administer and be viewed as arbitrary. There are trade-offs between how many carers can be compensated, and the amount of the compensation that can be afforded by public authorities.

Cash benefits paid to the care recipient offer direct support to the person who is most in need, but are not only or necessarily used to compensate carers. Such cash benefits exist in many Member States. Cash benefits paid to the care recipients have some advantages, because they avoid having to define who the primary carer is. Moreover, the amount of the cash benefit can be more closely related to need. But they also leave carers dependent on the care recipient for compensation of their effort and may change family ties into a relationship where money is the driving factor. Requiring family carers to be employed under formal contracts (France for relatives other than spouses) has the advantage of clearly identifying the primary carer.

Both types of financial supports have the potential to help maintain informal caring by increasing the supply of care by family, but also involve some deadweight loss, i.e. the state will pay for some cases that would have been provided in the absence of any financial incentive. The extent to which cash benefits are used to reward family carers is nevertheless influenced by, among others, how flexible are the conditions for utilisation of the benefit.

Here, there can be trade-offs between maintaining incentives for family caring and controlling for inappropriate use of cash benefits, or for the emergence of unregulated grey labour markets (e.g., Italy, Austria).

A second trade-off regards the risk of trapping family carers into low-paid roles with few incentives for participating in the labour market. In this respect, designing financial incentives for

[78] This subchapter draws heavily on OECD's "Help Wanted" pp. 121-138 and pp. 189-212

carers might be especially delicate when care needs increase or a relatively high allowance is needed to provide sufficient financial support. As most carers are aged over 45 years, it will be important to minimise incentives for pre-retirement by avoiding offering too-high replacement rates or guaranteed pension and unemployment contributions. Policy should also not encourage women's withdrawal from the labour market for caring reasons. Last, reliance on a cash-benefit system where there is little supply of formal LTC workers can discourage the emergence of formal provider markets, unless the use of the cash is regulated to discourage black or unregulated markets. For all the reasons mentioned, financial support should not be regarded as the sole policy option to support family carers. Services are also needed. For example, cash benefits should be seen in the context of a personalised care plan, which could include basic training for the family member, work reconciliation measures, and other forms of support to carers, including respite care.

Care leave and flexible work arrangements help carers address the balance between workplace obligations and caring responsibilities, and so can induce the supply of both.

Many Member States have statutory rights to leave to care for people with LTC needs. Several countries also offer paid leave, typically limited to less than one month or to cases of terminal illness, while the amount paid is often so low that use is limited. As in the case of parental leave, it can be difficult to set the appropriate duration of care leave. Long leave may damage the labour market position of the carers, while a short leave might not be enough and could encourage workers to withdraw from the labour force.

Care leave conditions are generally restrictive relative to parental leave to care for children. Still, considering the expected future growth in LTC needs and that many carers might be caught between dual caring responsibilities (for children and for old parents), there could be advantages if caring roles were better recognised.

Flexible work conditions can reflect variation in the availability of formal care and in care needs. The United Kingdom has flexible work arrangements which appear to be effective in attenuating the risk of a reduction in working hours associated with caring. The rights to work part-time for carers of the frail elderly exist only in a few countries.

Some support services, such as respite care, training and counselling, can contribute both to ensure quality of care and to improve carers' wellbeing. Besides, such policies are of prime importance because many carers – particularly siblings and partners – are becoming older themselves and possibly frailer. Although there is a dearth of evidence on cost-effectiveness, such services can be arranged for a relatively low cost, especially if leveraging upon the widespread and invaluable contribution of the voluntary sector, as is done already in some countries.

Respite care provides carers with a break from caring duties and an opportunity to get trained to care better. Often, this is the only and most prevalent form of carers' support, although there can be shortage of services as signalled by waiting lists in some countries. Most often, families are the main funders of short-term respite care, but there can be means-tested subsidies or full financial support for respite as in Denmark. A few countries provide a legal entitlement to respite of varied duration (a few days per month in Finland, 4 weeks per year in Germany and Austria). Respite is of vital importance to reduce risk of carers' burnout.

Effectiveness is the highest when services are targeted to high-intensity carers or those with the highest perceived burden, those in paid employment, and for night-care respite. Flexible services or combination of services are more likely to be appropriate to adapt to diverse carers' needs. As many carers are reluctant to seek temporary respite, financial support or geographical proximity of service facilitate access to respite.

Counselling can be effective at relieving carer's stress, and carers often lament the lack of psychological support. Sweden promotes a comprehensive and integrated counselling system. In Ireland, training for family carers is available, while the Netherlands offers preventive counselling and support services. Germany provides legal rights to individual care counsellors.

One-stop shops for carers and their families, or arrangements that link information on public, private, and voluntary organisations, can inform carers of available services and help to plan medical and social care. Care managers, too, can be a real asset in advising carers and helping them co-ordinate services. Assessment of carers' needs, as in Sweden and the United Kingdom, is a first important step to identify carers and advise them on appropriate services. Researchers in several countries have developed various assessment tools to this end. Nurses and General Practitioners broadly can also play a key role in identifying carers' distress early and suggest appropriate remedies.

Measures to expand recruitments pools for LTC workers, including both existing workforce pools and new potential pools, have met with mixed success. Germany has measures seeking to encourage young people into LTC training and jobs. Economic incentives directed to LTC workers have been employed in several countries, such as financial support for re-training workers for LTC jobs in Germany. Efforts to re-hire LTC workers who had exited the LTC sector exist in Germany and the Netherlands and Australia. Other countries have re-activation measures targeting long-term unemployed and those economically inactive (e.g., Finland, the Netherlands and the United Kingdom).

There is generally little evidence on long-term cost and effects of policies aimed at increasing entry and retention from new target groups. But, where it exists, evidence suggests that such recruitment efforts have had mixed outcomes or, where successful, only concerned relatively few people. In addition, re-activation measures have often targeted work in itself, rather than work in the LTC sector, without lasting improvement in job retention in the sector.

No strategy to develop new recruitment pools or make better use of existing pools will be successful if job retention and job quality is poor. Mass exit of LTC workers reduces returns on investment in recruitment and training, and depresses quality of care. Unattractive work conditions lead more workers to quit which, in turn, further increases the work burden and stress on those who remain – a vicious spiral. Measures to keep the workforce in place are therefore of utmost importance.

Investing in higher remuneration and benefits, better working conditions, training opportunities, more responsibilities on-the-job, feedback support and supervision, have all been found to be important ingredients of a successful LTC job attraction and retention strategy. Health and safety concerns are another area of paramount concern, and possibly one more difficult to manage in home-care settings, a consideration that also applies to reducing work pressure and improvement in management.

Training can be a route to upgrading the status of LTC work as a profession. Most EU countries do not have compulsory training or qualification requirements for care workers, although many have locally organised or nationally-set training schemes for LTC workers. There is little proof of nurses in training being prepared for a potential career in LTC (i.e., gerontology knowledge, managerial skills, and internships). LTC managers should be trained in leadership skills.

There is evidence of good results from measures aimed at upgrading LTC work. Dutch and German LTC-workers' retention rates, for example, are relatively high, as workers appear to be more satisfied with their working conditions and responsibilities. Sweden and Denmark also appear to be success stories on this front. The introduction in Germany of elderly care nurses led to a redesign of tasks and responsibilities for nurses, with a positive impact on attractiveness of the sector for nurses. This suggests the importance of specific measures to improve career opportunities for nurses working in LTC and upgrade their skills.

The flip side of the coin is that by "professionalising" a still relatively easy-to-enter sector, it may raise entry barriers in the future, increasing rigidity in a sector that is regarded by workers as being highly flexible. These measures require investment of resources, too. Countries, which have in place relatively good benefit packages for LTC workers, such as Denmark and Belgium, have relative high public spending on LTC. But attaching importance to LTC jobs as a "profession" brings tangible payoffs. The Netherlands, which have put emphasis on creating a "LTC profession", has been successful at creating a large LTC workforce. Public awareness initiatives to raise public perception on the image of LTC work could contribute to better recognition for the workforce, and, ultimately, better retention.

4.7. Avenues to better reconciliation of employment and informal care duties

In order to identify good practices on reconciliation, Eurofound[79] has undertaken more than 50 case studies of public and private company initiatives in 11 Member States – Austria, Belgium, Germany, Finland, France, Ireland, the Netherlands, Poland, Portugal, Slovenia and UK.

The study revealed that the majority of working age carers currently are in employment, some part time but the majority full time. They are a very heterogeneous group in terms of the intensity of their caring responsibilities and the ways in which these interact with their work situation.

Initiatives included leave-related provisions, hours-reduction possibilities, work flexibility and work adjustment, awareness-raising and skills development among managers and the workforce, occupational health and wellbeing measures, care-related supports, such as information, counselling and practical support with the caring role.

A combination of targeted and universal approaches seemed especially effective: Such approaches explicitly identify caring as an important work–family balance situation that may be experienced by employees. They ensure that carers are known and have access to relevant universal provisions for the workforce. They also provide specifically carer-oriented measures to cater for needs that cannot be met through more universal provisions. Where long-term leave had been taken, some companies were making efforts to maintain contact with those on leave and to

[79] http://www.eurofound.europa.eu/publications/htmlfiles/ef1147.htm

facilitate their return to work at the appropriate time – e.g. by offering participation in training activities, circulating newsletters about the company or work team, enabling networking with other colleagues who are on leave, encouraging participation in staff outings, or even employing them to a limited extent. In a few cases, a faster return to work than initially planned was facilitated in situations where carers found that the long-term leave was not working out for them. A number of cases highlight the importance of cooperation between the social partners in promoting and supporting initiatives. In certain cases, the initiatives for working carers have been joint projects or have involved close cooperation with works councils or other employee representative mechanisms.

For the majority of employees with caring responsibilities, the preferred option (by choice by financial necessity) is to continue to work full time while they are caring. Company-level measures to provide work flexibility are a key requirement for this, as are attention to carer health and wellbeing as an occupational health issue and, more generally, the promotion of a carer-friendly culture. For a minority of employees, the possibility of reversibly reducing their working hours or withdrawing temporarily through long-term leave may be the preferred or only viable solution. Access to worker-centric flexibility in working arrangements are key requirements to support working carers and to minimize the negative impact these arrangements may have on their career prospects.

The first prerequisite for implementation of carers-related measures is that employers are aware of and recognise the difficulties of reconciling work and LTC duties and that initiatives also bring tangible benefits for them. A noticeable number of employers had recognised the business case for the company in addressing carers' needs, including outcomes such as reducing absenteeism, attracting and retaining staff, and better motivation of staff or better corporate image. Yet, because of the prevalence of awareness and knowledge gaps about the pressure from elder care duties (as opposed to child care), efforts to raise awareness of the working carer issue among managers, supervisors and staff are essential.

4.8. Filling the carer-gap through recruitment of migrants: which challenges and limits?

As highlighted above the reservoir of potential family carers is expected to shrink over the next decades. Moreover, recruitment and retention of sufficiently skilled personals remain difficult. Compared to other industries undeclared work is particularly prevalent in LTC. Many EU countries are seeking to overcome the insufficient supply of domestic LTC workers through employment of migrant care workers. In the UK, the Scandinavian countries, the Netherlands, Belgium, France and Germany this is mainly done through the official recruitment of migrant labour. In many other countries, the main trend is that families informally employ migrants as live-in carers for their elderly relatives. A Peer Review[80] organized in Berlin on 23-24 October 2013, discussed the benefits, caveats and pitfalls of using migrant workforce to bridge this gap.

Based on the participants' experience and knowledge, the Peer Review could identify the key learnings of general application: envisioned needs and tasks should be clearly defined by the host country in collaboration with the social partners before launching the recruitment process; to align expectations better the source country, the recipient country and the professional should

[80] http://ec.europa.eu/social/main.jsp?catId=1024&langId=en&newsId=1889&furtherNews=yes : all available information on Peer Review process and material.

seek an agreement covering the legal, financial and administrative dimensions of the tasks and costs to be shared; arriving at a better recognition of professional care and medical qualifications of non-EU nationals is key; the integration of migrant care workers should be holistic and involve also the cultural dimension; recruitment processes should bring a benefit both to the host country and the sending country and respect the WHO Global Code of Practice on the International Recruitment of Health Personnel[81] and the ILO Domestic Workers Convention[82] while drawing on the World Bank's initiative to tackle the problem of brain drain and the EU mobility partnership agreements[83].

Box 15 "Triple Win programme" in Germany

The 'Triple Win' Migration Programme in Germany offers also a good example of how to set up global training partnerships between source and recipient countries, by training students in the source country before they go to the recipient country for work and further training. It develops training and development partnerships between medical institutions in recipient and source countries. On recruitment students receive language training and support to come to Germany, where they have jobs on arrival and receive further geriatric and elderly training in German health care facilities. When they have completed their training they receive support to return home.

It is called "Triple Win", as source (non-EU) countries improve their medical knowledge and build up a better-skilled workforce, Germany increases the number of medical staff and improves social diversity and students gain job opportunities and skills' enhancement. There are schemes in Serbia, Bosnia, the Philippines and Tunisia and Vietnam, and plans for schemes in Morocco and India.

[81] http://www.who.int/hrh/migration/code/practice/en/
[82] http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C189
[83] http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/international-affairs/global-approach-to-migration/index_en.htm

5. CONCLUSIONS

This report has highlighted the major challenges facing long-term care in Europe.

- In the years up to 2060, it will become increasingly difficult for EU Member States to close the gap between LTC demand and supply, as numbers in the age groups at particular risk of developing LTC needs treble, and numbers in the working age population shrink.
- LTC needs are likely to rise dramatically over coming decades even if the incidence of disability declines.
- Many current European models of informal & formal care provision risk being overwhelmed, unless reformed and improved.

This report points out the equity and efficiency reasons why Member States should ensure that their societies provide adequate access to affordable quality care, and establish social protection against the risks of LTC dependency. In accordance with the Treaty on European Union, the EU's role is to support Member States in their efforts to achieve these aims. The SPC can contribute by helping Member States develop a better understanding of 'adequate' long-term care provision.

Innovative policies are needed to avoid a rapidly widening gulf between needs and supply. Existing long-term care arrangements are essentially reactive in the face of changes in need and demand; there are few examples of comprehensive strategies to tackle these major and - with ageing populations - increasingly important social protection challenges in a sustainable manner.

Member States need to move from a primarily reactive to an increasingly proactive policy approach, which seeks both to reduce care demand and to boost cost-effective care provision. Such a response has to be led by Member State governments. And it is in their interests to do it because failure to act in the area of long-term care will have serious repercussions, on the life and dignity of dependent people, on the social situation of their close relatives, and on employment and economic growth.

The main elements of a proactive response can be summarised as follows:

- preventive measures to reduce the fast-rising number of older people needing long term care, with a particular focus on prevention of disability and frailty;
- management of functional decline and frailty through targeted interventions in physical fitness, nutrition status, cognitive function, chronic conditions and diseases and on the social or psychological wellbeing of older people;
- rehabilitation and re-enablement for those whose health and fitness have been impaired to improve their ability to live independently;
- realising the full potential of technology to help older people to remain at home, to raise the efficiency of care services and to compensate for the expected decline in the number of carers;
- better coordination of health and social care to improve the effectiveness of care overall;
- measures to improve supply and retention of formal carers and to support informal carers, including by helping them to reconcile work with family and care responsibilities;

- the promotion of age-friendly environments which facilitate independent living and thus reduces the need for care and help to a minimum;
- measures to boost the efficiency, productivity, accessibility and affordability of long-term care; and
- measures to improve the quality and responsiveness of care, which can make a real difference to long-term care users' quality of life.

What role can the EU play in helping Member States to meet these challenges in the future?

The EU can promote innovation and social investment in long-term care through various initiatives such as the Ambient Assisted Living Programme, which facilitate innovation and boost investment in age-friendly environments and the European Innovation Partnership on Active and Healthy Ageing, which highlight good practices in the area of long term care for older people and support the scaling up of these innovative approaches to new regions and to more users.

The EU can mobilise the structural funds to support capacity building for LTC provision including training of professional carers and to boost investment in age-friendly environments. And on the basis of the evidence presented in this report, it can act to improve the knowledge and data foundation for further work (see annex of suggestions).

ANNEX 1. SUGGESTIONS FOR AREAS OF FURTHER WORK

The EU can help to highlight the social challenges posed by dependency on LTC for both care recipients and care givers. To that end, some improvements in the main surveys on income and living conditions and on the labour force could provide valuable information of the impact of long-term care needs on living conditions and on the employment and/or income situation of people who are closely related to people in need of long-term care.

Suggestion 1: The Indicators Sub-Group and EUROSTAT should investigate how EU-SILC, the LFS and SHARE can be used or enhanced to monitor the social and employment impact of dependency and the degree of social protection against this risk in EU Member States.

A better understanding of what support is available across EU Member States to people in need of long-term care and to their informal carers would provide national policy makers with a clearer picture of how their approach to tackling long-term care needs differs from that in other countries. It would also enable the SPC to discuss what should be the main elements of adequate social protection against the risk of dependency.

Suggestion 2: MISSOC to review the information it provides in the chapter on long-term care with the aim of making it more comparable and comprehensive, including with regard to the support that is available to informal carers, the obligations of relatives and the extent of means-testing.

The European Commission/OECD Joint Action, "Measuring Effective Social Protection in Long-Term Care" will pave the way for the development of a store of national data on long-term care services. It will be particularly useful to have an agreed methodology for estimating the costs of long-term care (including informal care, where costing is most problematic), as a basis for assessing the costs and benefits of new technology, innovative care practices and measures designed to improve productivity in the care system.

Suggestion 3: Through the European Commission/OECD Joint Action, "Measuring Effective Social Protection in Long-Term Care", the EU to develop in cooperation with Member States a methodology for estimating the costs of long-term care (including informal care), as a basis for assessing the costs and benefits of new technology, innovative care practices and measures designed to improve productivity in the care system, and assisting cross-country exchange of data, information and experiences.

As well as having a clearer picture of the support available in the event of dependency, it is also important to have reliable data on social protection spending on long-term care. The main data source is ESSPROS which, however, does not collect data on long-term care spending as a separate function. A specific Working Group involving the OECD, WHO and EUROSTAT and steered by the Institute of Macroeconomic Analysis and Development, the Slovenian Social Protection Institute of the Republic of Slovenia, and the Statistical Office of the Republic of Slovenia is working on defining an international accounting paradigm for LTC cost.

Suggestion 4: Eurostat to examine how long-term care spending could be presented as a separate function in ESSPROS or to propose alternative ways of producing aggregate LTC spending data on a regular and comparable basis, which should also be a suitable base for spending projections as carried out in the Commission/EPC Ageing Reports.

The diversity of long-term care arrangements across the EU provides a major opportunity for mutual learning, which the EU can facilitate. Chapter 4 has cited some examples of highly successful practices and initiatives in individual Member States. There are many more. The European Innovation Partnership on Active and Healthy Ageing offers an excellent framework for gathering such examples of good practice, fostering new partnerships and promoting innovation. Knowledge of what works - and what does not - is critically important. It will be crucial to invest in methodologies and tools for assessing the cost-effectiveness of measures to prevent dependency (through public health and rehabilitation measures and age-friendly environments and technical aids) and to provide for the needs of dependent people more efficiently (e.g. through care coordination, better combinations of professional and informal care) ensuring their dignity and quality of living. This will allow policy makers to make best use of scarce public funds and to benefit fully from the wealth of information available to them through the European Innovation Partnership on Active and Healthy Ageing and initiatives such as peer review at EU level under the Open Method of Coordination.

Suggestion 5: EU funding to be made available to support the establishment of a network of institutions that can develop and spread expertise in assessing the cost-effectiveness of various ways of tackling long-term care needs. Also, consideration to be given to using EU research funding under the Horizon2020 programme to gather more evidence on the main causes of dependency and on the best ways of preventing or mitigating its effects.

While an important part of the population still lives in rural areas, the overwhelming majority of older people now lives in cities. The the creation of an age-friendly urban and rural environment is critically important for enabling older people - whatever their needs or capabilities - to live independently for as long as possible. This means drawing on the views and experience of older people themselves to identify their priorities in terms of removing barriers to independent living and remedying gaps in the provision of services.

Suggestion 6: Promotion of more age-friendly environments, including by adapting the WHO guide to age-friendly cities to the European context and by developing a framework which would allow local and regional policy-makers to commit themselves to age-friendly environments.

Functional and cognitive decline (i.e. frailty) is highly prevalent in old age and constitutes a major predictor for long-term care use. Frailty is associated with an increased risk of adverse health outcomes, high use of community resources, hospitals and long-term care institutions. Addressing frailty in old people will contribute to more efficient use of resources, improve the health and quality of life of older people, delay disability and avoid unnecessary hospitalization and institutional care.

Suggestion 7: Encouraging a systematic and integrated approach to implementing strategies for the secondary and tertiary prevention of frailty to reduce the associated physical, functional and cognitive disability in particular promotion of systematic routine screening for pre-frailty stages in at-risk patients and older people.

The growing number of older people in need of care raises issues of quality of care and of monitoring and protecting the fundamental rights of frail older people.

Suggestion 8: Cooperation with the European Group of National Human Rights Institutions (NHRIs) to promote greater respect for the human rights of people in long-term care.

ANNEX 2. DELEGATES IN THE SPC-WG-AGE WORKING ON LTC

CHAIR (SE)
Niclas JACOBSON

The following persons were registered as national delegates for one or more meetings:

Austria
Simone FLOH
Tina KONRAD
Helmut LANG
Alexander MIKLAUTZ
Erich OSTERMEYER

Belgium
Karel Van den BOSCH
Dirk MOENS
Michel ENGLERT
Marianne VAES

Bulgaria

Cyprus

Czech Republic

Germany
Ulrich DIETZ
Nicole ELPING
Mark KAMPERHOF
Thomas SALZMANN
Dorika SEIB
Eva STEDE

Denmark
Rikke AGERGAARD
Anne-Mette KJAER HESSELAGER
Eva S. PEDERSEN

Estonia
Lauri LEPPIK

Greece
Aspasia STRANTZALOU

Spain
Mercedes CASTRO LOPEZ
Diego RODRIGUEZ TORNOS

Finland
Christina LINDELL

France
Denis MAGUAIN
Anne-Juliette LECOURT-GIRAUD
Violette FISCHER

Croatia

Hungary

Ireland
Angela NOONAN
John HEUSTON
Nic Giolla Mhicil DEARBHÁIL

Italy

Lithuania
Audrone MAZURKIENE
Inga BUSKUTE

Luxembourg
Claude SCHMITH

Latvia

Malta
Maya MILJANIC-BRINKWORTH

The Netherlands
Adrie MOONS
E.J. van ASSELT

Poland
Marzena BREZA
Ryszard MIKONOWICZ
AGNIESKA NOWRASKA

Portugal
Ana FERREIRA REIS
Rute GUERRA

Romania

Sweden
Anna GRALBERG
Hakan NYMAN
Olle SUNDBERG

Slovenia
Davor DOMINKUS
Andraz RANGUS

Slovakia
Barbora VAVROVA
Maria NADAZDYOVA
Slavomir DURISKA

United Kingdom
Ashley SAWYER

ANNEX 3. PRESENTERS & DISCUSSANTS AT SPC-WG-AGE WORKSHOPS

***Rehabilitation and Independent Living* 29 April 2013:**

Sophie CES	Catholic University of Louvain, Belgium
Antonin BLANKAERT	CNAV (French national Pension Insurance Funds)
Jeny BILLINGS	University of Kent, UK
Alison AUSTIN	UK Department of Health
Stephen BARNETT	European Social Network
Anne-Sophie PARENT	Age Platform Europe
Yuki MURAKAMI	OECD
Stephanie CARRETERO	Joint Research Centre – IPTS

Better social protection through re-engineering of LTC* 25 June 2013*:

Pia KÜRSTEIN KJELLBERG	KORA, Denmark
J. PINTO ANTUNES	European Commission, DG SANCO DG02 – EIP AHA Team
Yuki MURAKAMI	OECD
C. TJADER	Swedish Institute of Assistive Technology
Stephanie CARRETERO	Joint Research Centre – IPTS
Frank GOODWIN	Eurocarers
Anne-Sophie PARENT	Age Platform Europe
Balasz LENGYEL	European Commission, DG SANCO
Nagy ORSI	European Commission, DG SANCO
Barbara KERSTIËNS	European Commission, DG RTD

ANNEX 4. COUNTRY PROFILES

AUSTRIA

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Austrian population is expected to grow from 5.0% to 11.1% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 2 from 2.4% to 6.8% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 27.7% to 38.6% (EU-28: 27.8%-41.5%), and from 13.3% to 23.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 29.2% (EU-28: 29.9%) to all of 55.1% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.6/20.9 years (EU-27: 17.2/20.7) in 2010 to 22.4/25.6 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 2.1 and 2.6 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.6% to 3.0% (EU-27: 1.8%-3.6%).

The healthy life expectancy at the age 65 is currently somewhat lower in Austria while life expectancy is higher than the EU-average. This indicates that there are some deficits in health promotion, prevention and rehabilitation, which unless corrected may lead to a higher burden and financial costs within the area of long-term care.

2. CURRENT LONG-TERM CARE PROVISION

The Austrian system of long-term care has a twofold design, consisting of cash benefits on the one hand, and publicly organised long-term care services on the other hand. The respective cash benefit is called long-term care benefit (*Pflegegeld*). As from the beginning of 2012, long-term care benefits have fallen within the sole competency of the central state, whereas before the federal provinces also granted this kind of benefit for specific groups. *Pflegegeld* is granted without means testing (against income or assets) and according to seven different levels, corresponding to a categorisation of different individual care requirements / the health status of the person in need of care. The benefit currently amounts to EUR 154.20 per month in level 1 (the lowest level), but may be as high as EUR 1,665.80 in level 7. These cash benefits are to be used to buy formal care services from public or private providers or to reimburse informal care giving and in accordance to Art. 3 lit. a of the Convention on the rights of persons with disabilities, are meant to guarantee, an autonomous and need-oriented life. The federal ministry for labour, social affairs and consumer protection organizes every year about 20.000 home visits to ensure the quality of informal long-term care (care at home). These visits are made by professional carers (“qualified nurses”). They aim to offer advice to the informal carer and to check the living situation of the person in need including if the cash benefit is in fact used to provide care for this person. The collected information is evaluated to ascertain if there is a deficit in the care-situation.

Also when people in need request a higher level of the cash benefit because their care needs have increased or in cases of check-ups by doctors the care situation is checked.

In every case where the person of need is not getting as much care as he or she needs, people are informed about the need of changing the situation and in case of a continuing deficit situation, it can come to a change from cash benefit to benefits in kind (§ 20 Bundespflegegeldgesetz - § 20 Federal Long-term Care Benefit Act).

In addition, the federal provinces are responsible for the delivery of institutional inpatient, ambulatory, semi-outpatient and outpatient (i.e. at-home) care services. These services are de facto implemented in cooperation with municipalities and not-for-profit organisations. These services are financed through (co-)payments from persons in need of long-term care (who simultaneously receive the long-term care cash benefit, intended to partly cover these outlays) and by the general budgets of the federal provinces and municipalities (on a needs-tested basis in case of insufficient financial resources of the person in need of long-term care).

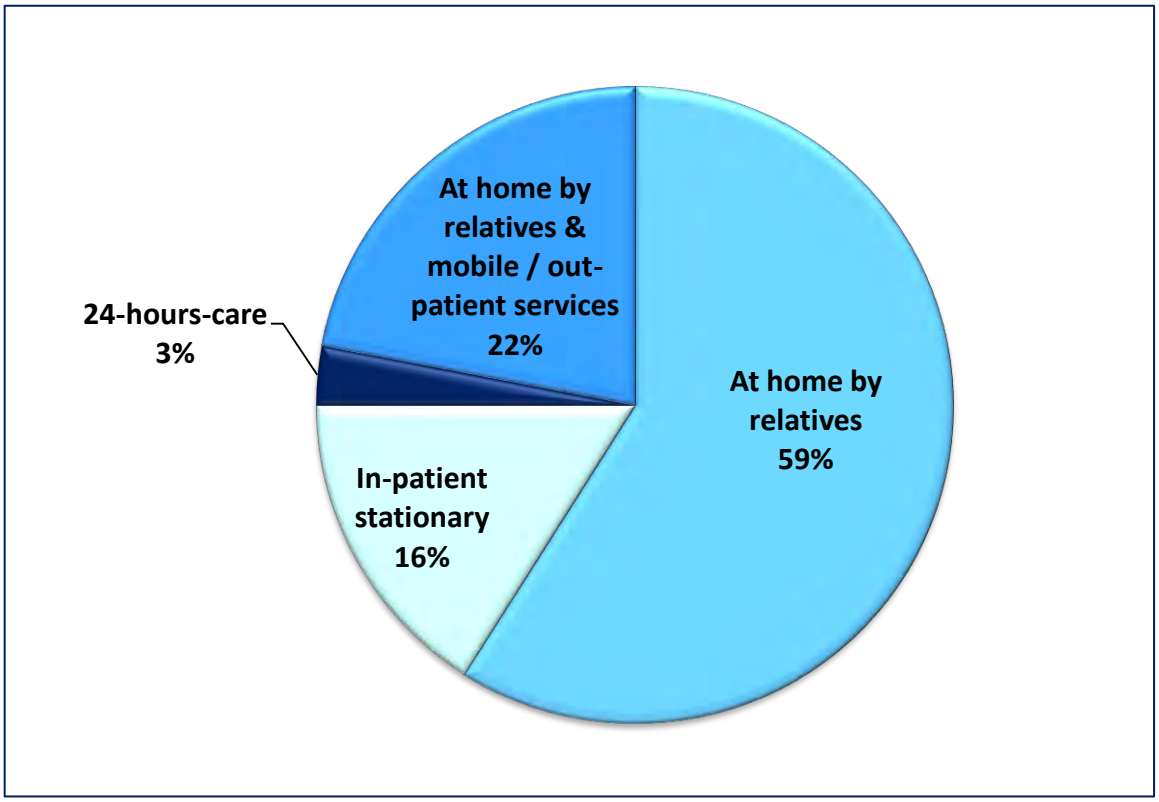
In 2010, 30.7 long-term care beds per 100,000 inhabitants were available in hospitals in Austria. This number is somewhat higher than the average of EU-27 (26.5 beds per 100,000 inhabitants).

In 2012, the federal provinces and the federal state agreed on introducing a so-called long-term care database (this agreement was part of the reform covered in the so-called Long-term Care Funds Act; Pflegefondsgesetz; BGBl. I Nr. 57/2011).[84] Respective data are now accessible via the web page of Statistik Austria.[85]

[84] http://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20007381

[85] http://www.statistik.at/web_de/statistiken/soziales/sozialleistungen_auf_landesebene/pflege_und_betreuungsdienste/index.html

Figure 1. Long-term care arrangements (2013) of recipients of long-term care cash benefits



Source: Federal Ministry of Labour, Social Affairs and Consumer Protection (BMASK).
Note: 440 783 recipients of long-term care cash benefits (2013)

Financing of long-term cash benefits comes from the general budget of the federal state, public financing of benefits in kind derives from the budgets of the federal provinces and municipalities and via the general fiscal equalisation scheme (*Finanzlastenausgleich*), as well as the so-called Long-term Care Funds (*Pflegefond, 2/3 financed by the federal state and 1/3 financed by the federal provinces*), introduced in 2011, and from the budget of the federal state. This means that public spending on long-term care (in the more narrow sense, i.e. without care provided by the health system) is 100% tax-financed in Austria.

Regarding the overall public spending for LTC the EC reports that respective outlays amounted to 1.6% of GDP in Austria in 2010, which is 0.2 percentage points lower than the average of EU-27. The figures for outlays for cash benefits are rather high (0.83% of GDP) in Austria when compared to the average of EU-27 (0.52%), whereas spending is lower than the average of EU-27 in respect of long-term care in institutions (AT: 0.34%; EU-27: 0.80%) and – to a lesser degree – of LTC at home (AT: 0.47%; EU-27: 0.53%). However, in this context one should bear in mind that cash benefits are, de facto, also used to finance LTC in institutions, where these benefits, are managed by the institution (with the exemption of a small amount of pocket money) if people in need of LTC cannot finance the required services from other resources. It is also planned that LTC cash benefits are used to finance LTC services at home.

As already mentioned above, LTC cash benefits (*Pflegegeld*) in Austria is not **means tested** in terms of personal or family income or assets, but in principle granted as a universal benefit. In contrast, access to LTC benefits in kind and LTC services is, in principle, not free of charge. Here, means testing applies, where all kinds of personal income, including LTC cash benefits and assets (which may get capitalised) are taken into account. Only if the respective services cannot

be financed via these resources, they are fully or partially financed by the federal provinces within Social Assistance and the Guaranteed Minimum Income Scheme. Furthermore, in most federal provinces a scheme of so-called "***Familienregress***" has been in place, which obliged relatives of persons in need of institutional care to means-tested co-payments, if costs could not be covered via personal income (including LTC cash benefits) and capitalisation of assets of persons in need of LTC. These schemes of "*Familienregress*" were gradually abolished in all federal provinces, but in Styria, co-payments by children for parents (and by parents for children) in need of institutional LTC were re-introduced in summer 2011.[86]

Municipalities increasingly follow the strategy to offer additional places in institutions of "alternative dwelling" (instead of traditional intramural LTC), with the goal to promote more independent living up to higher ages. Beyond adapted housing policies to promote independent living also include rehabilitation and various preventative measures.

The question of **quality** of LTC at home and in institutions is a long standing issue of debates in Austria. Over the past decade, several measures were decided and implemented to improve the quality of LTC in both contexts. A related situation applies for **problems of access**. The evident large variation of coverage rates of LTC benefits in kind and LTC services points to the direction that substantial deficits are likely in a number of federal provinces, but, again, more evidence-based and encompassing assessments are largely missing.

With the establishment of the long-term care fund, the federal provinces receive additional money of € 1,335 Billion until 2016 for the maintenance, improvement and expansion of their care services. This also aims on region wide offers of services.

3. CARERS

According to recent data provided by the Federal Ministry of Labour, Social Affairs and Consumer Protection (see Chart 1 above) 59% of all recipients of LTC cash benefits were solely looked after by relatives. 22% were looked after by relatives and additionally received mobile/outpatient LTC services. In 3% of all cases LTC services were primarily performed by privately hired cared attendants (so-called 24 hours care at home), who are mainly women coming from new EU Member States.

Over the past decade, an increasing number of measures were introduced to support informal carers. These include *Support of 24-Hour-Care*, *Social insurance for care giving relatives* (including *Continuing (pension) insurance for care giving relatives*, *Voluntary (pension) self-insurance for care giving relatives* and *Health insurance for care giving relatives*), *Support for care giving relatives* (§ 21a BPGG – § 21 Federal Long-term Care Benefit Act) and *Paid Care-Leave*.

Regarding **formal carers,** problems of shortage of availability and the question of unfavourable working conditions within this sector are long-standing issues in Austria. Within the past decade,

[86] http://www.politik.steiermark.at/cms/beitrag/11538246/2494255/

several measures have been introduced to improve this situation, but many challenges still prevail[87].

The new Long-term Care Database delivers **data on formal care attendants** according to different kinds of LTC services and federal provinces (in full-time equivalents). To examine the density of care attendants, these data can be put into relation to a) the respective number of recipients of long-term care cash benefits and to b) the number of people aged 65+ and 75+. What becomes clear here again is a considerable variation of the density of care attendants across the federal provinces.

According to estimations by The Working Group on Long-term Care Reform, the demand for formal care attendants within services and benefits in kind provided by the federal provinces will rise from approximately 45,000 full-time equivalents in 2010 to about 67,500 full-time equivalents in 2025.

4. POLICY AND RECENT DEVELOPMENTS

The future of LTC has gained increased political attention in Austria over the last few years. To deal with respective problems and to develop a strategy for the future, the governed established the above mentioned Working Group on Long-term Care Reform, which presented its final report in December 2012 (*Reformarbeitsgruppe Pflege 2012*). Some of its suggestions were then taken into account within an amendment of the Act on Long-term Care Funds, which was adopted in 2013.[88]

Overall, these developments do not point towards a structural change of the main features of the Austrian LTC system. The aim appears to be to safeguard financial sustainability in view of rising demand (and without reduced accessibility). Within this context, the Reform Working Group rejected the idea of a separate contribution-financed LTC insurance and clearly stated that LTC services should remain tax-financed. Furthermore, the currently existing model of a combination of universal cash benefits and (means-tested) LTC services administered by the federal provinces and municipalities has not been put into question. It is, however, the declared aim to do more to harmonise the access to available services, to focus on the further development of mobile/outpatient services (also for reasons of cost containment) and to promote innovative approaches.

The financing of the current LTC system appears to be safeguarded for the next three years, partly due to the decision to prolong the Long-term Care Fund until 2016. After that, given the rising demand, additional funds will have to be made available. But the degree to which economic resources for LTC will be raised will then again be subject to negotiations between the federal state and the federal provinces.

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87 See e.g. the report of the "Reform Working Group Long-term Care" (*Reformarbeitsgruppe Pflege*), presented in December 2012 (Reformarbeitsgruppe Pflege 2012

88 For an overview on the content of this amendment see: http://www.sozialministerium.at//site/Soziales/Pflege_und_Betreuung/Pflegefonds/

5. BACKGROUND STATISTICS

Austria (AT)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	18.1	15.6	20.4	23.3	21.2	25.3	26.7	24.4	28.9	28.8	26.6	30.9	10.7	11.0	10.5			
80+	5.0	3.4	6.5	6.7	5.4	8.1	9.8	8.2	11.3	11.1	9.3	12.9	6.1	5.9	6.4			
85+	2.4	1.4	3.4	3.5	2.6	4.4	4.8	3.7	5.9	6.8	5.3	8.3	4.4	3.9	4.9			
80+/65+	27.7	21.9	31.9	29.0	25.4	31.9	36.7	33.6	39.2	38.6	34.8	41.8	10.9	12.9	9.9			
85+ /65+	13.3	8.8	16.7	15.1	12.3	17.3	18.2	15.3	20.5	23.7	20.1	26.7	10.4	11.3	10.0			
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2			
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3			
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3			
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1			
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1			
Old-age dependency ratios, % [2]	**Austria (AT)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	29.2	24.7	33.7	55.1	49.5	60.8	25.9	24.8	27.1	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	19.8	16.1	23.4	38.2	33.5	43.0	18.4	17.5	19.6	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Austria (AT)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	77.6	83.0		84.8	89.1		7.2	6.1		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	17.6	20.9		22.4	25.6		4.8	4.7		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	6.8	6.9		8.9	9.5		2.1	2.6		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	40.0%	34.0%		48.9%	44.8%		8.9	10.8		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.6			3.0			1.4			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

BELGIUM

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060, the share of people aged 80+ in the Belgian population is expected to grow from 5.3% to 8.9% (EU-28: 5.1%-11.8%), i.e. to increase by almost 70% with most of the growth happening before 2045. At the same time the share of people 85+ will more than a double from 2.4% to 5.2% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 30.0% to 37.4% (EU-28: 27.8%-41.5%), and from 13.7% to 21.8% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 29.4% (EU-28: 29.9%) to all of 44.1% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.4/20.9 years (EU-27: 17.2/20.7) in 2010 to 22.3/25.7 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for both men and women rose by 1.3 years.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would more than double rising from 2.3% to 5.4% (EU-27: 1.8%-3.6%).

As many of the policies addressing the challenges of long-term care and age dependency are set at a sub-national level, it is important to understand the differences in demographics between the Belgian Regions. In 2060, 25% of the population will be 65 years or older and about 6% will be at least 85 years old. Yet, in Brussels higher fertility rates and increased migration will result in merely about 18.5% being 65 or older, and only 3.8% 85 or older. The overall dependency rate would be highest in Flanders (48.2%) and much lower in Brussels (29.5%).

This evolution will undoubtedly lead to an increase in LTC dependency. Generally, it is expected that the number of persons in need of LTC will double by the year 2060.

2. CURRENT LONG-TERM CARE PROVISION

From an organisational point of view, long-term care in Belgium is part of an integrated system of health care, complemented by social service provision. The focus on health care is accentuated by the fact that there is no specific long-term care legislation at the level of social security legislation.

On the Federal level (social security), reimbursement for the medical aspects of long-term care is provided through the federal public compulsory health insurance system. The federal level is also responsible for the overall long-term care budget (for residential care and home nursing care, which are part of the public health insurance system), overall capacity planning (the number of beds in nursing homes), fees and level of public intervention.

Medical services are organised and paid for by the federal health insurance system, while personal care is organised on a regional level. How these services are provided depends on the specific care settings.

The part of long-term care covered by the universal health insurance system (residential and home nursing care) is financed with social security contributions. Other long-term care services and allowances are financed by general taxes, collected mainly at the federal level. The Flemish long-term care insurance is financed by a specific contribution which is paid by every adult resident and by general taxes.

Costs for the patient that are not covered by social security benefits or the cost-compensation mechanisms of the health care system have to be borne personally. But cash benefits seek to offset expenses related to non-medical long-term care, which are otherwise borne by the individual. On the federal level, a monthly allowance for disabled persons and the elderly (*Tegemoetkoming voor hulp aan bejaarden; Allocation pour l'aide aux personnes âgées*) is allocated to persons aged 65 and older for whom a severe need for care is certified. This allowance is means-tested. Several other types of allowances exist, aimed at specific costs (e.g. incontinence material) or circumstances (e.g. for palliative care at home).

On the level of the Communities (which have the competence to provide additional assistance to the elderly), the Flemish Community has created a specific "Flemish Care Insurance" in 1999 ("*zorgverzekering").* It covers the costs of non-medical help and services borne by people with reduced self-sufficiency. The system is organised as a residence-based compulsory insurance-type scheme: every person residing in Flanders is compulsorily covered. Persons residing in Brussels are allowed, but not obliged, to join. The *zorgverzekering* only provides financial benefits; insurance under the scheme is not a requirement for receiving long-term care services. On 31 December 2012, the Flemish Care Insurance provided benefits to 222 798 individuals.

No social insurance system covering specific needs for dependency-related nonmedical assistance is in force in the French or German-speaking parts of the country.

Communities are further responsible for organising the provision of long-term care, the recognition of service providers, the integration of services and quality monitoring. Both the Flemish and French Communities regulate and organise home care, aimed at enabling patients to continue to live in their own home while they receive care.

At the level of the municipalities, services and even residential care are provided as part of the package of social assistance, through the involvement of Public Centres for Social Welfare (OCMW). Patients in residential care without the means to pay for board and lodging are helped through social assistance services, which are provided by the municipalities.

In residential care, nursing care is provided to patients with low to moderate limitations in homes for the elderly, and to patients with moderate to severe limitations in nursing homes. In 2011, there were 129 732 beds available in residential care, more or less equally divided between nursing homes and homes for the elderly. This reflects a steady decline in the number of beds in homes for the elderly and an important increase in the number of places in nursing homes, as persons with low limitations are increasingly helped at home. Relative to the population aged 65 and over, the number of beds in residential care facilities has remained more or less constant at 70 beds per 1000 over the past decades. In 2010, 126 720 people aged 65 or older made use of residential care.

Others (mostly patients who still live in their own homes, but who have limited or temporarily restricted access to informal care) are helped under semi-residential care arrangements provided in day care and "short-stay" care centres.

Help at home is provided in the form of home nursing care and home care services, which include assistance with personal care such as cleaning, cooking and other domestic tasks. In 2011, 176 598 people received nursing care at home, of which 157 280 were aged 60 years or older.

Between the years 2000 and 2011, the number of home nursing care users has grown by more than 40% and the number of users of home care services has grown by more than 20%. By contrast, the increase in residential care users amounts to less than 10%. In residential care, the share of places for persons with moderate to severe limitations has increased.

Many of those not eligible for subsidised home care buy services privately, mainly by using vouchers which can be purchased to pay for domestic services provided by public bodies or private firms (so-called service checks). Through this system, the government subsidises around two-thirds of the hourly costs of a service. The exact amount spent on long-term care is unknown, as the system can also be used for domestic help by non-care dependent persons.

Quality assurance and improvement in LTC is to a large extent part of quality regulations in the overall health care system. Quality standards for institutions, for instance, are set for nursing homes just as they are for hospitals. Still, specific regulation is being developed in the LTC sector. Thus, nursing homes are required to have a quality programme as well as training programmes for their staff. Moreover, both the Flemish and the Walloon regions have developed quality monitoring systems for nursing homes, day-care centres and homes for the elderly. These facilities are required to develop a quality manual specifying procedures and mechanisms that facilitate monitoring.

3. CARERS

Recent reliable statistics on the number of informal carers do not seem to be available. According to estimates Belgium counts approximately 668 000 informal caregivers aged 15 or older and 455 000 aged 45 or older.

Several surveys and studies provide insight about who these carers are. The probability of giving care depends to an important extent on the gender and the occupational status of the potential caregiver. From this data, it is apparent that informal care is mostly provided by women aged 45 to 75.

Informal caregivers are supported through information provision, social and psychological services and by the existence of day centres and short-stay care centres which allow to alleviate temporarily the burden of informal care-giving.

Combining care-giving with a career is to some extent supported by paid leave schemes (for employees and civil servants). These schemes allow taking time off to care for a dependent person whilst receiving a replacement income provided by the unemployment insurance scheme. Periods of leave taken under these schemes count as contributions to other social security benefits such as pensions.

As a result of the measures aimed at increasing the effective retirement age and extending career durations, the use of these schemes is, however, becoming more restricted. This highlights the need for a specific recognition and social protection of informal carers.

While no special provisions exist yet, steps towards such recognition are currently being taken. In March 2013, the government proposed a new Act towards a legal recognition of informal carers. The text seeks to define what constitutes an "informal carer" (*mantelzorgers*, *aidants proches*). Some elements in the definition are that informal carers provide help in a non-professional way and in cooperation with at least one professional care-giver, and that the time spent providing informal care must amount to at least 20 hours per week. The next steps will be to define specific categories and to add various (financial and other) rights and obligations to the legal recognition as informal carer, meaning that "formalising informal care" may still take a while.

Formal long-term care is provided by many different actors, depending on the care setting (residential or non-residential, and everything in-between) and on the type of care provided (nursing care or personal care).

Residential and home nursing care is organised by the federal public health insurance system and is provided by qualified nurses, many of whom are self-employed. At the end of 2012, 174 849 qualified nurses were registered, 4 215 of which had a specific qualification in geriatric care. At over 87%, the profession is mostly taken up by women. Care professionals (*zorgkundigen*) are persons who are authorised to help nurses within a structured team (for example in residential care). In 2012, 86 379 care professionals were registered.

Home care services (including meals service, help with domestic chores and basic personal help) are organised locally by staff employed by a public agency or by private non-profit firms. The number of people engaged in the delivery of these services is not known. The subsidised home care sector produced about 25 million care hours in 2006; this is equivalent to 17 000 full-time workers.

4. POLICY AND RECENT DEVELOPMENTS

Belgian policy aims at providing universal access to affordable and high-quality long-term care. As is the case in most European countries, the emphasis lies on policies that allow the elderly LTC dependent person to keep on living in his or her natural home environment.

Affordability and accessibility are to a large extent achieved because the medical aspects of long-term care are part of the public health care system, which offers near-universal coverage. A "Maximum Billing System" (*Maximumfactuur*) limits the amount of out-of-pocket payments an individual has to pay, and various (mostly means-tested) allowances help people cope with the financial burden of non-medical expenses. A special statute for patients with chronic illnesses will result in lower out-of-pocket payments from 2014 onwards.

In order to delay or even to avoid the move of care-dependent elderly people from their own home environment to residential care, the focus should be on the development of more diverse services that allow an easier transition from one care setting to another, according to developments in the needs of the patient. Because of fragmented responsibilities, the further development of long-term care policy in Belgium requires integration and cooperation across different levels of government.

In 2002, the Federal Government introduced the "Integrated Home Care Services" (*Geïntegreerde Diensten Thuiszorg (GDT)/Service Intégré de Soins à Domicile (SISD)*), which are financed by the statutory health insurance system. This structure coordinates all medical disciplines involved in the care for patients for a specific geographical area.

At the regional level, home care is coordinated by "Cooperation Initiatives Primary Care" (*SamenwerkingsInitiatieven Eerstelijnsgezondheidszorg* or *SELs*) in Flanders and by the "Coordination Centres for Home Care and Services" (*Centres de Coordination de Soins et Services a Domicile* or *CSSDs*) in Wallonia. Their main task is to guarantee the quality of care and the cooperation between staff involved in providing LTC to people in their own homes such GPs, home nurses, accredited services for home care and home help, aid for the elderly and social work, etc.

At the policy level, cooperation between the federal and regional governments takes place in working groups organised under the "Interministerial Public Health Conference".

While there is a broad consensus on the strategies needed to further develop long-term care services, cooperation is sometimes difficult – especially in light of budgetary pressures an the fragmentation of overall responsibility for LTC. For example, building and renovating residential and semi-residential facilities is financed by the regions, while the nursing care provided in these facilities is paid for by the federal health care system. Therefore, when new places for residential care are created, these facilities need to be recognised by the federal government so that the cost of nursing care can be covered. The failure to do so results in patients having to bear these costs themselves.

Programmes for prevention, support for rehabilitation and schemes promoting independent living are mostly found on the regional level.

In Flanders, a policy of coordination and cooperation between residential and home care services is implemented through the Act on Residential and Home Care (*Woonzorgdecreet*, 2009). The legislative framework combines self-care, informal care and professional care in existing and new forms of home care; care that supports home care, and additional care and residential care. The Act paves the way to new care settings in which independent living is combined with the provision of care services and takes into account a more diverse profile of care dependent persons.

While no such integrated legislative framework seems to exist in Wallonia, policy in this region focuses on the same issues and offers broadly the same solutions.

Overall, new initiatives focus mostly on providing flexible services in different settings and to enhance awareness on care needs in different fields (such as for example the design of new social housing), making it possible to offer different forms of care according to the needs of the patient, and putting less emphasis on the specific setting in which care is provided.

5. BACKGROUND STATISTICS

Belgium (BE)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	17.6	15.3	19.8	21.2	19.3	23.0	22.6	20.6	24.4	23.7	21.9	25.5	6.1		6.6		5.7	
80+	5.3	3.7	6.7	6.0	4.8	7.2	8.2	6.8	9.6	8.9	7.4	10.3	3.6		3.7		3.6	
85+	2.4	1.5	3.3	2.8	2.0	3.6	4.3	3.2	5.3	5.2	4.0	6.3	2.8		2.5		3.0	
80+/65+	30.0	24.5	34.1	28.3	24.7	31.3	36.4	32.7	39.5	37.4	33.8	40.5	7.4		9.3		6.4	
85+/65+	13.7	9.8	16.6	13.2	10.3	15.5	19.0	15.7	21.7	21.8	18.4	24.7	8.1		8.6		8.1	
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2		10.2		10.2	
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7		6.2		7.3	
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7		4.0		5.3	
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7		14.8		13.1	
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7		11.8		12.1	
Old-age dependency ratios, % [2]	**Belgium (BE)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	29.4	25.0	33.8	44.1	39.9	48.4	14.7	14.9	14.6	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	19.4	15.8	23.1	30.8	27.2	34.5	11.4	11.4	11.4	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Belgium (BE)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	77.3	82.6		84.6	89.0		7.3	6.4		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	17.4	20.9		22.3	25.7		4.9	4.8		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	9.4	9.8		10.7	11.1		1.3	1.3		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	56.6%	48.5%		60.7%	52.2%		4.1	3.7		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	2.3			5.4			3.0			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

BULGARIA

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Bulgarian population is expected to grow from 4.3% to 12.1% (EU-28: 5.1%-11.8%), i.e. to almost treble by rising gradually over this period. At the same time the share of people 85+ will expand by more than a factor 3 from 1.6% to 6.3% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 22.4% to 38.0% (EU-28: 27.8%-41.5%), and from 8.3% to 19.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 30.6% (EU-28: 29.9%) to all of 64.8% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 13.8/17.0 years (EU-27: 17.2/20.7) in 2010 to 20.6/23.6 years (EU-27: 22.4/25.6) in 2060.

For 2012 the healthy life expectancy for men and women is 8.7 and 9.5 years at 65, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.5% to 0.9% (EU-27: 1.8%-3.6%).

Bulgaria is experiencing negative population growth since the early 1990s due to high emigration. As from 1989 to 2012 the population dropped from 9.0 million to 7.3 million i.e. by almost 20%, it also became considerable older as primarily it was the younger who left and as the fertility rate dropped to below 1.5.

2. CURRENT LONG-TERM CARE PROVISION

Formally the system of long-term care (LTC) in Bulgaria is based on the principles of solidarity, equity and access of all persons in need. Its stated objective is to improve the quality of life of people with disabilities and elderly people with impaired ability to handle activities of daily living (ADL) and instrumental activities of daily living (IADL) by means of providing conditions for an effective exercise of their right to independent living and social inclusion and for a reduced dependence on institutional care.

The EU definition of long-term care corresponds to a number of different services provided in this area, and although there is no specific legislation for long-term care, the issue is addressed in a number of policy acts[89].

Depending on the cases, LTC can be provided by the state, the municipal authorities or private providers through the systems of social insurance and social welfare. The system is multifaceted

[89] The Social Assistance Act (SAA), the Disabled People's Protection, Rehabilitation and Social Integration Act, the Ordinance No. 4 on the Terms and Conditions for Social Service Provision, the Ordinance on the Criteria and Standards for Social Service and the Health Insurance Act, which provides a basis for the services rendered as part of the national mandatory health insurance system.

depending on the type of provider involved. It is also experiencing a transition aimed at strengthening decentralization and reinforcing the focus on individual care recipients' needs. The main target groups of long-term care are people with impairments (disability) and frail elderly people (65+). Services are provided in specialized institutions, at home, or in an environment that is close to the family (day care centres).

There is no national definition of "need of care"; instead, specific eligibility criteria are defined in different pieces of legislation related to different types of services. Assessment of LTC needs is individual and normally based on an application to the respective welfare service. Generally, the minimum eligibility criteria are defined in the legislation and they are nation-wide and binding. These may include the applicant's income, property status, family status, potential care providers (friends or relatives), type and severity of disability, etc.

Once placed in specialized institutions, the recipients of care must pay a fee for their stay. In most cases, the amount of this fee is 70% of the monthly income received. In case that the recipient has claims, deposits, shares and securities whose total value exceeds BGN 500; holds contracts to provide property against liability for support and/or care; has transferred fee title to real estate and/or common parts of it in the last five years and the total value of transactions exceed 60 times the guaranteed minimum income for the period; has transferred by agreement the ownership of personal property and/or shares in the last 5 years, they must pay a fee matching the real costs of their support. However, the fee cannot exceed the real income of the applicant. The amount of the fees for community-based social services of residential type is significantly lower.

Currently, the medical and social aspects of LTC services in Bulgaria are organised separately and regulated by different bodies and legislation. At the same time, the respective legislation also targets other categories of people. This makes it difficult to integrate the services needed by the recipients of LTC.

According to a recently published World Bank Report[90], total public and private expenditure on LTC in Bulgaria ranges between nil and 0.2% of GDP. This places Bulgaria among the European countries that spend the least on LTC.

However, the long-term care system in Bulgaria has expanded considerably in recent years as a result of actions aimed at deinstitutionalisation and provision of more community-based services and services in a family environment. Despite some progress, the institutionalisation of people with disabilities - including frail and disabled elderly - is still predominant. Care is provided mainly in older peoples homes, homes for elderly people with disabilities, specialised hospitals for continued treatment and rehabilitation and in hospices.

To provide assistance to people with dementia or Alzheimer's disease social services are delivered in Homes for People with Dementia (HEPD) and Centers for family-type accommodation for elderly people with dementia. As of February 2012, there are 14 HEPDs in Bulgaria with a total capacity of 836 beds and 2 small centres for family-type accommodation for elderly people with dementia with a capacity of 25 beds.

[90] Mitigating the economic impact of an ageing population: Options for Bulgaria. World Bank 2013

In order to improve coordination and integration of social services and ensure equal access to quality social services for disabled people from vulnerable groups, a qualitatively new approach to the development and provision of social services through regional and municipal planning was introduced in 2010.

As part of the implementation of the "Concept of Deinstitutionalisation and Prevention of Social Exclusion of People Living in Institutions", the Agency for Social Assistance has developed a Plan for reforming the specialised institutions for elderly people and people with disabilities 2010-2011, which outlines concrete measures and activities for the reform of 14 specialised institutions for adults with disabilities. In 2011, 12 specialised institutions were abandoned and 28 new community based services of residential type were established. 150 people were deinstitutionalised and accommodated in community based social services of residential type. As of July 2012, the number of specialised institutions is 163 with a capacity of 11,326 places.

The transition from traditional institutional care in Bulgaria to community and family based services is mainly realised through an expansion of the range of services (Day Care Centres, Social Rehabilitation and Integration Centres, Protected Housing), as well as the further development of the model for services provided at home (personal assistants, social assistants, domestic assistants, domestic social patronage). In July 2012, the number of community based social services for elderly people was 370 with a capacity of 8,043 places.

In parallel to the provision of community-based services, the provision of services in family environment is a key prerequisite for the improvement of the quality of life of elderly people and people with disabilities An example of good practice in this field is the provision of “Personal Assistant” and “Social Assistant” services under the National Programme “Assistants for People with Disabilities” implemented since 2003. It provides care in family environment for people with permanent disabilities, seriously ill or living alone by employing unemployed persons as personal and social assistants.[91] By the end of June 2012, 3 635 unemployed persons were employed as personal assistants under the Programme.[92] Thanks to these schemes, more than 45,000 people with disabilities and people living alone have received support at home since 2007.

The family physician is responsible for the initial examination and monitoring of the health status of the elderly. In case of impaired health and the need for LTC, the elderly patient is referred to the relevant health institutions and medical nursing care is arranged if needed. The arrangements for any medical services, medical nursing care included, are made by the family doctor. Where necessary, the doctor alerts the social services. Upon receiving an application from the elderly patient or his/her family physician, friends or relatives, the local unit of the social services makes an initial assessment of the situation and decides on the LTC measures and programme to be applied in each specific case.

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[91] The programme is funded by the state budget. For the provision of the services “Personal Assistant”, “Social Assistant” and “Domestic Assistant” there is additional funding under the Operational Programme “Human Resources Development” (OP HRD).

[92] Since its start in 2007, OP HRD has been contributing to the implementation of several schemes with a direct effect on long-term care goals. “Personal Assistant” services include the provision of permanent care for disabled children or adults suffering from severe diseases, enabling them to fulfil their daily needs. “Social Assistant” services include the delivery of social work services, psychological support, expert consultations, provision of information, development and delivery of individual social care community-based programmes. “Home Assistant” services include the delivery of home-based services aimed at maintaining personal hygiene, house cleaning, shopping, cooking, administrative services, etc.

At first sight, this system seems to be well-integrated and work well, but its operation is often compromised due to inadequate access to medical and social services. In particular, this is the case in remote regions and villages, which often lack family physicians or social workers and are therefore unable to respond quickly to emergencies or organise regular home-based LTC. Extended periods of time may elapse before such patients can be placed in specialised public institutions; regular residential or home based LTC arrangements are often not available, so such clients usually have to stay and receive LTC in hospitals. Currently, many hospitals, including acute hospitals (hospitals for active treatment) are responsible for long-term care patients who could receive higher quality services at lower cost in an environment better adapted to this purpose.

The financial resources for social services development and support are provided from several sources: the state budget, the local budgets, financing via programmes and projects, including EU funds, out of pocket payments of the beneficiaries, own incomes in the cases of private providers of social services. However the main share of the funding comes from the state which has been steadily increasing in past years.

Municipalities provide funds from their own revenues for local social services. This means that the amount and quality of social services provided by local authorities vary greatly depending on the municipal budget.

Despite the government's announced measures and strategies for de-institutionalisation and development of community based services the existing national programmes for fail to meet the growing demand for LTC services or for improvement of their quality. This is largely due to the limited financial resources for their implementation (especially at local level). While the community-based forms of LTC are hailed with enthusiasm as a major vehicle of de-institutionalisation, in fact their efficiency and accomplishments have not been studied in depth. Moreover, they seem to be jeopardized by a lack of resources and staff problems. Another missing element in the puzzle is the lack of an operating LTC system linking the different units of the system and permitting the efficient exchange of data and information.

Though control mechanisms formally are in place, there is no system of quality control in residential and home care. Moreover, so far no independent research has been conducted to assess the quality of formal LTC services and the actual possibilities for positive change.

3. CARERS

In Bulgaria there is no established information system collecting data on formal carers providing long-term care. There is even less information about the number of people providing informal care. But there is little doubt that the overwhelming bulk of LTC is provided by informal carers in families.

The cultural traditions in Bulgaria encourage care for elderly people to be provided by family members, who are not trained professionally, but accept that responsibility out of a sense of family duty. The provision of LTC is considered to be a family matter.

Though informal care thus is of outmost importance it has so far neither been legally recognised or financially encouraged within the system of LTC services. No cash benefits or services in kind are available to support informal carers. And in line with this one of the placement requirements of LTC institutions for the elderly is that the clients do not have any family members capable of providing care for them.

The state supports a system of personal assistants and home helpers who are paid to provide basic cooking, cleaning, personal hygiene and shopping help for people who do not require institutionalization but cannot meet these basic needs on their own. This system was originally established to provide relatives of elderly and disabled residents who need constant care with a salary and insurance coverage but it is open to third parties as well. According to the Health Insurance Act the parents or spouses taking care of persons with disabilities are insured for the account of the State Budget if those have lost more than 90 per cent of the working ability and require constant attendance.

4. POLICY AND RECENT DEVELOPMENTS

Since late 2009 the political debate on LTC has intensified. The initiative was undertaken by the NGO sector and the National Social Security Institute (NSSI). LTC was for the first time defined as "a social risk" also in terms of social insurance[93]. It was suggested that the solution to the problem should be sought along the lines of establishing special schemes for social security (through the system of social and health insurance). Some of the measures proposed include: LTC to be integrated in the social security system as a mandatory social security risk; establishment of an independent LTC fund; financing LTC from public funds, or an insurance fund and fees from the families of persons in need; increase of the health insurance fee so that LTC and palliative care are covered, etc.

In order to provide qualitative and affordable services for senior citizens and people with disabilities the government has established a number of projects under the ESF funded Operational Programme Human Resources Development (OP HRD) for the service "Social Assistant" and "Home Assistant" have been carried out. The "Help at Home" scheme enabled the existing home social patronage to expand their activities by setting up "Units for home care services".

Although since 2010 legislation for another organizational form of long-term care (home for medical and social care) has been adopted to implement continuous medical observation and specific care for individuals of all ages with chronic illnesses, specific care at homes for people with chronic incapacitating diseases, and medical and social problems, at present such homes have not yet been established, and there is no public funding for their activities.

A recently released World Bank report recommends municipal hospitals to be converted into social centres that provide a range of social and medical care delivered at home and at a municipal level. Such services are the provision of municipal nurses, mobile medical care, outpatient services, physical therapy services, day care and care for respite and hospice services (provided both in institutions and at home). In the medium to long term perspective it will be necessary to design a model for interdisciplinary teams (composed of doctors, nurses, therapists and social workers), who can assess in a complex way the patients required long-term care. Finally, to overcome the fragmentation of financing and behaviour in terms of cost, it will be necessary to consolidate the financing of long-term care between social and health ministries, and municipalities.

Priorities in the field of social services as a component of the long-term care development policy have been defined as:

[93] Concept for the development of long-term care (draft). Ministry of Health (2012)

- extending the range of services targeted specifically at elderly people and people living alone, people with disabilities and others and improving their quality of life;
- moving from institutional care to services allowing these groups to live in their community and family environment through the development of a modern network of community services;
- creating incentives for informal carers through financial support and relief services;
- raising the capacity of the LTC system through better training of staff.

In order to achieve these goals, a National Strategy for Long-Term Care was adopted by the Council of Ministers on January 7, 2014. It was developed with all stakeholders. The main objective of the Strategy is to create conditions for independent and dignified life for older people and people with disabilities through better access to social services of quality. This should be achieved through an expansion of the network of these services in the country, deinstitutionalisation, better interaction between the health and social components of LTC services and through various measures of support to families, who care for older family members and family members with disabilities.

The specific objectives include:

- Developing and offering a network of social services according to the needs of elderly, people with physical disabilities, people with mental disorders and people requiring palliative care. These services should provided in people's homes as well as in day care centres;
- Legislative regulation of a wide range of fixed and mobile services in the community for people in the target groups and their families, relying on the best practices and applying innovative approaches;
- Ensuring sustainable financing of long term care services;
- Improving coordination mechanisms between the systems of social and health care;
- Gradually restructuring and reducing the capacity of specialized institutions transforming them into new forms of community services;
- Gradually restructuring the system for inpatient treatment of patients with mental disorders and the development of deinstitutionalization;
- Implementation and provision of sustainable funding for palliative care.

The implementation this strategy is planned to be funded through the state budget and the European structural funds for the new programming period 2014-2020.

5. BACKGROUND STATISTICS

Bulgaria (BG)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	19.2	16.0	22.2	24.3	20.6	27.7	28.9	25.9	31.7	31.8	29.1	34.4	12.6	13.1	12.2
80+	4.3	3.2	5.3	6.6	4.7	8.3	8.8	6.7	10.7	12.1	10.0	14.1	7.8	6.8	8.8
85+	1.6	1.1	2.1	2.6	1.7	3.4	4.4	3.1	5.7	6.3	4.8	7.7	4.7	3.7	5.6
80+/65+	22.4	19.9	24.1	27.0	22.9	29.9	30.4	26.0	33.8	38.0	34.4	41.0	15.6	14.5	16.9
85+/65+	8.3	7.0	9.3	10.7	8.4	12.3	15.3	12.0	17.9	19.7	16.6	22.3	11.4	9.6	13.0
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Bulgaria (BG)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	30.6	24.7	36.6	64.8	57.2	72.7	34.2	32.6	36.1	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	19.0	14.9	23.0	46.2	40.2	52.4	27.2	25.3	29.4	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Bulgaria (BG)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	70.3	77.5		81.7	86.6		11.4	9.1		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	13.8	17.0		20.6	23.6		6.7	6.6		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	:	:		8.7	9.5		:	:		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	:	:		62.6%	55.2%		:	:		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.5			0.9			0.4			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

CYPRUS

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Cypriot population is expected to grow from 2.9% to 9.4% (EU-28: 5.1%-11.8%), i.e. to more than treble with most of the growth happening before 2045. At the same time the share of people 85+ will expand by nearly factor 4 from 1.3% to 5.1% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 22.2% to 34.9% (EU-28: 27.8%-41.5%), and from 9.5% to 19.1% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 20.8% (EU-28: 29.9%) to all of 51.1% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.8/20.0 years (EU-27: 17.2/20.7) in 2010 to 22.5/25.3 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 2.0 and 2.7 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.2% to 0.3% (EU-27: 1.8%-3.6%).

Cyprus has a high rate of life expectancy and also a high rate of healthy life expectancy at birth but relatively low healthy life expectancy rate at age 65. This poses a challenge on future care service provision.

2. CURRENT LONG-TERM CARE PROVISION

The system of long-term care is based upon need and is not compulsory. Only persons entitled to public assistance may be entitled to free-of-charge long-term care (i.e. older persons, persons with disabilities, dysfunctional families). No qualifying period is required. The evaluation of care dependency is based on the individual needs of a claimant in cooperation with a welfare officer who assesses and develops a personal care plan (e.g. type of care, frequency).

Given the lack of a statutory scheme,, informal social care by family members plays an important part in long-term care; however its availability is expected to decline, as people are having fewer children, who may also live further away from their elderly parents and be unable to provide intensive care.

Apart from services of institutional and open care[94], there are public schemes for reinforcing recipients with the aim of encouraging families to keep their elderly members at home and provide care for them (i.e. the *Scheme for the Provision of Social Aid for Improving Housing Conditions* and the *Scheme for the Reinforcement of Families for the Care of their Elderly and/or*

[94] Open care in Cyprus includes all social services outside an institution.

Disabled Members). Public long-term care services are developed in the context of the national welfare and health care schemes.

The Public Assistance and Services Law[95] (supervised by the Ministry of Labour, Welfare & Social Insurance) covers every person who is legally staying in Cyprus and whose income fails to guarantee decent living standards. Besides rendering cash benefits the scheme also provides personal social services aiming at the empowerment and the socio-economic re-integration of the users.[96] The categorical sub-schemes are in principal influenced by the target group they cover and include the following forms of protection:

- community care services (home care[97] and day care centres) and residential care services (accommodation and care within specialized institutions)
- benefits in kind (home care by state home carers)
- social and financial advantages (cash benefits for the coverage of basic and special needs of the beneficiaries), as well as for their social and economic re-integration (ex. subsidy for their self-employment).

Personal social services focus on the coverage of needs of specific groups and, depending on the users' profile and the content of the care provided, they can be categorized as follows:

- Home care;
- Day care is provided in the Homes for the Elderly and the Adult Centres (which are subsidized through the State Subsidy Scheme) during the day and covers needs such as the preparation of meals, clothes laundry, entertainment etc.;
- Residential care is provided to persons whose need of constant care cannot be addressed by their family or through home care and day care services provided near their residence.

The *Scheme for the Provision of Social Aid for Improving Housing Conditions* provides a lump sum up to €12.000 to persons who are public assistance recipients or are just above the limits of public assistance scales[98], for building works, additions or alterations, with a view to improving their housing conditions. /As of 1/72014 the Scheme will be reformed and incorporated within the new Law on the minimum guaranteed income.

The *Scheme for the Reinforcement of Families for the Care of their Elderly and/or Disabled Members* aims at reinforcing families in order to enable them to keep their elderly and/or disabled members at home (with the addition of rooms and/or equipment and/or redesigning of areas) so that the need for institutionalisation will be avoided. The upper limit of the lump sum provision is €12.000. As of 1/7/2014 the Scheme will be reformed and incorporated within the new Law on the minimum guaranteed income.

For persons with disabilities, the *Persons with Disabilities Laws of 2000 and 2004* safeguard the right to independent living, social inclusion and equal participation in social and economic life.. Within this framework the Social Welfare Services operate Homes in the Community.

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95 It is regulated by the Public Assistance and Services Law of 2006 (as amended in 2012).

96 Care services include home care, day care, residential care and tele-care, and may be provided by the government, by non-governmental organisations and by the private sector (private for-profit enterprises).

97 Home care is provided by state, community and private carers with government subsidy for public assistance recipients, which also covers members of the family of the person receiving care when the family member stops working in order to offer the care required at home.

98 This scheme is targeted at persons in need of care due to old-age, physical and mental disability who receive public assistance and need to improve/change their housing environment to adapt their needs.

The Ministry of Health is responsible for the rehabilitation of the disabled persons immediately after their treatment. The recovery process takes place at Physiotherapy Centre and Paraplegic Wing, depending on the case. The functionality of the individual from health professionals is partially investigated, followed by restoration.

Currently, formal social care services[99] are provided by the private sector, the Social Welfare Services of the state and the community, i.e. NGOs or local authorities**.**

Given the absence of a public long-term care scheme and the limited number of active beneficiaries, no sustainability issues are seriously discussed. The long delay in introducing the NHIS affects also negatively the social care area, in the sense that fragmentation of rudimentary long-term care provision persists. Expenditure on long-term nursing care services amounts to a tiny 0.2% of GDP, which is among the lowest rates in EU-27.

A total of €2,1 mill. in 2012 was granted to NGOs by the Ministry of Labour and Social Insurance as a financial aid in organising, planning and running various programmes which are aimed towards elderly care

For the year 2012, 1,895 elderly received public assistance from the Social Welfare Services in order to pay their fees for residential care, and 4,146 elderly received financial aid in order to buy services for home care.

3. CARERS

In the mid to late 2000's formal home care provided by state carers showed a considerable decline. The number of persons served by private carers also declined significantly, whereas the number served by community carers expanded. One of the reasons for this tendency seems to be the reduction in the number of state carers (due to lack of interest by health and social care professionals), by about half.

In 2010, out of the 49.167 disabled persons aged 15+ in the country, 7.427 were accommodated in institutions and 42.190 were supported by formal home carers, informal carers or did not receive any support.[100]

The SWS monitors the provision of home care services to public assistance recipients, through the Social Services Officers regular visits at the house of the recipients and close cooperation with the NGOs and the local authorities that implement home care programmes.

Small scale client's satisfaction studies for long term care reveal that the majorities of elderly are satisfied with their carers and the quality of the services.[101]

4. POLICY AND RECENT DEVELOPMENTS

In order to secure regional coverage and equality of access to long-term care, the Ministry of Labour, Welfare and Social Insurance has been promoting a set of measures:

a) Through the State Aid Scheme, of the Social Welfare Services, under the Regulation 360/2012 of the Commission for the provision of services of general economic interest (known as De

99 Social care in Cyprus includes all services that address specific risks, not to be confused with cash benefits and benefits in kind.

100 LIPSYC, Barbara, SAIL, Etienne and XAVIER, Anna (2012): Long-term care: need, use and expenditure in the EU-27, European Economy, Economic Papers 469/2012.

101 GEORGIADIS, S. (2008)

Minimis), state aid is provided on an annual basis, to Non Governmental Organizations as well as Local Authorities for the operation of programs concerning the field of Social Care, including long term social care services for the elderly and people with disabilities.

(b) The Department for Social Inclusion of Persons with Disabilities operates a number of social benefits schemes and services regardless of income criteria, which aim to offset the cost of disability experienced by persons with disabilities and especially those with severe disabilities.

Presently there is no legislation regulating quality standards of home care despite the fact that it is provided by both the government and the private sector. But the Social Welfare Services (SWS) are working on the development of such a law which will regulate the provision of Home Care, set up the minimum quality standards, as well as the qualifications of the carers.[102]

[102] PAPATHEODOULOU, Irene and AGATHANGELOU Charalambos (2013).

5. BACKGROUND STATISTICS

Cyprus (CY)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	13.2	12.5	13.9	20.4	19.3	21.4	24.0	21.4	26.4	26.9	24.7	28.9	13.7		12.2		15.0	
80+	2.9	2.5	3.4	5.5	4.8	6.0	8.1	7.1	9.1	9.4	7.6	11.1	6.5		5.1		7.7	
85+	1.3	1.0	1.5	2.4	2.0	2.7	4.1	3.5	4.7	5.1	3.9	6.3	3.8		2.9		4.8	
80+/65+	22.2	19.9	24.2	26.8	25.1	28.3	33.7	32.9	34.4	34.9	30.6	38.4	12.7		10.7		14.2	
85+/65+	9.5	8.2	10.6	11.6	10.4	12.7	17.1	16.1	17.8	19.1	15.9	21.7	9.6		7.7		11.1	
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2		10.2		10.2	
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7		6.2		7.3	
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7		4.0		5.3	
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7		14.8		13.1	
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7		11.8		12.1	
Old-age dependency ratios, % [2]	**Cyprus (CY)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	20.8	19.7	21.7	51.1	45.7	56.7	30.3	25.9	34.9	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	13.2	12.2	14.1	35.8	31.1	40.7	22.6	18.8	26.6	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Cyprus (CY)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at birth	78.3		82.8	85.1		89.0	6.8		6.2	76.7		82.5	84.6		89.1	7.9		6.5
years at 65	17.8		20.0	22.5		25.3	4.8		5.3	17.2		20.7	22.4		25.6	5.2		4.9
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at 65	6.8		5.0	8.8		7.7	2.0		2.7	8.6		8.9	8.4		8.5	-0.2		-0.4
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
at 65 (%)	40.5%		26.2%	48.9%		37.6%	8.4		11.4	52.1%		44.5%	48.3%		40.4%	-3.8		-4.1
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.2			0.3			0.1			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

CZECH REPUBLIC

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Czech population is expected to grow from 3.9% to 11.4% (EU-28: 5.1%-11.8%), i.e. to almost treble but rising gradually over this time. At the same time the share of people 85+ will expand by more than a factor 3 from 1.6% to 5.9% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise considerably from 23.0% to 40.4% (EU-28: 27.8%-41.5%), and from 9.5% to 20.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 26.5% (EU-28: 29.9%) to all of 55.8% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 15.3/18.7 years (EU-27: 17.2/20.7) in 2010 to 21.2/24.5 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 1.7 and 1.9 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.8% to 1.6% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

The system of long-term care (LTC) in the Czech Republic, similarly as in some other EU countries, is not regulated by single scheme or legislation. The competencies for health and social component of long-term care (social and health services) are divided between health and social systems. LTC is not considered as a specific or separate sector of the social security system and health and social services are not regulated by a single legal scheme and administered by one single national and/or regional institution. Rather, long-term care services are provided within the health and social sectors.

Thus the social services and health/nursing care components of long-term care are provided by providers of health care and social services, which are registered, evaluated and operated according to different roles and legislation (for health care facilities or for social services). The health care elements are financed by the public health insurance system. Home health care services are provided by home care agencies that are financed from health insurance. Home health care is prescribed by general practitioners and delivered by home care agencies which are financed by the public health insurance system. A fee-for-service mechanism is used for the remuneration of health care provided by home care agencies. In-patient health care services for long-term patients are provided in establishments for long-term patients or in residential social care institutions (for example in “nursing units” of seniors homes). Health care in residential social care facilities includes especially nursing care, health monitoring, help with medication etc.. The health care provided in residentialsocial care homes are financed directly by health insurers on fee-for-service basis. Health establishments for long-term patients are financed predominantly by health insurers. Discrepancies in funding of health care for

patients in health facilities for long-term patients and in residential social care homes is one of the weak points in the long term care system in the Czech Republic.

Social and personal care, including basic nursing care services are provided either by informal carers (family members etc.) or by professional providers of social services or by a combination of both. Providers of social services are registered by regional authorities. If registered they have to follow the price regulation (limits on charges, which can be paid by users) imposed by the Ministry of Labour and Social Affairs, but they also become eligible for public subsidies. Unregistered providers of social services (e.g. residential homes for seniors) are free in their pricing policy; however they have to cover all the costs of their services from the payments of recipients. The price regulation stipulates maximum prices for individual social services. Some services, e.g. social prevention or social rehabilitation are provided free of charge for recipients. For residential services the price regulation determines a ceiling for accommodation and catering more or less equivalent to an average pension in the Czech Republic[103] and the law on social services stipulates that maximum 85% of an inhabitant's pension can be transferred to a residential social care institution to cover the costs of a full-time inhabitant.

Social services are provided according to a contract between a recipient of social services and a registered provider of social services. The recipient pays for social services out of his/her own financial means or financial means of his/her relative. In addition, care recipients are eligible to care allowance (cash benefit) based on the level of the recipient's need for support due to health impairment and disability (the needs of care are assessed by a public medical assessment service in co-operation with the social situation assessment which is prepared by social workers in homes of a claimant). There are four levels; the highest level of dependency entitles a recipient to a care allowance of around half of the average salary and slightly more than the average pension in the country. Care allowances are only means-tested for recipients below 18 of age.

As regulated recipients' payments cover only part of costs of registered providers of social services these are entitled to receive public subsidies for their operations. Subsidies are granted by the Ministry of Labour and Social Affairs through offices of regional governments. Subsidies are also provided by municipalities, but there is no formal regulation governing the amount of these latter subsidies.

The Czech law on social services recognizes as one of forms of provision of social services so called sheltered housing. Sheltered housing, which is getting increasingly popular, presently represents about 7 % of the number of dwellings reserved for seniors and new sheltered housing units are established in such a steady tempo that so far it has prevented waiting list from growing.

The quality of services is supervised from within the health care system and social services systems separately. Regarding quality assessment in social care establishments, there is a set of mostly structural and procedural standards of quality for provision of social services developed by the Ministry of Labour and Social Affairs. Care providers are checked on sample basis by regional authorities. Informal carers can be checked as well.

[103] Slightly more than 400 EUR a month

The current share of public financing of long-term care comes to around 0.8 % of GDP. According to prognoses under different scenarios[104] the share of public funding of long-term care would grow to between 1.3 and 1.6% of GDP in 2060 provided current policies are continued.

3. CARERS

According to national statistics the number of personnel in formal care comes to about 57.000 with about half working in social services. In all per 1000 persons aged 65+ the Czech Republic has 42 social care beds and 24 nurses or personal carers.

The care allowance, to which persons in need of care are entitled, is provided at four levels[105] depending on the extent of support needed (expressed as the number of personal activities for which the person is disabled). The allowance can be used for purchasing of formal social services from registered providers or it can be used as a form of compensation to informal carers.

Regarding usage of the care allowance, more than two thirds of recipients don't use any social services provided by registered providers, slightly less than 20% of them use residential social services, slightly less than 10% use home services and less than 5% use ambulatory social services[106]. The three fifth of recipients who don't use residential social services use the care allowance for coverage of costs of drugs that are not covered or are only partially covered by the public health insurance scheme. Only a limited share of recipients use their care allowance for the purpose of informal care (e.g. only 10 % use it for paying an informal personal carer).

In the Czech Republic, more than 80 % of care for the elderly in need is provided by the family. The average period in which care is provided is 4 to 5 years. The persons providing informal long-term care are mostly women. The dependent elderly persons are looked after by adult children (around 50 %) and spouses (around 20 %), by other relatives (10 %) or by friends (around 15 %). The average daily time of care depends on the level of dependency. It is about 6.5 hours for the first level, around 10 hours for the second level, around 16 hours for the third level and finally around 18 hours a day for the fourth level.

The principal informal carer from the family of the recipient of the care allowance receives various benefits as compensation for their engagement. Firstly, the care allowance is not considered as taxable income and it is not taken into account in any other state allowance system. If a person also cares for a child below 7, he/she can still get the parent allowance. The period during which care is provided is recognized as a so called substitution period qualifying for the state pension system (care crediting). The principal informal carer person is exempt from paying health insurance contributions. He/she is considered as a so called "state" insured for whom the state pays contributions. There are no constraints relating to other earning activities of the caring persons.

There are requirements for professional social workers that include either formal education (secondary or university) in specific fields or a specialized education provided within accredited

[104] See Long-term care in ageing societies - Challenges and policy options, Commission staff working document, Brussels, 2013

[105] First grade-800 Kč monthly (around 32 EUR), the fourth grade- 12 000 Kč (around 480 EUR)

[106] PRŮŠA, L. Ekonomická efektivita zajišťování péče o příjemce příspěvku na péči, VÚPSV, v.v. i. Praha, 2013 (Economic effectiveness of ensuring of care for recipients of contribution for care)

educational programs lasting at least 200 hours and a period of practice in the field of provision of social services (5 or 10 years depending on the grade of formal education). The Ministry of Labour and Social Affairs is in charge of accreditation of educational centres.

The average wage of workers providing health and social services comes close to the average salary in the Czech Republic (currently slightly less than 1 000 EUR). Workers in the health care sector are paid a bit better than workers in the social care sector.

4. POLICY AND RECENT DEVELOPMENTS

There is traditionally a rather high share of institutional long-term care in the Czech Republic. Thus there is a relatively high number of beds in residential long-term care institutions. There is also a considerable backlog of unsettled applications for residential long-term care in social care homes making for substantial waiting lists. While institutional long-term-care is clearly more costly than home care the differences in net public costs are much smaller due to the fact that more than 50% of the costs of institutional care is covered by the care recipients themselves and that the social contributions and taxes collected from the personnel of these institutions nearly equal the public subsidies granted to them. So, the rationale behind shifting from institutional long-term care to home care is not so much in sustainability of public funding as in quality of life of recipients of long-term care when care is provided in their private homes rather than in institutions.

One of the expectations when the care allowances were introduced[107] was that that the recipients would use it to pay for formal home social care services. Thus it also aimed at fostering the development of formal social care services delivered to people in their private home. This expectation was not met as only less than 25 % of recipients of care allowances used it at least partly for purchasing formal social services. Subsequently, proposals are emerging for mandatory use at least a part of the care allowance to pay for the use of formal social services. The general objective of moving from institutional to home care and of developing formal home services has been declared by the government. Nevertheless it is not easy to set up incentives for achieving them in practice.

Care coordination between various social and health services and informal carers is not very developed and differs from place to place.. Provided the dependant person is not in an institutional establishment it is still more or less up to the family of a dependent person to arrange coordination of long-term care. Recently, a legislative proposal foresaw that the community nurse should take over the coordination of long-term care within a community. The legislation has not been passed yet.

[107] In 2007

5. BACKGROUND STATISTICS

Czech Republic (CZ)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	16.8	14.0	19.5	22.2	19.4	24.9	26.5	24.2	28.8	28.3	26.0	30.5	11.5	12.0	11.0
80+	3.9	2.5	5.1	6.5	4.8	8.1	8.0	6.3	9.7	11.4	9.6	13.2	7.5	7.1	8.1
85+	1.6	0.9	2.3	2.7	1.8	3.5	4.3	3.1	5.5	5.9	4.6	7.1	4.3	3.7	4.8
80+/65+	23.0	18.1	26.3	29.2	25.0	32.4	30.1	26.0	33.5	40.4	37.0	43.3	17.4	18.9	17.0
85+/65+	9.5	6.6	11.6	12.0	9.2	14.1	16.1	12.7	18.9	20.7	17.7	23.3	11.2	11.1	11.7
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Czech Republic (CZ)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	26.5	21.4	31.6	55.8	49.9	61.9	29.3	28.4	30.3	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	15.5	11.8	19.2	40.0	35.2	45.1	24.6	23.3	25.9	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Czech Republic (CZ)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	74.3	80.4		83.2	87.8		8.8	7.4		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	15.3	18.7		21.2	24.5		5.9	5.8		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	6.6	7.0		8.3	8.9		1.7	1.9		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	45.8%	39.5%		53.2%	46.4%		7.4	6.9		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.8			1.6			0.8			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

GERMANY

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the German population is expected to grow from 5.4% to 13.4% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3 from 2.6% to 8.5% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 26.3% to 41.4% (EU-28: 27.8%-41.5%), and from 12.4% to 26.2% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 33.9% (EU-28: 29.9%) to all of 64.6% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.4/20.6 years (EU-27: 17.2/20.7) in 2010 to 22.4/25.4 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 0.3 and 1.0 year, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.4% to 3.3% (EU-27: 1.8%-3.6%), assuming that the current law remains unchanged, the share would remain almost constant.

Estimates of the number of LTC dependent elderly in 2030 ranges from 3.17 to 3.37 million. By 2050 around 4.4 million people are expected to be in need of LTC. Yet current projections of LTC demand have to be interpreted carefully as they are likely to be updated once more detailed information of the German population census of 2011 is published.

2. CURRENT LONG-TERM CARE PROVISION

The social and private long-term care insurance (LTCI) were introduced on 1 January 1995 as a compulsory insurance to cover a portion of long-term care nursing costs. All persons insured by social health insurance (SHI) funds were automatically assigned to the respective social LTCI funds and all those insured by private health insurance companies (PHI) to a private LTCI. Therefore, every health insurance funds resp. company includes a separate long-term care insurance funds resp. plan.

In 2013, according to the Federal Ministry of Health, 69.8 million citizens were covered by social LTCI and 9.5 million citizens by a private LTCI. There are no differences in benefits between social and private LTCI. Premiums for social LTCI are independent of the individual's health risk and calculated as a fixed proportion of the insured person's labour income, which is 2.05% in 2013. Insured persons without children have to pay 2.3%. Employers bear almost one half of it and children and spouses with no substantial individual labour income are co-insured without extra costs. By contrast, private LTCI premiums are not connected with income, but with age at enrolment into the private health insurance. However, there is a statutory upper limit set for the individual amount of premiums to the compulsory private LTCI.

In 2011, there were 12,354 nursing homes and 12,349 home care providers: 41% of all nursing homes were private-for-profit, 54% private-not-for-profit and 6% public. In home care, 63% of providers were private-for-profit, 36% private-not-for-profit and 1% public. Market shares (measured in number of care recipients) are slightly lower for private-for-profit providers because they are smaller on average.

In general, there are three different arrangements through which a recipient can receive LTC: care allowance, home care (in kind), and residential care. Care allowance refers to so-called informal care, i.e. the person in need of care receives only monetary support, typically lives at home and is looked after by close relatives. Home care (in kind) means that a professional care provider visits the recipient regularly at home. The provider is directly paid by LTCI (unless the care received exceeds the appropriate level of benefits so that a difference has to be beard by the person in need of care; see below). Residential care refers to either short-term or long-term stay in a nursing home.

In 2011 2.5 million people received benefits from social or private LTCIs. Of these, 1.18 million got a care allowance, 0.58 million received home care in kind and 0.74 million residential care (including beneficiaries of short-term residential care and day care benefits in kind). The number of recipients has risen by 24% per year between 1999 and 2011. At the same time total expenditure of the social LTCIs has grown by 35% from 16.3 to EUR 22.0 billion.

The LTCI distinguishes between three levels of increasingly severe care needs. In level I extensive care of at least 90 minutes per day is assessed to be needed. People in level II (severe care) are assessed to be in need of at least 180 minutes of care per day, and in level III (most severe care) recipients are assessed to need at least 300 minutes of care per day. If the need for care exceeds level III by far (so called hardship cases), it is possible to apply for further assistance. Furthermore, the beneficiary is supposed to be in need for care at least for six months. The expected time in need for care and the level of care is formally assessed by an independent Medical Review Board of the Statutory Health Insurance Funds (MDK) for the social LTCI and by an equivalent body for the private LTCI. Furthermore, people with "erheblich eingeschränkter Alltagskompetenz" – i.e. people with dementia, mental handicaps or comparable mental-health problems – are entitled to receive additional support, regardless of the care level assessed. The assessment of the "erheblich eingeschränkte Alltagskompetenz" is assigned to the MDK and the equivalent body for the private LTCI, too.

Every LTCI funds resp. company pays the same fixed benefits according to the level of care, but irrespective of the price for the actual goods and services. Thus, the person in need of care has to bear the difference[26]. If recipients or their children or near relatives cannot pay the total difference out of their income or other assets, the difference has to be covered by the social assistance scheme (Support for care - *Hilfe zur Pflege*, §§ 61 ff. SGB XII). Meanwhile, the definition of being in need of care is wider in the social assistance law. Even persons with a temporary impairment, i.e. less than six months, or with less need for support than needed in care level I can apply for *Hilfe zur Pflege*.

Between 1996 and 2007 there was quite no change in the nominal amount of the benefits, which therefore gradually lost its real value. Monthly benefits were increased for the first time by the

[26] In 2009 the social and private LTCI bore roughly 50% of residential and 54% of home care (in kind) costs (Statistisches Bundesamt 2011a).

reform act Pflege-Weiterentwicklungsgesetz [27] in 2008, with higher increases especially for home care and care allowance to strengthen both types of arrangements in comparison to residential care ("*care at home prior to residential care").* The rising of those benefits enacted by the Pflege-Weiterentwicklungsgesetz took effect in three steps in 2008, 2010, and 2012. From 2014 onwards benefits will be assessed every three years and possibly adjusted to keep up with general price inflation. This will happen for the first time in 2015.

Care coordination has for long been a major issue in LTC provision but a determined effort to overcome this problem was launched with the LTCI reform in 2008 which committed the various involved actors to secure a better coordination and integration of the involved systems. Also as of 1 January 2009, every person in need of care obtained a legal claim to help and support through a long-term care counselor. Counseling for persons in need of care and their relatives is provided by case managers employed by long-term care insurance funds at a long-term care support base or through qualified experts.

Table 1. Benefits of LTCI in EUR per month

		1996-2007	2008	2009	2010-2011	2012-2013[108]
Residential care						
	Level I	1,023 €	1,023 €	1,023 €	1,023 €	1,023 €
	Level II	1,279 €	1,279 €	1,279 €	1,279 €	1,279 €
	Level III	1,432 €	1,451 €	1,470 €	1,510 €	1,550 €
Home care (in kind)						
	Level I	384 €	402 €	420 €	440 €	450 €
	Level II	921 €	951 €	980 €	1,040 €	1,100 €
	Level III	1,432 €	1,451 €	1,470 €	1,510 €	1,550 €
Care allowance						
	Level I	205 €	210 €	215 €	225 €	235 €
	Level II	410 €	415 €	420 €	430 €	440 €
	Level III	665 €	670 €	675 €	685 €	700 €

Source: Bundesministerium für Gesundheit (2013).

The principle of "*rehabilitation prior to care*" has been a prominent but difficult issue in Germany so far. Reimbursement regulations for rehabilitation measures also may pose a problem in this regard by setting inconsistent incentives: health insurance funds have to pay for rehabilitation measures, but it is not only them (e.g. by reducing costs curing chronic disaeases) but as well the LTCI that reap the benefits from cost savings regarding less intensive care. Furthermore, additional expenses for rehabilitation measures are fully borne by the individual funds. Against this background, HI funds may feel that there ist not enough economic incentive to offer rehabilitation measures, even though they are by law obliged to do so. The recent reform puts more pressure on insurance funds/companies. Since 2013, every new applicant for benefits from LTCI has to receive recommendations for potential rehabilitation measures.

[108] Increased supplementary benefits for persons with a considerable general need of care due to "severely impaired daily living skills ("erheblich eingeschränkte Alltagskompetenz"), e.g. Alzheimer's diseases, from 2013: long-term care allowance: care levelzero: 120 Euros, care level I: 305 Euros, care level II: 525 Euros; Home care in kind: care level zero: 225 Euros, care level I: 665 Euros, care level II: 1,250 Euros.

For the assessment of efficiency, quality of care has to be measured. To this end, so called transparency reports for formal care have been introduced in Germany in 2009. Both home care providers and nursing homes are audited yearly by the MDK of the LTCIs. The MDK rates every nursing home with 77 standardised items in five dimensions: (i) care and medical provision, (ii) interaction with people with dementia, (iii) social assistance, (iv) board and lodging, (v) interviews of the people in need of care; the instrument for home care providers comprises 49 items. The underlying guidelines are regularly adapted to the latest innovations in medical and nursing care so that the most recent scientific findings in terms of appropriate patient care play a role in the inspection. The results of the audits must be published in a manner that is easily understandable and consumer-friendly. However, some critics maintain that the items refer not enough to outcome quality as most of them are about structural and process quality. There also was some criticism that equal weighting of all items would make it possible to compensate "bad quality" in care by "good quality" in other services. A revised version of the auditing and transparency rules for care homes reacting on these debates came into force at the beginning of the year 2014; furthermore the introduction of new instruments concentrating on outcome indicators for care home quality has been initiated. [28].

3. CARERS

In total, around 661,000 people (480,000 full-time equivalents, FTE) have been working in nursing homes in 2011, while approximately 291,000 (193,000 FTE) have been employed by home care providers. The figures regarding nurses with at least a three-year vocational training are substantially lower: In FTE, approximately 171.000 nurses have been working in nursing homes and 106.000 as home care providers. The average monthly gross income of employees in nursing homes[29] was around 2 800 € in 2012. In Germany, there is already an intensive public debate about the current and expected lack of qualified nurses. Providers report difficulties in finding qualified personnel. Several measures have already been implemented to alleviate it: Apart from general measures such as increasing the number of full-time employed, the attractiveness of the job of a LTC nurse is discussed broadly. Immigration of qualified nurses from outside Europe is promoted. An increasing number of LTC nurse trainees is to be reached by fostering existing vocational measures combined with additional financial incentives in the context of the "Ausbildungs- und Qualifizierungsoffensive Altenpflege". Furthermore, the German government ist working on new regulations for the three-year vocational training for nurses, based on propositions developed by a commission of *Länder and Bund.*. So far, nurses for the elderly, nurses for children and nurses for acute-care of adults have separate vocational trainings. It is planned to merge all three in one general vocational training for nurses in order to enhance attractiveness and to broaden job perspectives. Additionally, nursing courses are expected to be introduced on an academic level.

Currently, the majority of people in need of care receive either a care allowance or home care in kind, which is in line with the principle "care at home prior to residential care". The typical scenario is that either spouses or children between the ages of 50 to 65 years care for the beneficiary. Official numbers of these informal carers, i.e. persons caring non-professionally, are not available. However, under certain circumstances informal carers are eligible for being insured

[28] See Hasseler and Wolf-Ostermann (2010) or Weibler-Villalobos and Röhrig (2010) for a more detailed discussion.
[29] Figures relate to monthly gross income (including special payments) of qualified employees working full-time in nursing homes. (Fachserie 16, Verdienststatistik des Statistischen Bundesamtes)

in the social pension insurance (SPI). Around 414.000 informal carers were insured in SPI in 2010. Informal carers are eligible, if they care for someone in need of care at least 14 hours per week. Since January 1st 2013 to fulfil the minimum of 14 hours a week, the informal care provided to more than one beneficiary can be added up. The LTCI of the person in need of care pays the contributions to SPI for the informal carers, if

- the informal carers live in European Economic Area or in Switzerland,
- they care for at least 60 days per year, and
- they are not gainfully employed for more than 30 hours per week, and
- they are not already receiving a full old-age pension.

Since the generation between 50 and 65 years belongs to the so-called baby boomers, their number will increase in this decade. Therefore, there might be an increasing potential of informal care by family members. However, once the baby boomers will reach the age of 80 themselves, starting from 2025, family members will become rarer and thereby increasing demand for professional care is to be expected.

Since 2008, a person who provides home care to a close relative assessed at not less than care level I has had a right to care-giving leave. This is an unpaid leave from work of up to six months with continued social insurance coverage (Act on Caregiving Leave). This leave may only be taken if the caregiver's employer employs more than 15 persons. The employer must be notified in writing ten days before the caregiving leave is taken up, including information about the dates and duration of the leave. Moreover, employees are entitled to a leave of up to 10 days if they need this time to organise long-term care for a close relative in a situation of urgency.

In January 2012 a new legislation for employees caring at home came into effect (Family Caregiver Leave Act). Employees with a family member in need of care at home are allowed in agreement with their employer to reduce their working hours to a minimum of 15 hours per week during a maximum of two years. Their employers can top up the reduced salary by half of the difference between the old and the new salary with an interest free credit from the *Bundesamt für Familie und gesellschaftliche Aufgaben*. Afterwards, the employee has to work full-time until the credit is paid back. The new government has indicated its intention to further improve possibilities for the reconciliation of work and informal care responsibilities.

The Coalition Agreement stipulates that "acting as a caregiver to another person takes time, and the caregiver must be able to reconcile these responsibilities with their work. We will combine the possibilities offered by the Act on Caregiving Leave and the Family Caregiver Leave Act under one roof and take them forward in an effort to further promote the compatibility of caregiving tasks and the world of work. Building on the provisions in place, we will link the ten days' leave for relatives who have to organise new long-term care arrangements at short notice with a wage replacement benefit along the lines of the child sickness benefit."

4. POLICY AND RECENT DEVELOPMENTS

4.1 Act to Reorient the Long-term Care Insurance

The Act to Reorient the Long-term Care Insurance ("Pflege-Neuausrichtungs-Gesetz"[30] - PNG), coming into effect partly on October 30th 2012 and partly on January 1st 2013, improved a number of benefits, e.g. the benefits of respite care and short-term residential care for persons receiving care allowance. (The benefits of respite care and short-term residential care cover the following: If the informal carer gets sick or goes on holiday, for example, the LTCI pays benefits for up to four weeks of respite care or short-term residential care, but not more than 1,550 € per year, each). Since the PNG came into effect, the beneficiary of the a care allowance still gets half of it during times of respite care or short-term residential care. However, concerning respite care the informal carer has to take care of the recipient for at least six months prior to application.

The Pflege-Neuausrichtungs-Gesetz (PNG) further strengthened care allowance and home care by (1) raising supplementary benefits for people with dementia or rather with "erheblich eingeschränkter Alltagskompetenz") -, and (2) introducing “domestic support” (Häusliche Betreuung) as a new category of home care in kind. Now, people with dementia can receive a greater range of benefits, even if they are not eligible for care level I yet or they get additional benefits in care levels I and II. Domestic support refers to communication, keeping up an adequate day structure or activities for maintaining social contacts in or near the domestic environment, for example.

The contribution rate to the social LTCI increased by 0.1 percentage points to finance these additional expenditures. This will raise roughly additional EUR 1.1 billion for the social LTCI per year. However, these measures will not suffice to finance the strong increase in demand for care in the years to come. Without further reforms the capital reserves of LTCIs will decrease in the future.

Taking into account the character of "partial coverage" of the LTCI, the PNG introduced an additional private LTCI-plan option for insured persons subsidized with a maximum of EUR 60 per year. However, as insurance companies are not allowed to perform a medical risk assessment, i.e. nearly everyone (everybody except people already receiving or having received LTC benefits) is allowed to join the plan, However, as the existing data proves, this has not happened up to now (i.e. 40 per cent of insured are younger people.) Given that non-subsidized insurance plans with medical risk assessment already exist in the market, a risk selection was expected by several scientists. However, as the existing data shows here that in January 2014 already around 400,000 people signed additional subsidized insurance plans. Furthermore, as the additional insurance is voluntary, the uptake was expected to be insufficient. Although, as the case may be, additional benefits from subsidised, voluntary long-term care insurance contracts can close an individual's funding gap, it is unlikely that this will be the case with the entire community of the insured.

[30] Pflege-Neuausrichtungs-Gesetz: Law on reorienting LTCI.

4.2 Legislation to strengthen the Long-term care system ("Pflegestärkungsgesetze")

The Federal Government intends to introduce a new assessment tool and the according new definitions of care during the current legislative period with a reform to be conducted in two steps. A first reform act is to be enacted to introduce improvements of benefits quickly. The first step of the reform especially aims to increase the individual adaptivity of benefits, broaden the range of services available and improve the reconcilability of care and career, e. g. by strengthening the benefits for day care. The legislative procedure for the first reform step has already begun: Adopted by the Federal Cabinet on 28th May 2014, the Bill for a Fifth Act to Amend Social Code Book XI (*Fünftes SGB XI-Änderungsgesetz - "Pflegestärkungsgesetz* 1") will implement major elements of the first step towards strengthening the long-term care insurance as envisaged in the Coalition Agreement. The Act is due to become effective on 1st January 2015.

The Bill expands the benefits and services provided under the long-term care insurance and renders them more flexible - also in view of the introduction of the new definition of long-term care needs envisaged for the next step. Additionally, benefit amounts will be adjusted to factor in price increases of recent years To mitigate the impact of demographic change, moreover, a long-term care provident fund ("Pflegevorsorgefonds") will be introduced.

In respect of home care, particularly if provided by relatives or outpatient nursing services, the Bill facilitates near-term benefit improvements to the tune of approx. 1.4 bn euros. Also, the Bill includes more flexible arrangements for and the expansion of benefits in the fields of short-term residential care, stand-in (respite) care, day care and night care. Benefits will be easier to mix and take up and so ease the burden on beneficiaries and their family caregivers At the same time, the benefit rates of the long-term care insurance will be increased by 4 per cent across the board (2.67 per cent for the benefits only introduced in 2012 under the Act to Reorient the Long-term Care Insurance.) This serves to accommodate the price increases of the last three years.

The supplementary benefits provided for so-called low-threshold care offers will be upgraded, as well. New additional relief benefits will be introduced. Moreover, the above mentioned additional supplementary care and relief benefits which up to now only insurance members with considerable general need of care due to severly impaired daily living skills ("erheblich eingeschränkte Alltagskompetenz"), e.g. Alzheimer's diseases, were eligible to, will be accessible to all persons with care needs - even those with predominantly physical impairments, i.e. whose daily living skills are not severely compromised. This will facilitate home care and support family caregivers. Moreover, the maximum rates for measures to improve the person's living environment and for comsumable nursing aids will be markedly raised. All of these benefit improvements taken together will go a long way towards ensuring that persons with care needs can stay longer in their own home.

However, also in the residential sector, the long-term care insurance benefits will be enhanced and raised by approx. 1 bn euros especially in residential care settings. Moreover, the companion caregiver ("zusätzliche Betreuungskraft") to resident ratio will be enhanced from 1:24 to 1:20 for additional companion care offers and the renumeration supplement for this auxiliary staff providing assistance for persons in need of considerable general care will be expanded to all residents. The additional number of caregivers will also tangibly improve nursing routines in residential institutions.

The contribution rate will be raised by 0.3 percentage points. The envisaged benefit improvements will be funded from the revenue from 0.2 percentage points (ca. 2.4 bn euros annually). The revenue from the remaining tenth (approx. 1.2 bn euros annually), will go towards the establishment of a long-term care provident fund in the form of a dedicated fund to mitigate the consequences of demographic change. This is a new element in the long-term care insurance system. This new element builds on future generations and their performance potential. Specifically, the resources from this fund will, from 2035, serve to stabilise the contribution rates to the long-term care insurance precisely at the time when the baby boomers (1959 - 1967) are likely to develop their care needs.

In many places, persons with long-term care needs will receive the same benefits, irrespective of whether their impairments are predominantly physical or cognitive. This will make it easier to introduce the new definition of long-term care needs. Under this definition, no distinction will be made between persons who need care for physical reasons and persons who have care needs due to cognitive impairments. In a second reform step within this legislative period the Federal Government intends to introduce a new assessment tool and the according new understanding and definition of the need of care. The new assessment tool currently is put to the test in practice with a close monitoring by nursing scientists; reports are due at the end of this year.

5. BACKGROUND STATISTICS

Germany (DE)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	20.7	18.2	23.2	27.8	25.6	29.9	31.4	29.2	33.6	32.3	30.2	34.4	11.6	12.0	11.2
80+	5.4	3.8	7.0	8.1	6.6	9.6	12.5	10.7	14.2	13.4	11.5	15.2	8.0	7.7	8.2
85+	2.6	1.5	3.6	4.6	3.5	5.6	6.3	5.1	7.5	8.5	7.0	9.9	5.9	5.5	6.3
80+/65+	26.3	21.0	30.3	29.2	25.8	32.0	39.8	36.8	42.4	41.4	38.1	44.3	15.1	17.1	14.0
85+/65+	12.4	8.4	15.4	16.5	13.7	18.7	20.2	17.5	22.5	26.2	23.0	28.9	13.8	14.6	13.5
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Germany (DE)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	33.9	28.9	39.0	64.6	58.7	70.8	30.8	29.9	31.8	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	24.0	19.8	28.3	46.2	41.3	51.3	22.2	21.5	23.1	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Germany (DE)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	77.6	82.7		84.8	88.9		7.2	6.2		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	17.4	20.6		22.4	25.4		5.0	4.8		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	6.4	5.9		6.7	6.9		0.3	1.0		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	37.9%	29.4%		32.3%	37.0%		-5.6	7.6		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.4			3.3			1.9			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

DENMARK

1. DEMOGRAPHIC BACKGROUND

Although the ageing of the Danish population is more moderate than the average in the EU27 it is still marked. In the period 2013-2060 the share of people aged 80+ in the Danish population is expected to grow from 4.2% to 9.2% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by nearly a factor 3 from 2.0% to 5.8% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 23.3% to 39.5% (EU-28: 27.8%-41.5%), and from 11.5% to 23.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 30.6% (EU-28: 29.9%) to all of 45.9% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 16.8/19.5 years (EU-27: 17.2/20.7) in 2010 to 22.0/25.1 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women decreased by 2.6 and 1.1 years, respectively, although its levels are still above the EU average.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 4.5% to 8.5% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

The Danish system of LTC services for the elderly is among the most extensive in the EU. Earlier and more than other countries, Denmark has given explicit policy priority to community care over residential care, to enable older persons with LTC dependency to continue living in their own homes.

The goal of Danish eldercare is to increase the quality of life of senior citizens and their ability to manage independent living. Denmark's overall objective for long-term care policy calls for services to ensure continuity in older persons' lives even if they become ill and infirm. Older persons in need of personal assistance and care are to be offered help. For elderly with few to moderate limitations assistance aims at helping recipients to help themselves and to remain active, with the starting point being enabling the recipient, to the greatest extent possible, to perform (or participate in) as many tasks of daily living as possible.

In support of this aim the system is currently undergoing a process of further of restructuring with an increased focus on preventive health care and rehabilitation. In particular efforts seeks to strengthen re-enablement to raise and maintain capacities for independent living and well-being and so as to free up resources for tending better to those with more severe needs.

Any person who develops a need for LTC is entitled to receive personal care and help with practical tasks, irrespective of income or wealth. There are no minimum requirements in terms of impairments to receive personal and practical help. After an individual assessment, the help needed is to be provided, even if the required time for help is less than two hours per week.

The system is organized locally in 98 municipalities and financed by local taxes and general revenue based on block grants from the state. In accordance with national legislation the municipality decides on the content and scope of services and is responsible for ensuring that the individual receives the necessary care. Once a year the municipality publishes "a quality standard ". The standard is primarily intended for citizens and entails information on the quality of care they can expect in case they need help. Among other things it entails information on staff competences and the demands municipalities place on private providers of homecare.

Citizens, who are in need of long-term care, may reside in institutional care facilities, receive homecare in their own homes or receive informal care. The bulk of persons in need of long-term care receive home help and home (nursing) care while institutional care is concentrated on those most in need of care and monitoring.

Those in need of care who are living in their own home or in special dwellings for the elderly are eligible to receive home nursing, home care and practical help. Health services include health promotion. Home help includes rehabilitation and refers to personal care services (i.e. assistance with activities of daily living, ADL) and domestic tasks (e.g. shopping, meal preparation and cleaning IADL). Additional measures to help enable care recipients to remain active are also included (e.g. through participation in mentally and physically stimulating activities in daycentres).

Home help is granted following a concrete and individual assessment of the recipient's functional abilities and needs based on the local council's adopted service level. Since 1996, people aged 75 and older have been entitled to annual 'preventive' visits from a case manager employed by the municipality in order to evaluate individual needs and assist with planning for independent living. Assessments have to be multidimensional and comprise all aspects of the individual's well-being, i.e. functional ability, welfare, life content, home conditions and possibilities of self-determination. They also include a review of medication, rehabilitative support, visitation and referral to specialists or other health care professionals if needed. Clients needing formal care are further assessed by a home-care manager, and the resulting care plan ends up as a contractual specification for the services needed. There are no pre-defined categories of dependency, but the applicant will be classified along a continuum of dependency according to his/her specific needs. If the client disagrees with the allocation of services, the allocation decision can be appealed.

Policies with a preventive aim are also focused on establishing a larger stock of age-suited dwellings and securing investments in a better physical infrastructure to achieve a more age-friendly environment. The objective is for older people as they age to have good conditions for a healthy, well-functioning and high-quality life and thus preventing or postponing the need for home help and care.

To manage the rise in LTC needs with the ageing of the population authorities are now placing more and more emphasis on self-care, and effective preventive, re-enabling and health-promoting activities. Local authorities are also increasingly seeking to mobilise the positive resource network that relatives represent for older and disabled persons.

In 2012 132.810 persons above the age of 65 received permanent homecare in their own home. On average recipients received 3.6 hours of homecare per week. Current developments in the number of people receiving homecare and the average amount of hours allotted are influenced by general improvements in the health of the elderly, by the municipalities' new emphasis on rehabilitation measures and the greater use of welfare technology that enable citizens to stay

independent for a longer period of time, and by overall efforts to streamline the long-term care sector.

Table 1: Homecare to citizens above the age of 65: Key figures

	2008	**2009**	**2010**	**2011**	**2012**
Total users of homecare services	154,571	153,669	148,955	140,276	132,810
Users receiving personal care only	14,419	14,485	14,475	14,252	14,745
Users receiving practical help only	74,606	74,383	71,297	67,076	62,484
Users of both personal care and practical help	65,547	64,801	63,184	58,948	55,582
Total allocated hours per week	558,742	553,260	539,563	487,221	466,175
Allocated hours for personal care, total per week	430,353	433,707	426,914	387,981	378,272
Allocated hours for practical help, total per week	128,389	119,553	112,649	99,240	87,903
Total allocated hours per week per user	3.7	3.7	3.7	3.5	3.6
Allocated hours for personal care per week per user	5.5	5.6	5.6	5.5	5.5
Allocated hours for practical help per week per user	0.9	0.9	0.8	0.8	0.8

Source: Statistics Denmark, Statistics bank tables AED06, AED021 and AED022.

3. CARERS

In 2012, about 60.600 persons were employed by municipal authorities as professional carers working either with older people or disabled children and adults. 'Social and health assistants' and 'social and health helpers' constituted by far the two largest categories of employees.

Table 2: Municipally employed professional carers servicing older and disabled persons

	Fulltime Workers	Part time Workers	Hourly Workers	Total
Social- and health Assistants	2.779	11.142	397	14.318
Social- and Health Helpers	3.895	24.372	1.184	29.451
Nursing Assistants	471	3.678	109	4.258
Homecare Assistants	204	1.312	47	1.563
Staff with no social- or health education	681	1.819	2.290	4.789
Other Social- and Health professionals	23	27	32	82
Nurses	1.337	4.644	123	6.104
Total	9.389	46.994	4.183	60.566

Source: The Homecare Commission, 2013: p. 88

As elsewhere informal carers are primarily spouses and children or grandchildren. But due to the extensive access to formal LTC services informal carers tend to deal only with light to moderate cases of dependency. There is also a growing number of volunteers providing various forms of care to people in need of LTC. The municipal council offers substitute or respite services to spouses, parents or other close relatives caring for a person with impaired physical or mental functions.

4. POLICY AND RECENT DEVELOPMENTS

The move from institutional to home care started in the beginning of the 1990s under the banner of 'as long as possible in one's own home'. Hence, there is a long tradition of trying to support continued independent living, also when people as they age may develop an increasing need for support with IADL and ADL activities.

Across political parties, municipalities and interest groups there's an increased focus on preventive health care and rehabilitation for older people and in 2012 an extra DKK 26.5 million was allocated to qualify the work with rehabilitation in the municipalities.

Over the last 15 years the government and many municipalities have invested in a multitude of innovative pilot projects focused on the rationalisation of LTC provision and enhancing the capacity for independent living of frail older people including with the help of smart ICT etc.

In 2013 98% of the municipalities offered some form of rehabilitation as part of their program of elder care. The application of re-enablement measures in the municipality of Fredericia have made a positive demonstration of the possibilities in innovative approaches that seek to mobilise the mental and physical resources of older people with LTC needs for continued independent living with less support and more self-care. Here the rehabilitation programme is carried out by a specialised unit with therapists, who draw up individual rehabilitation plans and co-operate closely with social and healthcare assistants, who work as home trainers for the participants. The results from this and the many other innovative practises are informing ongoing restructurations of the LTC sector.

In the last few years two commissions have analysed present services and developed recommendations for how to improve and adjust LTC services in view of population ageing. The Commission on the Elderly (Ældrekommissionen), published its main report with 43 recommendations for residential nursing care in February 2012. The Home Care Commission (Hjemmehjælpskommissionen), published its main report in July 2013 with 29 recommendations on how a coherent system of support services should focus on the reinforcement and mobilisation of older people's own resources and on dignified, high quality care for the most vulnerable.

Recommendations from the 'Commission on the Elderly' primarily focus on how the quality of life and the overall well-being of people in residential care can be improved and how a dignified end of life can be ensured. In 2012 an extra DKK 30 millions were allocated to five follow-up projects. Among other things the projects aim at strengthening management skills and improving palliative treatment at nursing homes.

The overarching recommendation from the Home Care Commission is to make a paradigmatic shift in Danish LTC policy from a primary focus on service provision to a combination of emphasis on a) prevention for older people without functional limitations, b) re-enablement for the big group of elderly with few to moderate limitations and c) more compensatory and nursing care measures for persons with large and complex care needs. A major programme of training and updating of staff in home care is envisaged to ensure that it can assume the task of re-enablement coaching of people with frailties and functional limitations. Early detection and addressing of frailty should become part of preventive measures. ICT and other smart aids should be used to a larger extent to help people retain the capacity for independent living and to raise productivity in home care delivery. More intensive LTC should be targeted to weak persons

without the potential to enter rehabilitation or who have a substantial need for help also after rehabilitation.

As part of the budget negotiations for 2014 an extra DKK 1 billion was allocated to eldercare (for which the total municipal budget in 2013 amounted to DKK 38.4 billions). The government emphasized that the money should be spent in line with the recommendations of the Home Care Commission.

5. BACKGROUND STATISTICS

Denmark (DK)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	17.8	16.3	19.4	22.2	20.7	23.8	24.0	22.2	25.8	24.5	22.7	26.3	6.7	6.4	6.9			
80+	4.2	3.1	5.2	7.0	5.9	8.1	8.6	7.2	9.9	9.7	8.1	11.2	5.5	5.0	6.0			
85+	2.0	1.3	2.8	3.2	2.5	3.9	4.5	3.5	5.5	5.8	4.6	7.0	3.8	3.3	4.2			
80+/65+	23.3	18.9	26.9	31.4	28.4	33.9	35.6	32.6	38.2	39.5	35.8	42.7	16.2	16.9	15.8			
85+ /65+	11.5	8.0	14.3	14.4	12.0	16.5	18.8	15.8	21.3	23.7	20.2	26.7	12.2	12.2	12.4			
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2			
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3			
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3			
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1			
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1			
Old-age dependency ratios, % [2]	**Denmark (DK)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	30.6	27.5	33.7	45.9	41.6	50.3	15.3	14.1	16.6	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	17.9	15.4	20.5	31.5	27.9	35.2	13.6	12.5	14.8	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Denmark (DK)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	77	81.1		84.4	88.4		7.4	7.3		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	16.8	19.5		22	25.1		5.2	5.6		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	13.2	14.0		10.6	12.9		-2.6	-1.1		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	82.0%	73.3%		60.8%	63.7%		-21.2	-18.3		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	4.5			8.5			4.0			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario. It should be noted that estimates for expenditure on long term care for Denmark are particularly uncertain.

ESTONIA

1. DEMOGRAPHIC BACKGROUND

Estonian demographics are characterised by three key features. Firstly, the population is ageing and the natural increase is low; secondly, there is a high emigration rate; and thirdly, low life expectancy, with a large difference between men and women, compared to Western Europe.

In the period 2013-2060 the share of people aged 80+ in the Estonian population is expected to grow from 4.7% to 11.7% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3.5 from 1.9% to 6.7% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 26.3% to 39.0% (EU-28: 27.8%-41.5%), and from 10.7% to 22.4% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 29.3% (EU-28: 29.9%) to all of 61.1% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 14.1/19.1 years (EU-27: 17.2/20.7) in 2010 to 20.9/24.9 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 2.0 and 1.9 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.5% to 0.9% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

In order to provide health care services in Estonia, an institution has to be certified by the National Healthcare Services Act. According to this act's standards, there are 47 institution-based service providers, 43 home nursing service providers and 1 cancer homecare, all of which are funded by the Estonian Health Insurance Fund (EHIF). In addition to this, 7 hospitals provide geriatric assessments.

In order to provide social services in Estonia, institutions must have been certified by the National Social Welfare Act. According to these standards, in 2007 there were 118 general nursing homes providing 24-hour nursing care (with no right to provide health care services) to 4,970 patients. Activities for the elderly and to some extent day-care services were offered in 82 senior day centres. In 2005 there were 692 domestic service providers, which included services like helping out in daily activities (shopping, heating, cooking).

Approximately 0.4% of persons under the age of 65 and 2% of the people over 65are in care institutions. About 0.1% of persons aged below 65 and 2.2% of persons older than 65 years receive home help.

In 2007, 9,580 persons used institutional nursing care services. Home services were provided to 6,428 persons, including 3,960 with special needs (i.e. disabled) in 2007. Nursing home care

services were used by 4,200 persons in 2007 (including nursing care for people with cancer). 1,100 persons used geriatric assessment services.

Benefits in cash and in kind are granted to all residents in Estonia. Cash benefits are provided either by the state or the municipalities, in-kind benefits by the municipalities only. Social welfare services are organised by the municipalities. The municipality may provide social welfare services by itself or purchase the services from a third party. The form of ownership among service providers is irrelevant, but the service given must meet the established requirements. In order to improve service efficiency, municipalities co-operate between them to provide together the best possible service. As there are many small municipalities in Estonia, it is not financially possible or feasible for each of them to offer every service independently.

LTC is provided as an in-kind social service and is organised at the municipality level and regulated by Social Welfare Act. Care services can be provided by the state, institutions, public or private legal entities or their offices. There is also a caregiver's allowance paid by local municipalities to caregivers.

LTC services are mostly financed from local budgets and the beneficiaries themselves. In some cases, cash benefits can be provided by the state budget. However, geriatric assessment and nursing care are mostly covered by the EHIF. Either way, due to the limited budgets of local municipalities and the EHIF, LTC services are under significant financial strain. Therefore, Estonian LTC services are experiencing difficulties with inadequate facilities, lack of trained personnel and shortage of appropriate and stable financing. In addition, there is a shortage of LTC beds[3].

Family obligations regulated by the law are for permanent care services. Community care is provided by the state or with a symbolic cost sharing. For example, 50.3% of the cost of 24-hour care was covered by the customer or their families, and 47.6% by local governments.

Table 1. Health expenditure

Share of health expenditure in state budget, % (2011)				13.4%		
Share of total health expenditure in GDP, %				7 %		
Share of public health expenditure in GDP, %				5.3 %		
Public LTC expenditure in GDP, % (2010)				0.5%; 0.9% (expected 2060)		
Of which by type (2010):	Institutional	Home	Cash benefits	0.19%	0.01%	0.33%
Rate of hospital beds per 100,000 inhabitants				543		
Rate of care beds per 100,000 inhabitants / per 100,000 inhabitants aged 65 and older				116.2 / 683		

Source – SIMPHS2 and datasheet

Health expenditure in the state budget reached 13.4% in 2011. Even though this figure is still smaller than the EU27 average, it has increased in recent years (11.1% in 2006). Public expenditure on LTC was 0.5% of GDP in 2010, but it is expected to increase up to 0.9% in 2060.

Cash benefits account for the biggest share (0.33%) of the current LTC expenditure, followed by institutional care (0.19%).

Table 2. Estonian Health Insurance Fund LTC expenditure 2012 (in 1000 EUR)

EHIF expenditure on LTC in € (2012)	17 538
Institution-based LTC services	13 796
Home nursing services	3258
Cancer care services	398
Geriatric assessment services	87

Source – EHIF annual rapport

The evaluation of the need for LTC is done by a doctor (GP or a specialist) according to Healthcare Services Act and by a local social worker under the Social Welfare Act. Doctors assess the health status and the need for personal assistance, guidance or supervision. Social workers assess any necessary actions in consideration of the needs and wishes of the person and their family.

Each municipality is responsible for ensuring the quality of care services and monitoring the care system (care services, benefits, etc.). Municipalities also process the complaints of service users[1,2]. The Ministry of Social Affairs is responsible for developing the quality standards for services which the municipalities then apply to quality controls[1].

Accessibility to services is uneven and often limited in different part of Estonia. This is mainly due to the fact that the welfare and healthcare systems are financed from different sources - from the state budget and through the EHIF. Many social care home residents also need LTC, but the amount of LTC provided in social care homes is constrained by limited local budget resources.

3. CARERS

Key figures on formal carers are given in the table below (Table 3).

Table 3. Professional Carers

	2010	**2012**
Homecare nurses, number/per 100,000 inhabitants	5,94	8,88
Care nurses, total number/per 100, 000 inhabitants	202,81	212,80
Average salary of homecare nurses, €/h	4,31	4,50
Average salary of carers €/h	2,46	2,49

Source – The National Institute for Health Development TAI database

Regarding people who provide home help/care or volunteer carers, working under the contract entitles the carer to an old-age pension and health insurance. If the carer works in a certified welfare institution, the employment contract is between the employer and the employee. If the carer works at the dependent person's home, the contract is between the local municipality and the carer.

Information on the number of informal carers is very limited. The Estonian Labour Force survey provides information on the share of inactivity due to taking care of children or other members of the family, but it is not possible to derive from these data the reasons for care.

4. POLICY AND RECENT DEVELOPMENTS

The Ministry of Social Affairs has launched a national strategy with the main goal that by the year 2015 the operational care network will have expanded evenly across Estonia. The strategy, called “The Long-term Care System Strategy of Estonia for 2004-2015”, aims at increasing the number of nursing care beds in order to meet the demand and facilitating that service users move between different services according to their care needs.

Another of the Strategy's main goals is to reach certain proportions of funding for total nursing care expenditures by 2015. This means that 56% of the funding is by health insurance, 31% by local municipality and 13% by service users. The aim is to provide all services free of charge for service users, except services in care homes and nursing homes (Unit cost indicator for Estonia was not available.)

5. BACKGROUND STATISTICS

Estonia (EE)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	18.0	12.9	22.5	24.2	19.0	28.9	27.6	23.3	31.5	30.0	26.5	33.3	12.0	13.6	10.8			
80+	4.7	2.5	6.7	7.1	4.2	9.7	10.0	6.8	12.9	11.7	9.0	14.3	7.0	6.5	7.6			
85+	1.9	0.8	2.9	3.5	1.8	5.1	5.4	3.3	7.4	6.7	4.7	8.7	4.8	3.9	5.8			
80+/65+	26.3	19.4	29.8	29.2	22.0	33.5	36.2	29.2	40.9	39.0	33.9	42.8	12.7	14.5	13.0			
85+ /65+	10.7	6.5	12.8	14.6	9.4	17.6	19.6	13.9	23.5	22.4	17.6	26.0	11.7	11.1	13.2			
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2			
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3			
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3			
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1			
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1			
Old-age dependency ratios, % [2]	**Estonia (EE)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	29.3	20.0	38.4	61.1	51.6	70.9	31.7	31.6	32.5	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.4	13.0	27.3	44.7	37.0	52.6	24.3	23.9	25.3	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Estonia (EE)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	69.8	80.1		81.6	88.0		11.8	7.9		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	14.1	19.1		20.9	24.9		6.8	5.8		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	3.4	3.6		5.4	5.5		2.0	1.9		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	26.2%	20.0%		36.3%	27.3%		10.1	7.3		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.5			0.9			0.4			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

GREECE

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Greek population is expected to grow from 5.7% to 15.2% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening after 2030. At the same time the share of people 85+ will expand by more than a factor 3.5 from 2.4% to 8.9% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 28.3% to 46.0% (EU-28: 27.8%-41.5%), and from 11.9% to 26.9% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 33.4% (EU-28: 29.9%) to all of 67.1% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.9/20.2 years (EU-27: 17.2/20.7) in 2010 to 22.6/24.6 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women decreased by 1.1 and 2.7 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.4% to 2.8% (EU-27: 1.8%-3.6%).

Longevity gains will increase demand for LTC. Yet it is particularly the prevalence of disability in old-age that can push expenditure on long-term care upwards. Severe inability to perform daily personal tasks in old age is a crucial indicator of long-term care needs. Recent trends (2005 to 2011) indicate a significant increase in the non-healthy life expectancy of women at 65 (from 9 to 13 years), and a smaller increase among men (from 7 to 9 years). Hence Greek women spend about two thirds of their life expectancy (at 65 years) in bad health, and men half of it.

According to EU-SILC data, the share of men aged 65+ experiencing severe limitations in daily activities increased from16% to 22% from 2005 to 2011 (EU 27 rose from 16% to 17%). Among women the share increased from 17% to 26% (EU-27: from 20% to 21%). For people aged 85+ the share rose from 30% to 44% for women and from 33% to 44% for men (EU-27: 38% - 39% for women, and 32% -> 33% for men). This worrying trend, combined with the medium to long-term effects of the crisis on public health due to harsh cuts in public health care expenditure, increasing fees and co-payments, together with a rapidly growing number of people with no access to health care may have a serious impact on future disability and the demand for LTC in Greece.

2. CURRENT LONG-TERM CARE PROVISION

There is no universal statutory scheme for LTC. Social insurance funds provide disability pensions and allowances. Other (non-contributory) disability benefits (in cash and in kind) are provided by social welfare institutions to persons who are in need of care because of a specific chronic illness or incapacity. According to 2011 administrative data (referred to in OECD 2013), about 60% of disability benefit recipients (either insurance or assistance-based) were above 50 years of age. Depending on invalidity levels (of 50%, 67% or 80%) and the type of chronic

illness, recipients are entitled to different levels of care provision. People with serious incapacity (e.g. quadriplegics) who are not in institutional care are entitled to non-residential care benefits that can be used to pay professional providers and informal carers. The degree of incapacity is evaluated by the Centres for Certifying Incapacity (KEPA). Legislation passed in 2011 disbanded all centres operating at the level of prefectures and brought the certification process under the authority of IKA (the Social Insurance Organization).

In 2010 public spending on institutional care was negligible (0.13% of GDP; EU-27 average: 0.80%), while spending on home care and cash benefits amounted to 1.27% (EU-27 average: 1%).

In 2010, 12% of people aged 15 years and over in need of long-term care were in institutional care, 28% in home care, and 60% either had no access to care or were looked after by informal carers.[109] The state provides residential care to indigent, lonely aged people in need of care through the 25 Chronic Illness Nursing Homes. Yet only three of them (two in Northern Greece and one in Crete) have a geriatric section. In 2009, there were roughly about 1,900 people (of all ages) in residential care and 80 people in open care in these Chronic Illness Nursing Homes (total employment in them amounted to about 1,400 personnel).[110]

Public nursing homes for the chronically ill are financed by the state budget and by *per diem* fees paid by social insurance organizations. In addition, according to recent legislation, 40% to 80% of the pension income of the chronically ill in state residential care (including psychiatric hospitals) is withheld by social insurance organizations for funding care expenses. After the recent reorganization of the public-hospitals sector there are about 2,000 beds in psychiatric hospitals (that can be counted as long-term care beds), while in all other hospitals out of the 35,000 beds it is estimated that about 1,000 may be used for long-term care.[111] Although there are not clearly designated long-term care beds in public hospitals, on the basis of the above information we estimate that there are 27.7 long-term care beds per 100,000 population (including psychiatric care beds); or 1.4 long-term care beds per 1,000 people aged 65 years and above. There are no available data per unit cost of type of long-term care.

A number of private clinics under contract with EOPYY provide long-term care (mostly to the terminally ill), but no data are available for the number of long-term care beds in these clinics. Long-term care to frail, incapacitated (mostly lonely and indigent) elderly people is also provided by about 100 non-profit residential care homes. The majority of them are run by the Church of Greece, and the rest are run by specific endowments and some local authorities. There are also about 100 for-profit residential homes for the elderly. In total, non-profit and for-profit residential care homes for the elderly have a capacity of about 15,000 beds. The former are partly subsidized by the state and partly funded by donations (as well as by *per diem* fees paid by social insurance organization for those entitled to social insurance). For-profit residential homes are privately paid by the persons in care and their families. Interestingly, over the last few years occupancy has

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[109] By 2060 it is projected that a little over 50% of the population 15+ will have no access to formal "Home Care" or institutional care.

[110] Data obtained from ELSTAT. Some beds are also provided by private elderly care units contracted by the Ministry of Labour, Social Security and Welfare for indigent elderly (due to insufficiency of beds in state run institutions), but there is no information about their total number.

[111] Data obtained from the Ministry of Health. In 2010, overall, 84% of beds in the NHS were curative care beds and the rest were psychiatric care beds (see OECD 2012, p. 77). With the recent reorganization the respective rates are 94% and 6% (as the Ministry closed down most psychiatric hospitals in the country).

significantly fallen from 100% to about 80%. Due to the crisis and economic hardship, families opt to look after the elderly at home as pension benefits are a major source of income particularly among households with unemployed members.[112]

Semi-residential, day-care to the elderly is provided by the 68 Day Care Centres for the Elderly (KIFI).[113] They undertake the day care of old-aged people who cannot care for themselves, have serious economic and health problems and their family members cannot look after them because of their work. Most of the centres are operated by municipal enterprises, joint municipal enterprises, and/or municipal business associations of local authorities. Since their establishment they have been funded mostly by EU resources. According to current regulations, they are co-funded by the European Social Fund[114] and national/local budgets. Presently they accommodate about 1,500 old-aged people (and have a staff of about 270 employees). KIFI cooperate with local social and health services as well as with the welfare directorates of the regional units (ex-prefectures) of the country.[115]

The "Home Help" programme was introduced on a pilot basis in 1998 and later on was expanded to cover most areas of the country. As with the centres of day care, it has been mostly funded by EU resources. There are currently about 879 "Home Help" schemes providing services to about 76,000 beneficiaries. Employment amounts to about 3,680 people (social workers, nurses, physiotherapists and home helps). The schemes are operated by municipal enterprises and provide nursing care, social care services and domestic assistance to elderly people who live alone and are unable to take care of themselves, and also to disabled people who live in isolation or in families experiencing crisis conditions. Its primary aim is to support frail elderly people to live independently at home. According to recent legislation the programme will be placed under social insurance. It will be funded by the resources of the so-called AKAGE (the Insurance Fund for Intergenerational Solidarity, established in 2008 as a reserve fund for meeting the future funding needs of social insurance). The resources devoted to "Home Help" will be administered by IKA. The "new" programme is strictly means-tested and is addressed to lonely indigent elderly people (or couples) aged 78 years and over, as well as to disabled pensioners (with a disability level of 67% and over) who, irrespective of their age, meet the required income criteria (the threshold is set at the level of EUR7,715 per year for one person and the double of this amount for couples).[116] Obviously, strict means-testing and age and disability criteria significantly reduce the number of potential beneficiaries.

Competition among providers is encouraged as, apart from the schemes operated by municipal enterprises, other non-profit as well as for-profit "Home Help" units can submit bids for being included in the registry of certified schemes administered by IKA, from which beneficiaries can choose a provider. State funding to municipal "Home Help" schemes will be discontinued. The option offered to those working in municipal schemes is to form "social cooperatives" and bid for becoming accredited providers under the new, competitive system.

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[112] Information obtained from representatives of the Greek Health Care Homes Association.

[113] There are also Open Protection Centres for the Elderly (KAPI) operated by municipal enterprises and non-profit entities. However these have primarily a recreational function (prevention and medical care services provided are of a limited range).

[114] Under the Operational Programme of Human Resource Development 2007-2013 – Measures for elderly support and support of persons needing care, so as to promote employability of household members

[115] Information on KIFI and "Home Help" programmes obtained from the Central Union of Municipalities of Greece (KEDE).

[116] It equals the income threshold below which pensioners are eligible for the social assistance benefit, EKAS. In addition, beneficiaries must not receive the benefit of total disability and/or the non-residential care benefit.

Means-testing criteria are relevant for access to residential care as well (care centres for the chronically ill and nursing homes for the elderly), but they are applied in a more flexible way than in the case of eligibility for "Home Help". Admissions to state operated care centres for the chronically ill and to contracted non-profit and for-profit clinics are subject to referral by the social services of local authorities, of "regional units" (ex-prefecture level social welfare directorates), and of the NHS hospitals. However, existing legislation does not define a specific income threshold. It rather stresses that economic hardship is a crucial criterion, but other factors defining the severity of need should be taken into account too in the evaluation of each specific case.

Prevention measures and promotion of independent living among the elderly are rather neglected policy areas (as are also public health and health promotion). Moreover, over the last few years the combined effect of cuts to benefits and rapid increases in co-payments for medical devices and materials of vital importance for the chronically ill place a heavy burden on low-income pensioners.

Accreditation of institutions providing care to elderly chronically ill and incapacitated persons is carried out for non-profit and for-profit elderly nursing homes and care centres by the Directorate of Welfare of the Ministry of Labour, Social Insurance and Welfare. Regular inspections of both state and non-state institutions also take place by the health inspectorate services of the Ministry of Health. Currently, in collaboration with the Technical University of Athens (TEI) a pilot project for implementing a systematic preventive approach to food safety (a so-called HACCP system (funded under the National Strategic Reference Programme 2007-13) is under way in three state operated care centres for the chronically ill. So far no systematic quality assessment of residential care and care at home schemes has been introduced.[117]

In a nutshell, there are no comprehensive formal LTC services guaranteeing universal coverage. Existing services are addressed to the neediest, indigent people. Care for the chronically ill (either in state residential units or contracted non-profit and for-profit care centres and clinics) hardly covers the demand due to an insufficient number of beds, the low rates paid by social insurance organizations, and a rapidly shrinking public budget. Private insurance for LTC is negligible and the cost of private residential care, by those who can afford it, is met by out-of-pocket payments.

3. CARERS

There are no data available for professional long-term care workers (nurses and personal carers in institutions and in home care). Indicatively, in the state care centres for the chronically ill and rehabilitation centres, the day care centres for the elderly and the "Home Help" programme operated by municipal enterprises there are about 6,500 employees (social workers, health personnel, home helpers in activities of daily living etc.). No systematic information is available as to level of education of this staff. Particularly in the Day Centres for Elderly Care (KIFI) and the "Home Help" programme, long-term care workers are on a contract basis, given the fact that most of these schemes have been operating as EU funded projects. Discontinuity in work contracts and persistent employment insecurity for much of the staff has been a serious problem. According to information obtained from KEDE, payment is pending for over nine months for

[117] As referred to by Kagialaris et al. 2010 (p. 31) the Greek Care Homes Association (PEMFI) has drafted a quality standards guide for elderly care homes that can voluntarily be adopted.

long-term care workers in "Home Help" municipal schemes. The proposal by KEDE to continue the funding of the schemes with resources from the NSRF (National Strategic Reform Framework) has not been accepted by government authorities. Hence, as stressed above, existing programmes are under risk of being terminated.

A combined indicator of total health and social employment in Greece in 2007[118] shows that, in head counts, this figure amounted to about 40,850 people, with a density of 21.5 workers per 1,000 population (one of the lowest rates among OECD countries, after Mexico, Korea and Turkey). From these, the professionally active caring personnel amounted to 9,480 people with a density of 0,84 carers per 1,000 population by far the lowest among the OECD countries for which there is such an available statistic (the Netherlands and Norway exhibited the highest density –nearly 19 carers per 1,000 population).

There is an alarming shortage of nursing and (formal) care personnel in Greece. This condition may further worsen in the short to medium term. In addition to the fact that low prestige and low pay do not make such jobs attractive work option, the freezing of new appointments of health personnel under the bailout programme is exacerbating shortages. At the same time, increasing emigration of skilled health personnel (mostly to North European countries) constitutes a significant drain of human resources.

There are no available data on the total number of informal carers, given the fact that no formal process of registering (and certifying) informal carers is in place. Most of informal carers are relatives (mainly wives, daughters and other female relatives), or paid workers (female legal or illegal immigrants, though the crisis has rendered paid help unaffordable even for middle income families/households).

Data retrieved from OECD Health at a Glance 2011 (drawing upon the SHARE project) show that in 2007 nearly 9% of people aged 50 years and over provided services of informal care (OECD-16 countries average 11.7%). Almost 45% of them provided informal care for 20 hours or more per week (OECD-18 countries corresponding average: 32.3%). Disaggregated by age and gender, close to 80% of those aged 50 to 64 years were women in Greece (OECD-17 countries average: 66%). The proportions of female informal carers among those aged 65-74 and 75 and over were, respectively, 68% and 46% (corresponding OECD averages for these age groups: 65% and 60%).

Issues concerning the interaction between informal carers and formal care services, respite care, training and counselling of informal carers, pension rights etc., rank very low on the public agenda. Support services rarely exist. In Athens and other big cities some self-help and support groups are organized mostly by NGOs (e.g. the "Alzheimer Athens" and the Hellenic Gerontological and Geriatric Society, see Kagialaris et al. 2010, p. 16).

[118] Retrieved on 26 September 2013 from the OECD Health Database, at http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#

4. POLICY AND RECENT DEVELOPMENTS

Overall, LTC is fragmented and insufficient, as nearly two thirds of people (15 years and over) needing care because of chronic impairment and reduced degree of independence in activities of daily living either receive informal care or no care at all. The issue of introducing social insurance for LTC is a low priority on the public agenda, despite increasing future needs due to rapid demographic ageing. Regulation enacted about a year ago provided for the introduction of an additional social contribution to cover the needs for "Home Help" of elderly (though in a means-tested way). Yet this provision has not been implemented so far, as it will further increase the level of social contributions, deemed to be already high. It runs counter to policy options under the bailout plan for reducing non-wage costs (in tandem with falling wages) as a means for improving competitiveness. Instead, as mentioned above, funding for this system is provided by the AKAGE (and partly by the "social solidarity ad hoc tax" introduced for pensioners - and employees - under the bailout programme).

The severe economic crisis leaves little room for an expansion of public provision. However, it could be an opportunity for improving coordination of existing schemes that provide benefits in cash and in kind, redefining the links between formal and informal care and developing support for carers.

5. BACKGROUND STATISTICS

Greece (EL)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	20.1	18.2	21.9	25.6	23.0	28.0	32.5	29.8	35.1	33.1	30.6	35.5	13.0	12.4	13.6
80+	5.7	4.7	6.6	8.0	6.7	9.3	11.2	9.3	13.0	15.2	13.1	17.3	9.5	8.4	10.7
85+	2.4	1.9	2.9	4.0	3.2	4.7	6.0	4.8	7.1	8.9	7.3	10.5	6.5	5.4	7.6
80+/65+	28.3	25.9	30.2	31.4	29.3	33.1	34.3	31.2	36.9	46.0	42.7	48.7	17.7	16.8	18.5
85+/65+	11.9	10.2	13.2	15.6	14.0	16.8	18.4	16.0	20.3	26.9	23.7	29.5	15.0	13.5	16.3
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Greece (EL)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	33.4	29.7	37.0	67.1	60.0	74.6	33.7	30.2	37.6	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	22.7	19.8	25.5	50.5	44.6	56.6	27.8	24.8	31.1	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Greece (EL)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	77.8	82.8		84.9	88.3		7.1	5.5		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	17.9	20.2		22.6	24.6		4.7	4.4		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	9.7	10.0		8.6	7.3		-1.1	-2.7		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	56.7%	52.1%		47.7%	34.6%		-9.0	-17.5		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.4			2.8			1.4			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

SPAIN

1. DEMOGRAPHIC BACKGROUND

Spain is one of the EU countries where a high impact of ageing is expected. In the period 2013-2060 the share of people aged 80+ in the Spanish population is expected to grow from 5.5% to 14.9% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening after 2030. At the same time the share of people 85+ will expand by more than a factor 3 from 2.5% to 8.7% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 30.9% to 49.3% (EU-28: 27.8%-41.5%), and from 14.3% to 28.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 28.3% (EU-28: 29.9%) to all of 58.9% (EU-28: 55.3%).

Life expectancy in Spain - including at age 65 - is already one of the highest in the EU. Moreover, life expectancy for men and women at age 65 is projected to rise from 18.2/22.1 years (EU-27: 17.2/20.7) in 2010 to 22.9/26.3 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women decreased by 0.5 and 0.2 years, respectively, even though still remaining well above the EU average.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.8% to 1.6% (EU-27: 1.8%-3.6%).

In 2010 life expectancy at birth was 78.6 years for men and 84.7 for women, while in the EU27 these were 76.7 and 82.5, respectively. More particularly, life expectancy at age 65 was also higher in Spain –18.2 (vs. 17.2 in the EU) for men,22.1 (20.7) for women–, and it will increase by 4.7 years for men and 4.1 for women by 2060. Although the increase is lower than for the EU average, Spanish life expectancy at age 65 will still be one of the highest in Europe.

2. CURRENT LONG-TERM CARE PROVISION

In Spain, the long-term care system as such started in 2007 with the Bill 39/2006 on the Promotion of Personal Autonomy and Assistance to persons in situations of Dependence (LAAD). This piece of legislation established the SAAD (System for Autonomy and Care of People in a Dependent Situation). The objective was to provide the necessary assistance to persons requiring help in order to carry out essential daily activities. Benefits can be both in kind and in cash, and are financed and provided jointly by the central government and the autonomous regions, with a certain degree of copayment by beneficiaries in most cases. At the national level, the above mentioned legislation only ensures the provision of a minimum level of protection and/or financial aid for dependency. Each region may then establish additional benefits that complement these minimum levels. Finally, municipalities can also complement the basket of benefits within their constituencies. Regions are also responsible for the registration of providers. inspection and evaluation duties.

Three different degrees of dependency are considered: Degree I –moderate; Degree II –severe; and Degree III –high dependence. Initially, each degree was in turn divided in two levels, where

level 1 referred to less severe and level 2 to more. A progressive calendar, from 2007 to 2015, was established in order to incorporate all dependants in the system: Only persons with the Degree III could apply during the first year (2007), then Degree II level 2 in 2008, Degree II level 1 in 2009-2010 and finally moderate dependants (Degree I) in 2011-2012 (level 2) and 2013-2014 (level 1). The process is expected to finish in 2015.

Regarding the benefits, these include different services and cash benefits. Chapter 15 of the LAAD lists a wide range of available services to be carried out through a public network of social services controlled by the regions, through public or private centers subsidized by the public sector. These services include tele-assistance, home care, personal care help, residential care and day/night residential services. The network of public institutions belonging to regional governments, together with local organizations, national reference centers and duly certified private providers deliver these services. With respect to cash benefits, which are granted according to the person's degree of dependency and economic status, the LAAD foresees cash benefits for home care (accompanied by the payment of the social contributions for the carer by the SAAD) as well as a monetary provision for personal assistance.

Nevertheless, the reform of the LAAD was addressed already before the legislation had been fully implemented. Hence, it altered both the application plan and the benefits. The deep economic crisis and fiscal consolidation efforts led to successive reforms that delayed the full application of the SAAD and reduced some of the benefits. First, the Royal Decree 20/2011, of 30 December 2011 established that moderate dependants (Degree I) who were not yet incorporated into the system had to wait until 2013 (level 2) and 2014 (level 1). A second delay was enacted barely seven months later, with the Royal Decree 20/2012 of 20 July 2012. Firstly, as there was no clear distinction among those levels which resulted in delays in the assessment of people in situation of dependency. the two levels within each degree were eliminated, so that dependants are only evaluated in three Degrees.. Secondly, all moderate dependants (Degree I) not yet incorporated into the system at that point needed to wait until July 2015. With regard to benefits, a cut in the number of hours for home assistance was implemented but the most significant change affected the cash benefit for home care (more than 50% of beneficiaries receive this type of benefit). Because the LAAD set out this benefit as exceptional on the one hand, the benefit was reduced by 15% (for both new and existing duties). On the other hand, the SAAD stopped paying for social contributions of home carers –about EUR160 a month. These changes were made in order to prevent the SAAD becoming a system of subsidies instead of a welfare service network.

According to the 2012 Ageing Report, the expenditure in LTC services in Spain represented 0.8% of the GDP in 2010. Interestingly, 0.46% of the GDP was devoted to institutional care, 0.22% to home care and 0.14% to cash benefits. Nevertheless, institutional care is clearly the most expensive option, as its unit cost is 81% of GDP per capita, while home care is only 25% and cash benefits 15%. In cases of institutional and home care, the figures are below the EU27 averages –106% and 36% of GDP per capita respectively. Spanish figures on LTC expenditure are far from the EU average and projections do not show an improvement in this regard. In 2010 the EU27 LTC expenditure was 1.8% of GDP and is expected to increase to 3.6% in 2060, whereas Spain is only expected to reach 1.6% of GDP in that year. This increase may even be higher according to other studies. The final effect depends on the coverage of the system –the extent to which informal care is transferred to the formal sector- and the expected future evolution of the combination of institutional and non-institutional care.

In 2010 it was estimated that only 10.5% of disabled people aged 15 and over had access to institutional care, and 16.5% to some kind of home care. Thus, 72.9% of them were receiving informal care or no care at all. By 2060 it is expected that institutional care will cover 13,4% of

all formal care and home care 21.5%. These figures are similar to some other countries in the EU, but far away from the higher coverage rates reported by Belgium, the Netherlands or the Nordic countries.

According to the SAAD data in August 2013, there were 1.228.207 people in Spain with some degree of dependency. In particular, 370.479 people were recognized as highly dependent (30%), 444.218 as severely dependent (36,2%) and the rest (413.510, 34%) as moderately dependent. In the last case, and due to the successive delays in the fully application of the LAAD, only 126.756 people were entitled to benefits, whereas there might be a great number of people who have not been able to apply for benefits yet. Hence, at the moment 941.453 people have been incorporated to the SAAD as potential beneficiaries, of which only 739.724 are actually receiving benefits while the other 201.729 (21%) are on the waiting list. It should be noted that there are large differences across regions, which are responsible for managing the system. Overall 2.0% of population is recognized as dependent in Spain. This ratio is 2.7% in Andalucía and Cantabria, while is only 1.1% in Canarias, 1.3% in Comunitat Valenciana and Baleares and 1.4 in Navarra.

Regarding the type of benefits, it should be noted that each beneficiary receives an average of 1.26 different benefits, although this figure varies again across regions. Clearly, the most important benefit is the cash benefit for home care for this reason the modification of Laad was made.. According to SAAD data, as of August 2013, 403.284 people (54.5% of total dependants) are receiving this type of benefit. The importance of in-kind benefits is lower, i.e.17.5% of beneficiaries were receiving residential care, 16.4% of them had assistance in their homes, 16.2% were in a program of home tele-assistance and 9% were cared for in day/night centers.

In 2010 Spain had 29.4 long-term care beds in hospitals per 100,000 inhabitants, slightly over the EU-27 average (26.5).

SAAD provides also in-kind services, mainly through professional carers, in institutional care, day/night care centers or tele-assistance. As these services are managed directly by the regions and municipalities, large regional disparities are observed in the number of places available, services offered and prices. Also, regions have established different rules regarding both means-testing and co-payments. In general, most institutions are private –only about 25% of residences and 41% of day centers are publicly-owned– but around 28% of residents in private institutions and 62% of users of day centers receive a public subsidy.

According to IMSERSO (2012), at the beginning of 2012 Spain had 377.505 places in residences for elderly people, which represented 4.6% of the population aged 65 and over[119]. However, less than 80% of these places were occupied. Around 3.3% of people aged 65 and over in Spain were living in residences, while 18% of the population reports a preference for living in a residence if they need care[120]. This mismatch between demand and supply can be explained by different reasons, but probably high costs of residential care and the co-payment that users should assume are the most relevant ones. 53% of people living in residential care centers are dependants, and another 14% has some kind of dementia. The average age is around 82, and 57% of them are women.

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[119] INE, Censos de Población y Viviendas 2001.

[120] According to the survey carried out by the IMSERSO for the *Libro Blanco sobre el Envejecimiento Activo* (2010)

Regarding the day care centers, the number of places available in thus type of institutions has grown considerably in the last decade. On 31 December, 2011 there were 87,343 places distributed in 3,027 centers, which means a coverage rate of 1.06% of the population aged 65 and above, while it was 0.26% in 2001. It is worth noting that 49% of the users of day care centres are aged 80 and over and 55% of them are women. It is estimated that the cost for this type of care in a public center is 7.818€ a year, considerably lower than the 21.513€ needed for residential care.

Tele-assistance is also a service which has grown sharply during the last years. In 2012 there were 692.462 users – around a 20% of them financed by the SAAD–, while hardly 80.000 in 2000. It is a quite cheap service –about 287€ a year per user– which allows for professional help in case of need.

Among the benefits considered by the SAAD in Spain, some of them are clearly aimed to promote independent living, prevent the dependency situation and help people to rehabilitate if possible. The tele-assistance service is one of them. This service is offered by local and regional governments since the nineties, much earlier of the SAAD creation. It is a quite cheap service which provides professional assistance in case of emergency and permits that some dependents – especially those with a moderate degree of dependency – can remain living at home in secured conditions, reducing the need for institutional and home care and hospital attention. Some pilot experiences are being developed about exchanging medical information through the tele-assistance service, as the access to biometric indicators and vital signs of the patient, which can have an important impact in the effectiveness of this service in the future.

Regarding prevention programs aimed at older people at national level, there are programs like social tourism and hidrotherapy since 1985 which reached 1050.000 users in 2013. A network of National reference Centers develops prevention and rehabilitation programs. Moreover, according to the development of LAAD, the contents of services for the promotion of personal autonomy (BOE, August 22, 2011) have been defined as well as the "Recommendations and minimum standards for prevention of dependence" (BOE april 2013) to be developed by the Autonomous Communities which have the competence to do so.

Regarding quality assessment, the Spanish law stipulates the need for certification, professionalization and inspection, as well as the use of quality standards for all benefits and services. The regions retain an important role as regulatory powers and quality overseers. There are guidelines for the latter, mainly on structural and process standards. Some regions have already taken the initiative to establish their own standards.

Without undermining the power that regional governments have to determine such issues (article 16), the SAAD Inter-territorial Council (CISAAD) establishes a common framework of quality standards for the certification of centers and quality programs, as well as quality and safety criteria, quality indicators for continued improvement and benchmarking, best practices and the development of quality standards. For instance, the 2008 CISAAD Agreement (*Ministerio de Educación Política Social y Deporte*, 2008) established cross-regional minima in quality standards that should be met by the nursing home sector in categories such as staff qualification, material resources, equipment and documentation. Furthermore, the 2009 CISAAD Agreement (*Ministerio de Sanidad y Política Social*, 2009) established further minimum standards regarding the certification of informal caregivers' expertise and knowledge.

3. CARERS

Regarding professional carers, the long-term care workforce in Spain remains one of the smallest compared to the number of persons in need for care. Spain has taken some measures to increase the availability of professional carers. Persons who are already working in care institutions can acquire different certificated until 2015: a professional certificate for working with dependent persons in social institutions with a minimum of 450 hours of training needed; a professional certificate for providing home care services with a minimum of 600 hours needed; a vocational training scheme with the title "technician in care for people in situation of dependency" or "technician in auxiliary nursing care" both with 2000 hours of training.

After the LAAD approval, the number of non-professional carers in Spain increased sharply. Many dependants (more than a half) applied for cash benefits to receive assistance within their families in their own homes. Until the last reform in July 2012, non-professional carers were also incorporated to the contributory Social Security system, with the SAAD being responsible for paying their monthly contributions. Nevertheless, since the last reform, it is the beneficiary himself/herself who has to pay the social contributions. This has resulted in a dramatic reduction of affiliation figures, so that non-professional carers have returned to the informal sector, as prior to the LAAD.

In May 2008, at the beginning of the LAAD, there were 9.955 non-professional carers affiliated to the Spanish Social Security system. Since then, this figure has risen considerably until a maximum of 180.021 in July 2012, when the last reform of the LAAD was approved. In August 2013 the non-professional carers contributing to the Social Security were 18.344, while the number of dependants receiving cash benefit for home care was 403.284. This means that 5% of informal carers are affiliated to the General System of Social Security through a special agreement, according to which they have to pay their own subscription to the system. This means that barely 5% of carers are in the formal sector. This percentage would be even lower if dependants not yet recognized by the system and those on waiting lists were also considered. In fact, according to OECD (2011), Spain has one of the highest proportions of informal carers: 15.3% of population is reported to provide personal care and help with activities of daily living to. By comparison this proportion is 8.0% in Sweden, 9,3% in Denmark, 10,7% in France and 11.0% in Germany.

Regarding the characteristics of the non-professional carers, as in all countries they are mostly women, although for higher ages (after 75) the proportion of male caregivers is close to the female one. It should be noted that care intensity in Spain is particularly high among the OECD countries. According to the survey carried out by OECD (OECD, 2011), more than 50% of the Spanish non-professional carers devoted more than 20 hours per week to care giving, while this proportion is below 35% in the OECD average. This is a particularly interesting point as, according to the same report, high-intensity carers are generally older, less educated and poorer. Also they are more likely leave the formal labor market, suffer higher poverty risk and a higher prevalence of mental health problems.

4. POLICY AND RECENT DEVELOPMENTS

The LTC system in Spain is far from being well-established. It was introduced with a considerable delay compared to other EU countries and austerity measures halted its implementation. It is crucial that future developments are carefully designed, given that Spain will be hit by a drastic ageing process starting in the 2020s with the retirement of the baby boomers. Nevertheless, the need to foster the quality of care and the need to increase labor participation and to protect carers calls for an extension of the formal sector. Coordination between the different government levels is still an issue. First, the asymmetry of the Spanish regional financing system -most of the expenditures are decentralized while revenues are mostly handled by the central government- does not foster the responsibility and the efficiency of public provision. Paradoxically, the more efficient regions are now punished, i.e. the quickest regions in processing applications and benefits before the interruption of the system in 2011 are now facing the largest expenditure levels. The central government, in turn, has reduced the extent of co-funding, leaving regions in a strained financial situation (CES, 2012). Secondly, as a result of the autonomy of regions to provide different levels of LTC above a minimum, there are significant differences in the quality of services and the level of cash benefits across regions. Finally, the coordination across levels of governments is ensured by the Territorial Council of Social Services and SAAD, a body with representatives from the general state administration, the autonomous communities and local governments. This council adopts agreements establishing minimum criteria regarding different issues to be applied by the different administrations.

5. BACKGROUND STATISTICS

Spain (ES)																	
Demography																	
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**				
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**		
65+	17.7	15.4	19.9	25.0	22.6	27.4	33.0	30.4	35.5	30.3	27.3	33.1	12.6	11.9	13.2		
80+	5.5	4.0	6.9	7.6	6.0	9.1	11.1	9.1	13.1	14.9	12.6	17.2	9.4	8.6	10.3		
85+	2.5	1.7	3.4	3.8	2.8	4.9	5.8	4.4	7.2	8.7	6.9	10.4	6.2	5.2	7.0		
80+/65+	30.9	26.2	34.5	30.4	26.6	33.4	33.7	30.0	36.8	49.3	46.1	51.8	18.4	19.9	17.3		
85+ /65+	14.3	10.8	17.0	15.3	12.3	17.8	17.7	14.6	20.3	28.7	25.2	31.4	14.4	14.4	14.4		
Elderly population as % of total population [1]	**EU-28**																
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**				
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**		
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2		
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3		
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3		
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1		
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1		
Old-age dependency ratios, % [2]	**Spain (ES)**									**EU-28**							
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	28.3	24.1	32.6	58.9	50.8	67.4	30.6	26.7	34.9	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	19.0	15.6	22.5	45.8	38.9	53.0	26.8	23.3	30.5	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																	
Life expectancy [3]	**Spain (ES)**									**EU-27**							
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	78.6	84.7		85.4	89.9		6.8	5.3		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	18.2	22.1		22.9	26.3		4.7	4.1		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	9.7	9.2		9.2	9.0		-0.5	-0.2		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	56.1%	43.2%		49.3%	39.5%		-6.8	-3.7		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																	
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.8			1.6			0.7			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

FINLAND

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Finnish population is expected to grow from 5.0% to 9.7% (EU-28: 5.1%-11.8%), i.e. to almost double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 2 from 2.3% to 5.5% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 26.4% to 37.4% (EU-28: 27.8%-41.5%), and from 12.1% to 21.3% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 31.9% (EU-28: 29.9%) to all of 49.6% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.3/21.3 years (EU-27: 17.2/20.7) in 2010 to 22.3/25.8 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 2.1 and 2.4 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 2.5% to 5.4% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

Entitlement to LTC in Finland is based on residence and the municipalities are responsible for providing, as well as financing, LTC services.

Social protection for older people consists of services and income security provisions that are organized within the social and health care systems. Municipalities are responsible for granting services and offer them on the basis of an individual assessment of service needs. Municipalities may produce the services themselves or buy them from other municipalities or from private service providers.

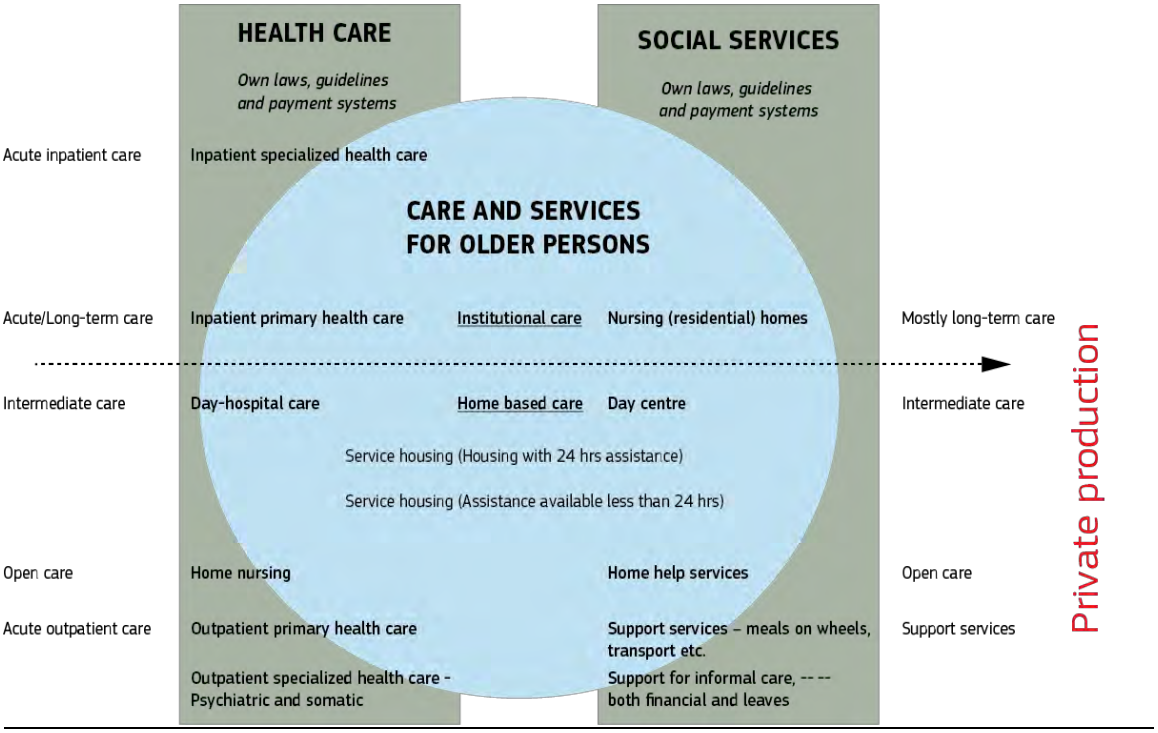
Since the beginning of the year 2011, recipients of LTC for more than one year have the right to change the municipality. In this case, the municipality of origin is responsible for the for paying the services offered in the new municipality.

If an older person requires home services, informal care, institutional care, services for older people, social assistance or other social care services, a specializend group of local officials assesses the individuals' needs prior to granting the services.

These services are in-kind benefits, with the exception of informal care support, which is a cash benefit. Benefits in-kind thus include institutional care for the elderly, home help services, support for informal care, day care for the elderly, the services of day and service centres, sheltered housing and family care. The Care Allowance for Pensioners, a cash benefit paid out by the Social Security Institution (KELA), is intended to allow pension recipients with an illness or disability to live at home, as well as to promote home care and reimburse pension recipients for

the extra costs caused by illness or disability. The average allowance is around EUR 100 per month.

Figure 1. Structure of the LTC system in Finland



Source: Quality Assurance and Quality Management in Long-Term Care – National Report Finland; Helsinki 2010

These services are in-kind benefits, with the exception of informal care support, which is a cash benefit. Benefits in-kind thus include institutional care for the elderly, home help services, support for informal care, day care for the elderly, the services of day and service centres, sheltered housing and family care. The Care Allowance for Pensioners, a cash benefit paid out by the Social Security Institution (KELA), is intended to allow pension recipients with an illness or disability to live at home, as well as to promote home care and reimburse pension recipients for the extra costs caused by illness or disability. The average allowance is around EUR 100 per month.

Home services and home nursing care are provided when an older person requires home help due to diminished functional ability or illness. In many municipalities, these are combined as home care, which is supplemented by support services.

If an older person cannot live at her own home or in service accommodation (service homes, sheltered housing), care may take the form of institutional care. Institutional care is provided both in nursing homes and in the inpatient departments of health care centres (sometimes also referred to as hospital beds).

Informal care support is targeted towards families in which a family member is caring for an aged spouse or parent, for example. The decision to grant informal care support is made by local authorities.

In the end of 2011, 6.777 persons aged 65 and over received institutional care in health centres and LTC beds in hospitals, and 15.099 persons received institutional care in residential homes. The total number of persons benefitting from institutional care in the end of 2011 added up to 21.876, or 2,2% of the total population aged 65 and over.

The number of persons in sheltered housing amounted to 35.892 (ordinary sheltered housing: 6.147; sheltered housing with 24-hour assistance: 29.745) or 3,6% of all inhabitants aged 65 and over. This form of long-term care has increased enormously during the last years (2005: 25.711). There are different forms of sheltered housing depending on the type of ownership and the organization of services. Sheltered housing can be owned or co-owned by the state, municipalities, organizations or private individuals. Residents can live in sheltered housing as tenants or as owners. Old people can purchase the services from either local or private service providers, or both. Sheltered housing can include different types of dwellings like sheltered dwellings, collective homes or dwelling groups and different combinations of these. In addition, sheltered housing can also serve as temporary accommodation. Sheltered housing can be a part of so-called service centres which offer the elderly versatile services that strengthen the independence of the elderly. Finnish research data shows that a very high proportion of persons living in sheltered housing are satisfied with their living conditions.

As of 30 November 2011, 63.866 persons (6,5% of those aged 65 or over) received regular home care[121] . 19.439 persons (2,7% among those aged 65 or over) in the end of 2011 received support for informal care (as cash benefit).

Developments over the last years show that a growing number of elderly people with LTC needs benefit from sheltered housing with 24-hour assistance. The number of recipients has grown from 10.007 in 2000 to 29.745 in 2011. In the same period the number of residents in health centres and long-term care beds in inpatient institutions decreased substantially from 12.164 in 2000 to 6.777 in 2011.

LTC services are financed by taxes collected at the local level, state subsidies and user fees. User fees in residential homes and health centres represent 85% of the recipient's net income. A minimum of EUR97 per month must remain for the recipient's own use. In case that the recipient of LTC in such an institution is married to a person with higher income, the net income of both persons is added and the LTC fee is then 42,5% of the joint net income. In every case, the LTC fee cannot be higher than the cost of LTC for the municipality.

In home care and sheltered housing, the maximum fee for LTC in these cases is 35% of monthly net income above EUR520.

In 2011, the total expenditure for LTC in Finland (benefits in kind) amounted to EUR 2.197 million. The state financed EUR 809 million and the local authorities EUR 1.388 million. Care recipients paid EUR 502 million in fees to the municipalities. The share of expenditure corresponding to Institutional LTC amounted to 32,9% of the total expenditure on LTC. Home care expenditure was 24,4%, and the share of support for informal care was 4,9%.

[121] As the data collection criteria have been revised, figures are not comparable with the statistical reports from previous years.

A considerable variation in the type of services provided can be found across municipalities in Finland. Some municipalities addressed the issue of poor quality levels in LTC, especially in institutional care. To address this concern, already in 2001 the first national quality guidelines for elderly care were published by the Ministry of Social Affairs and Health. Quality indicators for service needs, service structure and health and welfare promotion were central elements of these guidelines. Part of these were also related to staff indicators; it was recommended that municipalities define the ratio of personnel per recipient needed for each service. As a result of the "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People" (more details in section 4), which entered into force on July 1st 2013, a new quality recommendation was published shortly afterwards by the Ministry of Social Affairs and Health Care together with the organisation of Finnish municipalities.

Since 2001, the interRAI Long-Term Care Facilities Assessment System (interRAI LTCF) carries out on a voluntary basis a comprehensive, standardized evaluation of the needs, strengths, and preferences of persons receiving short-term post-acute care in skilled nursing facilities, as well as of persons living in chronic care and nursing home institutional settings. By 2012, nearly 80% of all Finnish municipalities used interRAI LTCF in institutional and home care. The data are collected by THL (Finnish National Institute for Health and Welfare). THL also holds RAI-registers for R&D purposes. Feedback reports are sent to users of interRAI LTCF in Finland twice per year.

A commonly used way to prevent disability and postpone institutional care among older people is to perform comprehensive multidisciplinary geriatric assessments (CGA). This standardised assessment instrument is used in Finland by care professionals to assess the needs of care recipients, derive quality indicators and plan care provision.

The following quality results were reported for Finland:

- The percentage of people with pressure ulcers in inpatient units and home care has decreased from 11.9% in 2000 to 8.7% in 2011.
- The incidence of falls among people in inpatient units and home care has increased. This was 19% in 2003 (with a 2% incidence of fall-related fractures), whereas in 2011 the incidence of falls was 23% and 2.7% for fall-related fractures.
- The prevalence of the use of physical restraints among residents has remained stable over time: 16.6% in 2000 and 16.3% in 2011.
- In 2003, 47.4% of the people in inpatient units and home used nine or more medications, and this percentage increased to 58.6% by 2011.
- The rate of residents who experienced an unplanned weight loss increased from a 1.3% in 2003 to 4.1% in 2011.
- The rate of uncontrolled diabetes hospital admission rates in 2009 was 389 per 100 000 persons aged 80 and over, the fourth among OECD countries.

Current policy discussion in Finland concentrates on the implementation and expected results of the new "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People". The act aims to ensure healthy ageing and good functional ability at old age. Local authorities must offer health examinations, appointments and home visits that foster wellbeing, health, functional capacity and independent living, in particular for those older persons with additional risk factors that increase their need for services.

Some important regulations with regard to quality in the new act are:

- The number of personnel and their qualifications and job duties must be consistent with the number of older persons being provided services by the service provider and the level of service that their functional capacity requires.
- Local authorities must appoint an employee responsible for an older person if the older person needs help in matters regarding the provision of services and their coordination.
- Service providers must engage in self-monitoring in order to maintain and further develop the quality of their services.
- The service provider must draw up a self-monitoring plan, which must be kept on public display. The implementation of the plan must be monitored.
- Self-monitoring must be developed on the basis of the feedback gathered on a regular basis from the older persons obtaining services of the unit, their family members and other persons close to them as well as from the staff of the unit.

3. CARERS

As already shown before, in the end of 2011 19.439 clients (2,7% of all inhabitants aged 65 or over) received support for informal care (as cash benefit). The number of persons receiving informal care increased from 14.355 in 2000 to 19.439 in 2011. The share of this group over the total population aged 65 and over has risen from 1,8% (2000) to 2,7% in 2011. The principle for informal care is that a relative may provide care at home for an older person (or person with a disability or chronic illness) and receive payment. The minimum payment for the informal carer is EUR 375,41 per month and EUR 749,01 for acute care conditions. The informal carer has the right to a minimum of 3 days of leave per month during which the municipality must provide for the care. Informal carers are insured against occupational accidents and diseases and the municipality has to pay for pension contributions.

The number of professional LTC carers in Finland amounted to 73.500 in 2010. This means a substantial rise of 26,1% with respect to 2000, when the number of professional carers in LTC was 57.100. In the same period, the number of social and health personnel rose by 2,3%.

That means that 78,1 carers per 1.000 population aged 65 an over (2000: 73,5) worked in Finland in 2010. Most of the personnel belonged to public services (48.500) and non-profit organizations (12.500), while the number of professionals from private for-profit organizations amounted to 12.400. 24.000 carers worked in the field of residential homes, health centres and other long-term inpatient institutions, 23.500 in the different forms of sheltered housing, and 21.400 in home care. 32.760, or 44,6% of carers in LTC had received training as practical nurse (*lähihoitaja*), 17.535 as home aid (*kodinhoitajat*).

4. POLICY AND RECENT DEVELOPMENTS

The political goal of Finnish governments with regard to LTC and elderly care since the beginning of the 1990s is to reduce the number and the proportion of elderly people living in LTC institutions and to increase the number and the proportion of elderly people living at home or in sheltered housing.

As already stated above, partly as a consequence of long during discussions about sometimes poor quality, but also to ensure good LTC service in the future, the Finnish government suggested a reform for LTC in 2012. The “Act on Supporting the Functional Capacity of the

Ageing Population and on Social and Health Care Services for Older People" was adopted by the Finnish parliament on December 28th 2012 and entered into force on July 1st 2013.

Two groups are in the centre of the new act:

- older population, defined as population aged 63 and older, and
- older persons, defined as those whose physical, cognitive, mental or social functional capacity is impaired due to illness or injuries that have developed or worsened due to high age or to high age-related degeneration.

Central objectives of the new act are:

- give priority to services provided at home
- institutional LTC should be provided only if medically justified or necessary to guarantee a safe and dignified life for older people.

Finland has also adopted a "National Memory Program 2012-2020" in 2013. The overall goal is to create a "memory-friendly" Finland on the basis of the following activities:

- Promoting brain health
- Fostering a more open attitude towards brain health, treatment of dementing disease and rehabilitation
- Ensuring a good quality of life for people with dementia and their families through timely support, treatment, rehabilitation and services
- Increasing research and education

Approximately 13.000 people are diagnosed with a memory disorder every year in Finland and this figure is growing rapidly. Just over 95,000 people had been diagnosed with at least moderate dementia and approximately 30,000–35,000 people with a mild memory disorder in 2010. It is estimated that 130,000 people will be suffering from at least moderate dementia in 2020.

The majority of LTC costs in these cases result from the need for 24-hour care. Approximately 80% of patients in 24-hour care suffer from cognitive decline or a diagnosed progressive memory disorder. In 2010, the average cost of 24-hour care was EUR 46,000 per person and year. The average cost of home care was EUR 19,000 per person and year.

Nevertheless, the incidence of progressive memory disorders and dementia can be decelerated. For example, by treating the prodromal stages of Alzheimer's disease, the onset of the disease can be delayed by as much as five years. This could reduce the incidence of Alzheimer's disease by 50% in a single generation.

5. BACKGROUND STATISTICS

Finland (FI)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.8	16.2	21.2	24.4	22.0	26.7	24.4	22.2	26.5	26.0	24.2	27.7	7.2	8.0	6.5
80+	5.0	3.3	6.5	7.8	6.2	9.3	9.6	7.8	11.4	9.7	8.2	11.2	4.7	4.9	4.7
85+	2.3	1.3	3.2	3.3	2.4	4.3	5.4	4.0	6.7	5.5	4.3	6.7	3.2	3.0	3.5
80+/65+	26.4	20.4	30.8	32.0	28.3	35.0	39.5	35.2	43.1	37.4	33.7	40.6	11.0	13.3	9.8
85+/65+	12.1	7.9	15.2	13.6	10.7	16.0	22.0	18.1	25.3	21.3	17.8	24.4	9.2	9.9	9.2
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Finland (FI)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	31.9	26.7	37.1	49.6	45.4	53.9	17.7	18.7	16.8	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	19.5	15.4	23.6	34.5	30.9	38.1	15.0	15.6	14.5	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Finland (FI)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at birth	76.6		83.2	84.4		89.2	7.7		6.0	76.7		82.5	84.6		89.1	7.9		6.5
years at 65	17.3		21.3	22.3		25.8	5.0		4.5	17.2		20.7	22.4		25.6	5.2		4.9
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at 65	6.3		6.6	8.4		9.0	2.1		2.4	8.6		8.9	8.4		8.5	-0.2		-0.4
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
at 65 (%)	37.5%		31.4%	46.9%		41.6%	9.4		10.2	52.1%		44.5%	48.3%		40.4%	-3.8		-4.1
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	2.5			5.4			2.9			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

FRANCE

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the French population is expected to grow from 5.6% to 10.6% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 2 from 2.8% to 6.6% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 32.1% to 42.6% (EU-28: 27.8%-41.5%), and from 15.9% to 26.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 30.4% (EU-28: 29.9%) to all of 47.6% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 18.5/22.7 years (EU-27: 17.2/20.7) in 2010 to 23.0/26.6 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 1.0 and 0.7 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 2.2% to 4.4% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

French public provision for the LTC needs of the dependent elderly and the disabled relies on a two-pronged system. On the one hand, the health insurance scheme covers the cost of health care provided in an institutional setting to the dependent elderly or to disabled patients. It also finances LTC units in hospitals, as well as nursing care provided in the patient's home. Such health care costs are paid for directly by the health insurance scheme, i.e. patients do not need to advance the money themselves.

On the other hand, two schemes, essentially financed by the state and by local authorities, provide social benefits to the dependent elderly and to the disabled to help them meet some of the cost of care that is not covered by health insurance, whether that care is provided in institutions or in a domiciliary setting.

For the disabled, a new benefit came into force in January 2006, called the *Prestation de Compensation du Handicap – PCH –* (Disability compensation benefit) which aims to better cover the needs of the disabled whatever the causes of the disability and the age or life-style of the person. This benefit is intended to help cover the needs of the disabled person regardless of whether those needs have to do with professional insertion, home adaptation, human and technical aids, etc. This benefit replaces the previous ACTP (third person compensatory benefit) although those who already received the ACTP can continue to remain under that scheme if they wish.

On 31st of December 2011, 184 917 people were receiving the PCH, compared to 7 180 in 2006[122]. This sharp increase can be attributed both to the fact that some people who previously were covered under the ACTP scheme transferred to the PCH benefit, as well as to the fact that this new benefit is open to a larger category of people than the former ACTP scheme (the ACTP was only open to people over the age of 20, whereas the PCH can also be claimed by children regardless of age). Average spending per beneficiary was EUR 760 per month during the first trimester of 2013[123].

The dependent elderly can also receive the *Allocation Personnalisée d'Autonomie* – APA (Personalised Autonomy Benefit) which is a universal benefit for people over 60 that came into force in 2002. This benefit is calculated based on a "help plan" designed for each individual, on the basis of the assessment of the person's needs. The APA benefit is intended to cover part of the cost of the "help plan", the rest (about one quarter of the total amount on average) is paid by the beneficiary through user fees which increase proportionally to the elderly's income. Elderly people with an income below EUR 689.50 per month do not pay user fees. The benefit amount thus varies both according to the person's level of dependency (established by a socio-medical team, using a nation-wide unified grid – the AGGIR grid – which identifies 6 levels of dependency, with only the first 4 levels being taken into account for the granting of the APA benefit) and according to the elderly's financial resources.

On December 31st 2011, there were 1,200,254 people above the age of 60 who received the APA dependency benefit. 60% of APA beneficiaries lived at home, and 40% in special accommodation for the elderly. The average amount of the help plan granted to people receiving domiciliary care was EUR 487 per month (of which around 20% are covered through user-fees), and 517 euros for institutional care (of which around 33% are covered through user-fees)[124].

The fast increase (partly unforeseen) in the number of APA recipients since it came into force in 2002 (when there were only 469,000 beneficiaries) has put a strain on public finances, especially for the départements who finance over two thirds (72%) of the cost of the APA, the rest being covered by the National Solidarity Fund for Autonomy – CNSA. Today, altogether EUR 22 billion are spent on long-term care.

Between 2007 and 2011, the institutional capacity for LTC increased by 5,3%. On 31st of December 2011 there were 10 481 LTC institutions, with a total capacity of 720 500 places. The institutional care capacity (number of beds) for inhabitants aged 75+ is 101 per thousand, but this hides strong geographical disparities, for example the coverage is 31 per 1000 in Paris but 185 per thousand in the Lozère department[125].

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122 http://www.drees.sante.gouv.fr/spip.php?page=recherche#articles

123 http://www.drees.sante.gouv.fr/IMG/pdf/pch_2_2013_t1-2013.pdf (accessed on 19-11-2013)

124 DREES (2013) « Allocation personnalisée d'autonomie (APA) : données trimestrielles sur les bénéficiaires, les montants moyens et les GIR » available from (accessed 19-11-2013)

125 DREES (2013), "Enquête auprès des établissements d'hébergement pour personnes âgées en 2011(EHPA 2011, DREES) »

3. CARERS

According to survey data, there are about 3.5 million informal carers when counting care for people across all levels of dependency. From the same data, it can be estimated that there are at least 300,000 informal carers tending to people with severe LTC needs.

As much as 85% of informal carers are close relatives of the 'cared-for' old person. However, informal carers also include neighbours and friends (9%) in particular for single people living at home. Intergenerational relationships in the family remain important as elderly care by a descendant is based on the notion of giving and receiving at different periods in life. 50% of the main care-givers are spouses and 30% are children.

When the partner/spouse or children are the main carers the informal carer is typically a woman. Older men are mainly cared for by their wives, while older women, often widowed, are mainly cared for by a daughter. Due to female life expectancy, adults are likely to care for their mothers or mothers-in-law.

The highest likelihood that someone will become a family carer seems to be between 60 and 75 years of age. When the informal carer is the spouse, the average age is 70; when they are the child, the average age of the informal carer is 51. Spouses typically provide LTC in relation to both ADL and IADL limitations. Children are more likely to handle only IADL tasks.

Although the family is the main provider of care for the elderly, there is no real 'care for the carer' policy in France. But this does not mean there is no attempt to contribute some support to informal care-givers. Working carers can benefit from the right to leave their job for three months without losing retirement rights. Informal carers also have the possibility to have caring qualifications recognised. Three measures tend to increase the value of informal care: The creation of a specific status of informal care-giver in law; the creation of 'the informal care-givers' notebook' which gives information to the caregivers about their rights; and the possibility for informal care-givers to be paid, thanks to the APA allowance.

4. POLICY AND RECENT DEVELOPMENTS

The President announced at the end of 2007 that a bill would be proposed to the Parliament early 2008 concerning the creation of a fifth social insurance branch, aiming at covering the loss of autonomy for the disabled and the elderly. A senatorial information mission was set up in order to follow up on the preparatory work around this proposed scheme. The senatorial mission published its report in July 2008 (the 2008 Vasselle Report[126]). However, the adoption of the bill relative to this fifth social insurance scheme ("l'assurance cinquième risque") has been postponed several times, after some more expert reports, the last of which being the 2011 Vasselle Report.

Among the guidelines adopted by the Senate based on this report are:

- The rejection of the proposal to create a fifth branch of social security given the worsening situation of public finances,

[126] cf. Annual Report 2010 France.

- The principle of a "mixed public-private financing", combining a "high base level of solidarity" with (non-compulsory) private insurance involved in a complementary manner,
- Widespread coverage of the population by private insurance through the reorientation of life insurance policies or retirement plans towards a dependence guarantee, along with the integration of a dependence guarantee in the supplementary health coverage contracts,
- The possibility to reclaim part of the dependency benefit on the inheritance of the more wealthy elderly to finance part of the personal autonomy allowance (APA)
- The introduction of a second day of solidarity,
- The alignment of the General Social Contribution (CSG – Contribution Sociale Généralisée) rate paid by retirees on that of working people.

There was thus a clear re-orientation of the debate away from the idea of setting up a fifth social insurance scheme, the government having highlighted the difficulty in financing a new social insurance scheme in the present context of important public deficits.

Further to these two reports, a national debate was launched in February 2011, involving a six months consultation process with parties, trade unions, associations, representatives from religious groups, etc. Four task groups were set up to deal with different aspects of long-term care. The first group addressed the issue of ageing and the place of elderly people in society. The second group dealt with the demographic and financial forecasts of long-term care. The third group dealt with care facilities and support for the elderly, addressing amongst other things the use of the new care technologies and examining the transformation of professions in the care sector. Finally, the fourth group sought to develop a strategy for the long-term care coverage of the dependent elderly. The issue of financing (new modes of financing and the cost for individuals and families) was at the center of this group's reflexions. These consultations provided the basis of a report submitted to the President in July 2011[127]. This was intended to lay the ground for the proposal of some preliminary measures to be integrated in the Social Security Funding Bill in 2012 (voted in the autumn of 2011).

However, no financial measures were integrated in the Social Security Funding Bill and the government announced that any new measure would be postponed to early 2012. Beginning of January 2012 the government announced that reform plans had been dropped. According to the government, it would be irresponsible to set up new measures given the economic crisis and dire state of public finances[128].

In 2013, the government introduced a new Additional Solidarity Contribution for Autonomy (CASA). This takes the form of an extra 0.15% tax that is levied on the income of pensioners who pay income-tax, on top of the 0.15% tax they already paid (this was expected to bring in 450 million euros in 2013 and 640 million in 2014). However, CASA has not been allocated to LTC,

[127] RAHOLA, Axel, Rapporteur du Comité interministériel de la dépendance (2011), *Synthèse du débat national sur la dépendance*, Ministère des Solidarités et de la Cohésion sociale.

[128] Le Monde (05-09-2011), « Le discret enterrement de la réforme de la dépendance ».
Le Monde (06-01-2012), « Roselyne Bachelot renonce à la réforme de la dépendance ».

but was instead rechanneled on "an exceptional basis" to the Old Age Solidarity Fund in 2013. The 2013 Social Security Financing Bill indicates that this will be the case in 2014 also[129].

Amongst the main issues that have been at the forefront of public debate, the issue of the costs that users have to meet themselves for the care they receive, especially in institutions, has been particularly central. Indeed, despite the APA benefit, the remaining cost that users have to meet themselves remains high – between 2200 and 2900 euros a month for institutional care, and 1400 euros on average for domiciliary care. Since no reform has been implemented, the situation has not changed in this respect.

Another critical issue relates to the governance of the system. As the system stands today, there are a great number of actors involved in the financing and organisation of long-term care which makes the system very difficult to understand and make good use of for the dependent elderly and their relatives, and also creates many inequalities between beneficiaries.

Another issue has to do with the strong socio-economic differences that prevail in France with regard to the risk of dependency or rather with respect to healthy life expectancy[130]. This is a reflection both of the strong inequalities that prevail in access to healthcare throughout the life-course, but also of the LTC system since the costs of LTC services remain excessively high for those on low incomes.

The issue of a LTC reform is particularly pressing in light of the forecasted evolutions. A recent publication by the DREES / Ministry for Social Affairs[131] has compared different long-term projections for the number of dependent people. The intermediate scenario suggests that there will be 2,3 million beneficiary of the Allocation Personalisée d'Autonomie – APA (Personalised autonomy benefit) in 2060, compared to 1,2 in 2012. Differences between the 3 scenarios are moderate until 2030 but increase thereafter when the baby-boom generation reaches the age of 80.

The transition of individuals from autonomy to the various levels of dependence and ultimately to death is also modelised, based on individual characteristics: sex, age, number of children, relative education level (compared to the cohort's average). Results indicate that the length of time spent receiving the APA benefit would increase from 4 years today to around 5 years in 2020, and to 6 years in 2040. The proportion of people having experienced a state of dependence before their death would also increase, from 25% today to 32% in 2020 and 36% in 2040.

This study further suggests that the proportion of dependent elderly receiving informal care from family members is likely to decline. Today, 80% of dependent elderly above the age of 60 living at home receive regular help from a relative. This is particularly due to the baby-boom generation become very old. While today this generation are the ones who are potential care-givers, when they reach the age of 80 their children will be fewer, more will be still professionally active (not least women) and thus less available, and also the children will be older due to increases in life expectancy and possibly less healthy or even deceased. All these factors are likely to lead to a deterioration in the ratio between the dependent elderly and potential informal care-givers.

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[129] The Minister in charge of elderly people has justified this with the fact that since the reform of LTC has not yet been passed, money cannot be affected to any LTC scheme.

[130] http://www.inserm.fr/espace-journalistes/esperance-de-vie-en-bonne-sante-dernieres-tendances

[131] DREES (2013), « Projection des populations âgées dépendantes. Deux méthodes d'estimation», Dossiers Solidarité et santé, n°43, septembre.

This analysis also indicates a stronger progression of the number of dependent elderly in institutions compared to home care. The average increase in the number of dependent elderly in institution would be 2.2% per year compared to 1.9% for those living at home. Between 2010 and 2040, the proportion of dependent elderly in institutions would increase from 35% to 37%.

5. BACKGROUND STATISTICS

France (FR)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	17.6	15.3	19.7	23.1	20.8	25.4	25.2	22.5	27.7	24.8	22.3	27.3	7.2	7.0	7.6
80+	5.6	4.0	7.2	7.3	5.8	8.7	9.9	8.0	11.8	10.6	8.6	12.5	5.0	4.6	5.3
85+	2.8	1.8	3.8	3.5	2.5	4.4	5.6	4.2	7.0	6.6	5.1	8.2	3.8	3.3	4.4
80+/65+	32.1	26.3	36.3	31.7	28.2	34.4	39.5	35.4	42.7	42.6	38.6	45.8	10.5	12.3	9.5
85+/65+	15.9	11.5	19.1	15.0	11.9	17.3	22.4	18.6	25.4	26.7	22.7	29.9	10.8	11.2	10.8
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**France (FR)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	30.4	26.0	34.7	47.6	41.6	53.9	17.3	15.6	19.3	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.2	16.4	23.8	34.7	29.6	40.1	14.6	13.2	16.3	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**France (FR)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	77.9	84.6		85.1	90.0		7.2	5.5		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	18.5	22.7		23.0	26.6		4.5	3.9		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	8.5	9.7		9.5	10.4		1.0	0.7		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2011***			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	48.0%	44.1%		50.4%	41.8%		2.4	-2.3		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	2.2			4.4			2.3			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

CROATIA

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Croatian population is expected to grow from 4.3% to 11.0% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3.5 from 1.6% to 5.9% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 23.5% to 37.3% (EU-28: 27.8%-41.5%), and from 8.6% to 20.1% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 29.7% (EU-28: 29.9%) to all of 57.1% (EU-28: 55.3%).

In 2012 healthy life expectancy for men and women with 7.7 and 8.2 years, respectively, was below the EU average.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.6% to 3.0% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

Up until 1990, Croatia, like many socialist countries, had no long-term care policy. Care for the elderly and the frail fell upon their families, or as a last resort, institutions (hospitals, nursing homes, etc.). A major overhaul of the social protection system after 1990s and the subsequent reforms of health and social welfare system did not pay too much attention to creating an integrated approach to long-term care. As a result, Croatia currently lacks a comprehensive long-term care strategy.

LTC in Croatia is mainly PAYG financed (from contributions in health care system and from taxes within the social welfare system) and dispersed between the health and the social welfare systems.

Long-term care in Croatia is organised within the system of social welfare, at the national as well as the regional level. Health protection for the elderly and infirm is provided through the health care system.[132]

Long-term care is organised on the principle of social assistance and financed mainly from the state budget (96%), while the remainder comes from beneficiaries' participation in payment of costs of care outside one's own family. Local and regional self-governing units participate in the financing of the system and organisation of social welfare services within the scope of their competences.

Long-term care is covered by health insurance through hospital facilities (e.g. psychiatric or geriatric departments in hospitals). If a person is placed in a social welfare institution or nursing

[132] I.e. the right to health visitor, the right to sanitary transportation, to right to home health care.

home, health care is provided based on the contract with health teams in those institutions or with local health centres. It is admitted even in the National Health Development Strategy 2012-2020 that there are no reliable data on expenditures for long-term care including health care for elderly. Based on the number of days in hospital treatment and expenditure for health care of elderly at home, a ballpark figure is that this expenditure in 2011 amounted to 0.1% of GDP, but this should be taken with caution.[133]

The persevering problem of long-term care in Croatia is that it is dispersed between health and social welfare system, which has a negative impact on accessibility, recognisability and adequacy of the provided services. According to the World Bank, long-term care for many elderly people is provided at high cost and with long waiting lists by hospitals and other facilities within the health system, even when social services would better satisfy the needs of such persons than medical services.[134]

There is a considerable coverage gap regarding the estimated number of dependent people (around 300,000) and those who have actually received some type of care (estimated around 50,000 people in the past[135]) and shortages of formal services in institutionalised context. There are long waiting lists for county nursing homes, whereas private providers are financially unaffordable to many. Lack of informal care will likely increase the demand for institutionalised types of care. Wheras the number of beneficiaries of institutional care increased between 2003 and 2009 by 19%, the number of institutions (mostly private) increased by 27%.[136]

According to available data for 2011, there were 23% beneficiaries of social welfare services in the 66 – 80 age group and 8% in the 80 years and over age group among the total number of adult beneficiaries of welfare services (18+).[137] Among persons without sufficient means of livelihood (23.2% of the total number of adult beneficiaries), the share of elderly and infirm was 47%, while the share of seriously ill was 52%. According to the data from the Ministry of Social Policy and Youth, in 2012 there were 45 county-owned nursing homes for elderly and frail with 10,574 beneficiaries, 84 nursing homes established by other founders (private, local municipalities, etc.) with 4,550 beneficiaries[138] and two state-owned nursing homes with 167 beneficiaries. In addition, there are numerous so-called family homes for elderly and frail persons (no estimates regarding the number of beneficiaries are available) and 18 state-owned homes for mentally ill adults with just over 3,000 beneficiaries. Although support for non-institutional types of care is proclaimed as one of the overarching objectives of policies for elderly and frail persons, the pressure on institutional forms of care for elderly remains constant. According to the available data from 2010, the largest share of beneficiaries of institutional care was in the age group of 80+ (44.3% of all recipients), out of which 77.8% were women. Given the multitude of social entitlements and a non-unified census on which these entitlements are granted, it is extremely difficult to provide exact data regarding the number of beneficiaries and rights accorded to elderly and frail within the social welfare system. According to data retrieved from the Ministry

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133 National Health Development Strategy 2012-2020, op. cit. (FN 37).

134 The World Bank (2012), op. cit. (FN 62).

135 In 2009, 23,400 adults and elderly were taken care in LTC institutions (public and private homes for the elderly, disabled, mentally ill); additional 15,200 received home-based or day care services in 2010; 3,100 received foster care; 2,400 received care at home; there are 6,000 hospital beds for chronically ill. The World Bank (2012), op. cit. (FN 62).

136 The World Bank (2012), op. cit. (FN 62).

137 Croatian Bureau of Statistics, Beneficiaries and services of social care 2011, First Release No. 8.4.1., 9 July 2012.

138 The address book of nursing homes by other founders on the web-site of the Ministry of Social Policy and Youth counts 118 nursing homes.

of Social Policy and Youth,[139] beneficiaries of services, including institutional services in 2012 include 1,191 persons who received aid and care at home, 319 elderly and frail persons and 356 mentally ill adults who received the services of day-care in a social welfare home, 4,165 elderly and frail and 4,117 mentally ill adults in residential nursing homes, 822 adults and elderly persons in family homes and 3,549 adults and elderly in foster care. However, these figures refer only to beneficiaries for whom the state covered the entire cost of the service.

It is impossible to estimate exactly how much public funding is spent on long-term care policies, since they are dispersed between the health care system and the social welfare system. In the health care part, it is estimated that around 0.1% of GDP was spent in 2011 on hospital treatment and health care of elderly at home. The total share of social welfare expenditure in 2012 was 0.94% of GDP, of the majority (0.6%) concerns compensations and welfare assistance. Around 95% of those expenses are financed from the state budget, with the remaining covered from participation by the insured persons. Local and regional expenditure for the entire social welfare component in 2012 amounted to HRK 2.5 billion.

3. CARERS

The scale of informal family care in Croatia is above the EU27 average. Around 17% of the respondents aged 35-49 report having to care for elderly relatives at least several times a week.[140] The age cohort 50-64 apparently bears the greatest load when it comes to taking care of elderly: 24% female respondents and 13% male respondents of that age group are involved in those activities, which places Croatia among the top three countries in Europe (after Italy and Estonia).[141]

4. POLICY AND RECENT DEVELOPMENTS

The following rights for the elderly and frail persons are guaranteed under the Social Welfare Act[142], which was enacted in 2012: supplement for assistance and care, assistance and care at home, daily stay, accommodation in institution. In addition to these rights, the Ministry of Social Policy and Youth has continued to finance two broad programmes for elderly from the previous years, which are directed at providing non-institutional forms of care: "In-home assistance to elderly" and "Day-care services and in-home assistance to elderly". Beneficiaries are persons over 65 years of age and the programmes are primarily aimed at those who live in single households or whose family members are not able to provide adequate care, persons without sufficient means of livelihood, persons with diminished functional capabilities and poor health, as well as persons who are not using other rights and services from other systems. Services are provided through 91 local and regional self-government units who have contracted these services

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139 Ministry of Social Policy and Youth (2013), Annual statistical report on rights in social welfare, legal protection of children, youth, marriage and persons devoid of capacity to exercise rights and on protection of bodily or mentally injured persons in Croatia in 2012.

140 EU-27 average is 15% for women and 7% of men. Interestingly, there are no gender differences in that age cohort in Croatia, whereas in the age cohort 50-64 the gender gap is significant: 24% of women as opposed to 13% of men take care of elderly relatives. European Foundation for the Improvement of Living and Working Conditions (2010), Second European Quality of Life Survey: Family Life and Work, retrieved on 05.03.2012 at http://www.eurofound.europa.eu/pubdocs/2010/02/en/1/EF1002EN.pdf, 23.

141 Loc.cit.

142 Social Welfare Act, Official Gazette of the Republic of Croatia, *Narodne novine* no. 33/12.

with the Ministry. Currently about 160 local communities implement these programmes, with 15,550 elderly beneficiaries. 1,045 persons are employed through the programmes. The financing of the programmes continues, despite the fact that no strategy is adopted in this connection.

In 2011, amendments to the Health Protection Act[143] enabled the performance of palliative care at secondary level and establishment of departments for palliative care within hospitals. There are currently 142 contracted hospital palliative beds, as presented in the Strategic Plan of Palliative Care 2014 – 2016, which was prepared by the Ministry of Health in July 2013. The Plan envisages the opening of five regional centres for palliative care in the next four years. The Plan is based on estimates that only few hundred out of over 50,000 persons who die each year receive palliative care. The needs exceed capacities, since it is estimated that a minimum of 20% of tumor patients and 5% of non-oncological patients need palliative care in the last year of their life. According to the Plan, the goal is to have at least 175 palliative beds per clinical hospital and 85 beds per special hospital by 2016, while the remaining 85 beds would be allocated in children and psychiatric wards, health facilities at primary level, prison hospitals, etc.[144]

World Bank analysts warn that the demographic transition will result in much heavier public spending on long-term care for three reasons: (i) public spending per LTC beneficiary is likely to rise with income levels and standards of living, but given the fact that Croatia currently lags in the quality of LTC services, expenditures per LTC beneficiary are likely to increase faster than income per capita; (ii) currently, relatively few of the dependent population actually demand formal LTC services or receive publicly funded in-kind benefits and that number is likely to rise in the future; (iii) the dependent population is expanding.[145]

As a result of the fact that LTC is PAYG –financed, the system will become increasingly unsustainable in the future.

The World Bank analysts point to several directions when it comes to the LTC policy reform. On the supply side, LTC needs to shift from medical to social care services; social services must shift from institutionalised to community-based care (e.g. assisted living, day care, home-based care); LTC sector needs to be reorganised to move from care fragmentation to care coordination. Since public sector will not be able to provide the increasing care in the future, a shift to private sector is expected; shifting from in-kind to cash benefits and vouchers is an option to support informal care and subsidise demand for services provided by the private sector.

In the short term, the World Bank suggests that the Government should refresh the LTC strategy and consolidate responsibility for LTC policy, expand LTC services in direction of community-based care; decrease publicly provided LTC care and financing fragmentation.

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143 Act on Amendments to the Health Protection Act, Official Gazette of the Republic of Croatia, *Narodne novine* no. 84/11.

144 Ministry of Health, retrieved at http://www.zdravlje.hr/novosti/novosti/ministar_ostojic_predstavio_strateski_plan_razvoja_palijativne_skrbi_2014_2016 on 30 October 2013.

145 World Bank (2012), op. cit. (FN 62).

5. BACKGROUND STATISTICS

Croatia (HR)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.1	14.8	21.3	24.1	20.9	27.1	27.3	24.1	30.2	29.5	26.8	32.1	11.4	12.0	10.8
80+	4.3	2.7	5.7	6.1	4.3	7.7	9.4	7.2	11.5	11.0	8.9	13.0	6.7	6.2	7.3
85+	1.6	0.8	2.2	2.8	1.7	3.7	4.8	3.4	6.2	5.9	4.4	7.4	4.3	3.6	5.2
80+/65+	23.5	18.6	26.7	25.2	20.6	28.5	34.4	29.8	37.9	37.3	33.1	40.6	13.8	14.5	13.9
85+ /65+	8.6	5.8	10.4	11.5	8.3	13.7	17.7	14.1	20.4	20.1	16.4	23.1	11.5	10.6	12.7
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Croatia (HR)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	29.7	23.3	36.0	57.1	50.1	64.3	27.4	26.8	28.4	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.1	15.2	25.0	40.3	34.6	46.2	20.2	19.4	21.2	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Croatia (HR)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at birth	:		:	:		:	:		:	76.7		82.5	84.6		89.1	7.9		6.5
years at 65	:		:	:		:	:		:	17.2		20.7	22.4		25.6	5.2		4.9
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at 65	:		:	7.7		8.2	:		:	8.6		8.9	8.4		8.5	-0.2		-0.4
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
at 65 (%)	:		:	51.5%		43.7%	:		:	52.1%		44.5%	48.3%		40.4%	-3.8		-4.1
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	:			:			:			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

HUNGARY

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Hungarian population is expected to grow from 4.1% to 11.6% (EU-28: 5.1%-11.8%), i.e. to more than double by gradually increasing over time. At the same time the share of people 85+ will expand by more than a factor 3 from 1.7% to 5.9% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 27.7% to 38.6% (EU-28: 27.8%-41.5%), and from 13.3% to 23.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 27.4% (EU-28: 29.9%) to all of 57.4% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 14.0/18.1 years (EU-27: 17.2/20.7) in 2010 to 20.9/24.6 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 1.3 and 1.4 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.8% to 1.6% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

Hungary has no integrated LTC system. LTC services are administered within the health care system and the social care system. The two branches have their own legislation, financing mechanisms and services. They maintain parallel institutional networks both in institutional care and home care. Cooperation between them is still weak, despite some minor improvements over the last three years due to the concentration of health care and social affairs portfolios into one single authority, the Ministry of Human Resources (MHR).

The services provided in health care are nursing care in the nursing sections of hospitals and home nursing care. The three main types of services in social care are home care (including "meals on wheels" services), day care and residential care. Key figures of the system are presented in Table 2.

The LTC-system does not offer benefits that enable recipients to access services. There is only one type of social allowance for relatives who provide care for a disabled family member; i.e., the nursing allowance (*ápolási díj*). Applications, based on the expert opinion of the GP, are to be submitted to the local authority. The nursing fee can also be claimed by relatives caring for a severely disabled or a permanently ill young (<18) family member. Therefore, the nursing allowance is not specifically targeted to LTC of the elderly. In addition, social legislation allows local governments to provide financial help to relatives caring for a family member aged over 18. The government spent 0.07 per cent of GDP on nursing allowances.

Table 1. Summary statistics of the LTC-system

	2010, total	2011, total	2011, per 1000 inhabitants	2011, per 1000 65+ inhabitants
Health care				
Acute wards	44 388	44 403	4,5	
of which acute psychiatry	*2 991*	*2 991*	*0,3*	
Chronic beds	27 149	27 094	2,7	
of which lasting care	*2 606*	*2 626*		*1,6*
chronic psychiatry	*5 655*	*5 643*		*3,4*
pulmonology, after-care, rehabilitation	18 888	18 825	1,9	
Home nursing care patients	50 441	53 509	5,4	
of which 65+	*35 398*	*37 740*		*22,5*
Social care				
In kind				
Home care recipients	75 054	87 941		52,3
Home care nurses, total	10 611	11 975		7,1
Meal-on-wheels recipients	146 443	155 091		92,3
Alarm system-based home assistance	25 242	25 503		15,2
Attendees of day-care for elderly	37 905	37 066		22,1
Number of elderly homes		1 004		
Residents in elderly homes	51 736	52 140		31,0
Unit cost of residential care (% of per capita GDP)	24	23		
Unit cost of home care (% of per capita GDP)	6	6		
In cash				
Recipients of nursing allowance	56 853	57 970	5,8	
Total spending on nursing allowance (% of GDP)	0,07	0,07		
Nursing allowance per recipient (% of per capita GDP)	13	13		

Source: CSO 2012b,c; annual government budgets[146].

All other LTC expenses finance in-kind services.

Unit costs of both residential and home care are low in comparison with the EU. Both in 2010 and 2011 the financial support was HUF 635,650 (about EUR 2,100) for residential care a year, an equivalent of 24 and 23% of annual GDP per capita in these two years. The corresponding figure was HUF 166,080 (around EUR 550) for home care in both years, which made about 6% of GDP per capita.

The bulk of LTC activities are carried out by households or within the informal market.

[146] The source of the data is the Yearbook of Welfare Statistics of the Central Statistical Office, which, by its nature follows the events with a delay of somewhat more than a year. A recent development in the sector, the creation of a social register based on half-yearly reports of welfare institutions, gives the opportunity of more updated decision making. For the time being this data base is not available for research.

3. CARERS

Nursing professionals in the formal labour market have experienced significant gains in qualification over the last two decades (see Table 2). By 2011 the number of nurses was roughly equal to that of the mid-1990s but currently two in three are qualified for the job, as against one in five in 1995.

Table 2. Carers in formal care

	Number of nurses	of which (%)		Number of care recipients by nurse
		professional	qualified	
1995	12 448	38	21	3,6
2000	8 664	54	36	4,7
2005	7 601	71	53	5,9
2010	10 611	81	66	7,1
2011	11 975	83	67	7,3

Source: CSO 2012c.

Yet, a large part of LTC activities are left to untrained informal carers such as relatives and carers of the informal market. Empirical evidence shows that familial relations play a particularly important role in long-term care for the elderly. Early analysis of the 4th wave of SHARE (Survey of Health, Ageing and Retirement in Europe), which for the first time included Hungary, found that Hungarian older people are the most likely to mention their children among the confidants they can rely on and second most likely to name their spouses (Stoeckel and Litwin 2013).

4. POLICY AND RECENT DEVELOPMENTS

Until recently, the LTC system was still reminiscent of a central-planning logic. Thus translated into centralisation, a preference for institutionalised care compared to managing personal networks such as home-based care and a degree of organisational blindness against needs that are beyond the system's sphere of operations. The result of this is a dual structure. On the one hand, a centralised system of institutions and, on the other hand, a wide range of household activities by which people adjust to the situation.

This institutionalised structure is shifting to home care. Whereas residential capacities remained practically unchanged, currently the number of home care recipients and nurses has grown by about 80 percent between 2008 and 2011 and meal-on-wheels services by about 40 percent (see Table 3).

The expressed government preference, also introduced in the new Constitution, for intergenerational responsibility within the family is indicative of further steps towards de-institutionalisation.

Table 3. Dynamics in home care, 2008-2011

	2008	**2009**	**2010**	**2011**
Total				
Recipients of home care	48 120	63 392	75 054	87 941
Nurses in home care	6 815	9 433	10 611	11 975
Recipients of meal-on-wheels services	107 803	124 693	146 443	155 091
2008=100				
Recipients of home care	100	132	156	183
Nurses in home care	100	138	156	176
Recipients of meal-on-wheels services	100	116	136	144

Source: CSO 2012c.

5. BACKGROUND STATISTICS

Hungary (HU)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	17.2	13.4	20.6	21.9	18.0	25.5	26.7	23.4	29.9	29.4	26.6	32.1	12.2	13.2	11.5
80+	4.1	2.5	5.5	6.0	4.0	7.7	8.0	5.8	10.0	11.6	9.4	13.7	7.5	6.9	8.2
85+	1.7	0.9	2.4	2.7	1.6	3.7	4.5	3.0	5.9	5.9	4.4	7.4	4.2	3.5	5.0
80+/65+	23.8	18.9	26.7	27.3	22.5	30.4	29.8	24.7	33.6	39.4	35.1	42.7	15.6	16.2	16.0
85+/65+	10.0	7.1	11.7	12.4	9.2	14.5	16.8	12.8	19.8	20.1	16.6	22.9	10.1	9.5	11.2
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Hungary (HU)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	27.4	20.6	34.0	57.4	50.2	64.9	30.0	29.6	30.9	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	17.4	12.3	22.2	39.6	33.7	45.6	22.2	21.4	23.3	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Hungary (HU)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	70.4	78.4		81.9	87.4		11.5	9.0		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	14	18.1		20.9	24.6		6.9	6.4		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	5.1	5.0		6.4	6.4		1.3	1.4		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	38.3%	29.1%		45.0%	35.4%		6.7	6.3		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.8			1.6			0.7			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

IRELAND

1. DEMOGRAPHIC BACKGROUND

While Ireland currently has one of the youngest populations and lowest rate of people over 65 in the EU, the aging of the population will have significant social and economic implications as well as increased demand for long term care.

In the period 2013-2060 the share of people aged 80+ in the Irish population is expected to grow from 2.9% to 10.2% (EU-28: 5.1%-11.8%), i.e. to more than treble by gradually increasing over time. At the same time the share of people 85+ will expand by more than a factor 4 from 1.3% to 5.8% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 23.8% to 47.1% (EU-28: 27.8%-41.5%), and from 11.0% to 26.8% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 29.2% (EU-28: 29.9%) to all of 55.1% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 16.8/20.0 years (EU-27: 17.2/20.7) in 2010 to 22.2/25.5 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 1.8 and 2.1 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.1% to 2.7% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

The Health Service Executive is the national public provider of health and social care.

The Nursing Home Support Scheme (NHSS) was introduced in 2009 with the aim of providing consistency in how nursing home care was funded by the State and individuals. It aimed to ‘make long term nursing home care accessible, affordable and anxiety free’. It replaced a Nursing Home Subvention Scheme which hugely subsidised some people’s care but left many paying for the majority of the extremely high costs of their care.

All nursing homes both public and private are eligible for the NHSS. Under the scheme people make a contribution of 80% of their income and 7.5% of the value of any assets towards the cost of care and the State will pay the balance. The first EUR 36,000 of your assets, or EUR 72,000 for a couple, is not counted in the financial assessment. Where assets include land and property in the State, the 7.5% contribution based on such assets may be deferred and collected from your estate. This is an optional Nursing Home Loan element of the scheme. The Programme for Government committed to reviewing the NHSS in 2013.

Recent figures show there are currently 21,967 people funded by the Health Service Executive (HSE) in long term residential care. These figures show there are currently 5,056 people in public nursing homes, 14,942 in private sector and 1,849 in ‘subvention’ and ‘contract’ beds which are

also private sector beds. While the vast majority of these are over 65, some of them maybe people with long term residential needs who are under 65 years of age. It is not possible to get an age break down of those funded.

The NHI survey finds different figures. Its latest 2010 survey found a total of 30,223 public and private nursing homes beds, 20,590 in private sector, 9,633 in public sector totally 30,233. These figures also include people with disabilities who are under 65 and in need of long term care. They also include short term and convalescent beds and empty beds.

The NHI survey found that 4% of residents were under 65 years of age, 11% were between the ages of 65 and 75, 37% were 76 to 85, while 48% were aged over 85 years. This survey also found 16% of residents were low dependency, 30% medium dependency, 54% were high dependency. It also found that in 2010, there were 15.5 people aged 65 and over per nursing home beds.

There has also been a persistent problem of older people remaining for long periods of time in acute hospital beds despite numerous efforts to address this problem. These are known as delayed discharges. While not all delayed discharges are over 65 years of age, the majority of them are.

Figure 1. Average number of delayed discharges in Irish public hospital beds

Year	**Average no of delayed discharges in Irish public hospital beds**
2007	548
2008	709
2009	816
2010	668
2011	723
2012	682
2013 (up to June)	781

As can be seen from the above figures delayed discharge numbers remain persistently high, despite efforts to reduce them. Also there has been a consistent decrease in the numbers of public hospital beds during this time, reflecting significant budgetary cuts throughout the economic crisis. There are 1,248 fewer public hospital beds in 2007 than there is in 2013. In 2007, delayed discharges occupied 5% of public beds, by 2013, this had increased to 8.6%. This combined with declines in home care services means a greater demand for residential care,

There has been a consistent decline in public nursing home facilities since and an increase in private facilities, encouraged through generous tax breaks introduced in 2001 and 2002. For example, the NHI 2010 survey found 9,633 public beds, whereas most recent HSE figures show 5054 public beds. The NHI also details how the numbers of private nursing home bed numbers for older people increased from 14,946 in 2003 to 20,950 in 2010. While some of the NHI survey beds could be short term, convalescent and disability beds, many public beds have shut in the last

three years. This is a combination of the shortage of funding and many of the public facilities are in old buildings which do not meet new quality and safety standards.

It is expected that over 13,000 additional residential long-term places, a 50% increase, will be required by 2021 to meet population need, when compared to the number of places provided in 2006 which was 22,500. It was projected that an additional 700 residential places would be needed each year between 2006 and 2021 to meet this need.

Figures from the Health Service Executive for June 2013 show 21,867 patients in long term residential care beds which are funded. These figures differ from the most recent Nursing Homes Ireland (NHI) survey which found 30,223 beds. The differences may be explained as they include people resident who are not state funded, those in short or convalescent beds, as well as empty beds. The HSE figures may include some people under 65 in their figures.

There are 27,324 people with an intellectual disability in Ireland, of these 3,452 (12%) are over 55 years of age. This report gives no further age breakdown. Of those over 55, the cast majority of them were living in a residential or group home setting. There are 25,170 people living with a physical or sensory disability, of these 3,363 (13%) are 60 to 65 years old. This research gives no figures for those over 65 years of age.

According to European figures provided public expenditure on LTC is 1.1% of GDP. Most recent Department of Finance figures show that in 2012, €962 million was allocated to LTC. This increased to an allocation of €974 million in 2013.

These same figures also show a decrease in other services for older people budget, reflecting across the board cuts to community care, in 2012, there was a €403 million allocation, in 2013, this was reduced to €392 million. The overall HSE budget for 2013 is €12.3 billion, therefore LTC represents 7.9% of the whole public health budget, and when combined with community based care for older people represents 11% of the health budget.

Home care services in the form of home help and home care packages were formalised in the mid-2000s. In line with government policy of caring for people at home and in the community, there was a substantial increase in home help hours and home care packages up to 2008. Since 2008, there has been a steady decline in both since 2008, reflecting cuts to overall health budget and staffing. In 2005, seven million home help hours were provided. By 2008, this had risen to 12.6 million hours. In 2012, 9.8 million hours were provided, over 2.5 million fewer than four years previously.

Ireland does not have a universal health system. The Irish health budget quadrupled between 1997 and 2007, however due to budgetary cutbacks in the context of the economic crisis, there has been a 12% decline in the health budget and 11,000 fewer staff since 2008/9.

People with medical cards are entitled to a health and social care including GP care without charge. Medical cards are means tested and provided on the basis of need. From 2001 to 2008, all people over 70 years of age had medical cards. Since then, medical cards for over 70 years are also means tested but at a higher level than those for under 70 year olds.

There have been significant increases in medical cards since 2008 reflecting decreasing incomes and higher levels of unemployment due to the economic crisis. There have also been increases in GP visit cards which were introduced in 2005. Most recent figures available show 1,868,565 people with medical cards and 126,031 with GP only visit cards.

Most recent public figures available show that 26% of those with medical cards are 65 years and over. The HIA survey found 16.6% of those with private health insurance were over 60 years of age. Initial findings from Ireland's first older age cohort study show the following in terms of coverage for older people.

Figure 2. Entitlement status

Entitlement status	65-69 years	70-79 years	80+ years
Medical cards only	32%	52%	68%
Health Insurance only	42%	8%	3%
Both	17%	39%	29%
No additional cover	10%	1%	0%

50% of the Irish population have private health insurance and many aspects of the Irish health system require out of pocket payments. Due to the absence of data on private health spending it is not possible to estimate how much of health and social care for older people is spent privately.

OECD data shows that public expenditure on health as a percentage of total expenditure on health reducing from 75.7% in 2007 to 67% in 2011, the most recent year available. This same data also shows that out of pocket expenditure as a proportion of all health expenditure increased from 14.8% in 2007 to 18.1% in 2011. This reflects the significant decline in the public health budget and a government health policy of shifting care from the state to the people. This is evident in increased charges introduced in consecutive budgets since the onset of the economic crisis in 2008.

Most aspects of the public health system apart from public health nursing are means tested or require a payment. There are also moves to tighten up eligibility for medical cards in order to slow the persistent increase in those eligible for medical cards and to decrease the numbers with full medical cards.

According to the HSE home care packages, which are made up of home help hours, nursing services, allied health professionals, day care services and respite, are not means tested. The HSE say homecare packages are provided on the basis of assessed need, in order to keep older people out of hospital or nursing homes and at home. However due to cut backs in frontline services, the reality is that it may be very hard to get home care services if you do not have a medical card or if you can afford those services. Also, as reflected in the home help hours cited above, many people in receipt of home help services have had their hours cut. There are no figures on numbers of carers, but health and social care staff in the public health system have declined since 2009 despite a growing ageing population.

Since 2008, there have been independent, unannounced inspections of all public, private and voluntary nursing homes. These inspections are carried out by HIQA – the Health Information and Quality Authority. HIQA have published standards for residential care and publish regular inspections of nursing homes.

There are no independent inspections of home care services for older people. Home care is provided in three ways – the HSE has staff who directly provide homecare, the HSE contract the private sector to provide homecare and people buy homecare privately.

Since July 2012, approved service providers are available locally for clients requiring home care services under the Home Care Package Scheme. The approved providers, appointed under the tender process, meet a new uniform level of national standards. All of the Approved Providers have committed to meeting the new minimum required standards, this a first step in an overall plan to raise standards of home care provision. It is planned that home care services will be independently inspected but legislation is required to do this and there is no date by when it shall be in place.

3. CARERS

There are no national figures on carers in employment. HSE census of employment does not count carers and many carers are in the private system. It is assumed that some carer work takes place in the informal market.

Census 2011 showed that a total of 187,112 persons or 4.1% of the total population were providing unpaid assistance to others in April 2011. Of these carers 114,113 (61%) were women and 72,999 (39%) men.

Recently published cohort data found that the vast majority of caregivers are unpaid (89.5%), with 10.5% are paid. Spouses are the most frequently identified carers and seven out of ten of them are women. Of the paid carers, 62% are in the formal homecare sector and 38% are not affiliated to any organisation or company.

4. POLICY AND RECENT DEVELOPMENTS

The current Programme for Government committed to extensive health and pension reform is specifically committed to publish a National Positive Ageing Strategy 'so that older people are recognised, supported and enabled to live independent full lives'. In 2012, a National Carers Strategy was published and in 2013 the new National Positive Ageing Strategy constituted the first policy document focussed on older people since the publication of The Years Ahead in 1998.

Within Ireland's health reform programme, and of key relevance to the implementation of the National Positive Ageing Strategy, is Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025.

The National Positive Ageing Strategy and Healthy Ireland take a whole government, whole of society approach, to health and well-being, addressing the broader determinants of health. Specifically, the National Positive Ageing strategy commits to addressing the following priority areas:

- Healthy ageing
- Health and personal social services
- Carers
- Employment and retirement
- Education and lifelong learning

- Volunteering
- Cultural and social participation
- Transport
- Financial security
- Housing
- The built environment
- Safety and security
- Elder abuse

The Positive Ageing Strategy is the over-arching blueprint for age related policy and service delivery across Government and society in the years ahead. A detailed implementation plan is due to be published for the Positive Ageing Strategy by the end of 2013.

The Programme for Government also committed to the publication of a National Alzheimer's and Dementia Strategy in 2013. This carried out an extensive consultation process in 2012 and is not yet published.

While it is national policy to support older people to live independently and in their own homes for as long as possible, there is no specific policy on independent living. Similarly, there are no specific national policies or programmes for prevention and rehabilitation of older people. The only HSE specific prevention policy for older people is a falls prevention strategy. Published in 2008, the Strategy to Prevent Falls and Fractures in Ireland's Ageing population is to provide evidence based approach to minimise the impacts of falls.

There are a range of projects which aim to prevent, support rehabilitation and schemes to promote independent living such as age-friendly housing, ICT etc.

5. BACKGROUND STATISTICS

Ireland (IE)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	12.2	11.4	13.1	19.2	18.0	20.3	24.3	22.4	26.3	21.5	18.7	24.3	9.3		7.3		11.2	
80+	2.9	2.2	3.6	5.2	4.5	5.9	7.9	6.7	9.0	10.2	8.4	11.9	7.3		6.2		8.3	
85+	1.3	0.9	1.8	2.4	1.9	2.9	4.1	3.3	4.9	5.8	4.5	7.0	4.5		3.6		5.2	
80+/65+	23.8	19.4	27.5	27.0	24.8	28.9	32.3	29.9	34.3	47.1	44.9	48.8	23.3		25.5		21.3	
85+/65+	11.0	7.6	13.8	12.4	10.4	14.1	16.8	14.6	18.7	26.8	24.3	28.7	15.8		16.7		14.9	
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2		10.2		10.2	
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7		6.2		7.3	
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7		4.0		5.3	
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7		14.8		13.1	
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7		11.8		12.1	
Old-age dependency ratios, % [2]	**Ireland (IE)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	20.5	19.0	21.9	40.5	33.9	47.5	20.0	14.9	25.6	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	12.8	11.3	14.2	32.8	27.0	39.0	20.0	15.6	24.8	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Ireland (IE)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at birth	77		82.0	84.5		88.9	7.5		6.9	76.7		82.5	84.6		89.1	7.9		6.5
years at 65	16.8		20.0	22.2		25.5	5.3		5.5	17.2		20.7	22.4		25.6	5.2		4.9
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at 65	9.1		9.8	10.9		11.9	1.8		2.1	8.6		8.9	8.4		8.5	-0.2		-0.4
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
at 65 (%)	54.5%		49.5%	60.8%		56.4%	6.3		6.9	52.1%		44.5%	48.3%		40.4%	-3.8		-4.1
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.1			2.7			1.6			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

ITALY

1. DEMOGRAPHIC BACKGROUND

Among EU countries, Italy presents relatively particular demographics: it already has one of the oldest populations with the highest life expectancy at birth and at 65 for men and women. Meanwhile non-healthy life expectancy has recently increased.

In the period 2013-2060 the share of people aged 80+ in the Italian population is expected to grow from 6.3% to 13.2% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening after 2030. At the same time the share of people 85+ will expand by more than a factor 2.5 from 3.0% to 8.0% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 29.7% to 43.9% (EU-28: 27.8%-41.5%), and from 14.2% to 26.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 35.2% (EU-28: 29.9%) to all of 58.0% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 18.1/21.7 years (EU-27: 17.2/20.7) in 2010 to 22.4/26.1 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women decreased by 2.1 and 3.0 years, respectively, and are now below the EU average.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.9% to 3.0% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

When compared to the EU situation, especially the one in most Western European countries, the main features of the Italian LTC public system are:

- the overall public expenditure, measured in terms of incidence on the GDP, is similar to the average one in the EU-27 (1,9% vs. 1,8%);
- a very strong prevalence of cash benefits programs over services;
- a relatively weak investment in residential care;
- a medium investment in home care, although this type of service is fundamentally and informally supported by migrant care workers (working and being paid directly by families).

Italy spends the equivalent of 0,86% of its GDP in *cash benefits*: this expenditure is mainly related to the "Companion Allowance", which is the program we have just referred to in the previous section. It covers more than 10% of elderly people. After Denmark and the Netherlands, Italy is the country presenting for this type of expenditure the highest weight measures as % of GDP. However, what differs in comparison with the Netherlands is the incidence of this type of program on the overall LTC expenditure: around 45% of the overall LTC goes to cash benefits

(in the EU the average is 28,9%). Moreover, in comparison with Denmark and the Netherlands, this amount of resources is provided directly to households without any request of accountability to beneficiaries. This means that a good part of these resources (around EUR 500 per month) finance the migrant care –often grey– private labour market. Another shortcoming of the "Companion Allowance" is the fact that benefits are provided as lump sum payments. There is no differentiation on the base of how severe the disability is (as it happens instead in most other EU countries: for example, Germany – which has a three levels system -, France, England, Spain, etc.).

The second but often overlooked specificity of the Italian system, which goes is the fact that any serious "ageing in place" strategy needs anyway a strong *residential care* pillar. As shown in the background statistics, LTC beds in hospitals per 100 000 inhabitants are only 17,1 in Italy, whereas in the EU they are 26,5 on average.

Compared to most Northern and Central European countries Italy has a relatively low coverage of residential elderly care. According to Italian national sources the residential care recipients aged 65+ were around 295 000. Half of the elderly recipients were aged over 85, while 74% of them were non independent. If we include all the elderly, the coverage rate is 2,4%. Not only there is a lower diffusion of residential care, but there is also limited diffusion in Italy of housing facilities envisaged for older people who are still partially able to manage themselves (e.g. flats with home automation) and do not need neither residential homes nor nursing homes.

The fact that residential care coverage is relatively so low adds pressure on *public home care provision*. This means that in Italy, many (severe) cases that elsewhere would/could be treated through different forms of residential care (last stages of Alzheimer or other forms of dementia, etc.) remain at home (also respite care is not spread in the country). Therefore, a good part of the elderly receiving care at home present complex health status.

In 2010, 175 929 older people (equal to 1,4% of the 65+) received social home care representing a level of around EUR 2000 of expenditure per capita. In relation to 2010, Istat provides also information on the number of recipients who receive both social home care and nursing home care: 86 381 elderly beneficiaries (coverage rate 0,7%).

As for nursing home care recipients the number of elderly beneficiaries was equal to 501 607 (coverage rate 4,1%) in 2010.

If we estimate the overall home care recipients as social home care beneficiaries + nursing home care beneficiaries – beneficiaries of both services, there should be almost 600 000 elderly beneficiaries receiving either / or one of the two types of home care, equal to around 4,8% of the overall 65+ population.

However, the number of hours of nursing home care, which is the service most spread, per capita per year is equal to 20. Therefore if we analyse not simply the coverage level but also the (hourly) intensity of public home care, the help provided is quite scarce and limited over time.

Neither the access nor the amount of social transfers related to the main cash benefits program (the "Companion Allowance" - CA) are means-tested. The CA is provided only on the base of needs. The criteria of access to residential and home care are quite varied in the country as well as the criteria of co-payment. Practically in the whole country means-testing is applied to define the amount of economic resources households have to provide in order to receive the service.

3. CARERS

The fact that the Italian LTC public system covers only in a limited way the needs of frail individuals (mainly elderly) and their families is confirmed by other data. Italy has the highest percentage of disabled people (15+) who are not covered through neither institutional care nor home care (77,4%). This also explains the estimated existence of around 4 million informal carers (OECD, 2013).

Informal carers are not supported by specific policies (care leaves are not very spread, flexible working hours are negotiated at the enterprise or sector level and not at the national level, respite care is not extended, training is left to specific initiatives at the local level, etc.). Instead, its main instrument is the CA.

As already underlined, the CA has originated and fostered the expansion of a migrant care market: It is estimated that that around half of CA holders use the CA to pay privately a care worker. Recent INPS data (the National Institute for Social Security) estimate the existence of around 710 000 foreign care workers (equal to 81,5% of the overall labour force in the field).

However, occupation in the LTC sector tends to go hand in hand with a lack of attention to the quality of care provided. Apart from the fact that there is almost no regulation of the migrant care market (in terms of training, connection with the public services' system), the rest of the LTC personnel in Italy is not always specialized. Compared to Western European countries, such as Denmark and Germany, we can notice that Italy tends to rely on a lower qualified LTC labour force: i.e., in Italy only 5.7% of workers in the sector are nurses and almost 70% of them are employed in home care.

Table 1. Formal LTC workers: Italy compared with Denmark and Germany (year 2008-10)

	% nurses on total formal LTC care workers	% workers at home on total formal LTC care workers
Denmark	39,3%	32,2%
Germany	26,3%	31,7%
Italy	**5,7%**	**69,1%**

Source: OECD Health Data 2012

4. POLICY AND RECENT DEVELOPMENTS

Since the mid-1990s there has been a debate about national reform of the LTC system in Italy – with various proposals being advanced on the contents, interventions and funding modalities. Yet so far, national reform of the LTC system has not been implemented.

It is only since the beginning of the new millennium that LTC issues have entered at least the public reform agenda. In recent years, several national reform proposals were put forward, but so far with limited success. The only public action specifically aimed to address care needs over the last ten years was the creation of a very modest and temporary "National Fund for Dependency" in 2007. Two other measures have also indirectly offered some assistance to those with caring needs: the establishment of a national contract for homecare workers (including personal assistants) and the "regularization" (i.e. legalization) of migrants who wished to work as personal care assistants in 2009.

In general the LTC system is still underdeveloped with significant variation among regions. It is characterized by a high degree of fragmentation among institutions as well as sources of funding and governance, with management responsibilities spread over local (municipalities) and regional authorities, according to different modalities in relation to the institutional models of each region.

The Italian LTC system presents a number of unresolved issues. The first concerns the residual role played by social care services compared with the rest of social security and health interventions. The Italian welfare system has always preferred cash benefits.

The second issue pertains to social rights (juridical) weaknesses. As opposed to health policies, social policies cannot appeal to rights guaranteed by constitutional or other kinds of laws. Policies for the elderly have always been vague and solely focused on some important but not necessarily essential aspects (for example the structural requirements for nursing and residential care facilities).

Preventive measures are not very widespread in Italy, whereas rehabilitation is becoming an intervention of growing importance aimed at older people. There are limited experiences, especially in the Centre-Northern part of the country. One of the main areas of interest and innovation has to do with differentiated types of intervention for people with dementia problems. Emilia-Romagna is one of the regions with a higher investment on developing a specific model of intervention in this field.

5. BACKGROUND STATISTICS

Italy (IT)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	21.2	18.6	23.6	25.1	22.7	27.5	29.7	27.3	32.0	30.0	27.9	32.1	8.8	9.3	8.5
80+	6.3	4.6	7.9	8.0	6.4	9.6	10.4	8.5	12.3	13.2	11.0	15.3	6.9	6.4	7.4
85+	3.0	1.9	4.0	4.1	2.9	5.2	5.4	4.1	6.8	8.0	6.3	9.7	5.0	4.4	5.7
80+/65+	29.7	24.4	33.6	32.0	28.0	35.1	35.2	31.2	38.4	43.9	39.6	47.5	14.2	15.2	13.9
85+/65+	14.2	10.2	17.1	16.2	12.8	18.8	18.3	14.9	21.1	26.7	22.5	30.2	12.5	12.3	13.1
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Italy (IT)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	35.2	30.3	40.1	58.0	52.4	63.8	22.8	22.1	23.7	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	23.9	19.8	28.0	41.7	36.8	46.8	17.8	16.9	18.9	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Italy (IT)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	78.9	84.2		85.5	89.7		6.6	5.6		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	18.1	21.7		22.8	26.1		4.7	4.4		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	9.9	10.2		7.8	7.2		-2.1	-3.0		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2011***			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	56.9%	47.9%		43.2%	31.0%		-13.7	-16.9		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.9			3.0			1.1			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

LITHUANIA

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Lithuanian population is expected to grow from 4.8% to 11.5% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3.5 from 1.9% to 7.3% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 26.4% to 44.3% (EU-28: 27.8%-41.5%), and from 10.5% to 28.1% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 30.0% (EU-28: 29.9%) to all of 52.0% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 13.5/18.4 years (EU-27: 17.2/20.7) in 2010 to 20.4/24.2 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 0.4 and 1.8 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.2% to 2.5% (EU-27: 1.8%-3.6%).

There were 2971.900 inhabitants in Lithuania at the beginning of 2013. This figure is decreasing every year, mainly due to emigration and low fertility rates. Since 2010 there was a reduction of 170 000 inhabitants. The percentage of older population (65 and above) is increasing and it is projected to increase further. At the beginning of 2012 there were 543.3 000 people above 65 (18.1 % of all population). In the last decade the number of people above 65 increased by 58.700 (12.1 %); in the same time the population in the country decreased by 479,200 (13.7 %). The largest growth was among people above 80 years old – the figure increased by 72.4 %. It is projected that the share of people above 65 will almost double up to 31,2 percent in 2060.

Life expectancy in the year 2011 was lower than the EU average: 73.65 years (males - 68.05, females - 79.14 years). Life expectancy at age 65 in 2010 was 16.35 years (males – 13.38; females – 18.25). Life expectancy at birth and at the age 65 in the last five years has increased. Due to social inequalities, the difference between male and female life expectancy in Lithuania is very big; i.e. 11 years.

Healthy life expectancy has also increased in the last five years. It is projected to further rise till 2060 by 5.7 years for males and 7.5 years for females. Healthy life expectancy at 65 (6,1 years for men and 6,7 for women) is also increasing in the country and this trend is expected to continue.

2. CURRENT LONG-TERM CARE PROVISION

LTC in Lithuania is provided in two sectors: health and social care. In the health care sector, LTC is mostly provided as inpatient services in separate nursing facilities or nursing departments in general hospitals. Between 2005-2010 the number of beds in nursing hospitals within the health

care sector increased from 2,735 to 2,835, whereas the number of hospitals dropped from 59 to 49. During the same period, the total number of nursing beds (both in nursing hospitals and in other health care facilities) increased from 3,527 to 4,614, reaching a ratio of 14.2 per 10,000 population. Patients over 65 represent 33 percent of all hospitalizations in general hospitals. There is a limit of 4 months per year of inpatient nursing care, as services provided in public hospitals are paid from the National Health Insurance Fund (NHIF). After the 4 month of treatment, a patient must be placed in a care institution controlled by the local social sector. A proposal to increase the abovementioned limit to 180 days is currently under negotiation.

In 2008 nursing services at home financed by the NHIF were introduced. 261710 services for persons with special nursing needs were provided in 2011. Palliative care services were also introduced. 28 000 services were provided and covered by NHIF in 2011. There are plans till the end of 2013 to establish 180 beds for palliative care. In 2011, the Ministry of Health has approved special requirements for geriatric services which led to the establishment of more more inpatient health services of a specialized nature for elderly people over 60 years of age.

The number of institutions in the social care sector in 2012, as well as the number of beds and recipients in these institutions is presented in Table 1.

Table 1. Institutions for long term care in social care sector

	Number of institutions	Number of beds	Number of recipients (inhabitants)
Care institutions for elderly	102	4885	4515
Care institutions for disabled	38	6190	6118
Houses of independent living	14	342	262

Source: Lithuanian Department of Statistics

Total number of beds in the social sector in 2012 is 11417, while there are 4833 beds in health care. These figures result in 30 beds per 1.000 of population aged 65+ (our calculation). The number of recipients of home care in 2012 was 15902 (12946 elderly, 2822 disabled at working age and 134 disabled children). The average number of recipients of cash benefits (care allowances) in 2012 are presented in the table 2.

Table 2. Average number of recipients of special compensations

	Number of recipients		**Expenditures (thous. LTL)**
Special Compensation for Attendance Expenses	Disabled at work age	10822	38133.9
	Above retirement age	43103	80372.3
Special Compensation for Care Expenses	Disabled at work age	6558	59922.3
	Above retirement age	31561	289628.1
Total		**92044**	**468056.6**

Source: Data of the Ministry of Social Security and Labour

Benefits in kind [147]

1. Home care

Social attendance or social care at home includes the performance of housework and care by home helpers by a team of specialists (social workers, social workers assistants, health care assistants and others at the recipients' home. Elderly and disabled people can receive day care services at home from 2 hours till 8 hours per day up to 7 times per week or short - term care up to 8 hours per day till one month at the person‘s home. Services are financed from the municipal budget. Services for persons with severe disabilities may be financed by ear-marked subsidies from the state to local budgets and directly to individuals (or families). In some cases, the provision of services may be transformed into a cash allowance. The allowance is paid to hire assistance in the household. Cash allowances are financed from municipal budgets.

Primary health care institutions are responsible for the organization and provision of nursing services at home. Palliative care and nursing services can be provided at home by a team of specialists: a doctor, nurse and social workersNursing at home is financed from the NHIF.

2. Semi-residential care

Elderly and disabled people can receive care services in day care centers during 3 hours per day up to 5 days per week. Alternatively, short-term social care for elderly and disabled people can be provided at a minimum of 12 hours per day up to 6 months per year or 5 days per week or without a time limit in institution. Long term care in residential social care institutions can be provided depending on the kind of recipients of the services, for elder persons at a minimum of 6 months per year or without a time limit.. Semi-residential care is financed from the municipal budgets or special targeted subsidies of the state budget to municipal budgets and persons (families) payments.

3. Residential care

Residential care is provided to children deprived of parental care, children and adults with disabilities and elderly people through foster families and social care houses (old-age homes, housing for disabled, specialized social care homes, etc.). Residential care is financed from the state, local budgets or special state subsidies channeled to local budgets and recipients. Nursing and maintenance treatment is provided in nursing or general hospitals. The NHIF finances long-term medical treatment in hospitals providing treatment for a period not longer than 120 days per year. Palliative care is provided in general, cancer and nursing hospitals.

Benefits in cash

1. Special Compensation for nursing and care Expenses

This compensation is paid for disabled children with a severe degree of disability, to disabled persons with a diminished ability to work (75% - 100%) or to the persons of retirement age if the need of permanent care is determined. The amount is 250% of the social insurance basic pension

[147] Benefits in kind and in cash are described according to the TRESS Analytical study "Legal impact assessment for the revision of Regulation 883/2004 with regard to the coordination of long-term care benefits" (2012). See www.tress-network.org

(currently LTL 900 (EUR 261). Since 2010, benefits are temporarily paid only at 85% of the above-mentioned amounts.

2. Special Compensation for Attendance Expenses

This compensation is paid to disabled children with a severe and moderate degree of disability and to disabled persons with a reduction in capacity for work of at least 60% and to persons of retirement age with an assessed need of permanent care. The amount is 50% or 100% of the social insurance basic pension depending on the category of the recipient (respectively LTL 180 -EUR 52- or LTL 360 -EUR 104-. Temporarily, since 2010 benefits are paid at 85% of the above-mentioned amounts only. Special compensations are financed from the state budget.

Financing arrangements: source of financing

LTC expenditures represent 1.2 percent of GDP in Lithuania: 0.51 percent is in the institutions, 0.48 percent at home and 0.23 percent are benefits. Expenditure is expected to double until 2060. In 2011 expenditure on long term nursing services in the health care sector was 0.5 percent of GDP. LTC nursing financing constitutes 8 percent from National health outlyas.

Means by sources of financing for elderly a disabled persons institutional care in the year 2011 are presented in the table 3.

Table 3. Means by sources of financing for elderly an disabled persons institutional care (thous.LTL)

	State	Municipalities	Persons	Other	Total
Care institutions for elderly	21805 (23%)	27601(28%)	41927 (44%)	4567 (5%)	95900 (100%)
Care institutions for disabled	76728 (57%)	7218 (5%)	41308 (30%)	10191 (8%)	135445(100%)
Total	**98533 (43%)**	**34819 (15%)**	**83235 (36%)**	**14758 (6%)**	**231345 (100%)**
	133352 (58 %)				

Source: Department of Statistics and Ministry of Social Security and Labour

Extent of means-testing and family obligations

Means-testing is applied in the case of residential LTC. A person may not pay more than 80 % of his or her full income (including special compensations mentioned above) for residential care. The rest is covered by local governments. Payment could be more than 80 % of income when the recipient has property above a certain limit (i.e. if person's property exceeds the normative established by the local municipality, 1% is calculated in respect of property value exceeding the normative). In any case, no less than 20 % of income is exempted in order to ensure daily life expenses. In the case of home care not more than 20 % of the income is deducted. There are no financial obligations for families in the case of residential LTC.

Quality assessment in institutions and at home

Institutional LTC, like all health care institutions, is supervised by the State Health Care Accreditation Agency under the Ministry of Health. Licensing of health care organizations is

mandatory in the country. License has to be renewed every 5 years. Institutions have to prove their staff qualification, the quality of their equipment and facilities, etc.

As for the social sector side, the Department of Supervision of Social Services under the Ministry of Social Security and Labour is responsible for the supervision of institutions of long term care. Licensing of care institutions will be mandatory by law since 2015. The process of licensing was started in January 2013. Ten types of licenses are foreseen by law (different requirements for the institutions providing children, disabled persons, elderly care, etc.).

3. CARERS

Municipalities have the mandate to support informal carers with information and advice. There are no direct benefits for the carers themselves. Special compensations for care and attendance need to be paid by care recipients. Carers before retirement age who take care of a disabled person (child or adult) are insured by pension insurance. Contributions are based on the minimum wage level and are paid by state. Carers who provided care for a disabled person (child or adult) for at least 15 years and reach the retirement age or become disabled are entitled to a social assistance pension (if they are not entitled to a higher social insurance pension).

The number of workers in care institutions is presented in table 4. Figures in parentheses show the number of full-time workers.

Table 4. The number of workers in care institutions

	Number of staff	Number of social workers	Number of assistants of social workers
Care institutions for elderly	2726 (2157)	228 (196)	640 (549)
Care institutions for disabled	3208 (2890)	343(328)	1481 (1406)
Houses of independent living	*174 (135)*	*28 (28)*	*63 (51)*

Source: Lithuanian Department of Statistics

The level of education of social workers is usually university bachelor (college education in rather rare exceptions). Minimum requirements for social workers and their assistants are set by the Law on Social Services. Special high education is required for social workers, who are required to pass certifications periodically. According to the data of the Ministry of Social Security and Labour the wages of directors of social care institutions and their deputies were 4200-3400 LTL (EUR 1200-970) per month; wages of social workers were 1800-1900 LTL (EUR 510); wages of their assistants around 1400 LTL (EUR 400) per month. The average wage in the public sector in Lithuania in 2012 was 2318 LTL (EUR 671) per month.

There are 4833 nursing beds for LTC in 2012 in the health care sector. 272 doctors and 1134 nursing staff work at LTC hospitals in the country. There are 0.5 staff of doctors and 2.3 nurses per 10 nursing beds. The salary of nurses is quite low (about LTL 1600 per month which is about EUR 463), below the average salary in the country. There is no shortage of nurses; in contrast, there are shortages of doctors in a few local health care institutions in a several the regions

4. POLICY AND RECENT DEVELOPMENTS

An Action plan of implementation of a national strategy to overcome the impact of population ageing 2005-2013 was approved in 2005 in Lithuania and is under implementation till now. The strategic document "Outline of further health system development 2011-2020", which was approved by the Lithuanian Parliament on 7 June, 2011 is covering long term care nursing strategic goals too. The vision of the nursing system and means how to achieve the goals is described in this document. A draft of National health program till 2020 is currently under negotiation in Lithuania. In recent years, a National Health Forum was established to introduce and develop innovative health care processes.

From institutional to home care?

In 2010 and 2011, the Ministry of Social Security and Labour continued to carry out the Programme for the Adaptation of Housing for People with Disabilities for 2007–2011. The amount of LTL 3.217.400 was used for the implementation of the Programme measures. In 2011, 57 municipalities carried out works of adaptation of housing for the disabled. 253 dwellings were adapted to the needs of 255 disabled persons, of which: 138 dwellings for 140 persons with very clear movement and self-service dysfunctions; 95 dwellings for persons with clear movement and self-service dysfunctions and 20 dwellings for persons with average movement and self-service dysfunctions.

At the end of 2012, the Guidelines for Deinstitutionalization of the Social Care Homes of Disabled Children, Children Deprived of Parental Care and Adult Disabled Persons were approved. The guidelines provide the trends of transition from institutional social care to the services of assistance in the community till 2030. Deinstitutionalization aims at forming consistent and coordinated system assistance and services which would create possibilities for each disabled child, child deprived of parental care, disabled person to receive individual personalised services and required assistance, be involved in community life and participate in it without experiencing social exclusion.

Care coordination

One of the major problem in LTC in the country is the coordination between the social and health care fields. Various pilot projects (for example in Klaipeda region) of care integration are ongoing. In 2011, seeking to enhance the social services infrastructure, the Ministry of Social Security and Labour launched the *Programme for the Modernisation of Infrastructure of Institutional Social Care Establishments.* The purpose of the Programme is to ensure high quality of social services provided to elderly persons, disabled persons and children deprived of parental care through the modernisation of existing and setting up of new modern institutional social care establishments. In 2012, implementation of *the Integral Development Assistance Programme* financed from the funds of the European Social Fund aimed at high quality integral assistance (nursing and social services) for disabled persons, elderly people and consultancy support for family members taking care of such persons was commenced. During the period of 2013–2015, 21 municipalities will implement pilot projects. The pilot projects aim at recruiting and training specialists of mobile groups , include health care specialists into the social assistance process, provide mobile groups with vehicles, provide consultancy services to family members taking care

of disabled or elderly close relatives, and promote informal assistance. The amount of LTL 20.7 million is to be allocated for the programme[148].

Rehabilitation

Licensed providers of rehabilitation services are paid by the NHIF. The cost of the first rehabilitation stage (interventions provided at health care facility where the patient is treated) is included into the price of the treatment. Further (second stage) rehabilitation is provided in specialised rehabilitation units in general hospitals and in specialised hospitals and sanatoriums. Rehabilitation units have to meet the criteria for minimum number of beds and the requirement of service availability of 6 days per week. The third rehabilitation stage requires either outpatient or tertiary level rehabilitation. There were 4 rehabilitation hospitals (with 705 beds in total) and 7 other medical rehabilitation facilities (3 for children and 4 for adults) in the country in 2010. Since 2002, the number of rehabilitation beds has increased from 1092 in 2002 to up to 1378 in 2010. Beds in rehabilitation hospitals are occupied at 80% and the average length of stay is about 20 days. In sanatoriums the bed occupancy rate is lower (74%), while average length of stay is higher (21 days). In 2010, about 50 000 inpatient rehabilitation services were provided (15.2 per 1,000 population) Outpatient rehabilitation service volume has increased by 20% in 2010 (in comparison with 2009), although with 8.1 services per 1,000 population it only amounts to about half of total inpatient services.

Increased availability and quality of outpatient rehabilitation is one of the goals in the strategic health policy documents. This is being implemented through the establishment of outpatient rehabilitation units in municipal health care facilities, larger investments in infrastructure, as well as through regulatory measures, e.g. prohibiting primary health care providers to refer adult patients to specialised inpatient rehabilitation and instead direct patient flows towards outpatient rehabilitation. Since 2005 outpatient rehabilitation services increased by 30 percent thanks to the implementation of special projects financed by Structural Funds and the establishment of special departments for ambulatory rehabilitation.

[148] Social Report 2012-2013. Ministry of Social Security and Labour. Vilnius, 2013, p.40.

5. BACKGROUND STATISTICS

Lithuania (LT)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	13.3	22.4	27.4	21.6	32.3	30.1	24.0	35.5	26.0	20.9	30.6	7.8	7.6	8.2
80+	4.8	2.8	6.6	7.5	4.6	10.0	11.9	8.2	15.1	11.5	8.0	14.8	6.7	5.2	8.2
85+	1.9	0.9	2.8	3.9	2.2	5.4	6.0	3.7	8.0	7.3	4.7	9.7	5.4	3.8	6.9
80+/65+	26.4	20.8	29.2	27.5	21.2	31.0	39.4	34.1	42.6	44.3	38.1	48.2	17.9	17.3	19.0
85+/65+	10.5	7.1	12.3	14.3	10.0	16.6	20.0	15.6	22.6	28.1	22.5	31.6	17.6	15.4	19.3
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Lithuania (LT)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	30.0	21.1	38.3	52.0	39.2	65.3	21.9	18.1	27.0	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.9	14.0	27.0	37.3	27.1	47.6	16.4	13.1	20.6	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Lithuania (LT)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at birth	67.7		78.7	80.7		87.1	12.9		8.4	76.7		82.5	84.6		89.1	7.9		6.5
years at 65	13.5		18.4	20.4		24.2	6.9		5.8	17.2		20.7	22.4		25.6	5.2		4.9
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at 65	5.2		4.3	5.6		6.1	0.4		1.8	8.6		8.9	8.4		8.5	-0.2		-0.4
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
at 65 (%)	40.0%		24.4%	39.7%		31.9%	-0.3		7.5	52.1%		44.5%	48.3%		40.4%	-3.8		-4.1
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.2			2.5			1.2			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

LUXEMBOURG

1. DEMOGRAPHIC BACKGROUND

The foreign population in Luxembourg represents 44% of total population and is on average younger than the population with Luxembourg nationality. From the 65+ age group, there is a drop in the foreign population, mainly because a share of migrant workers and cross-border workers with their spouses return to their countries of origin when they retire.

This leads to a particularly favourable demographic situation for the Luxembourg health insurance system where the percentage of insured elderly people aged 65+ represents only around 10% of the total insured population. Thus Luxembourg enjoys a comparably moderate old-age dependency ratio compared to other EU countries

In the period 2013-2060 the share of people aged 80+ in the Luxembourgish population is expected to grow from 3.9% to 7.8% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 2 from 1.7% to 4.5% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 28.0% to 35.8% (EU-28: 27.8%-41.5%), and from 12.1% to 20.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 22.2% (EU-28: 29.9%) to all of 38.9% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.3/21.1 years (EU-27: 17.2/20.7) in 2010 to 22.4/26.1 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 2.4 and 2.6 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.0% to 3.2% (EU-27: 1.8%-3.6%).

In 2012, the elderly population aged 65+ amounted to 14% of the total population.

2. CURRENT LONG-TERM CARE PROVISION

The public long-term care insurance was introduced in 1999 as a new pillar of the social security scheme. The law was mainly inspired by the long-term care set up in Germany; however, the principle of classifying the dependent persons into three levels was not upheld for Luxembourg.

Four principles were at the base of this law:

- *Priority for rehabilitation measures before long-term care;*
- *Priority for at-home care before institutional care;*
- *Priority for in-kind services before cash benefits;*
- *Continuity in long-term caregiving.*

The CEO was created and started its work of evaluating requests from dependent persons. During the initial phase, efficient procedures first had to be developed for assessing the needs of the applicants. Another problem at this early stage was a lack of beds in care institutions and meeting the needs for technical adaptations in the homes of dependent persons.

A first modification of the law on long-term care was carried out in 2005 and came into force two years later:

The law recognized for the first time the importance of quality of care, which led to the establishment of the Quality Commission in 2007. Technical adaptations for the dwelling of a dependent person could now be granted independently of the previous prerequisite of a care plan with a certain minimum of hours of care needed. Persons in rehabilitation now had the right to in-kind services during a temporary stay at home. Additional services were introduced for situations of unforeseen aggravation of the dependency level. The modified law allowed the limit of 24.5 hours to be exceeded, up to a maximum of 38.5 hours per week for activities of daily living in case of an exceptional aggravation. Intermittent-care centres for handicapped persons were introduced. The long-term care insurance negotiated the labour agreement for the first time with COPAS, the representative organisation of the care providers, instead of with each single care provider. The cash benefits were reduced to EUR 25 per hour instead of being 50% of the in-kind benefits, an amount that was considered too high in comparison to the minimum salary. The CEO prepared an action plan for the years 2007 to 2010 in order to reduce the delay in the evaluations of dependent status.

The following types of care providers were registered as of the end of 2011:

- *16 ambulatory networks offering nursing care at home,*
- *50 day-care institutions,*
- *50 intermittent-care centres for alternating short-term stays and*
- *50 nursing homes and so-called integrated homes for the elderly, with a mix of dependent and less-dependent residents*

In addition to the huge sector for ambulatory networks for home care, which are dominated by two major providers (Hellëf Doheem, HELP), day-care institutions offer various activities that allow dependent or elderly people to escape from social isolation and to maintain or improve their autonomy. Services of day-care institutions are covered by the long-term care insurance and their positive therapeutic impact is very well recognized. Another important aim of the day-care institutions is to disburden the informal carers and to ensure that dependent or elderly persons can live at home for as long as possible. A recent survey showed that 96% of beneficiaries were satisfied or very satisfied with their day-care centre.[149]

There are nearly 13,000 beneficiaries of LTC in 2012. The number of beds in care institutions amounts to a total of 4,790 in 2010, which corresponds to 68 beds per 1,000 of population aged 65+[150]. Approximately one-third of the beneficiaries reside in care institutions (3,929 persons in 2011) whereas two-thirds are cared for at home (8,398 persons in 2011)[151]. Beneficiaries cared for at home can receive all care services that they are entitled to from professional carers (so-

[149] Lëtzebuerger Gemengen, Combattre les idées reçues, newspaper article, May 2013, p. 38.
[150] See datasheet.
[151] IGSS 2012 p.149.

called in-kind services) or subcontract up to 10.5 hours per week to informal caregivers of their choice. Both types of service provision can be combined, which represents the most preferred type of care provision (used by two-thirds of the home-care beneficiaries.

The assessment of the dependency status on an applicant is done on individual basis by a specific administration under the Ministry of Social Security, the "Cellule d'Evaluation et d'Orientation – CEO", which in the event of a positive assessment results in the issuance of an individual weekly care plan. Above the threshold of 3.5 hours of care provision per week for a period of at least 6 months, nursing care will be fully covered by the long-term care insurance. In 2011, the CEO received around 4,300 requests to classify or reclassify the individual need for nursing care services. 35% to 40% of all applications are regularly revaluated.

To a large extent, the long-term care benefits are offered as benefits-in-kind. If the person lives in an integrated nursing home, the long-term care insurance takes care of all care services, care products and, in exceptional cases, some care-relevant instruments.

If the dependent person lives at home, the long-term care insurance reimburses some of the costs to adapt the living environment or for purchasing instruments which will increase the autonomy of the dependent person. For a maximum of 10.5 hours per week and at the beneficiary's request, it is possible to replace the benefits-in-kind provided by a professional caregiver with cash benefits at an amount of EUR 25 per hour. The dependent person should use the cash benefit to pay an informal caregiver of her/his choice, who is frequently a family member. Only activities of daily living and domestic tasks can be performed by an informal caregiver, whereas psychological support and counselling can only be offered by professional caregivers.

In 2010, in-kind benefits for at-home care amounted to around EUR 100 million and cash benefits to almost EUR 50 million. For institutional care, the in-kind benefits amounted to around EUR 240 million.

The current expenditure of the long-term care insurance system amounts to EUR 416.4152 million in 2010, equalling 1% of GDP. The expenses for long-term care are expected to increase to 2.8 – 4.8% of GDP in 2060.[153] The whole budget is administered by the long-term care insurance branch of the National Health Insurance (CNS).

In the budget for 2013, the state contribution to financing the long-term care insurance amounts to 40% (estimated at EUR 225.1 million) compared to 35% in 2012. Total expenses have risen from EUR 482.7 million in 2011 to the budgeted EUR 560 million in 2013. Thus, the financial result for 2013 is estimated at a loss of EUR 6.1 million. Still the cumulative result including reserves from past years will end up in surplus. This surplus continues to diminish progressively from EUR 106.7 million in 2010 to an estimated EUR 53.8 million in 2013. The long-term care insurance is expected to be in deficit by the end of 2015 (i.e. expenses exceed income to such an extent that the reserves will drop below the legal minimum).[154]

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152 IGSS 2012, p. 170.
153 See datasheet
154 Un budget déficitaire en apparence..., Wort.lu, newspaper article, 13.12.2012.

In addition to the state contribution, sources of financing are a special levy applied to high energy consumption (EUR 2 million in 2011) and contributions at a rate of 1.4% on all earnings (including fringe benefits and capital) without any upper threshold (EUR 295 million in 2011).[155]

According to calculations by IGSS, the long-term care insurance should financially remain stable until 2030 if the contribution rate is gradually raised from 1.4% to 1.7%. However, according to the representative organisation of the care providers (COPAS), even a contribution rate of 1.7% will not be sufficient provided that growth of GDP remains low in the coming years.

Eurostat projections expect a tripling of total expenditure for long-term care, measured as a share of GDP, from 1% in 2010 to 3.2% in 2060. This trend equals the EU-27 projections, whereas the EU-27 are already embarking from a higher percentage (1.8%) on average in 2010.

In 2010, the costs for institutional care are almost double those for at-home care, which against the background of a 2/3 provision of all long-term care at home unambiguously demonstrate the much higher cost of institutional care (unit cost in % of GDP per capita of 69% for institutional care versus 25% for home care). The cash benefits presented by Eurostat represent the long-term care insurance support of informal care. Despite the case that more than 80% of the recipients of at-home long-term care gain from this support, it only amounts to 9% of all public expenditure for long-term care.

The government provides mean-tested financial support for those residents in nursing homes and integrated homes for the elderly without sufficient revenues to cover the costs for accommodation and individual needs (accueil gérontologique). Based on an individual assessment, the National Solidarity Fund (FNS) covers all necessary costs for accommodation and for those long-term services which are not part of the long-term care insurance (i.e. socio-cultural support). As a maximum, the FNS grants EUR 1,625 for a double room, plus supplements in certain circumstances of up to EUR 185 per month. The financial aid is directly transferred to the care institution.

The calculation of personal income takes into account all revenues from a professional activity, from goods and properties, pensions and all other form of financial income, for both the applicant and his/her spouse. To calculate one person's income, the shared income is split into two. The incomes of any children are not taken into account.

Dementia is the second largest main diagnosis for dependency in Luxembourg (behind osteo-articular disorders) and represents almost 18% of all dependent persons (2,206 persons in 2011). The majority reside in care institutions.[156] By taking into account equally those long-term care recipients for whom dementia is only considered as a secondary diagnosis responsible for dependency, the share rises to 33.5% of all dependent persons. The costs of dementia to the long-term care insurance amount to EUR 311 million, which represents 74% of the total expenditure of the long-term care insurance.[157]

A Quality Commission for long-term care was created in 2007 as a consultative organ, charged with suggesting norms and quality standards for long-term care. As yet, almost none of the

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155 IGSS 2012, p. 177, 179.
156 IGSS 2012, p. 155.
157 Response by the Minister of Social Security to the Parliamentary Question No. Q-2012-O-E-2755-02 of 8 July 2013.

initially agreed multi-year work plan, such as an improved documentation quality, enhanced hygiene standards or the development of a framework for self-evaluations of care providers, has led to any major result. Its members[158] have experienced numerous difficulties in reaching agreements. For example, in 2011 the Quality Commission made hygiene suggestions for care personnel, which still need to be validated by the representative organ of care providers, COPAS. Furthermore, as a consultative organ, the Quality Commission's role is limited to making propositions, which then need to be negotiated between the long-term care insurance (CNS) and COPAS. Overall, in the backdrop of the afore-mentioned eligibility criteria, the provision of adjudicated long-term care benefits with almost no co-payments and the possibility of receiving means-tested financial support for necessary stays in nursing homes show that there are no problems of access to long-term care benefits.

3. CARERS

There are no figures available on the exact number of informal caregivers; however, in 2011 a total of 6,637 beneficiaries received cash benefits (82% of at-home care recipients). The long-term care insurance furthermore takes over the costs for counselling of the informal caregiver. However, in 2010 only 318 persons received counselling services. The long-term care insurance also pays the pension fund contribution for the informal caregiver if the dependency status of the dependent person has been approved and if the informal caregiver does not benefit from a personal pension.

Table 1. Total number of nurses and personal carers (at home and in institutions)

Care provider	***Number of nurses and carers in 2010[159]***
Ambulatory networks	*1,715*
Day-care institutions	*268*
Intermittent-care centres	*674*
Integrated nursing homes	*3,021*
Total	***5,678***

Number of nurses and personal carers per 1,000 of population aged 65+ amounts to: *81 nurses and carers per 1,000 of population aged 65+ in 2010[160].*

The total care personnel employed in 2010 amounted to an average of 5,678 full-time equivalents (FTE). Nearly 60% of these are employed by care institutions (3,021 FTE in integrated nursing homes, 674 FTE in intermittent-care centres, 268 in day care institutions), while 40% work for at-home care networks (1,715 FTE). Per 1,000 of population aged 65+, there are 81 nurses and carers in 2010.[161]

In the medium term, increasing demand for more developed and hence more costly long-term care services will bring the system under further pressure. This could lead to a growing shortage of qualified nursing staff, as even today the labour market faces difficulties in meeting the specific demand.

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158 CEO, COPAS, Family Ministry, Health Ministry, Patient Representation Association

159 IGSS, MiFa, Bilan sur le fonctionnement et la viabilité financière de l'Assurance Dépendance, 2013, pp. 252, 255, 258, 260.

160 Population aged 65+ in 2010 (Statec.lu): 70,046

161 See datasheet.

4. POLICY AND RECENT DEVELOPMENTS

Over the last three years, the networks of home care services have implemented a number of new approaches to better link acute and long-term care periods for the long-term care beneficiaries.The networks run offices in hospitals to improve the coordination between in- and outpatient caregiving ("infirmier de liaison"). They also introduced the so-called "reference nurse", a concept of care coordination and management by a specific caregiver. The reference nurse supervises the care plan for a number of familiar patients and coordinates with the individual health and care networks of this person (doctors, social assistants, and relatives).

5. BACKGROUND STATISTICS

Luxembourg (LU)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	14.0	12.2	15.8	16.7	15.5	17.9	19.1	17.7	20.5	21.7	20.3	23.0	7.7	8.1	7.2
80+	3.9	2.8	5.1	4.4	3.5	5.2	6.3	5.4	7.2	7.8	6.6	9.0	3.9	3.8	3.9
85+	1.7	1.0	2.4	2.1	1.6	2.7	3.2	2.5	3.8	4.5	3.6	5.4	2.8	2.6	3.0
80+/65+	28.0	22.6	32.2	26.1	22.8	28.9	33.0	30.4	35.3	35.8	32.3	38.9	7.8	9.7	6.7
85+/65+	12.1	7.9	15.4	12.7	10.1	15.1	16.7	14.4	18.7	20.7	17.7	23.4	8.6	9.8	8.0
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Luxembourg (LU)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	22.2	18.9	25.5	38.9	36.0	41.9	16.8	17.0	16.4	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	14.9	12.0	17.8	26.8	24.1	29.6	11.9	12.1	11.8	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Luxembourg (LU)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	77.8	82.9		84.9	89.5		7.1	6.6		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	17.3	21.1		22.4	26.1		5.1	4.9		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005 (EU-27)**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	9.2	9.3		11.6	11.9		2.4	2.6		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005 (EU-27)**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	55.1%	45.6%		63.3%	55.6%		8.2	10.0		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.0			3.2			2.3			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

LATVIA

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Latvian population is expected to grow from 4.7% to 11.0% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3 from 1.9% to 6.4% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 24.8% to 38.8% (EU-28: 27.8%-41.5%), and from 9.9% to 22.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 30.3% (EU-28: 29.9%) to all of 57.0% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 13.5/18.1 years (EU-27: 17.2/20.7) in 2010 to 20.6/24.4 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 0.3 and 0.9 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure on LTC as share of GDP would rise from 0.7% to 1.2% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

At the end of 2012, there were 82 municipal nursing homes for elderly people, with 5647 recipients. The average number of beds is 5798, which constitutes 15,28 beds per 1.000 persons aged 65+.

Furthermore, there are 5 state-owned long-term care homes with 30 branches for mentally disabled people with 4381 clients, 34,19% of whom are elderly people above 62 years . Although beds in the nursing homes for mentally disabled people are not a part of institutional care for elderly *per se*, the proportion of recipients above working age or suffering from dementia as a principal diagnosis (18,5 % of total) indicates that these beds may be partly attributed to institutional LTC for the elderly.

The number of people receiving home care is increasing constantly. There was a slight drawback during the crisis years but since 2010 the number of recipients has been growing again. At the end of 2012 there were 7867 recipients of home care[162], including home care services purchased from NGOs for 1,800 elderly (1,700 of whom in Riga only) and those services purchased by Riga city for 1,500 elderly from private home care providers (private social care agencies). Most home care services are provided by social workers of local social services.

[162] Statistics refer to the people above the age of 62 years. Data on recipients aged 65+ are not available. *Ibid.*

There are no specific LTC cash benefits for older people, but there is a personal care cash benefit of discretionary use for disabled people. In 2012 there were 11,480 persons receiving this state benefit each month.[163] Most beneficiaries, 58.3% of all, were people above the age of 65 years.

There is also a cash benefit for disabled people with walking difficulties. It aims to compensate for expenses on specially adapted cars or other means of transportation. The number of recipients was 17,500 in 2013, 45,6 % of them older than 65 years.

Local authorities are free to grant benefits in cash for persons in need if local home care service is not available. Cash benefits can also be granted to family members or other persons who provide care. Unfortunately, no data on number of recipients of this kind of benefits is available.

There are no benefits for elderly home care foreseen at the state level. However, a new benefit for disabled persons who need personal care was introduced in 2008, irrespective of the age and income of beneficiary.[164] The benefit is granted on the basis of a formal disability status and the need for personal care according to medical assessment. The amount of this benefit is set at the level of EUR 142 per month. The introduction of this benefit was a response to a persistent shortage of accessible and affordable specialised nursing home services and personal care services. Therefore, disabled persons are presumably using this benefit to pay for the provision of care services.

Some municipalities offer financial support to persons and families with home care needs. This support is meant to cover, in part or fully, the costs of home care incurred by households. There are no clear legal bases or rules applied in this kind of benefit, which varies greatly between municipalities. In 2013, only 24 municipalities out of 119 reported spending for financial support to care takers[165] but the amount of resources for this purpose is growing: EUR 539,000 in 2010 and EUR 843,000 in 2013.[166] However, these figures include both support granted for elderly and also for disabled people of working age.

Financing: There are two sources of public financing of LTC. The central government pays for nursing homes (social care centres) for mentally disabled people and care benefits in cash for disabled people. In turn, local governments cover expenditure for institutional care (social care centres) for elderly, for home care of elderly and for all other forms of alternative care.

According to the Ageing Report 2012 the share of public LTC expenditure as a share of GDP in Latvia in 2010 was 0,7% (0.51% for institutional care, 0.05% for home care and 0.12% for cash benefits)[167]. The projected share for 2060 by AWG scenario is 1.0% of GDP, therefore the projected change 2010-2060 is 0.3% percentage points.

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[163] Data source: State Social Insurance Agency

[164] The benefit is reported in the MISSOC tables, chapter "V Invalidity"part"8.Other benefits", not in the chapter "Long-term care".

[165] Data source: statistical information from municipalities on social assistance and social services, available on the website of the Ministry of Welfare, http://www.lm.gov.lv/text/1382, retrieved at 02.08.2013

[166] *Ibid*

[167] Background statistics for country fiches of the SPC report on long-term care

According to the unit costs indicators used in the Ageing Report 2012 for Latvia, the unit cost of each type of formal care as a percentage of GDP per capita was the following: for institutional care, 107%: home care 10%: cash benefits 43%.

The unit costs in municipal nursing homes for elderly in 2012 were EUR 5150 per person per year; about 55% of the costs consist of wages of staff members. The unit costs for institutional care as % of GDP per capita estimated in the Ageing Report are very close to EU27 average (106%).

The unit costs of cash benefits are estimated at 43% of GDP per capita, the highest level among EU27 countries[168]. The EU27 average is estimated at the level 24%. As from July 1, 2014 the amount of personal care cash benefit for disabled people is increased by 50%, from EUR 142 to EUR 213 per month, what may lead to higher unit costs for cash benefits.

Extent of means-testing and family obligations: Legislation states that expenses for social care (with the exception of institutional care for mentally disabled) should be borne by recipients themselves or family members, except those with an income below the needy persons income level set by the government, i.e. EUR 128 per month in 2013. Municipalities are free to set a higher threshold for access to home care financed at the local level. Besides, there is another restriction in that elderly and disabled people are only entitled to home care services if there is no family member available to provide for the care needed.

As local municipalities are obliged to cover LTC expenses only for poor people and face limited resources for social services provision, they only provide care to individuals with incomes below the poverty line and without family members who can support them financially. As a result of this, municipalities tend to leave the rest of potential recipients in the hands of private care services, charities or NGOs. In any case, municipalities are free to choose their implication in the cases of persons with family members and incomes above the threshold: they may provide the service conditionally on the coverage of expenses (fully or partly) or offer information and advice to find another service provider (usually a private agency).

The benefit for disabled people (transportation compensation) who need personal care is universal (no means-test applied), as is the benefit for disabled people with walking difficulties.

[168] BACKGROUND STATISTICS FOR COUNTRY FICHES OF THE SPC REPORT ON LONG-TERM CARE

Table 1. LTC Institutions for elderly [169]

	2009	2010	2011	2012
Number of beds in social care institutions for elderly	5905	5684	5701	5798
Number of beds in social care institutions per 1.000 of pop aged 65+	15.32	14.80	14.96	15.28
Unit costs in (per person per year in EUR) in nursing homes for elderly	5395.56	5099.83	5026.07	5150.20
Unit costs in nursing homes for elderly as % of GDP per person	62.14%	58.80%	50.91%	47.44%

Quality assessment in institutions and at home: All service providers are obliged to be registered by the Ministry of Welfare. The Register of Providers of Social Services constitutes the basis for quality assessment. The Register allows verifying whether the service provider complies with requirements such as the number and qualification of the staff, the accessibility of care premises or their adjustment to recipients' needs. On 1 May 2013, there were 830 service providers registered. In spite of this, there is widespread non-compliance with the obligation to register. Some estimates show that depending on the region there might be even more than 40% of service providers not included in the Register.

Quality assessment is carried out by the Department of Social Services Quality Control in the Ministry of Welfare. Due to limited resources, only 6% of all registered service providers can be assessed per year. Most often, the quality of services is examined only as a result of the complaints received from recipients and their relatives.

Problems of access: Data on the situation on 1st January 2013 show that there were 358 persons on the waiting list for nursing homes for mentally disabled (waiting time up to 1 – 1,5 years) and 39 persons waiting to be placed in nursing homes for older people (waiting time up to 3 months). The existence of long waiting lists for institutions for mentally disabled persons may be explained in part by the lack of suitable alternatives of community-based care.

Although home care is the most widespread form of alternative care provided by municipalities, significant regional disparities exist across the country. In 2012 this service was available for clients in 9 cities and only 26 rural municipalities (out of 110).

Insufficient funding and high demand resulted in growing waiting lists also for technical aids for independent living. On 1 January 2013, 9,884 persons were in the waiting list for technical aids. These included persons in urgent need like children or people recovering from surgeries and accidents. For some specific technical aids like personal mobility aids, orthopaedic shoes or hearing aids, the expected waiting time can reach even two or three years.

[169] Data source: Statistical Summary Reports on long-term social care and social rehabilitation on years 2009, 2010, 2011,.2012 available on the website of the Ministry of Welfare, http://www.lm.gov.lv/text/1382, retrieved at 02.08.2013; age- specific data on numbers of population from Central Statistical Bureau of Latvia, viewed at 31.07.2013, and author's own calculations.

Municipalities are legally obliged to organise LTC services for elderly. The Law on Social Services and Social Assistance declares that social assistance should be intended for a client on the basis of an evaluation of his or her material resources – income and property, individually providing for the participation of each client. A client or his or her provider has a duty to pay for the received social care and social rehabilitation services. If a client or his or her provider is unable to pay for a social care or social rehabilitation service, the costs of the service shall be covered from the local government budget.

The local government covers all the expenses for the person whose monthly income is below needy persons income level - 128 EUR. (The threshold set by the government is very low, e.g. average monthly old age pension is two times higher (EUR 256), the poverty line (60% of median equivalised income) was EUR 221 per single person in 2011.)

The Law on Social Services and Social Assistance states that a person shall participate in the funding of the LTC (in an institution) with 90% of their monthly income – pension. If this doesn't cover the expenses, the person's provider shall cover the remaining expenses, if the provider can't cover the expenses, the local government covers the remaining expenses.

Prevention and rehabilitation: Although rehabilitation is theoretically accepted as a part of LTC, no prevention and rehabilitation programs exist at a national level targeted specifically to the elderly. Social rehabilitation is mainly seen as a service for disabled persons and children.

State financed, short term rehabilitation is provided in special rehabilitation institutions only for persons of working age or working pensioners with functional disorders. Due to limited resources, waiting time in this program is estimated to be about two years.

Depending on the municipality additional services are offered to support independent living among elderly and disabled persons. In 2012, there were 10 day care centres for older people with 4944 recipients[170]. Day care centres for people with dementia are recently becoming more widespread in Latvia. Several municipalities have developed new ICT services like security buttons. Also mobile care teams are used to provide more differentiated services. However, coverage of these services is low and territorially uneven. No assessment on effectiveness of any prevention or rehabilitation measures is available.

Dementia: The number of persons with diagnosed dementia in Latvia is constantly growing[171]. Also the share of patients with dementia living in nursing homes is growing – from 14% in 2009 to 19% of all clients in 2012[172].

Five specialized day care centres for elderly with dementia have recently been established in Riga city[173]. Specialized home care is hardly available (only from institutions providing limited home care service for out-patients and from NGOs).

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[170] Statistical information from municipalities on social assistance and social services, available on the website of the Ministry of Welfare, http://www.lm.gov.lv/text/1382, retrieved at 02.08.2013

[171] SLIMĪBU PROFILAKSES UN KONTROLES CENTRS(2012), Psihiskā veselība Latvijā 2011.gadā, Tematiskais ziņojums, Rīga, 2012, p.23

[172] Data source: Statistical Summary Report on long-term social care and social rehabilitation on year 2012 available on the website of the Ministry of Welfare, http://www.lm.gov.lv/text/1382, retrieved on 02.08.2013 and author's own calculations.

3. CARERS

Informal care provided by family members is common in Latvia. If a person applies for home care, local governments first assess the possibility of family members living together with him/her to provide for the necessary care. Only if the person lives alone or the family members living with this person are not able to ensure the care due to old age, health condition or employment status, the person is entitled to social care service provided (or at least financed) by the municipality.

Available statistics do not include informal care providers. About 50% of all municipalities report spending for the financial support of carers. Depending on the municipality, support can be granted in the form of simple benefit to the family members taking care of elderly or can be formulated as payment for service on the basis of a service contract. Usually contracts of this type are concluded between a neighbour or relative of the recipient and the municipality. In this situation, the care service is somewhere between formal and informal, the carer does not enter a labour relation, no qualification and training is required and no pension rights accrued during this period.

There are no specific measures to support caring family members. Informal caring duties usually mean cutting down paid work, taking only part-time work or early retirement. The only exception is when a person is taking care for a disabled child; this period is taken into account for pension rights and credited with contributions equivalent to those from a monthly income of EUR 71.

In recent years new services to support families with dependent family members has been introduced – assistant services in municipalities and education institutions.

As of January 1, 2013 a new service for persons with disabilities has been launched – a municipality based service of an assistant (up to 40 hours a week) for performing activities outside home[174]. An assistant service is eligible to person with severe or very severe disability (I and II group), on the basis of conclusion by the State Commission on Disability Expertise on the necessity for a service of an assistant; and to child with disability aged 5 to 18 years, on the basis of conclusion by the State Commission on the necessity for special care due to severe functional impairments. It is possible for family members or other trust persons to become an assistant.

From January 1, 2013 to September 30, 2013 the service of an assistant was received by 2191 persons with disability and service was provided by 2156 assistants. Service recipients 16% were children, 52% people with Group I disability, 32% people with Group II disability. Most of the recipients were elderly persons with disability.

408 nurses and carers were employed in the LTC institutions for elderly; 1092 social workers and nurses in social home care services. The number of nurses and personal carers working in public institutions for the elderly and in local home care services per 1000 of population aged 65+ was 3.95 at the end of 2012.

There are no data available on levels of education of professional carers working in the institutions (nursing homes, day centres etc.) and municipal social services. There are no

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[173] LA.LV(2012),Slimība, nevis vecuma līdzgaitniece – Alcheimers, 25.09.2012,http://la.lv/index.php?option=com_content&view=article&id=360101&Itemid=165, retrieved on 05 September 2013

[174]Assigning of a service of assistant in the municipality is regulated by the Cabinet Regulations of 18 December, 2012no. 942 „Procedure for Allocation and Financing a Service of an Assistant in the Municipality"

education requirements for them, but regular training courses are one of the formal requirements for caring staff. However, due to the limited financial resources this requirement is difficult to comply for most of the municipalities. Low wage levels for social carers are reported by the Ministry of Welfare as the main reason of high turnover in the institutions and difficulties to attract new, motivated staff. In the current situation of high unemployment, no serious shortages in caring staffs are reported. As the situation in the labour market changes and demand for labour increases, the availability of personal carers will certainly become an issue.

4. POLICY AND RECENT DEVELOPMENTS

The most relevant LTC-related topic on the recent political agenda was the quality of care and health services in the nursing homes for mentally disabled people and the need to develop alternative care for them. The Ombudsman's office publically announced that social rehabilitation in the institutions for adults with mental disabilities is poorly organised and insisted on the need to extend substantially the provision of alternative care. The Government has allocated funding in 2014 for the Health Points in the state's LTC facilities to improve the quality of health care.

Although it has always been recognized that alternative care should be more widely developed there has been very little progress in this direction especially during the crisis years. Home care services are underdeveloped and high demand for institutional care is persistent.

The Ministry of Welfare has recently published the Concept paper on the development of social services for 2014 - 2020[175] (the government has approved it on 04.12.2013) where the move from institutional to home care is one of the top priorities for people with limited abilities to perform their activities of daily living. Special attention is given to the two target groups: children and people with mental disorders. For elderly people, the document set a target of 100% coverage in municipalities with home care services until 2017, to increase the number of recipients (elderly and disabled) of home care services from the current 41 per 10,000 inhabitants to 55 in 2017 and to increase the number of recipients in day care centres from 58 to 65 per 10,000 inhabitants.

All forms of care for elderly (institutional, home care, day centers) are under the responsibility of local governments, while social care for mentally disabled and LTC (social and health) of chronic psychiatric patients are under the competence of the central government. This system generates conflicting interests between different levels of political power. Problems stem from separate budgets used to finance different services and client groups, the organization of service delivery and the existence of several bodies involved in the health and social sectors. According to the Concept paper on development of social services for 2014 – 2020, new guidelines for multi-disciplinary teams will be developed. This might help on a case-level basis. However, more systemic reforms are not proposed.

[175] Labklājības ministrija (2013), Pamatnostādnes sociālo pakalpojumu attīstībai 2014.- 2020.gadam, Informatīvā daļa, 29.07.2013, http://mk.gov.lv/lv/mk/tap/?pid=40294031, retrieved on 23 August 2013.

5. BACKGROUND STATISTICS

Latvia (LV)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.8	13.3	23.4	25.3	19.5	30.3	28.0	22.6	32.8	28.3	23.8	32.4	9.5	10.5	9.0
80+	4.7	2.4	6.5	7.0	4.1	9.5	10.2	6.8	13.2	11.0	7.8	13.8	6.3	5.4	7.3
85+	1.9	0.8	2.8	3.6	1.8	5.0	5.2	3.1	7.1	6.4	4.2	8.4	4.5	3.4	5.6
80+/65+	24.8	18.2	27.9	27.7	20.8	31.5	36.3	30.1	40.2	38.8	33.0	42.7	14.0	14.8	14.8
85+/65+	9.9	5.9	11.8	14.0	9.3	16.6	18.6	13.8	21.6	22.7	17.7	26.1	12.8	11.8	14.3
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Latvia (LV)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	30.3	20.4	39.5	57.0	45.2	69.3	26.7	24.8	29.8	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.9	13.3	27.7	41.6	32.3	51.2	20.7	19.0	23.5	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Latvia (LV)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	68.3	78.0		81.1	87.2		12.8	9.2		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	13.5	18.1		20.6	24.4		7.2	6.3		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	5.0	5.5		5.3	6.4		0.3	0.9		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	40.0%	32.0%		39.0%	34.4%		-1	2.4		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.7			1.2			0.5			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

MALTA

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Maltese population is expected to grow from 3.7% to 10.4% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3.5 from 1.6% to 5.7% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 21.6% to 36.5% (EU-28: 27.8%-41.5%), and from 9.4% to 20.0% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 27.6% (EU-28: 29.9%) to all of 55.8% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.0/20.2 years (EU-27: 17.2/20.7) in 2010 to 22.2/25.4 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 2.0 and 1.1 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.7% to 1.7% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

According to MISSOC Table XII, there is one central institution for permanent elderly residents in Malta, supplemented by 8 regional residences – all state-run. There are also private residential homes. In addition, there is a state-run central mental institution that provides treatment and care for mentally impaired persons who need psychiatric treatment.

Further research indicates that there are 16 private residential homes and 16 Church homes. The former have flourished rapidly over the past few years[176]. In additon, there are two rehabilitation centres, one state-run and one private, that provide rehabilitation to the elderly and younger adult patients. There are twenty day centres that cater for older persons and persons with disabilities. Activites are organised within these centres with the aim of motivating the elderly and persons with disabilities to participate so as to remain as independent and socially integrated as possible whilst providing respite for their relatives and carers[177]. As for institutional care, the country is facing the problem of waiting lists.

[176] Detailed information can be obtained from the Health Care Standards Department, Ministry of Health, at: https://ehealth.gov.mt/HealthPortal/public_health/healthcare_serv_standards/homes_for_older_persons.aspx

[177] If LTC is defined to include treatment and rehabilitation from substance addiction and abuse, facilities would then include one state run facility that provides a safe detoxification process from alcohol and drugs and two state run rehabilitation facilities. The Church offers rehabilitation for persons suffering from drug abuse within two residential facilities. Community services are provided within three facilities, two that are state run and one that is run by the Church.

In 2010, 43% of disabled people (aged 15+) were receiving institutional care, followed by 34% receiving informal/no care and 22.6% receiving home care. Projections up to 2060 reveal that institutional care will exhibit the largest increase to 55% whilst informal/no care faces the largest decline to 16.2%, possibly due to labour market trends and the evolution of family arrangements. From the perspective of a different data source, in 2012 there were 6,018 persons registered as disabled with the the National Commission for persons with disability (KNPD)[178]. 59% of these persons were aged 60+, up from 39% in 2003.

Over the last few years, LTC has benefitted from an expansion of community-based services and residential care places. In an effort to reduce bed blocking and save costs, LTC beds within Malta's single state run general hospital have been almost completely eliminated. This has occured since transfers have taken place to remove the elderly out of hospital and into elderly homes[179]. The number of psychiatric care beds in hospitals amounts to approximately 579 beds or 144.7 per 100,000 inhabitants. In 2012, the number of licensed beds in institutions amounted to 4,545 beds, 57% in the Government sector with the remaining located in Church and private homes.

Eligibility for LTC in one of the elderly state institutions that cater for permanent residents is granted to persons over 60 years and/or those with a disability that leaves them unable to cope with living within their own home. In order to cater for the increasing demand for long term care and ensure accessibility, the public system is being improved through the purchase of beds within the private sector. For all cases, eligibility is determined by a medical evaluation. Access to Church-provided services is hard to come by due to the limited number of places available.

There is no special cash benefit related solely to LTC. The disability and invalidity pensions are directly payable to the entitled individual, whilst social assistance is provided for somebody taking care of a relative on a full-time basis if the household does not include another person who is not in employment.

Benefits in-kind include community services such as home care which provides assistance to allow older persons and/or persons with special needs, to continue living in their community in as much of an independent manner as is feasibly possible. It also provides respite and support for informal carers, and averts/delays demand for long-term residential care. Persons in receipt of benefits in-kind are expected to make a contribution to the costs of goods or services that include meals on wheels, telecare (calls for assistance when required), home care help (offers non nursing, personal help and light domestic work to older adults and to persons with special needs), incontinence service (supply of heavily subsidised diapers), community nurse service and day centres.

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[178] Data available to date includes number of persons registered with the KNPD. Census data, as at November 2011 would provide a more precise estimate however data is not yet published. Persons receiving care in institutions can be traced from the census question that asks about place od residence whilst persons receiving home care can be traced through the Department for Elderly Care. Therefore, persons not receiving institutional care or home care may be taken as a proxy for those receiving informal/no care.

[179] http://www.maltatoday.com.mt/en/newsdetails/news/national/1-020-beds-provided-for-elderly-needing-long-term-care-20130306, http://www.timesofmalta.com/mobile/view/20130722/local/call-issued-for-provision-of-spaces-for-elderly-in-need-of-long-term-residential-care.479076

In-kind benefits are partly means tested and others are needs-based. Residents of government elderly homes contribute 80% of their pension and 60% of their remaining net income up to a maximum of EUR 16 daily, provided that residents are not left with less than EUR 1,398 per year (pension and other income) at their disposal. Therefore, residents continue to receive their pension entitlement minus the deducted monthly contribution[180].

In 2010, LTC spending as a percentage of GDP stood at 0.7, well below the EU-27 average of 1.8[181]. The major component of spending is institutional care. In comparison to other EU countires, Malta is classified as a low-spender on LTC and a medium-spender on health care. Over the long term, LTC spending is forecasted to reach 1.7% of GDP by 2060, remaining below the EU-27 average of 3.6%. Nonetheless, the issue of public spending on LTC will become a significant part of the debate on the long-term sustainability of public finances for Malta.

Inspections of government homes and LTC facilities for the elderly are coordinated by the Health Care Standards Directorate. A draft of National Minimum Standards for Homes for Older Persons was launched for public consulation in March 2014. It is planned to have this set of standards backed by a legislative framework."

3. CARERS

Informal care plays an important role in Maltese society due to the traditional strong role of the family. Most care givers are females aged between 40-59 years. Support measures offered include a combination of cash benefits and care leave. Cash benefits include the Carer's Allowance[182] and the Carer's Pension[183]. Care leave is granted through Responsibility Leave which involves unpaid leave for public employees (up to a maximum of 8 years during the whole working life) to take care of dependent elderly parents, sons and daughters, or spouses if no other live-in carer is available.

Respite and support for informal carers is provided through benefits in-kind provided to patients through community services and the CommCare Unit[184]. The latter consists of nurses, physiotherapists, occupational therapists, social workers and carers who provide services to clients that are house bound[185]. A number of one-off training initiatives have been organized by the private sector within a number of localities to improve the abilities and skills of informal

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[180] https://www.oconnorandassociates.ie/docs/malta/Social_Security_Rights_(ENG).pdf
It is the opinion of the authors that the latter potentially creates a risk of a perverse incentive for assets to be transfered from elderly parents to children, leaving the elderly in a more vulnerable position. Some private homes offer contracts involving claims on the estate of a person receiving care in exchange for reduced daily rates for the provision of services.

[181] Long-term care spending – Commission Services, EPC. The 2012 Ageing Report

[182] A single or widow male / female, whether registered or not as an unemployed person, and who is taking care of a sick or elderly relative all by herself and on a fulltime basis, may become eligible to Social Assistance Carers.
In orde to be eligible, there must not be another unemployed person in the same household and or if the other unemployed person is not medically fit to take care of the sick or elderly relative.

[183] A person who is either single or a widow and who all by her/himself and on full-time basis, takes care of a sick relative who is bedridden or confined to a wheel-chair in the same household, is entitled to receive Carer's Pension. Relatives referred to in this section can be the parents, grand-parents, brothers, sisters, uncles, aunts, brothers or sisters in-laws and father/mother in laws.
Eligibility is subject to the Capital Resource Test and Means Test. Capital Resources must not exceed €14,000.

[184] During the year 2012, the CommCare Unit received 8,446 requests for domiciliary nursing care, of which 3,173 were new referrals and 5,273 were follow-up cases (accessed at: http://www.independent.com.mt/mobile/2013-01-26/news/more-than-8000-elderly-persons-use-commcare-services-756744192/)

[185] https://ehealth.gov.mt/HealthPortal/default.aspx

carers. Sessions have been delivered on dementia and manual handling and lifting. Attendance has been strong and feedback obtained has been encouraging[186].

Statistical data allowing for a valid assessment of family care of elderly persons in Malta is not available. The Department of Social Security keeps a very basic statistical register of the persons who are eligible to receive the Carer's Pension and another for those benefiting from the scheme called the Social Assistance for Females taking care of a sick or elderly relative (National Statistics Office, 2013). In 2011, there were 162 beneficiares receiving the Carer's Pension and 372 persons receiving the Social Assistance. But, as such, there is no formal register of family carers in Malta.

A Diploma level in Health and Social Care is the minimum qualification required to commence work at an operational level in the elderly care sector. General concerns about staff shortages are not widespread but there are significant gaps with respect to specific areas of care, most notably dementia. A recent study showed that there will be almost 10,000 people aged over 60 suffering from dementia by 2030 (from 5,198 persons in 2010) or 2.3% of the total Maltese population. (Scerri A. & Scerri C.).

4. POLICY AND RECENT DEVELOPMENTS

Public spending on long-term care is expected to become increasingly important within the debate regarding the long-term sustainability of public finances for Malta. Important recent developments include a number of initiatives that have been undertaken to promote independent living within the community.

Dementia services and refurbishment of wards within the major state residence for these patients have improved in recent years, whilst further investment is expected to continue in the coming years. A Dementia Strategy is under preparation.

[186] http://www.caremalta.com/CareMalta/TrainingandEducationCentre/OutreachProgramme/tabid/767/Default.aspx

5. BACKGROUND STATISTICS

Malta (MT)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	17.2	15.1	19.2	24.4	22.3	26.5	25.4	23.3	27.6	28.5	26.7	30.3	11.3	11.6	11.1
80+	3.7	2.6	4.8	7.6	6.2	9.0	9.8	8.1	11.6	10.4	8.8	12.0	6.7	6.2	7.2
85+	1.6	1.1	2.1	3.2	2.3	4.0	5.6	4.2	6.9	5.7	4.4	6.9	4.1	3.3	4.8
80+/65+	21.6	17.5	24.9	31.2	27.6	34.1	38.6	34.6	42.1	36.5	33.0	39.6	14.9	15.5	14.7
85+/65+	9.4	7.1	11.2	12.9	10.2	15.2	21.9	18.1	25.1	20.0	16.6	23.0	10.6	9.5	11.8
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Malta (MT)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	27.6	23.8	31.5	55.8	51.0	60.8	28.2	27.3	29.3	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	15.5	12.6	18.4	38.6	34.6	42.7	23.1	22.0	24.4	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Malta (MT)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at birth	77.6		82.3	84.9		88.9	7.3		6.6	76.7		82.5	84.6		89.1	7.9		6.5
years at 65	17		20.2	22.2		25.4	5.2		5.2	17.2		20.7	22.4		25.6	5.2		4.9
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at 65	10.5		11.1	12.5		12.2	2.0		1.1	8.6		8.9	8.4		8.5	-0.2		-0.4
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
at 65 (%)	64.8%		57.2%	71.1%		58.0%	6.3		0.8	52.1%		44.5%	48.3%		40.4%	-3.8		-4.1
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.7			1.7			1.1			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

THE NETHERLANDS

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Dutch population is expected to grow from 4.2% to 11.1% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3.5 from 1.9% to 6.9% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 24.9% to 40.6% (EU-28: 27.8%-41.5%), and from 11.5% to 25.3% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 28.0% (EU-28: 29.9%) to all of 52.5% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.5/20.9 years (EU-27: 17.2/20.7) in 2010 to 22.3/25.6 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women decreased by 0.5 and 1.0 years, respectively, even though still remaining above the EU average.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 3.8% to 8.4% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

Capacity: Table 1 shows that the capacity of residential homes (*verzorgingshuizen*) has decreased whereas the capacity of nursing homes (*verpleeghuizen)* has increased. The average bed capacity of homes for residential care and/or nursing care in 2008 is 363 beds. Note that most of these homes are multi-site homes.

Table 1. Bed capacity of residential homes and nursing homes

	2000 (in thousands)	2008 (in thousands)	Capacity per 1000 persons 65 and over in 2008
Residential homes	118	99,6	3,6
Nursing homes somatic	26,4	28	1
Nursing homes psycho-geriatric	31,2	36,9	1,3
Total capacity	176,7	164,6	5,9

Source: De Klerk, 2011

Most nursing homes presently have rooms with one or two beds. The government's policy is to have only single bed rooms for privacy reasons. Other innovations are the introduction of small-scale home-like living places where 6-7 persons live together, the development of small-scale facilities based upon differentiations in life-style.

Table 2. Potential Recipients of LTC on Jan 1, 2013 (absolute numbers)

	Intramural	Extramural	Total
Persons with somatic problems	100,000	238,200	338,200
Persons with psycho-geriatric problems	80,655	17,705	98,360
Persons with psychiatric disorders	46,820	79,765	126,585
Persons with learning disability	91,955	70,565	162,520
Persons with sensory handicap	3,355	5,235	8,590
Persons with physical handicap	21,100	32,090	53,190
Unknown	5	10	15
Total	343,895	443,570	787,465

Source: CIZ 2013.

Types of benefits: The providers of LTC offer many different types of in kind services to their clients. Intramural services covered by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten,* AWBZ) include nursing and caring, medical treatment in nursing homes, accommodation, intensive 24 hour care, and rehabilitative care after hospital admission. Extramural services covered by the AWBZ include personal care, nursing, counselling, treatment, and short-stay. The Social Support Act (*Wet Maatschappelijke Ondersteuning,* Wmo) covers household services, house adjustments, scoot mobiles, and some other services. Both acts have the option for recipients to alternatively apply for benefits in cash to enable them to organize care for themselves. Cash benefits may be used to pay for in kind services but also to pay for informal care.

Financing arrangements: The financing arrangements for LTC consist of two main pillars. The first pillar is the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*) which funds most of LTC. The AWBZ, which is in place since 1968, is a national mandatory, contribution-based insurance scheme which covers personal care, nursing care, counselling, medical treatment in a residential setting, and accommodation. Clients are required to co-pay; the size of the co-payment is related to income, age, family situation (single or married), stage of care, and since Jan. 2013 private savings and assets. In 2012 a recipient co-paid on average EUR 6400 a year for residential care. Since 2013, 12% of a person's private savings and assets above a state-set threshold (approx. EUR 21,000) are accounted for in the calculation of the co-payment.

The second pillar is the Social Support Act (*Wet Maatschappelijke Ondersteuning*) which is in place since 2007. It is a tax-funded scheme run by municipalities. The Wmo pays, among others, for household (domiciliary) services. Before its introduction, these services were covered by the AWBZ. The transition of these services from the AWBZ to the Wmo meant that a rights-based scheme was converted into a provision-based scheme which gives recipients fewer rights. Municipalities have substantial discretionary power in the implementation of the Wmo.

Both acts have the option for recipients to alternatively apply for benefits in cash,the personal budget (*persoonsgebonden budget*). This benefit-in-cash arrangement was introduced in the mid-

1990s to give recipients an alternative for in kind services. The personal budget enables clients to organize their own tailor-made care arrangements.

Means-testing and family obligations: Means-testing is not used under the AWBZ. If after a need-assessment procedure a person is considered eligible for LTC, his (her) personal financial situation is only relevant for the calculation of co-payment. The AWBZ gives him (her) a legal right to healthcare. This is different under the Wmo, where municipalities may take the financial situation of the applicant into consideration in deciding on whether he (she) is eligible for publicly funded care. Means-testing is likely to be applied by the municipalities.

A similar observation can be made for family obligations. These have never played an important role in access to LTC, although the agency in charge of need assessment could take the family situation into account when assessing the urgency of LTC. Interestingly, however, municipalities may adopt a stricter policy under the Wmo and assess whether family members (or the client's social network) can be mobilized for informal care. Under current Dutch law, only the recipient's spouse can be held formally responsible for informal caregiving (not children).

Expenditure: The reports on AWBZ-expenditures indicate a rapid growth of LTC-expenditure. In the period 2001-2012 total AWBZ-expenditure increased by 71% and the personal budget scheme even by 518%. The real annual growth averaged 4,3% since 2000, which is almost three times GDP annual growth. Depending on the assumptions made, the National Bureau for Economic Policy Analysis estimated that LTC will represent between 7-9% of the GDP in 2040 (CPB 2011).

Quality assessment: Organizations providing residential and home care are supervised by the Healthcare Inspectorate (*Inspectie voor de Gezonheidszorg,* IGZ). Furthermore, insurers may require them to possess specific marks of quality (*keurmerk*) of external quality organizations as a precondition for contracting care. Quality is also fostered by quality guidelines and, since 2006, quality measurement based upon the Quality Framework for Appropriate Care (*Kwaliteitskader Verantwoorde Zorg*). This framework, agreed upon by the Minister of Health, the Healthcare Inspectorate and the main associations of provider organizations, insurers, clients and care professionals, distinguishes between recipient-related indicators, care-related indicators and organization-bound indicators (Maarse et al, 2013). Scores are publicly available at the website www.kiesbeter.nl, but only from providers who voluntarily agreed to do so.

Access to residential care: Around the turn of the century, waiting times in LTC were a hot political issue. Consequently the government committed to spend extra resources to reduce waiting times and waiting lists. This resulted in a significant reduction of waiting times.

Table 3. Waiting times for nursing homes and care homes in 2010 (percentages)

	Nursing home	Residential home
≤ 42 days (maximum acceptable waiting time nursing home)	93%	
≤91 days (maximum acceptable waiting time care home)		90,1%
43-91 days	2,8	
More than 91 days	4,2	9,9

Source: Nza 2012

3. CARERS

Informal carers: In 2008 there were about 3.5 million persons aged18+ active as informal caregivers compared to 3.7 million in 2001. The number of 'intensive' informal carers (more than 8 hours a week for a period longer than 3 months) increased significantly between 2001 and 2008. 60% of the informal carers are female; about 50% are between 45 and 65 years old.

Table 4. Number of informal caregivers aged 18 and over (in thousands)

	2001	2008
Total	3,700	3,500
More than 8 hours a week	1,050	1,400
Longer than 3 months	2,050	2,300
More than 8 hours a week and/or longer than 3 months	2,400	2,600
More than 8 hours a week and longer than 3 months	750	1,100

Source: SCP 2010.

In 2008 more than 450.000 informal carers compared to about 300.000 in 2001 reported to feel so overburdened that it could cause health problems, conflicts at their workplace or in the family and loss of income.

There are various arrangements in place to support carers. The possibilities of care leave and flexible working hours vary per employer. Facilities for respite care, counselling and training are available as well. Care recipients may also use their personal budget to pay a cash benefit to informal carers. MEZZO, the national interest organization of informal carers, warned in 2011 against a worsening of the financial position of informal caregivers due to various new government measures on social security. Furthermore, the Wmo requires municipalities to support informal caregivers by means of information, counselling and other forms of support (e.g. parking permit, hoists). However, the percentage of users of these support services is much lower than the expressed need for them, due to lack of knowledge among other reasons (SCP, 2013).

Professional carers: The majority of professional carers work in the nursing and caring sector (*verpleging en verzorging)*. There are concerns on the expected future gap between the demand and supply of professional carers (UWV 2013). The government's policy is to mobilize more informal care. However, its potential availability should not be overestimated, given that the size of informal care is already substantial.

Table 5. Employment in LTC (2011)

	Number of employees	Growth 2006-2011
Residential homes, nursing homes, home care	445,000	16%
Persons with cognitive handicap	164,900	12%
Persons with psychiatric disorders	88,100	18%
Hospitals	282,600	7%
Other (dental care, paramedical, ambulances, public health agencies)	159,200	30%
Total	1.140,200	15%

Source: UWV 2013.

Most employed persons are women (92% in residential homes and nursing homes and 94% in home care). About 12% of professional carers have the highest training level; 69% has a medium level and 19% a low level (UWV 2013).

4. POLICY AND RECENT DEVELOPMENTS

The general trend is that the number of persons in residential care has been declining since the early 1980s. The percentage of persons aged 80+ living in a residential home or nursing facility dropped from 63% in 1980 to 24% in 2010. The expectation is that this percentage will further drop due to a growing preference of older people to live in their own home for as long as possible. The government's policy is to foster this development, not only in elderly care but also in other sectors of LTC. Various programs are in place to make independent living possible. For instance, sheltered accommodation in the proximity of a care home. Residents can make use of the services (e.g. meal) of the care home (assisted living) and the accommodation has a direct alarm line with the care home. Another trend is to make use of ICT-applications and other technologies to assist people in their own environment.

Ever more nursing homes participate in integrated networks (care chains) to shorten the length of stay in a hospital and facilitate a smooth transition to a residential setting for what is termed geriatric rehabilitation (e.g. in cases of strokes, hip replacement, fractures).

LTC is currently undergoing fundamental reforms. The main driver behind these reforms is the need to make LTC spending sustainable in the future.

The key structural system changes are:

- Less intramural care, more outpatient care. The AWBZ will remain in place but only as a scheme for persons who can only be appropriately cared for in a residential setting.

- Decentralization of various services of LTC, currently covered under the AWBZ, to local government under the Wmo. Municipalities, which are charged with the implementation of the Wmo are assumed to be better capable than the national government to provide efficient tailor-made services to clients. Also note that the Wmo is a provision-based scheme, whereas the AWBZ is a rights-based scheme.

- Reductions in the available budget for publicly-fund benefit package of the AWBZ and the Wmo (personal counselling, household services).

- Raising the co-payment of clients. Since 2013, 12% (4% before) of recipients' savings and assets above a state-set threshold (approx. EUR 21,000) are taken into account for the calculation of the co-payment.

These changes are accompanied by normative modifications that emphasize individual responsibility and the need for a strong transition from a welfare state to a participation state ('big society').

5. BACKGROUND STATISTICS

The Netherlands (NL)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	16.8	15.2	18.4	24.1	22.6	25.6	27.0	24.9	29.0	27.4	25.2	29.5	10.6	10.0	11.1
80+	4.2	3.0	5.4	7.0	5.9	8.1	10.2	8.7	11.7	11.1	9.3	12.9	6.9	6.3	7.5
85+	1.9	1.2	2.7	3.1	2.3	3.8	5.3	4.2	6.4	6.9	5.5	8.4	5.0	4.3	5.7
80+/65+	24.9	19.6	29.2	29.1	26.0	31.7	37.8	34.7	40.5	40.6	36.8	43.8	15.7	17.2	14.6
85+/65+	11.5	7.7	14.6	12.7	10.3	14.9	19.7	16.8	22.2	25.3	21.7	28.4	13.8	14.0	13.8
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**The Netherlands (NL)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	28.0	25.0	31.1	52.5	47.0	58.3	24.5	22.1	27.2	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	17.1	14.4	19.8	36.9	32.4	41.7	19.8	18.0	21.9	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**The Netherlands (NL)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	78.7	82.8		85.2	89.1		6.5	6.3		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	17.5	20.9		22.3	25.6		4.9	4.8		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	10.5	11.1		10	10.1		-0.5	-1.0		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	64.0%	55.2%		55.6%	47.9%		-8.4	-7.3		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	3.8			8.4			4.6			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

POLAND

1. DEMOGRAPHIC BACKGROUND

Poland still has a relatively young population – the old age dependency ratio was the second lowest in the EU and much lower than the EU-28 average. This is due to high fertility and low life expectancy before 1990. However, with declining fertility and rising life expectancy population ageing is underway. The age composition will change dramatically and in 2060 Poland is forecast to have one of the oldest populations in Europe.

In the period 2013-2060 the share of people aged 80+ in the Polish population is expected to grow from 3.7% to 12.0% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 4 from 1.5% to 6.3% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 26.3% to 36.6% (EU-28: 27.8%-41.5%), and from 10.7% to 19.1% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 21.9% (EU-28: 29.9%) to all of 66.8% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 14.8/19.1 years (EU-27: 17.2/20.7) in 2010 to 21.2/24.8 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women decreased by 1.0 and 2.4 years, respectively, reaching levels below the EU average.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.7% to 1.9% (EU-27: 1.8%-3.6%).

Life expectancy rose again after 1990: life expectancy at birth for men rose from 66.23 years in 1990 to 72.44 years in 2011, and for women from 75.24 years in 1990 to 80.9 years in 2011. Life expectancy at 65 also increased clearly, reaching 14.8 years for men and 19.1 years for women in 2010. However, healthy life expectancy at 65, which was very close to the EU average for men and even higher for women in 2005, decreased to 7.6 years for men and 8.3 years for women in 2011.

2. CURRENT LONG-TERM CARE PROVISION

In Poland's long-term care (LTC) system, the family is still the main caregiver for elderly persons with limitations in the activities needed for daily living. Two indicators depict the significant role families play in the care system: the 'co-residence' index (elderly parents residing with their children) and the index of 'non-working women aged 55-64'. The levels of both indicators put Poland in an extremely high position in terms of family commitment. In the field of social protection, Poland belongs to the EU group of countries with a family-based welfare model. The development of formalised, non-family LTC is in the initial stages.

LTC is very fragmented; i.e., there is no separate long-term insurance or protection. Even the term LTC *(opieka długoterminowa)* is mainly used by experts only, especially in the health sector.

Informal care plays the prominent role: In most cases, LTC in Poland is provided by family members at home. There are several explanations for that:

- traditionally strong family relations, including high share of elderly residing with their children,
- traditional gender division of roles: women retire early (lower retirement age for women has been functional in this respect), also to care for their parents/ parents-in-law,
- insufficient institutional supply of publicly financed care,
- lack of affordable private care establishments.

The very low level of coverage by formal LTC in Poland can be seen in the share of disabled people (15+) receiving informal or no care. It was 92.9% in Poland in 2010, the second highest share in the EU after Bulgaria, with only 5.2% covered by institutional care and 1.9% by home care. The projected change of this situation until 2060 is relatively modest: still 89.7% are expected to receive informal care or no care at all. Only some 0.9% of the Polish population over the age of 65 received institutional LTC in 2008, well below the OECD average of 4.2% (OECD 2011).

There are both cash benefits and in-kind benefits for LTC in Poland.

Cash benefits include, apart from social assistance benefits which may also be awarded to persons in need of long-term care in difficult situations; medical care supplement and medical care allowance.

The medical care supplement (dodatek pielęgnacyjny) is granted to persons entitled to an old-age, invalidity or survivors' pension who have reached the age of 75, as well as to persons of any age entitled to an old-age, invalidity or survivors' pension who are totally incapable of work and require assistance from another person.

Medical care allowance (zasiłek pielęgnacyjny) is paid to persons fulfilling the health and age criteria, regardless of family income:

- children up to the age of 16 requiring permanent assistance from another person,
- children over the age of 16 with a moderate disability that began at the age of entitlement to the family allowance, or seriously disabled persons, without age criteria.

The formal LTC in Poland operates within both the health and social assistance sectors.

Table 1. Providers of long-term care in Poland

Type of care	Social assistance	Health care	Informal care/ Private sector
Home care	Nursing services Specialist nursing services Cash benefits	Nursing services, family doctors	Family care, informal groups (family, neighbours, friends), care paid by the person or his/her family, home for care
Semi-residential care	Day centres Support centres		
Institutional (residential) care	Social assistance centres (homes) (6 types)	Care and treatment facilities (*Zakład opiekuńczo-leczniczy*, ZOL) Nursing and care facilities (*Zakład pielęgnoacyjno-opiekuńczy*, ZPO) Geriatric hospitals/ units; palliative facilities	Private care centres

Source: Błędowski, Wilmowska-Pietruszyńska 2009, p. 12.

There are six types of social assistance centres reserved for:

- elderly people,
- chronically somatically ill people,
- chronically mentally ill people,
- mentally disabled adult people,
- mentally disabled children and young people,
- physically disabled people.

In 2011 there were 865 social assistance centres in Poland, including 635 in the public sector and 230 in the private one. In the health care sector, there were 32.3 long-term beds (except psychiatric) in hospitals per 100 000 inhabitants in Poland, above the EU-27 average.

Long-term care is financed on a public - private basis in Poland. The prevailing informal care is financed on a private basis. Health care services are financed from health insurance contributions and social assistance homes financed from general taxes. It is estimated that (formal) long-term care spending represented 0.7% of GDP in 2010, of which 0.30% went to institutions, 0.07% to home care and 0.37% to cash benefits. It is projected that spending will increase much faster than in most EU countries, reaching 1.9% of GDP in 2060.

Only the medical care supplement (dodatek pielęgnacyjny) granted to persons entitled to an old-age, invalidity or survivors' pension who have reached the age of 75 is universal. All in-kind benefits require a co-payment by the patient. In the health sector, only the cost of accommodation and board has to be covered. The monthly payment of care recipients in the social assistance sector is 250% of the lowest pension, with a maximum of 70% of the monthly individual income of the care recipient.

The quality of residential care in Poland is uneven, although general improvements have been observed. Standardisation of facilities can only solve this problem in part. There is a need of continued action in this field. Some arguments have been put forward for more private involvement in residential care, supported by state (inter alia fiscal) incentives, more competition, better information and higher involvement of NGOs in monitoring the quality.

Access to long-term care is often a problem. Many people in need wait for admission to an insufficient number of social welfare homes or are unable to pay for private care.

3. CARERS

Informal carers clearly dominate LTC in Poland. According to a recent comprehensive survey, families provide care to 93.5% of all dependent elderly people (Łuczak 2013, p. 170). The vast majority of carers are women. Traditionally, the retirement age for women has been low (60, with many early retirement possibilities). This was partly motivated by the traditional role of women as carers for their grandchildren and/or parents (parents in law). The average person taking care of the frail elderly is a woman aged 51 (Łuczak 2013, p. 171).

Nursing benefits *(świadczenie pielęgnacyjne)* were established to support people who do not undertake (or quit) employment due to the need to take care of a disabled child (thus not aimed at informal care for dependent elderly). The amount of money paid directly to the caregiver is PLN620 (EUR 152) per month in 2013. The caregiver can have his/her social insurance contributions paid from the state budget.

A social assistance centre pays the contribution to old-age and pension insurance, in the amount subject to income criterion per person in the family, to a person that gives up employment due to the necessity to exercise direct, personal care for a member of the family suffering from a long-term or serious disease, and for a non-cohabiting mother, father, or siblings. This is conditional on the fact that the actual income per person in the family of the person exercising such a care does not exceed 150% of the amount subject to income criterion per person in the family, and the person exercising such a care is not covered by mandatory old-age or disability pension insurance under other titles, and receives no old-age or disability pension (MISSOC 2013).

Professional carers within the health care sector in 2007 included 896 doctors, 4,499 nurses, 918 specialists for rehabilitation, 703 carers. In the social assistance sector, 34 thousand persons were employed in primary jobs in social assistance homes in 2008.

It is widely accepted that the training in LTC of general practitioners should be improved (through appropriate career long updating). Furthermore, specific training and motivation for nurses to work with the elderly with functional limitations are also needed.

4. POLICY AND RECENT DEVELOPMENTS

The present state of LTC in Poland has been assessed as not satisfactory due to factors such as fragmentation and lack of coordination, underfinancing, inefficiency of public spending, low supply of services and low incentives for the introduction of market elements.

In recent years, several plans to introduce compulsory LTC insurance were prepared. They were mainly based on German experience. The Polish Senate presented in 2009 a proposal of LTC insurance, with contributions between 1 and 1.5% of income. The new insurance would cover all individuals already insured by the health care insurance. A new insurance fund, managed by the National Health Fund, would be created. This proposal arose some criticism pointing at the fact that a new contribution would mean ‘rising taxes’. Plans were stopped due to the budgetary effects of the economic and financial crisis.

In 2010, the ruling party issues new reform proposals in a green paper calling for radical changes.

In 2011, the Senate work on a new piece of legislation on 'nursing vouchers' was announced. The voucher was expected to finance care delivered by a private care person either at home, at a day (semi-residential) centre or at a residential care home (centre). It was announced that the value of such a voucher, financed from the state budget, would be between 800 and 1,200 zloty, depending on the level of LTC needs. The new system should have started in 2012, although its full implementation would take some more time.

Two main arguments for the introduction of this new solution were presented. Firstly, LTC needs will grow due to rapid population ageing. According to the estimates of GUS (Central Statistical Office), the number of older persons in need of permanent care will grow from presently about 1 million to 2.5 million in 2035. Secondly, whereas families now provide care for their elderly, this will change dramatically due to the decrease in the number of young persons, longer working lives and higher retirement ages.

The 'nursing vouchers' would be a very valuable support for LTC in Poland. The proposed solution is based on freedom of choice between care at home and semi-residential or residential care as well as between public and private establishments.

In February 2012 a conference on „Long-term care in Poland – in need of changes" was organised by the Committee of Family and Social Policy of the Senate where a new proposal for a long-term care system was presented. The proposal includes the introduction of a nursing voucher and the financing of social insurance contributions of those caring for their family members from state budget. The project assumed a gradual introduction of the new system, starting in 2013 with those having the highest dependency levels. However, the project was not adopted due to growing problems in public finances.

5. BACKGROUND STATISTICS

Poland (PL)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	14.2	11.2	17.1	22.6	19.3	25.7	27.1	23.8	30.2	32.9	29.8	35.9	18.7	18.6	18.8
80+	3.7	2.3	5.1	5.6	3.9	7.2	9.5	7.2	11.8	12.0	9.7	14.2	8.3	7.4	9.1
85+	1.5	0.8	2.2	2.4	1.4	3.2	5.5	3.8	7.1	6.3	4.7	7.8	4.8	3.9	5.6
80+/65+	26.3	20.8	29.7	24.8	20.3	27.9	35.2	30.1	39.0	36.6	32.7	39.7	10.3	11.9	10.0
85+/65+	10.7	7.3	12.8	10.5	7.5	12.6	20.3	16.0	23.5	19.1	15.7	21.8	8.4	8.4	9.0
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Poland (PL)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	21.9	16.8	27.0	66.8	57.9	75.9	44.8	41.1	48.9	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	14.5	10.5	18.5	47.1	40.1	54.3	32.6	29.6	35.8	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Poland (PL)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	71.7	80.1		82.4	87.9		10.7	7.8		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	14.8	19.1		21.2	24.8		6.4	5.7		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	8.4	10.2		7.4	7.8		-1.0	-2.4		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	58.7%	55.1%		48.2%	39.3%		-10.5	-15.8		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.7			1.9			1.1			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

PORTUGAL

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Portuguese population is expected to grow from 5.3% to 16.0% (EU-28: 5.1%-11.8%), i.e. to gradually treble over this time. At the same time the share of people 85+ will expand by more than a factor 4 from 2.3% to 9.3% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 27.5% to 46.3% (EU-28: 27.8%-41.5%), and from 12.0% to 26.8% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 32.0% (EU-28: 29.9%) to all of 69.3% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 17.1/20.4 years (EU-27: 17.2/20.7) in 2010 to 22.1/25.1 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 1.3 and 1.1 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.3% to 0.6% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

Long-term care is delivered both by formal and informal networks. For many people, the sole available care is still the informal care delivered by families and neighbours at home or care within non-specialized residential institutions for the elderly. As a consequence, SNS (National Health Service) hospitals have been frequently over-occupied by post-acute users that could be clinically discharged but are in need of long-term care.

Table 1. Population stating full disability and full incapacity for ADL (2005-06)

Population	No. of persons	% of total population
With full disability	279,595	2.81
With full incapacity for autonomous daily living activities	1,797,666	18.05

Source: National Health Survey, 2005-06.

Non-specialized residential institutions deliver two types of social support to dependents: (1) Integrated Home Support (ADI – "Apoio Domiciliário Integrado"); (2) Integrated Support Units (UAI – "Unidades de Apoio Integrado"). After 2010 the number of institutions supplying ADI support and/or operating UAI has decreased in recent years as formal LTC network started and spread.

RNCCI ("Rede Nacional de Cuidados Continuados Integrados") is the national network for "integrated continuous care" launched in 2006 to provide post-acute health care and social

assistance to dependent persons vulnerable by age and/or disease whenever referred by hospitals and health primary care units. This initiative is under the joint coordination of the Ministries of Health and of Social Solidarity[187].

In 2010, institutional and home formal care covered 30.8% of the disabled adult population and this figure is expected to increase in the period 2010-2060 by 11 p.p. Public provision should account for an increasing part of this growth as total available places rise within RNCCI (Table 1).

In 2012, a total of 267 private, non-profit and public institutions coordinate within the RNCCI network to provide services with quality assurance by standardized processes and approaches. RNCCI integrated care includes convalescence, medium-term (less than 90 days of stay after admission) and palliative care, as well as LTC (over 90 days of stay). Home care is also delivered within RNCCI by formal carers.

Table 2 shows the evolution of the supply of beds within RNCCI after 2008. It doubled in four years and reached 5,911 beds by the end of 2012. LTC and palliative care account for most of this increase and amount to 55% of the total beds now available.

Table 2. Long-term care: Number of places by typology of institutional care

Typology of institutional care services	No. places 31-12-2008	No. places 31-12-2010	No. places 31-12-2012
Convalescence	530	682	867
Medium term care	922	1,497	1,820
Long-term care	1,325	2,286	3,031
Palliative care	93	160	193
Total	2,870	4,625	5,911

Source: ASISP Portugal Annual Report 2012 and ACSS- RNCCI monitoring Report for 2012 (http://www.acss.min-saude.pt/; retrieved 13 September 2013).

Table 3 shows the weight of the different types of providers of institutional long-term care: 71% of the institutions are charities (mostly "Misericórdias") that provide 68% of beds, and the private sector (18% of institutions) accounts for 23% of beds.

Table 3. Providers of long-term care within RNCCI in 2012

Providers	**No. of institutions operating within RNCCI**	**No. Beds**
National Health Service (SNS)	29	480
Charities	189	4042
Private sector	49	1389
Total	267	5,911

Source: ACSS- RNCCI monitoring Report for 2012 (http://www.acss.min-saude.pt/; retrieved 13 September 2013).

[187] Source for data on RNCCI: *ACSS- RNCCI monitoring Report for 2012 (http://www.acss.min-saude.pt/; retrieved 13 September 2013).*

Table 4 summarizes the evolution in the period 2010-12 measured by the indicator "number of beds in institutions per 1.000 of population aged 65+", which almost doubled from 1.5 to 2.9.

Table 4. Beds in institutions per 1.000 aged 65+ within RNCCI (2010-12)

Years	Population aged 65+	No. Beds	No. beds per 1.000 of population aged 65+
2010	1,953,410	2,870	1,469
2011	1,992,035	4,625	2,322
2012	2,020,127	5,911	2,926

Source: INE/PORDATA, http://www.pordata.pt/Portugal/*: retrieved on 11 September 201; ACSS- RNCCI monitoring Report for 2012 (http://www.acss.min-saude.pt/; retrieved 13 September 2013).*

Daycare centres: These offer a variety of daily care services, roughly from 9:00 am to 5:00 pm on weekdays, targeting elderly persons with low or medium levels of dependency. Daycare centres began to develop in an experimental way in the mid-1970s, with the aim of helping an individual to remain in his/her own socio-familial context for as long as possible and offering an alternative to institutional care (Carta Social, 2000). The latter form of care was not always the most appropriate response and moreover implied a substantial financial investment. Between 1986 and 1995, the number of daycare centres increased steadily (+55% from the previous period of 1975–85). The number of centres rose during the 1990s as did the number of users. On the whole, these establishments are mainly run by the private non-profit sector possible agreements with the social security centres.

Type of benefits (in cash, in kind): The specific cash benefit for patients in need of long-term care is the social security supplement for dependency ("Complemento por Dependência" - CD). Beneficiaries entitled to this allowance are: (1) pensioners whose pensions amount to less than EUR 600 euros per month and have full incapacity for autonomous daily living activities, and (2) non-pensioners with very specific incapacitating chronic diseases. The CD is calculated as a percentage between 45 and 90% of the legal social minimum ("pensão social") that rises as a function of the measure of dependency of the beneficiary.

For beneficiaries entitled to RNCCI support, social security will further co-finance social services subject to means-testing. Health care services within RNCCI are fully financed by the state and delivered at no cost for the user.

Financing arrangements: RNCCI LTC is financed by two main sources: (1) revenues from legal gambling ("Jogos Sociais") that are a state monopoly and (2) social security transfers. Revenues from "Jogos Sociais" are ear-marked to finance the cost of health care. Social security transfers, in turn, finance the difference between the full cost of the services of social assistance and the fee paid by the beneficiary (subject to means-testing).

The growth of RNCCI expenditure is impressive after 2010 (Table 5): an increase of 83%, up to 0.8% of GDP (in 2012) mainly driven by health care services provided to users.

Table 5. RNCCI long-term care expenditure (2010-12)

Year	No. of Beds	Social security expenditure (Million Euros)	Health expenditure (Million Euros)	Total expenditure (Million Euros)	Nominal GDP (Million Euros)	RNCCI Expenditure as % of GDP
2010	4,625	14.85	60.19	75.04	172,859.5	0.4
2011	5,595	19.56	113.49	133.05	170,960.2	0.7
2012	5,911	25.21	112.22	137.43	165,173.7	0.8

Source: ACSS- RNCCI monitoring Report for 2012 (http://www.acss.min-saude.pt/; retrieved 13 September 2013; INE – National Statistics Office, http://www.ine.pt/*; retrieved 15 September 2013).*

Extent of means-testing and family obligations: Family obligations are taken into consideration by accounting for the relative wealth of households in order to establish the eligibility of beneficiaries to social security support. For households not exceeding EUR 100,000 (in 2012) in wealth, social security means-testing will establish the fee to be paid by the beneficiary and the corresponding amount of subsidy that is transferred to the provider to finance the difference to the actual cost of the services provided.

Quality assessment in institutions and at home: Since 2007, RNCCI manages an integrated evaluation tool, collecting data on need (Katz evaluation, ADL, age), psychosocial wellbeing (emotional complaints) and social indicators (social status and habits). A system to monitor the RNCCI institutions - GestCare CCI – was set-up to operate a digital platform to manage and evaluate the processes and outcomes of LTC on-line. The inputs to GestCare CCI comprise human resources, ratios of performance and audited qualifications of providers. Previously existent indicators measure the outputs (discharges and the autonomy of patients). Need-assessment is carried out by a multidisciplinary team for bio-psychosocial evaluation of users in need of post-acute and long-term care. It focuses on functional and cognitive capacities, such as need for help with daily living activities or medical need. The results of needs assessment are registered on the GestCare CCI platform, allowing for continuous monitoring of the assessment results. This also allows for benchmarking of results at a national, regional, local, and unit level.

In 2009, 18 LTC units were analysed and the rates of compliance with technical requirements were calculated for this sample. Globally, 69.8% of the units complied with such requirements; 67.8% complied with the health care and rehabilitation requirements; and 71.8% complied with the managerial and organizational requirements[188]. More recently, the regulator of the health sector (ERS –"Entidade Reguladora da Saúde") delivered a complete study of access and quality of long-term care.

Problems of access: In 2011, 1% of the population over the age of 65 received LTC in institutions (4% OECD average) with 0.4% of this population receiving care at home (OECD average 7.9%).

In 2012, 2% of the population over the age of 65 was receiving long-term care in RNCCI. In the period 2007-2012 a total of 129,780 patients (6.7% of the population over 65) received LTC within the RNCCI network.

[188] BioConsulting, *Avaliação da Qualidade das Unidades de Internamento da Rede Nacional de Cuidados Continuados*, March 2009; http://www.umcci.min-saude.pt/SiteCollectionDocuments/avaliacao_qualidade_unidades_RNCCI_jan09_2.pdf ;retrieved 16 September 2013

Total users referred by SNS since 2007 amount to 135,047, implying that there has been progress of the access to care even if regional differences are still high as shown in Table 6. The largest urban concentration of Lisbon and the Valley of the River Tejo stands as the region where access is most insufficiently widespread[189].

Table 6. Coverage by regions (2012)

Region	Pop 65+	RNCCI users	%
North	636,756	15,379	2.4
Center	395,294	7,885	2.0
Lisbon/Tejo Valley	702,070	7633	1.1
Alentejo	129,033	4,286	3.3
Algarve	88,404	4,480	5.1
Total	1,949,557	39,663	2.0

Source: ACSS- RNCCI monitoring Report for 2012 (http://www.acss.min-saude.pt/; retrieved 13 September 2013).

3. CARERS

There is no data available on the number of informal carers.

Care leave is possible within social security protection, to assist members of the household for short periods of time. Few companies have flexible working hours.

There are few trained care workers and few people receive care services.

In 2010, there were 82,983 health professionals and 113,045 qualified workers of social assistance in the formal health and social assistance sector. They accounted for 7.2% of the total working population in the formal sector and translated into a ratio of 42.5 and 57.9 per 1,000 persons aged 65 or older. Only a small fraction of these were specialized in LTC.

In 2011, there were 4 long-term care workers in institutions per 1,000 persons aged 65 or older, compared to an OECD average of 3.2.

4. POLICY AND RECENT DEVELOPMENTS

The last decade before the crisis was characterized by the implementation and consolidation of the services previously developed (which remains true for the present situation), with particular attention paid to increasing the number of services but also their quality.

The National Network for Integrated Continuous Care (Rede nacional de Cuidados Continuados Integrados) has been implemented jointly by the Ministry of Health and the Ministry of Labour and Social Solidarity. Its mission was to provide various coordinated services according to the level of dependency that meet both medical and social care needs. It has mainly led to the setting up of a network for long-term and palliative care, which can take care of elderly persons in highly dependent situations. The goal was to promote individual autonomy and to strengthen family competences and involvement, prioritizing the opportunity for the elderly to remain at home.

[189] *ACSS- RNCCI monitoring Report for 2012* (http://www.acss.min-saude.pt/; retrieved 13 September 2013

This network was made up of public and private institutions providing care to dependent persons (not just the elderly), and includes community services, hospitals, health-care centres and ambulatory units. It also places particular emphasis on the establishment of hospitals for long-term and palliative care. The network would be progressively expanded until 2016. Between 2006 and 2007, several nursing homes for highly dependent persons were set up, with 2,718 places created in 2006–07. The number of places was expected to increase to 5,000 by the end of 2008.

Long-term care would also be provided through nursing homes, a policy that is associated more with a medical perspective than one focusing on the social integration of the dependent elderly in their own homes. Still, the latter continues to be emphasized in the care of those with low or medium dependency levels. A number of public programmes have sought to promote and stimulate the development of services provision. The government published a National Plan for Social Inclusion (for the period 2003–05 and subsequently for 2006–08), with the aim of expanding home-based care services for dependent elderly persons (expanding the services on offer as well extending the opening hours to longer periods during the day and to seven days a week). The goals included developing social care facilities, equipment and services (institutional care/nursing homes, home-based care and daycare centres) with 19,000 new places (by 2009).

The need to enhance the quality of care has also been underlined as a central issue. The need for improvement results from the poor quality of care, especially in residential care/nursing homes, which has been a persistent issue in public debate and policy over the last decade before the crisis. This has led to different governmental programmes not only to an increase in the number of places.

However, developments have largely been put on hold as Portugal struggled to consolidate its public finance so as to reopen its access for its government bonds to financial markets.

5. BACKGROUND STATISTICS

Portugal (PT)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	19.4	16.8	21.7	26.6	23.6	29.4	33.6	29.8	37.0	34.6	30.7	38.2	15.2	13.9	16.5
80+	5.3	4.0	6.6	8.0	6.2	9.7	11.8	9.4	14.0	16.0	12.8	19.0	10.7	8.8	12.4
85+	2.3	1.6	3.0	3.9	2.7	5.0	6.2	4.5	7.7	9.3	6.9	11.4	7.0	5.3	8.4
80+/65+	27.5	23.5	30.3	30.2	26.2	33.1	35.2	31.5	37.9	46.3	41.9	49.7	18.8	18.4	19.4
85+/65+	12.0	9.2	14.0	14.7	11.6	17.1	18.4	15.2	20.8	26.8	22.6	29.9	14.8	13.4	15.9
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Portugal (PT)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	32.0	27.3	36.4	69.3	58.1	81.1	37.4	30.8	44.7	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	21.3	17.7	24.7	50.8	41.6	60.3	29.5	24.0	35.5	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Portugal (PT)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	76.5	82.5		84.2	88.6		7.7	6.1		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	17.1	20.4		22.1	25.1		5.0	4.7		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2011***			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	6.5	5.2		7.8	6.3		1.3	1.1		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2011***			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	40.4%	26.8%		43.6%	29.3%		3.2	2.5		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.3			0.6			0.3			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

ROMANIA

1. DEMOGRAPHIC BACKGROUND

The share of older persons is presently lower than the EU27 average, but the expected demographic trend shows that Romania will experience a faster ageing process than the EU27 average. Consequently, the share of old people in the Romanian population in 2060 will be higher than the EU average while life expectancy will still be lower.

In the period 2013-2060 the share of people aged 80+ in the Romanian population is expected to grow from 3.8% to 11.5% (EU-28: 5.1%-11.8%), i.e. to gradually treble with over this time. At the same time the share of people 85+ will expand by more than a factor 4 from 1.4% to 6.1% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 23.4% to 39.6% (EU-28: 27.8%-41.5%), and from 8.7% to 21.1% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 26.0% (EU-28: 29.9%) to all of 57.3% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 14.1/17.2 years (EU-27: 17.2/20.7) in 2010 to 20.8/23.8 years (EU-27: 22.4/25.6) in 2060.

In 2012 the healthy life expectancy for men and women was well below the EU average with 5.9 and 5.1 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.6% to 1.9% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

The Romanian LTC system is aimed at old and disabled people. In the majority of cases, families take care of persons belonging to these two categories, so that primarily those in need of medical care are included in the formal system.

Most formal LTC responsibilities have been transferred to local authorities; the financing mechanism combines central and local resources, with NGOs playing an important role in the delivery of services. At the central level financing is shared by the state budget and the National Health Insurance Fund (NHIF), with the latter providing resources for medical services. Out-of-pocket-payments complement public resources; their level is set by the local authorities.

LTC for the elderly is coordinated by the National Council of Aged Persons[190] but the institution has essentially a consultative role. According to Law 17/2000, which regulates the social care for elderly persons, LTC for this category provides three types of community services: temporary or permanent *home attendance*; temporary or permanent attendance in a *residential centre*;

[190] http://www.cnpv.ro/

attendance in *daily centres*. Home attendance implies the provision of: *household services* (prevention of social marginalization and supporting social reintegration, legal and administrative counselling, payment of certain household obligations, catering, etc.); *socio-medical services* (personal hygiene, socio-cultural activities, etc.); *medical services* (medical consultations, medicine administration, etc.).

There is no precise information about the number of residential and daily centres or about the number of beneficiaries. Out of the 178 hospitals that were reorganised, 67 were expected to be transformed into residences for older people but only 14 had been transformed into this purpose by the end of 2012. The number of private residential institutions has increased significantly in the recent years, reaching 168 units by mid-2013, but the institution centralising the information on private residences[191] offers no details regarding the number of places in each centre or the number of beneficiaries residing there.

The only available information is the number of beds in hospitals destined for LTC: 77.7 per 100,000 inhabitants in 2010, which represents less than half of the number of beds available in 2000 but almost three times more than the EU27 average (26.5 LTC beds

The LTC of disabled persons is coordinated by the National Authority for Handicapped Persons (NAHP), which is part of the Ministry of Labour, Family, Social Protection and Aged Persons (MLFSPAP). At the end of the first quarter of 2013, a total of 699,780 persons were recorded by the NAHP, 61063 of which were children.

In 2013 32.63% of registered disabled people were aged +65, with the large majority of them (224,857 persons) being non-institutionalised.

Disabled persons are entitled to cash benefits (disability pensions, allowances and indemnities) and in-kind services of social and medical nature. Two types of services are provided: primary, aimed at preventing the social exclusion, respectively specialized, for ameliorating the individual's physical and psychical capacities. Concretely, the services provided to disabled persons are the same with than those delivered to aged people.

Benefits are granted on the basis of a medical certificate attesting the disability in case of pensions and indemnities, or in the case of in-kind services, respectively a certificate delivered by the local authorities. In order to better involve the family in taking care of the disabled person, the a supplementary allowance can be granted to a family member.

Depending on the nature of the benefit provided, financing is ensured from the public pension budget (pensions), the NHIF (medical services), local budgets (home attendance), and the funds allocated from the state budget to MLFSPAP (indemnities and allowances).

In 2012 RON 34.3 million were allocated for home medical assistance, which includes the medical services provided to old persons and disabled people, but the share received by these two categories is unknown. However, this form of medical assistance is primarily delivered to persons with low mobility due to age and disability, which presumably implies that a significant share of those allocations went to frail and disabled older people.

[191] Camine de batrani (http://www.camine-batrani.ro/).

The expected acceleration in ageing will accordingly increase the demand for LTC. In 2010 Romania allocated 0.63% of GDP on LTC expenditure, mostly on home care services (0.58% of GDP). This is three times lower than the EU27 average, but by 2060 it is expected that this gap will narrow, as Romania will allocate 1.9% of GDP for these purposes versus 3.6% in EU27. The allocated cash benefits for LTC represented in 2010 0.01% of GDP, as compared to 0.52% in EU27. This low proportion of overall long-term care expenditures in GDP is explained by specific family patterns in Romania, with strong inter-generational links. In a relatively large number of families two or even three generations live together, although in recent years this situation has started to change.

The quality of long-term care is regulated by several ministerial orders defining the quality standards of long-term care in terms of organization and administration, human resources, access to services, service provision, rights and ethics.

Changing social norms in the Romanian society, together with the phenomenon of emigration, have increased the number of old persons living alone, who need home or residential care. However, the provision of home care is difficult for many of them because the majority of aged Romanians live in rural areas where the provision of such services is absent or very insufficient. The demand for residential care has therefore increased faster than the available supply and consequently there are long waiting lists for places in specialised institutions. Although the number of private centres has increased in recent years in response to this demand, fees are affordable only to individuals with high pensions or whose families can afford the difference.

3. CARERS

There are no cash benefits for the informal care of elderly people, but only for persons who are officially recognised as having a disability. However, older persons who are chronically or terminally ill or have multiple comorbidities may be assessed a degree of disability. In this way, they can benefit from care allowances usually granted to a member of their family.

Most of dependent elderly people benefit from the care services provided inside the family. Yet, family care is ensured mainly in rural areas, where the traditions and moral values are maintained to a higher extent. Although the importance of informal care is recognised by authorities, no official estimates on the extent of informal care for old persons exist. This reality raises numerous problems that need to be solved since the urban population has a greater need for services for the elderly. Most family caretakers are women, wives or daughters. Many caretakers are elderly persons and may also become dependent.

Local budgets can grant allowances to the spouse or relative who takes care of a dependent older person but this is subject to local initiative. If the carer is salaried and working part-time, s/he can apply for support equal to the remainder of the salary. Alternatively, s/he may receive the equivalent of a gross monthly salary of a newly qualified social assistant with an intermediate level of training. In all cases, the allowance is granted on the basis of means-tested assessment.

At central level the informal care is supported mainly through subsidies granted to NGOs by MLFSPAP. In the first quarter of 2013, the Ministry allocated RON 6.97 million as subsidies to

167 organisations certified in 2012. On average, 16880 persons benefited each month from social services delivered by those NGOs.[192]

Regarding professional care, in 2011 the Romanian health care system employed 278754 medical professionals, 33.2% of which had tertiary education, 45.2% secondary education, and 21.6% were auxiliary staff. Overall, 564 socio-medical facilities for disabled persons were recorded at the end of 2011, of which 15 in the private sector; 77 of them offered non-residential socio-medical services and 487 hospitalisation or institutionalised assistance. These socio-medical units disposed of 24594 beds, of which 414 in private centres. Over 2011 a total of 24252 disabled persons received institutionalised medical assistance for an average of 311 days per person. 216 physicians, 8 dentists, 3835 nurses and 6117 auxiliary personnel worked in these institutions.

4. POLICY AND RECENT DEVELOPMENTS

The for some years the trend in Romania has been to shift elderly care away from institutional care to home care or assisted living (Strategic National Report Regarding Social Protection and Social Inclusion 2008-2010 – Romania). As elsewhere the assumption is that home care apart from being substantially cheaper is the preferred method of care by the elderly because it allows them to maintain their independence and social network and also decreases governmental expenditure on LTC.

Romanian authorities initiated recently a new reform of the health care system, which includes the LTC component. A new health care law has already been drafted and is supposed to be passed by the parliament this autumn. From the existing information available, no major changes are envisaged in the field of LTC for the elderly.

[192] http://www.mmuncii.ro/pub/imagemanager/images/file/Legislatie/Liste/LISTA%20%20din%20%202012.pdf

5. BACKGROUND STATISTICS

Romania (RO)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	16.3	13.4	19.0	20.8	17.7	23.8	26.8	24.0	29.5	28.9	26.4	31.4	12.6	13.0	12.4			
80+	3.8	2.8	4.8	5.3	3.9	6.7	7.5	5.8	9.2	11.5	9.5	13.4	7.7	6.7	8.6			
85+	1.4	1.0	1.8	2.3	1.6	3.1	4.2	3.0	5.4	6.1	4.8	7.4	4.7	3.8	5.6			
80+/65+	23.4	20.7	25.3	25.6	21.9	28.2	28.0	24.1	31.1	39.6	35.8	42.6	16.2	15.1	17.3			
85+ /65+	8.7	7.2	9.7	11.3	8.9	12.9	15.8	12.6	18.3	21.1	18.0	23.6	12.4	10.8	13.9			
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2			
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3			
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3			
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1			
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1			
Old-age dependency ratios, % [2]	**Romania (RO)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	26.0	20.9	31.2	57.3	50.7	64.0	31.3	29.9	32.9	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	17.5	13.6	21.3	41.7	36.3	47.3	24.2	22.7	26.0	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Romania (RO)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	70	77.5		81.8	86.7		11.8	9.3		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	14.1	17.2		20.8	23.8		6.7	6.6		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	:	:		5.9	5.1		:	:		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	:	:		40.5%	28.7%		:	:		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.6			1.9			1.2			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

SWEDEN

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the Swedish population is expected to grow from 5.2% to 8.9% (EU-28: 5.1%-11.8%), with most of the growth happening before 2045. At the same time the share of people 85+ will double from 2.6% to 5.2% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 27.2% to 36.8% (EU-28: 27.8%-41.5%), and from 13.8% to 21.7% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 32.9% (EU-28: 29.9%) to all of 45.9% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 18.2/21.1 years (EU-27: 17.2/20.7) in 2010 to 22.7/25.7 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women rose by 3.3 and 4.3 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 3.9% to 6.7% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION[193]

Since 1992, the 290 Swedish municipalities are responsible for long-term inpatient health care and care for older people. In the mid-1990s, the municipalities also took over the responsibility of care for the physically disabled and for those suffering from long-term mental illness. The Government's primary role in the field consists of establishing laws and ordinances or reaching agreements with the Swedish Association of Local Authorities and Regions (SALAR), a collaborative national organization, which represents all county councils/regions and municipalities.

The available LTC services are home help in regular housing (home care), special housing (institutional care), day activities, home medical services (home nursing care), meal services, personal safety alarms and home adaptations. In addition there are transportation services for elderly and functionally impaired persons who cannot use regular public transport and who are entitled to transportation services.

In 2012, the total number of **institutions** providing long-term care (LTC) for the elderly was about 2700, and there were 2300 different units providing home-based care. The total number of recipients of home help in 2012 was almost 220 000 people. The average level of care was 23.4 hours per month. 90 500 individuals were residing in care homes. This corresponds to 50.7 per

[193] In this section possibly information on how the assessment of care needs is organised and on quality registries could be added.

1000 in the population aged 65 years and over. Another 4 200 persons below 65 years, also lived in care homes. 27 % of home-help units and 15 % of care homes were privately run.

Table 1 shows the total number and percentage of **care recipients**, in relation to the whole population 65 and above, and in relation to those who have activity limitations. The latter figure comes from the EU-SILC survey and has been estimated for 2012 based on the data for previous years.

The total **cost** of health care and LTC was 14.1 % of GDP in 2011, a slight increase of 0.4 p. p. since 2002. 23 % of all care costs are allocated to elderly care (SoS, 2013). LTC is mainly **financed** through local taxes and supplemented by the central government subsidies and by user fees. Block grants to local governments are paid per inhabitant and related to age structure and several other parameters. Targeted grants must be used to finance specific activities, sometimes over a specific period of time. Sources of revenue have been stable over the past decade.[194]

User fees for LTC include care, rent, and meals. The maximum amount charged for care, whether home-based or in a care home, is SEK 1760 per month. All people receiving care are ensured a minimum of SEK 5,000 disposable income after tax and payment of other expenses. For older people with high housing costs and low pensions, there is a special means-tested housing benefit with a maximum of 5 000 SEK per month for a single person. Around 250 000 people receive this benefit yearly**.**

At the national level, the Swedish Civil Contingencies Agency supports **preventive work** in the municipalities by publishing guidelines on health promotion among the elderly, with a special emphasis on preventing falls, traffic accidents, fires and suicide. A national intervention project is currently underway involving 17 municipalities. The aim of the programme is to increase care coordination and improve health among elderly people with risk factors for diabetes, depression, and cardiovascular disease. An evaluation after 12 months has shown that regular health checks and feedback significantly increased health and well-being.

Municipalities are obliged to grant **housing adaptation** benefits for people with disabilities who need to adjust their accommodation to be able to stay at home. In 2011, 76 000 people were given this benefit, with an average amount of SEK 13 600 per person. Taxi and/or bus service is subsidised for persons whose functional abilities are an obstacle to using public transport. Persons qualifying for this service may also use public transport for free, including an escort. County councils are responsible for patients until the patient is discharged from hospital, while responsibility for home nursing and rehabilitation lies within the municipalities. This places high demands on the coordination of care between municipalities and county councils. Care plans are developed by the physician, social care services, other outpatient services and the patient designed to achieve further rehabilitation and to facilitate the coordination of services.

The **quality** of elderly care is being assessed by a new governmental agency, the Health and Social Care Inspectorate (prior to June 2013, this task was allocated to the National Board of Health and Welfare). Staff shortage has led the National Board of Health and Welfare to

194 http://hspm.org/countries/sweden25022013/livinghit.aspx?Section=3.2%20Sources%20of%20revenue%20and%20financial%20flows&Type=Section

introduce new binding regulations regarding dementia care and, from 2014, for all residential care homes. Many elderly feel that they are not included in planning their own care, and that information is not adapted to the individual. One quarter of the assessed municipalities had unsatisfactory routines in their handling of benefit applications. In many cases, documentation regarding whether interventions decided on had been actually carried out was lacking.

3. CARERS

Since the Swedish welfare system was established and some of the former responsibilities of the individual (or the family) have been taken over by the state, Swedes have come to trust and rely on the state to provide not just pensions but LTC services for the elderly, to the extent that the discussion of the role of informal care which began some 15 years ago has only recently been considered in political decision-making. Nonetheless, this does not mean that formal care has diminished in importance – formal care is still the backbone of care for the elderly in Sweden and is expected to remain so.

During 2007-2011, the total **number of employees** in LTC decreased by 6 %, while the total number of hours worked was stable (SoS 2013). In 2011, the total number of employees within municipalities was 192 000, and within private providers 38 400. 74% of these (full-time equivalents) work as nurses' aides/nursing assistants, and 4.5 % as nurses. This is equivalent to 4.2 nurses, and 69.5 nursing assistants per 1.000 in the population 65 years and above. The proportion of employees with tertiary education is stable at 13 %. As much as one quarter of employees in home care and 20 % in care homes lack professional credentials. The Board of Health and Welfare states that 1/5 of audited care homes have a shortage of nurses. 1.6 % of all nurses working in elder care have specialized training in gerontology. Statistics Sweden projects that staff needs will increase by 50% until 2050. Given the high average age in the largest occupational group (nurses' aides/nursing assistants) the supply of labour is estimated to fall short of demand by more than 100 000 in 2030.

One quarter of the adult population states that they provide help for a relative or friend as **informal carers**. Although the proportion has been stable over the past 20 years, the amount of time spent giving care has increased. A recent survey shows that the amount of care provided is especially high among spouses of frail elderly. One third of those providing help and care are estimated to spend 30 hours or more per week. Among adult children, 10 % are estimated to spend 10 hours or more per week, and out of those, 60 % are women. In this survey, 25 % of spouses and 20 % of adult children said that caring was mentally distressing. People caring for a seriously ill relative may apply for caring benefits, for a maximum of 100 days per year.

4. POLICY AND RECENT DEVELOPMENTS

The official objectives of LTC care in Sweden are to provide the elderly with support to carry on living a high quality and independent life for as long as possible, to participate and engage in civic and personal life, to be treated with respect and to have access to good elderly care. The government guidelines are meant to ensure that care recipients along with their relatives are able to trust that the care offered in Sweden is both dignified and high in quality. Recent government have also emphasised raising the ability of LTC users to choose between public and private providers and to promote outsourcing of services.

During the last few years, the share of 65+ residing in care homes has decreased, from 6.1 % in 2007 to 5.2 % in 2011. The proportion receiving home care is stable at around 12 % but the absolute number has increased by almost 22 000. There has been a shift in focus within home care, so that the typical number of hours per recipient has increased, and recipients with few hours (1-10 per week) have become increasingly uncommon. This is more pronounced among care recipients above 80 years. The use of subsidised home-based services, such as cleaning, laundry and gardening, has also increased.

The proportion with dementia in the population above 65 years of age is 5 %, which increases to 15 % among those aged 75+, and to 50 % among those aged 90+. An estimated 150 000 people have dementia, and the incidence is about 25 000 cases per year. Around 60-70 % of those have an Alzheimer diagnosis. Since 2011 an ongoing agreement between SALAR and the Government focuses on improving care for older people with extensive and complex health care needs. 17 % of those 65 years and above are estimated to fall in this group. The overall aim of the initiative is to enhance care coordination between county councils and municipalities. SEK 4.3 billion have been allocated to support mutual, long-term and systematic efforts within the overall aim. Prioritary areas are preventive care, mental health, dementia care, improved drug prescribing and end-of-life and palliative care. This money is available to local projects that follow written action plans, continuously document outcomes, and have reported improvements in indicators such as avoidable inpatient care and re-admittance within 30 days, decrease of medication with a high risk of side-effects, routine oral assessments and standardized care after a diagnosis of dementia. SALAR support this initiative e.g. through organizing networks, training managers and providing web portals for reporting indicators.

Another ongoing project is the development of local ‘dignity guarantees’ within elder care, with support from the government. Since 2011 national ethical guidelines are part of the Social Services Act. These state that care for the elderly should preserve dignity and wellbeing, respect individual integrity and self-determination, provide for social activities and ensure a safe environment. Municipalities may apply for grants to develop local dignity guarantees, with the purpose of increasing the quality of care and to clarify what the individual can expect from LTC. A follow-up in February 2013 shows that in 2012 117 municipalities were given this grant. So far, 106 municipalities have developed at least three local guarantees, but only a few have started to implement them.

In the short run, there is no immediate crisis in LTC financing, although the economic recession has meant decreasing tax revenues for many municipalities.

However, according to the Swedish Ministry of Health and Social Affairs, with the growing proportion of elderly, costs for LTC are expected to rise by 70% until 2050, and the costs for health care by 30%. The future demand for labour within LTC is expected to increase by 50% and as a percentage of GDP the total costs of both LTC and health care are projected to increase from 13% to 16%.

5. BACKGROUND STATISTICS

Sweden (SE)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	19.1	17.4	20.8	21.4	20.0	22.9	22.4	21.0	23.9	24.2	22.9	25.5	5.1	5.5	4.7
80+	5.2	3.9	6.5	7.2	6.1	8.2	7.9	6.8	9.1	8.9	7.7	10.1	3.7	3.8	3.6
85+	2.6	1.8	3.5	3.3	2.6	4.0	4.3	3.4	5.1	5.2	4.3	6.2	2.6	2.5	2.7
80+/65+	27.2	22.5	31.2	33.4	30.5	36.0	35.4	32.4	38.1	36.8	33.6	39.7	9.6	11.1	8.5
85+/65+	13.8	10.3	16.8	15.6	13.2	17.7	19.0	16.1	21.5	21.7	18.7	24.5	7.9	8.4	7.7
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Sweden (SE)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	32.9	29.5	36.5	45.9	42.8	49.1	13.0	13.3	12.7	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.0	17.2	23.0	31.4	28.7	34.2	11.3	11.5	11.2	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Sweden (SE)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	79.4	83.4		85.5	89.3		6.1	5.9		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	18.2	21.1		22.7	25.7		4.4	4.7		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	10.7	11.1		14.0	15.4		3.3	4.3		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	61.5%	53.6%		75.6%	73.1%		14.1	19.5		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	3.9			6.7			2.8			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

SLOVENIA

1. DEMOGRAPHIC BACKGROUND

In the period 2013-2060 the share of people aged 80+ in the **Slovene** population is expected to grow from 4.5% to 12.3% (EU-28: 5.1%-11.8%), i.e. to more than double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 3.5 from 1.9% to 6.9% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 26.4% to 41.9% (EU-28: 27.8%-41.5%), and from 11.0% to 23.6% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 26.9% (EU-28: 29.9%) to all of 58.3% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 16.4/20.2 years (EU-27: 17.2/20.7) in 2010 to 21.9/25.3 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men increased by 0.1, for women decreased by 4.5 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 1.4% to 3.2% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

LTC in Slovenia is split among various fields and legislations (pensions, health care, social and family care) and has not yet been systematically regulated.

Key characteristics of the current system are:

- The system lacks transparency and the rights are ruled by legislation in different areas. There are different entry points and different needs assessment procedures. The existing arrangements in some cases put the users in an unequal position and some are even excluded from the system.

- Institutional care is still prevailing and it is mainly based on the so called medical approach. It is also not differentiated enough (not taking into account individual needs of the users).

- There is a problem of regional accessibility, and differences between urban and rural areas in terms of access, especially to community and home based services. Formal community based services are still underdeveloped.

- Separation of health and social care services in case of community based and home based care (the need for coordination and unification).

- All the arrangements function mainly curative; there is not enough use of ICT and emphasis on rehabilitation and on prevention.

- Besides the systemic reasons for a reform of LTC system, there are also important demographic, fiscal, economic and social reasons for a reform.

For systematic statistics and monitoring of performance and development of LTC an Inter-institutional working group for statistical monitoring of LTC was set up in 2012[195]. The first LTC report[196] prepared by working group is presented in continuation.

Four modes of LTC provision can be distinguished in Slovenian current system of LTC (by following SHA framework) as seen in Table 1.

Inpatient LTC (institutional care) is organised by homes for elderly, special social institutions, centres for training, occupation and care and centres for education of children with special needs. There were 21 093 people altogether residing in these institutions at the end of 2011; mainly in homes for elderly (17 386). Inpatient LTC was provided for 5.0% of population aged 65 years and over.

There were less than 400 users of organised day care, which accounts to 0.1% of population aged 65 years and over. They were mainly included in day care organised by homes for elderly.

Home-based LTC is organised by community nursing care, home help, family assistant, personal assistance and housing groups. More than 20 000 people received home – based LTC services at the end of 2011; mostly community nursing care and home help. Home-based care was provided to 4.7% of population aged 65 years and over.

In the same period there were 18.334 recipients of cash benefits who only received cash benefit and were not included in any other LTC service. Cash benefit was received by 2.1% of population aged 65 years and over.

Table 1. LTC provision in Slovenia, 31. 12. 2011

	Recipients	***% of recipents aged 65 years and over***	***% of population aged 65 years and over***
Inpatient LTC (in institutions)	21 093	17 088	5.0
Day cases of LTC	377	214	0.1
Home-based LTC	20 918	16 199	4.7
LTC cash benefits	18 334	7 106	2.1
Sum	60 795	40 607	11.9

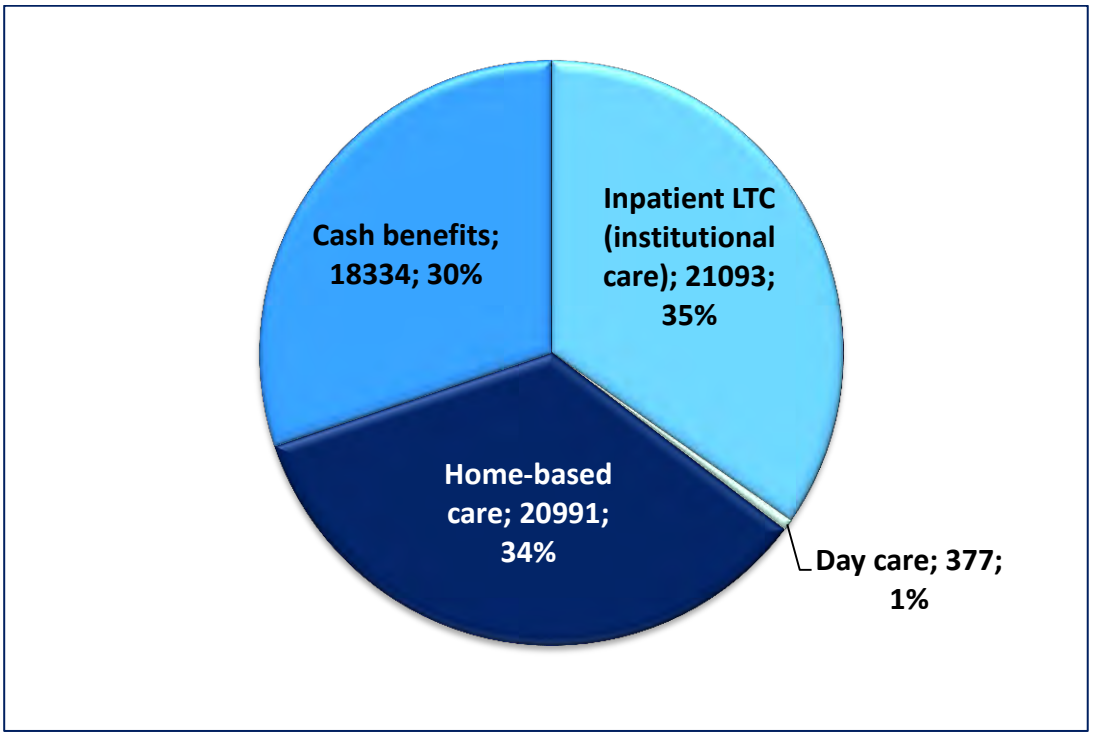
Source: Nagode, Mateja, Eva Zver, Stane Marn in Anita Jacović (in preparation). Dolgotrajna oskrba – uporaba mednarodne definicije v Sloveniji. Delovni zvezki. Ljubljana: UMAR

It is estimated that there were altogether 60.795 recipients of formal LTC at the end of 2011; this accounts to 11.9% of population aged 65 years and over. Inpatient LTC (in institutions) is very well developed and spread in Slovenia. It has a long tradition. On the other hand, home-based LTC started to develop approx. 20 years ago. It is not well spread and developed. Even though, as seen in the Table 1, the number of people receiving home-based LTC at home is relatively high, the care not so intense and comprehensive as in the case of institutional treatment.

[195] Appointed by Statistical Office of the Republic of Slovenia and led by Social Protection Institute of the Republic of Slovenia. The working group includes representatives of all main actors providing data on long-term care (in addition to already mentioned institutions, the Institute of Macroeconomic Analysis and Development, the Ministry of Labour, Family Social Affairs and Equal Opportunities, the Ministry of Health, the Slovenian Community of Social Institutions, the National Institute of Public Health, the Pension an Disability Insurance Institute, the Institute for Economic Research and the Health Insurance Institute of Slovenia).

[196] Nagode Mateja, Eva Zver, Davor Dominkuš, Stane Marn in Anita Jacović. Dolgotrajna oskrba – uporaba mednarodne definicije v Sloveniji. Delovni zvezki. Ljubljana: UMAR 2014.

Figure 1. LTC provision in Slovenia, 31. 12. 2011



Source: Nagode Mateja, Eva Zver, Davor Dominkuš, Stane Marn in Anita Jacović. Dolgotrajna oskrba – uporaba mednarodne definicije v Sloveniji. Delovni zvezki. Ljubljana: UMAR 2014

Formal LTC providers and problem of access

The providers of LTC services can be public or private entities. Private providers are selected through public tenders and are granted concession with limited duration; they have to fulfil the same conditions as public providers. The standards for provision of LTC services are quite strict (regarding the number of staff, qualifications, procedures, technical equipment and premises) and are defined by the state in the case of social care services (both institutional and home-based care), and by the Health Insurance Institute in the case of health care (institutional and community) services.

Institutional care is organised within the network of institutions for elderly, disabled adults and severely disabled children. Persons staying in residential care are provided with integrated health and social care services. The costs of accommodation are also part of institutional LTC service.

At the end of 2012 there were 20.077 available places in 99 institutions for elderly and adults (people over 18). These institutions comprise 55 public institutions for elderly, 39 private institutions for elderly and 5 special institutions.

Community nursing and home help are regulated within different regulatory systems. Therefore providers are not the same and operate separately under different regulatory systems. Community health LTC services are provided by community nurses who are employed by local health centres or are given concession. They perform preventive and health education services, health-related services at home and to a certain extent also home help services. They are one of the first professional workers to identify health and social hardship as well as the needs of individual persons and their families for home and long-term care.

Home help is adjusted to the needs of an individual and includes housework assistance (IADL); assistance in essential daily activities (ADL) and assistance in maintaining social contacts. The Social Protection Institute of the Republic of Slovenia carried out a few analysis of the situation of home care in Slovenia. The last analysis (Nagode and Lebar 2012[197]) showed that home help is provided mainly by public agencies (i.e. centres for social work and homes for older people) and only few were private organisations with concessions. The analysis shows further that 62.3% of the users were 80+ years old. Only 1.7% of the population 65+ receive formal home help, although the national goal stated in The Resolution on the National Programme of Social Assistance 2006-2010 (Ministry of Labour, Family and Social Affairs 2006) was set to 3.0%. The new Resolution on the National Programme of Social Assistance 2013-2020 (Ministry of Labour, Family, Social Affairs and Equal Opportunities 2013) is setting this goal even higher – 3.5%.

Financing arrangements

Funding for LTC comes from several sources: compulsory pension and disability insurance, compulsory and complementary health insurance, national budget and budgets of municipalities (plus out-of-the-pocket contributions of users). Additional part of finances comes from Foundation for Financing the Disability and Humanitarian Organisations in the Republic of Slovenia, which receives the funds from the National Lottery Fund.

As seen from Table 2, the funds for LTC system are increasing over the years, mainly due to increased number of users. In relative terms, the private expenditure (out-of-the-pocket payments of users) increased most (see Figure 2).

Table 2. Expenditure on long-term care by source of financing and by function, 2005-2011

Expenditure for LTC in Slovenia 2005-2011					**Nominal growth index**	**Average annual real growth, in %**
	2005	**2007**	**2009**	**2011**	**2011/2005**	**2011/2005**
Expenditure on LTC by source of financing (in million EUR)						
Total	317.0	350.6	437.0	477.0	186.8	4.7
Public	247.4	271.6	332.7	354.6	183.4	3.8
Private	69.6	79.0	104.2	122.4	197.6	7.4
Share in GDP (in %)	1.10	1.01	1.23	1.32		
Public	0.86	0.79	0.94	0.98		
Private	0.24	0.23	0.29	0.34		
Structure (in %)	100.0	100.0	100.0	100.0		
Public	78.0	77.5	76.1	74.3		
Private	22.0	22.5	23.9	25.7		
Expenditure on LTC by function of care (in million EUR)						
Total	317.0	350.6	437.0	477.0	186.8	4.7
Health care	197.1	219.2	263.3	273.8	177.4	3.3
Social care	119.9	131.4	173.6	203.2	201.2	6.8
Structure (in %)	100.0	100.0	100.0	100.0		
Health care	62.2	62.5	60.3	57.4		
Social care	37.8	37.5	39.7	42.6		

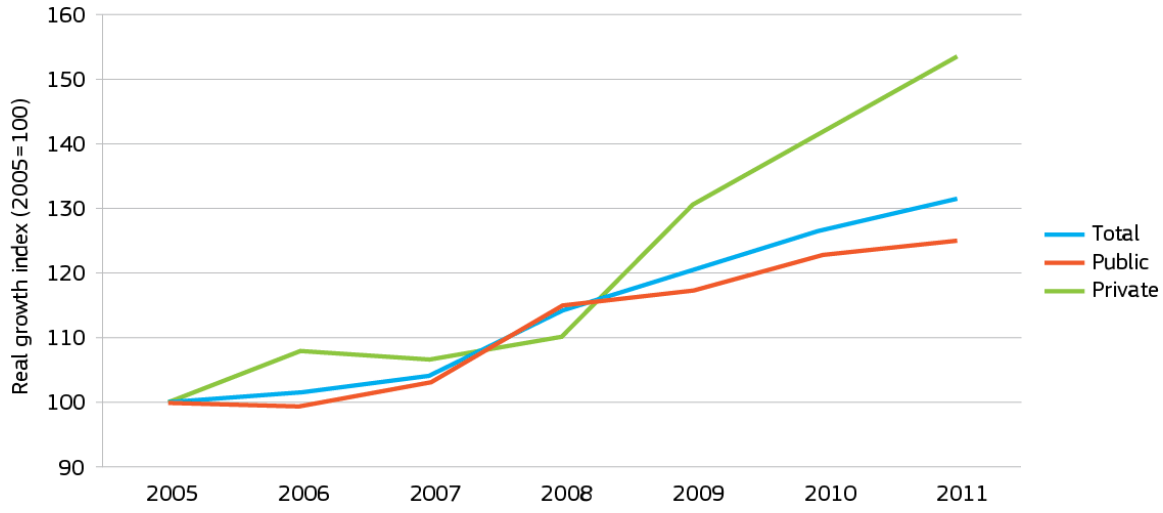
Source: Statistical office of the Republic of Slovenia – Expenditure on health 2003-2011, June 2013.

[197] Nagode Mateja, Lebar Lea (2012) Izvajanje pomoči na domu. Analiza stanja za leto 2012. Ljubljana: Inštitut RS za socialno varstvo. Available at: http://www.irssv.si/index.php/raz-porocila/socialne-zadeve#dolgotrajna-oskrba-in-varstvo-starejših.

Total expenditure on LTC in 2011 amounted to 1.32% of GDP (2010: 1.29%), of which public expenditure was 0.98% and private expenditure 0.34% of GDP. As seen from Table 3, the expenditure for LTC system are increasing over the years, mainly due to increased number of users. In relative terms, the private expenditure increased most (see Graph 1) especially private expenditure on long-term social care services (out-of-the-pocket payments of users). These mainly involve co-payments for accommodation and food in residential homes for the elderly, which raised mainly due to an increase in capacity (new homes for the elderly), and a higher, and hence more expensive standard of care in new, mostly private homes run on a concession basis. Private expenditure has been increasing much faster than public expenditure for a number of years. Therefore, in terms of financing sources, the share of total LTC accounted for by private expenditure increased in the period 2005-2011 from 22% to almost 26%, respectively. While in terms of functions of care (health or social care), the share of long-term social care in total LTC increased from 38% to 43% (Development Report 2014, 2014[198]).

In the structure of *public* expenditure on LTC half (50%) is financed by compulsory health insurance (Health Insurance Institute of Slovenia (HII)). These funds are intended for health care in institutions for elderly, disabled adults and severely disabled children, hospital in-patient long-term care and part of community nursing care. Almost a quarter of all public expenditure on LTC is contributed by the Pension and Invalidity Insurance Institute of Slovenia (PDII) (22%) of public expenditure, namely expenditure on care allowances, which are partly covered also by the Ministry of Labour, Family, Social Affairs and Equal Opportunities (4% of public expenditure). These funds of the HII, the PDII and the Ministry (together 75% of public expenditure) are used to finance long-term *health* care. The remaining 25% of public expenditure is intended for long-term *social* care, which is partly financed by the state budget (particularly the Ministry) and partly by local government budgets (Development Report 2014, 2014).

Figure 2. Expenditure on long-term care in Slovenia, 2005-2011



Source: Statistical office of the Republic of Slovenia – Health expenditure and sources of funding (release: June 2013). Note: According to international recommendations, instead of the consumer price index, the GDP implicit price deflator was used to calculate constant prices (AHRQ, 2011 and OECD Health at a Glance 2013). Note: According to international recommendations the GDP implicit price deflator was used to calculate constant prices.

Long-term projections of public expenditure on long-term care indicate that as a share GDP it will more than double by 2060. Under the AWG reference scenario, which takes account of population ageing in particular, public expenditure on long-term care in Slovenia is projected to rise by 0.3 percentage points of GDP by 2020 and by 1.6 percentage points of GDP by 2060

[198] Institute of Macroeconomic Analysis and Development (2014). Development report 2014.

(2012 Ageing report), however, by the coverage convergence scenario the rise of public expenditure would be even 4.2 p.p. by 2060.

Means-testing and family obligations: Based on the rules set by the Government of the Republic of Slovenia[199], the competent Centre for Social Work at the local level may decide on the partial or complete exemption of users from the payment of the services. Legislation defines the *border of social security*, as the maximum amount of money that has to remain in the hands of the user after paying for LTC services. Further on, the *ability to pay* is defined as the maximum amount up to which the user is able to participate in the payment of the LTC service.

If the contributions of the user and the liable person do not cover the costs of the LTC services, the remaining amount is paid by the local community or the central government.

Additionally to the criteria defined in the aforementioned Decree, local communities may further decide on additional exemptions from payment of the costs of home care services. If the user of the LTC service applying for an exemption owns real estate property, the exemption may include the property as a guarantee to the credit of the municipality which finances the institutional care of the user. However, this clause may only apply to non-primary residences.

Quality assessment in institutions and at home

The field of long-term care is not systematically settled and regulated since the services and benefits are organised, provided and financed within the framework of different legislation. In line with that, social and health care sector operate separately. These services are not integrated, especially when providing care at home. Along with that, **quality of services is not uniquely defined at the national level**; there is no national strategy for quality management in long-term care as is also the case in many other countries. The new Resolution on the National Social Assistance Programme 2013 - 2020, has set a target that all providers of social services with at least 10 employees till 2020 will acquire a certificate from certified quality management systems. About 50% providers of institutional care has already obtained E-Qalin or ISO certificate; some of them are also providing home help.

Quality measures for long-term measures are still in their infancy. Irrespective to this, there is a national strategy for measuring quality of health care provided, but it is more developed for hospital than for home care.

Regulation on quality assessment of social service providers is laid down in the 'Social Security Act' and the 'Rules on Professional and Administrative Control in the Field of Social Assistance and Social Services'. Home help providers are controlled professionally and administratively by a special commission/inspection (at least every three years). Furthermore, according to The Rules family members of eligible persons may also ask for a quality evaluation. Family assistants are, at least yearly, obliged to report about their care to the social work centres. Centres for social work must annually report about information or opinions of the disabled person. Some providers of home help (homes for older people, centres for social work) are using E-qalin model that is implemented in many homes for older people and some centres for social work in Slovenia.

Formal complaint procedures are obligatory for nursing care providers (Patients' Rights Act). Health care providers must appoint someone to receive and process client complaints. Complaints usually deal with the quantity of services and with lay helpers. If clients are dissatisfied with personal care and domestic aid, they may appeal against the provider at the council of the social welfare institution, and against a private undertaking at the Social Chamber (Social Security Act).

[199] Decree on criteria for defining exemptions in the payment of the services, OG RS 110/04,124/04,114/06.

Evaluation of client satisfaction as a component of service quality evaluation is not obligatory in Slovenia. Irrespective to this, some providers of institutional and home help measure client and carer's satisfaction on their own using own satisfaction instruments. These instruments are usually not comparable between providers and over time which would facilitate to detect developments. Similarly, some community health care centres perform client satisfaction studies. There is a tendency to set nationwide rules on measuring client satisfaction as a component of quality evaluation.

3. CARERS

Formal LTC caregivers must meet in relation to education and other working conditions strict rules.

Some non-professional providers (family assistant or personal assistant) must already take part in special education programs. Educational programs and their frequency are defined by the Social Chamber and approved by the National Professional Council.

Carers in home-based LTC

According to the data of Social Protection Institute of the Republic of Slovenia[200] there were 62.4 coordinators of home help at the end of 2012. Home help was carried out by 911 carers, 92.7% of them were regularly employed. In 10.6% local municipalities there was a shortage of carers. According to the data of National Institute of Public Health[201] there were altogether 821 community nurses in Slovenia at the end of 2012 (covering the whole field of community nursing and home care not only LTC).

Ministry of Labour, Family, Social Affairs and Equal Opportunities reports that there were 745 family assistants in 2012 and around 800 personal assistants.

Carers in inpatient LTC (in institutions)

Data of Associations of social institutions of Slovenia[202] indicate that there were 9943 people employed in homes for elderly and special social institutions in December 2012. Out of these, there were 4.823 people employed in social care and 4776 people in health care (344 in others). According to the data of Statistical Office of the Republic of Slovenia[203] there were 1.036 carers employed in centres for protection and training – 907 in social services, 61 in health care services and 68 in training services (employment).

[200] Nagode Mateja, Lebar Lea (2012) Izvajanje pomoči na domu. Analiza stanja za leto 2012. Ljubljana: Inštitut RS za socialno varstvo. Available at: http://www.irssv.si/index.php/raz-porocila/socialne-zadeve#dolgotrajna-oskrba-in-varstvo-starejših.

[201] Zdravstveni statistični letopis 2012. Ljubljana: Nacionalni Inštitut za javno zdravje. Available at: http://img.ivz.si/janez/2326-7215.pdf.

[202] Povzetek kumulativnega statističnega poročila 2012. Pregled področja institucionalnega varstva starejših in odraslih s posebnimi potrebami. Ljubljana: Skupnost socialnih zavodov Slovenije.

[203] Si-Stat: http://pxweb.stat.si/pxweb/dialog/statfile2.asp

Informal carers

The results of research done by Anton Trstenjak Institute of gerontology and intergenerational relations show that more than 55.000 people aged 50 or more is taking care of their mother and more than 50.000 of their frail partner[204]. Also, preliminary SHARE data show a similar situation in terms of informal care.

Until few years ago, Slovenia had no national policy that would deal with family carers directly. There were some acts, which indirectly concerned family carers: Pension and Disability Insurance Act mentions the right to attendance allowance; Health Care and Health Insurance Act the right to compensation for care-giving to a close family member, with whom the insured lives in a common household and Act Amending the Social Security Act that enables family carers as family assistants to get, under specific rules, a financial compensation. Since 2006 several strategic documents were adopted that emphasize the importance of informal carers, mainly to give adequate training and services on the local level (day care, respite care) to the families who care for a disabled elderly family member and to support measures allowing more flexible working arrangements (the right for part-time work without the danger that the carer would lose social security).

4. POLICY AND RECENT DEVELOPMENTS

Over the last 10 years there were several attempts to prepare the LTC system reform already. Several drafts of the act that would regulate the whole system of LTC and the potential (new) insurance for LTC were prepared by different stakeholders (Ministry of Labour, Family, Social Affairs and Equal Opportunities, Association of Providers of Institutional Care, NGO Pensioner's Association). The differences between different draft acts prepared by different stakeholders are not so much in the content (arrangements of the system), but mostly in the approach to financing the LTC system.

Since 2012, the LTC reform is high on the political agenda again. A working group for the methodological, statistical and financial issues regarding LTC was established in 2012. The group decided to work by the OECD definition of LTC and structure of services and rights based on SHA (system of health accounts), and already collected the data on the system that was missing before (on users of different services, on financing and similar).

The need for LTC system reform and plans for it also became part of strategic documents, such as the main national development strategy in the area of social protection in Slovenia, the Resolution on National Programme of Social Protection for the period 2013-2020 (passed in the parliament in April 2013). Besides the plan for LTC reform it emphasises the development of community based services and unification of health and social home care services. In the draft Operational programme for the use of structural EU funds in the new financial perspective, the emphasis in also on de-institutionalisation and support for development of community based services (such as day centres, smaller residential units, etc.).

At the end of 2013, the Government of RS adopted the starting points of the reform of LTC system, including the calendar for the reform. It was agreed that the first step of the reform will be the preparation and adoption of new legislation covering the whole LTC system and thus unifying it. A working group for the preparation of the new legislative Act was established, composed by representatives of three ministries (covering areas of health, social affairs and finances), different associations of users, different associations of service providers, Health Insurance Institute, Pension Insurance Institute, Institute of Macroeconomic Analysis and Development.

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[204] Ramovš, Jože, Tina Lipar, Marta Ramovš (2014) Oskrba v onemoglosti. V: Ramovš, Jože (ur) Staranje v Sloveniji – raziskava o potrebah, zmožnostih in stališčih nad 50 let starih prebivalcev Slovenije. Ljubljana: Inštitut Antona Trstenjaka.

The new act will be titled **Act on long-term care, personal assistance and long-term care insurance**, and will regulate both the LTC content (services) and stable financing of the system (introduction of public compulsory insurance and private compulsory LTC insurance with an additional possibility of voluntary private insurance for non-standard LTC services and accommodation costs in institutional care facilities).

Thus the Act will regulate:

- LTC insurance and financing of activities,
- definition of beneficiaries and rights (services),
- the procedure of claiming the rights (including needs assessment)
- provision of LTC services,
- the providers of LTC insurance and providers of LTC services.

The Act will also regulate the area of personal assistance to disabled persons who fully depend on assistance of another person (as a form of community care), including:

- definition of personal assistance (definition of the beneficiaries, services that are financed, relation to other LTC services),
- providers of personal assistance,
- particularities of financing the personal assistance,
- the procedure of claiming the personal assistance in relation to procedures for claiming other LTC services,
- provision of personal assistance in relation to provision of other LTC services.

The draft Act is based on the agreement that the need for LTC is a new social risk for which the residents of Republic of Slovenia have to be insured within the system of public social insurances.

5. BACKGROUND STATISTICS

Slovenia (SI)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	17.1	13.9	20.2	24.8	22.3	27.3	29.0	26.6	31.5	29.5	27.0	31.8	12.4	13.1	11.6			
80+	4.5	2.7	6.3	6.7	5.0	8.3	10.5	8.5	12.4	12.3	10.4	14.3	7.8	7.7	8.0			
85+	1.9	0.9	2.8	3.3	2.2	4.4	5.6	4.3	7.0	6.9	5.4	8.5	5.0	4.5	5.7			
80+/65+	26.4	19.4	31.1	26.9	22.5	30.4	36.0	32.0	39.4	41.9	38.3	44.9	15.5	18.9	13.8			
85+ /65+	11.0	6.5	14.0	13.3	9.9	16.1	19.4	16.1	22.3	23.6	19.9	26.6	12.6	13.4	12.6			
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**			
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2			
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3			
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3			
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1			
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1			
Old-age dependency ratios, % [2]	**Slovenia (SI)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	26.9	21.0	33.1	58.3	51.8	65.3	31.5	30.8	32.2	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	18.2	13.4	23.2	43.4	38.1	49.1	25.2	24.7	25.9	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Slovenia (SI)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	75.8	82.3		84	88.8		8.1	6.5		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	16.4	20.2		21.9	25.3		5.5	5.1		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	7.4	8.6		7.3	6.9		-0.1	-1.7		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	48.7%	44.6%		42.5%	32.5%		-6.2	-12.1		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	1.4			3.2			1.8			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

SLOVAKIA

1. DEMOGRAPHIC BACKGROUND

Cross-country comparisons show that Slovakia is facing a delayed ageing process. While the country displays one of the youngest populations in Europe at present, demographic projections suggest that the population is going to age at one of the highest paces in the EU.

In the period 2013-2060 the share of people aged 80+ in the Slovak population is expected to grow from 3.0% to 12.9% (EU-28: 5.1%-11.8%), i.e. to gradually increase more than fourfold over this time. At the same time the share of people 85+ will expand by more than a factor 5 from 1.2% to 6.5% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 22.7% to 36.6% (EU-28: 27.8%-41.5%), and from 9.1% to 18.5% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 20.0% (EU-28: 29.9%) to all of 71.7% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 14.1/18.0 years (EU-27: 17.2/20.7) in 2010 to 20.8/24.3 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men and women decreased by 1.3 and 2.3 years, respectively.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 0.3% to 0.8% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

Long-term care in Slovakia does not comprise a uniform system of social and health care. LTC is covered by separate pieces of legislation pertaining to different conditions and/or risks, including old-age, disability, social assistance and health care. Although legislative amendments have over the past years improved the links between the main components of LTC, an integrated legal framework remains one of the key policy challenges.

LTC for elderly people in the area of health is provided mainly in the form of geriatric care in outpatient departments, specialised hospital departments, day care centres, home nursing agencies, hospices and other facilities. Most of the medical services are covered by statutory public health insurance, but co-payments from clients are required for certain care provision. Selected geriatric health services may be provided also in facilities of social services. In 2011, there were 26 geriatric units in institutional health care with 802 beds with a total of 19,930 hospitalised patients. Specialised departments for the long-term ill (56 units) had 2,090 beds and 26,463 hospitalised patients. After-care departments (19 units) included 307 beds and hosted 7,469 patients transiting from hospital to home care. Institutional nursing care has been provided

to 1,388 patients in 11 units with 178 beds, while home nursing was offered by 166 home nursing agencies.[205]

Social LTC is provided in the form of benefits in kind and cash benefits. Benefits in kind are referred to as social services and typically include institutional care provided by public and non-public providers in facilities for seniors, homes of social services for persons with disabilities, facilities of supported living, nursing care facilities, day centres and rehabilitation centres, etc. Besides residential care, LTC services may be provided also at home to help persons in need with activities of daily living. A typical example is the home care service rendered by municipalities or private agencies. Social services are financed by local and regional self-governments, state subsidies, and payments by care recipients. Cash benefits include compensatory payments granted to severely disabled persons and/or their carers for the provision of home care. Typical recurring cash benefits are the personal assistance allowance (granted to a disabled care recipient for hiring a non-relative carer)[206] and the care allowance (provided to an informal carer, usually relative of a disabled person). Other compensatory payments are intended to support transportation, dietary meals, purchase or operation of medical aids and motor vehicles, adaptation of dwellings, etc.[207] Cash benefits are financed by the State and provided through a network of local offices of labour, social affairs and family.

As of 31 December 2012, there were 782 institutional social service facilities for adults with a total of 34,771 places/beds, of which 12,381 beds were in 271 senior homes, 18,427 beds in 359 social services homes for disabled persons, and 1,918 beds in 97 care service facilities. Out of the total number of 32,678 institutional clients, 73% were retired persons and 82% were persons with long-term health disabilities. There were 49.0 places/beds in these institutions per 1,000 of population aged 65+ in 2012.[208] Home care service is performed by 1,017 providers (as of September 2013). Consolidated data on the capacity of providers and numbers of recipients of home care service are not available. In 2011, municipalities provided this form of care to 14,727 resident citizens.

As regards cash benefits, 58,700 informal carers on average were receiving a care allowance in 2012. Almost 8,000 disabled persons were receiving an allowance to hire a personal assistant. More than 163,000 other recurring benefits and 617 one-off benefits have been provided to severely disabled persons in 2012.[209] Data on the age structure of recipients of cash benefits are not readily available.[210] The number of beds in geriatric hospital care has decreased from 3,643 beds in 2008 (5.6 beds per 1,000 inhabitants aged 65+) to 2,969 beds in 2011[211], i.e. a 18.5% decrease of beds in spite of a 5.6% increase in the 65+ population during the same period of time.

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[205] Health Statistics Yearbook of the Slovak Republic 2011, National Health Information Center

[206] The benefit may be provided to recipients aged 65+ only if they have been provided the benefit before reaching age 65.

[207] Combined drawing of a care allowance and a personal assistant allowance is not possible. Other cash benefits and also some benefits in kind may be combined.

[208] Social service facilities in the Slovak Republic, Statistical Office of the SR

[209] Statistics on social benefits, Central Office of Labour, Social Affairs and Family

[210] According to available sources, persons aged 65+ comprise more than 60% of care allowance recipients. Source: Repkova, Kvetoslava (2010), Support to informal carers - research based recommendations for social policy practice, Institute for Labour and Family Research, Bratislava

[211] More than 70% of the bed reduction concerned chronic beds. Source: http://www.employment.gov.sk

The entitlement to cash benefits is subject to a means-testing as income and assets of recipients may not exceed a certain ceiling. The level of income and assets also determine the amount of the benefits.[212] Recipients of benefits in kind have to co-pay for services in the sum specified by the service provider, but usually only up to the level of economically justified costs.[213] Charges are determined also based on the recipient's income and assets, but the person has to be left with a certain minimum income (20% of the subsistence minimum per month[214]). In case of home care services, the recipient must be left with at least 130% of the subsistence minimum.[215] Family obligations are stipulated in the principle of co-financing of financial allowances and social services. For the entitlement to compensatory cash benefits and social services, income of family members living in the same household with the recipient is regarded. Co-financing of social services may be imposed on closest relatives (children, parents) not living in the same household, only if their income is higher than 130% of the subsistence minimum; however, enforcement of this obligation is usually problematic. There is no public LTC insurance system in place and private LTC insurance products are not widespread.

Public expenditures on social services and cash benefits amounted to 0.76% of GDP in 2012 (0.74% of GDP in 2010).[216] Disaggregated data on LTC spending for the 65+ population are not readily available; however, based on existing research[217], spending on LTC for elderly citizens may be estimated at around 60% of total costs (i.e. 0.45% of GDP).

LTC in Slovakia is mainly of curative nature, i.e. it does not take place until a health-social problem arises and the affected person or his/her family apply for support. There is lack of more systematic primary prevention to avoid dependency on assistance from other persons and/or to avoid deepening of this dependency (e.g. by regular screening of older persons at home by geriatric nurses). In addition, there is also a lack of continuity of health and social care.[218]

The system of social services encompasses facilities and activities focused on social prevention and rehabilitation and support to independent living (e.g. rehabilitation centres, daily care stations, specialised activities such as ergotherapy, access to ICT and cultural events, social counselling). Compensatory cash benefits enable disabled persons to adjust their housing or improve mobility to reduce dependence on other person's assistance. However, preventive and rehabilitative activities comprise only a minor part of social LTC.

What seems to be missing is a coordinated multidisciplinary approach to prevention and rehabilitation in long-term care. Government strategies pertaining to this area acknowledge the need to pay increased attention to preventive programmes.

A 2011 ministerial report stated that health care for the long-term ill, immobile and geriatric patients in Slovakia is characterised by low physical accessibility and poor quality in practically

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212 In the event that the carer is a pensioner, the care allowance is not means-tested but provided as a flat-rate sum.

213 Exceptions are services provided by non-public providers with the aim to attain profit.

214 Subsistence minimum for a single adult person is set currently at EUR 198.09 monthly.

215 MISSOC Comparative Tables Database.

216 Not included are social insurance costs paid the State on behalf of informal carers and other costs associated with informal care provided in families of dependent persons.

217 Bednarik, Rastislav - Brichtova Lydia – Repkova, Kvetoslava (2010), Working Package 6: Governance and Finance. Slovak National Report. Institute for Labour and Family Research, Bratislava

218 Bednarik, Rastislav – Brichtova, Lydia – Repkova, Kvetoslava (2009), Working Package 5: National Report on Informal Care in the LTC System. Institute for Labour and Family Research, Bratislava

all forms of residential and home nursing care.[219] Affordability of drugs and medical aids, which are not fully covered by public health insurance, tends to be another problem. Surveillance over provision of health care (including quality assessment) and public health insurance is carried out by the Health Care Surveillance Authority. New legislation on social services stipulates since 2009 a system of quality assessment, focused on procedural, personnel and operational aspects of provided social care services[220]. Individual providers and/or founders (e.g. autonomous regions) set up their own quality assessment schemes. Providers are obliged to establish procedures and rules to assess the satisfaction of recipients with provided social services. Aggregate evaluation outcomes are not available, but there is a general belief that the quality of LTC is deficient especially in those types of (public) institutional care which are short of supply. A critical factor is the lack of financial resources in the system, which has aggravated since the onset of the economic crisis. Problems of physical access to social LTC may be illustrated by waiting lists – approximately 9 thousand adults (of which an estimated three quarters in retirement age) have been registered as wait-listed applicants for residential social care as at end of 2011. Similarly, demand for field nursing services provided by municipalities exceeds available capacity and funding.

As regards home care provided by family members and other informal carers, standards of quality are not legally stipulated or practically assessed.

3. CARERS

Informal care in Slovakia is typically provided by family members and less frequently by non-relatives living together with the person in need of care. According to a 2005 survey, as many as 82% respondents stated that they provide care for a dependent family member without any financial compensation.[221]

Some insight into the numbers of informal carers may be derived from statistics on recipients of care allowances, which are provided to persons who take care of persons with severe disability at least 8 hours a day. Of the average number of 58,700 care allowance recipients in 2012, more than 96% took care of one dependent person, while the remaining carers provided care to more than one person. According to available surveys, almost two thirds of recipients take care of dependent persons older than 65 years. Family carers are mostly adult children (usually aged 50+) taking care of their ageing parents (more than 40% of recipients).

The personal assistance allowance is used but minimally to finance informal family care. The main aim of the policy is to provide disabled persons with a financial allowance to finance non-kinship care at home, and thus to support the care recipient's independence from closest relatives in routine daily activities. In 2012, 7,965 personal assistance allowances have been disbursed monthly on average. The share of recipients aged 65+ is low at approximately 4% (they can make use of this policy only since 2005).

Support to informal carers is provided through cash benefits and services in kind, which aim to facilitate coordination of work and care responsibilities. The care allowance is a contribution to

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[219] Ministry of Health of the SR (2011), Report on the state of health care in Slovakia

[220] It shall become fully effective in 2015 under supervision of the Ministry of Labour, Social Affairs and Family.

[221] *Ibidem*

ensure basic income of an informal carer. It is provided up to the level of 111.32% of the subsistence minimum per month if care is provided to one disabled person and/or up to 148.42% of the subsistence minimum per month if two or more disabled persons receive care. Indirect forms of financial support include any other allowances provided directly to the dependent person that simplify the performance of providing care (e.g. allowances for adaptation of dwellings, purchase of medical aids, lifting equipment, etc.). Services in kind take different forms. The State pays contributions on behalf of carers' and personal assistants' old-age and invalidity insurance (for a maximum of 12 years), as well as health insurance. A respite service may be provided to a care allowances recipient for a maximum of 30 days in a calendar year to take rest and prevent worsened mental and physical health.[222] In addition, the carer may benefit from a short-term home care service provided by the municipality up to 8 hours per month in case he/she needs to operatively arrange personal matters. Informal carers may use free of charge counselling services provided by local and regional self-governments and territorial offices of labour, social affairs and family. They are not required to have any special qualification and/or to participate in training. Recipients of care allowances may earn an income from work up to a certain limit (two times of the subsistence minimum). Long-term care of a dependent relative is not covered by protective regulations (no care leave as an analogy to maternity or parental leave).

Formal long-term care is provided by professional carers working for public and non-public providers of residential and home care services. In 2012, a total of 18,091 persons were employed with facilities of social services for adults (of which 80% in the public sector), corresponding to 26.2 employees per 1,000 population aged 65+.[223] Home care service was provided by 6,274 social workers employed with municipalities (2011 data). Data on professional carers working in private home care agencies are not available.

The law on social services defines qualification requirements for different professions in the provision of social care. Requirements for the position of a carer include a minimum lower secondary education in the subject field caring or provision of health care and/or the completion of an accredited course on caring in the extent of 220 hours. Since 2012, care services may be provided also by workers without certified qualification, providing they are aged 55+ and have at least 3 years of practice.

Remuneration of professional carers is clearly below the economy's average. The average monthly salary of employees of social service facilities in 2012 amounted to EUR 580 (72% of the economy-wide average wage) and professional carers/nurses earned EUR 516 monthly (64% of average wage). Low earnings in the sector are one of the reasons for worker migration, low interest among young people to train for the profession of a carer, resulting in a shortage of qualified carers and nurses. Other disincentives include unappealing working conditions, stress, excessive workload and little opportunities for career advancement. This applies also to nurses working in the health segment of LTC. The Report on the state of health care in Slovakia224 concludes that shortage of nurses affects mainly care for the long-term ill.

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222 There is anecdotal evidence that municipalities are not able to flexibly provide for a substitute service due to a shortage of funds and professional careers.

223 Data on the numbers of employees involved directly in care provision are not readily available. Partial data on employment structure in social service facilities suggest that approximately 70% of employees are directly involved in care.

224 Ministry of Health of the SR (2011), Report on the state of health care in Slovakia

4. POLICY AND RECENT DEVELOPMENTS

A national strategy on deinstitutionalisation of social services was approved in 2011. It foresees a systemic transition from institutional to community-based care. An amendment to the law on social services, currently in the pipeline, pursues deinstitutionalisation through a set of restrictive measures, including limits on capacity of institutions and restrictions on the year-round provision of care in certain types of facilities (e.g. homes of social services shall provide only care on a daily or weekly basis). Positively, new types of services aim to support independent living of persons with disabilities and strengthen social prevention and early intervention.

The crucial role of informal (family) care in the Slovak LTC system is generally acknowledged.. However, policy reforms in the past years were targeted almost exclusively on the formal sector of LTC.

All available evidence points to a poor coordination between health and social long-term care, but lack of coordination is perceptible also between state administration and regional/local administration.

A number of legislative adjustments sought to improve the unsustainable model of LTC financing over the past years, but with no substantial effect. Regional and local governments hold competencies in the area of social services, but lack sufficient funding. Fiscal consolidation led to efforts to increase clients' participation in financing. These have run against strong public disagreement and the currently negotiated revision of the social services law envisages even a lessening of private co-financing of services.

There are approximately 50,000-60,000 persons suffering from some form of dementia in Slovakia, of which 35,000 are aged 65+ (5% of the 65+ population). About one sixth of affected persons are in treatment. An estimated number of 100,000-150,000 family members are taking care of the dependent persons. The number of elderly persons with dementia is expected to double by 2030.[225] The civil society sector is plays an important role in the prevention and treatment of seniors with dementia.[226]

[225] http://www.teraz.sk/zdravie/mesiac-alzheimerovej-choroby/58561-clanok.html
[226] See, for example: http://www.alzheimer.sk/

5. BACKGROUND STATISTICS

Slovakia (SK)															
Demography															
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	13.1	10.2	15.9	21.4	18.3	24.4	28.2	25.3	31.0	35.1	32.3	37.9	22.0	22.1	22.0
80+	3.0	1.9	4.0	4.8	3.3	6.3	8.7	6.6	10.7	12.9	10.7	15.0	9.9	8.8	11.0
85+	1.2	0.7	1.7	2.0	1.2	2.7	4.5	3.1	5.8	6.5	5.0	8.0	5.3	4.3	6.3
80+/65+	22.7	18.2	25.5	22.6	18.2	25.7	30.9	26.3	34.4	36.6	33.0	39.6	13.9	14.8	14.1
85+/65+	9.1	6.7	10.6	9.3	6.6	11.2	15.9	12.4	18.7	18.5	15.4	21.0	9.4	8.7	10.4
Elderly population as % of total population [1]	**EU-28**														
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	**Slovakia (SK)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	20.0	15.1	24.8	71.7	63.3	80.3	51.7	48.2	55.5	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	12.6	9.0	16.1	49.5	42.9	56.2	36.9	34.0	40.0	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**Slovakia (SK)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at birth	71.6	79.1		82.2	87.4		10.6	8.3		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	14.1	18.0		20.8	24.3		6.6	6.3		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
years at 65	4.8	5.4		3.5	3.1		-1.3	-2.3		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	**2005**			**2012**			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**		**M**	**F**	
at 65 (%)	36.1%	31.6%		24.0%	16.5%		-12.1	-15.1		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	0.3			0.8			0.5			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

UNITED KINGDOM

1. DEMOGRAPHIC BACKGROUND

The UK has a growing population largely due to comparatively high fertility rates and net immigration. This will have a moderating effect on the ageing of society.

In the period 2013-2060 the share of people aged 80+ in the British population is expected to grow from 4.7% to 9.5% (EU-28: 5.1%-11.8%), i.e. to double with most of the growth happening before 2045. At the same time the share of people 85+ will expand by more than a factor 2 from 2.3% to 5.7% (EU-28: 2.3%-7.0%), and the share of people aged 80+ and 85+ among the people above 65+ will rise noticeably from 27.3% to 38.1% (EU-28: 27.8%-41.5%), and from 13.2% to 23.1% (EU-28: 12.9%-24.6%), respectively.

Over the same period of 47 years the old age dependency ratio measured as 65+ as percentage of the 20-64 year olds will rise from 29.2% (EU-28: 29.9%) to all of 47.5% (EU-28: 55.3%).

Life expectancy for men and women at age 65 is projected to rise from 18.0/20.7 years (EU-27: 17.2/20.7) in 2010 to 22.8/25.7 years (EU-27: 22.4/25.6) in 2060.

From 2005 to 2012 healthy life expectancy for men rose by 0.1 and for women decreased by 0.8 years but still remained above the EU average.

Under an assumption of no policy change the Ageing Report scenario suggests that public expenditure as share of GDP would rise from 2.0% to 2.9% (EU-27: 1.8%-3.6%).

2. CURRENT LONG-TERM CARE PROVISION

The UK does not have a universal national system of social care, as the policy is devolved to the constituent nations. Currently, England operates a means-tested public system, whereas a free universal system is in operation in Scotland. Due to the fragmented structure of adult social care it is very difficult to provide a comprehensive overview with robust data. The following section will largely focus on England, where LTC has been among the most debated social policy issues.

The LTC system in England can be characterised as a 'safety-net' type of system that concentrates on supporting those with very severe needs, who are unable to meet the costs of their care. The philosophy of the current English LTC system places the primary responsibility for the non-health care components of long-term care with individuals and their families. Only individuals with income and assets below the means-tested level receive publicly funded social care and the system also directs services towards those who live alone and do not receive informal care.

Long-term care in the UK is usually taken to mean help with domestic IADL tasks (such as shopping and preparing meals), assistance with personal ADL care tasks (such as dressing and bathing) and nursing care. An increasing number of older persons are now receiving cash instead of services in the form of direct payments or individual budgets. Most long-term care for older persons living at home is provided by informal carers (Pickard et al., 2000). Formal services are provided by a range of agencies including local authority social services, community health services and independent (for- and non-profit) sector residential care homes, nursing homes,

home care and day-care services. Long-term care services are financed by the National Health Service (NHS), local authorities, charities and by older persons themselves. While health care services are free at the point of use and access is based on needs, most formal long-term care is considered social care and is strictly means-tested. There is also a non-means-tested benefit for older disabled persons with personal care needs and a benefit for carers.

Thus much of the care in England is provided through informal care of relatives, neighbours and friends Access to publicly funded services is mainly through an assessment of care needs coordinated by local authorities, leading to a great variability within a national framework of eligibility criteria. Those that have been assessed as eligible are then subject to a means test. In terms of financial eligibility for residential care, for example, currently an individual must have assets worth less than £23,250 in England to qualify for local authority placement into a care home. In most localities only people with the highest care needs and lowest means are eligible for services. This development has been exacerbated by the austerity policies of the current government, leading local authorities to cut social care by 20 percent since 2010 (Association of Directors of Adult Social Services 2013).

According to estimates in 2006, 325,000 older people, or 4 percent of the older population, are residents of care homes in England, of which 192,000 are funded by local authorities, 105,000 are privately funded residents and 29,000 are NHS-funded residents. 650,000 older people are receiving local-authority funded community-based services, including some 300,000 seniors receiving home care services. Older people in need can opt for so-called personal or individual budgets, to enable choice and control over support services. Approximately 150.000 severely disabled older people purchase home care privately (Comas-Herrera et al 2010). According to data for 2011, approximately 51,240 older people received direct payments from local authorities to arrange care services (Skills for Care 2012: 9).

The following table shows the number of estimated adult social care establishments for the time period from 2009 to 2011, indicating a small increase.

Table. 1. Estimated Number of Adult Social Care Establishments, 2009-2011

	Estimated totals			**% change**	
Service type	2009	2010	2011	2009-10	2010-11
Residential establishments	23,100	23,000	23,900	-0.4%	+3.8%
Non-residential establishments	23,900	25,300	25,800	+5,6%	+2.3%
All establishments	47,100	48,300	49,700	+2.6%	+3.0%

Source: Skills for Care 2012: 8.

Overall we can identify shifts towards greater private provision and funding. Of the approximately 480,000 places in residential and nursing care homes 92 percent are provided through private and voluntary service providers. Independent providers delivered about 170 million hours of home care, whereas local authority provision has dropped below 25 million hours in 2012. Approximately 43 percent of older and physically disabled residents of independent care homes fund the entire cost of their care; the percentage is significantly higher for residents of nursing care homes (49 percent) than for residents in residential care homes (39 percent) (Laing/Buisson 2013 as referenced by Humphries 2013).

The regulator for LTC services is the Care Quality Commission. Established in 2008 it was formed through the merger of the CSCI, which only covered social care services, and the Healthcare Commission, which covered health care services. Its role is to regulate, monitor and improve the quality of health and social care. It is responsible for the registration and inspection of specified services (those providing health or personal care). National Minimum Standards (NMS) for care were introduced in the early 2000s as a tool to improve the standard of care services. They have been updated to focus the standards on outcomes for people. The NMS form the basis for the inspection of services and the performance assessments. Such evaluations are based on diverse information, including interviews with staff and service users, information from the care service, surveys filled in by service users, their relatives and other professionals involved in their care, a key inspection visit by CSCI inspectors (normally unannounced) and information the CSCI holds about the history of the service. The resulting assessment for providers is summarised as a quality (star) rating. In May 2008 the CSCI rated as good or excellent 80% of services in the voluntary sector, 79% of council-run and 66% of services in the private sector. Of care homes for older persons, 67% were rated as good or excellent, 28% as adequate and 4% as poor. Among home care agencies, 73% were rated as good or excellent. Notably, 22% of those moving permanently into homes for older persons arranged for them by the council did so to a home that was rated as 'poor' or 'adequate'.

3. CARERS

Informal carers: According to the recent Census there were 5.8 million people providing unpaid care in England and Wales; the number of unpaid carers has grown by 600,000 since 2001. The following table provides a breakdown of the hours of care provided by unpaid carers.

Table 2. The breakdown of unpaid care categories for England and Wales

England and Wales		**Percent**
Extent of unpaid care	2011	2001
No unpaid care	89.7	90.0
1-19 hours unpaid care	6.5	6.8
20-49 hours unpaid care	1.4	1.1
50 hours or more unpaid care	2.4	2.1

Sources: 2001 Census, 2011 Census

Table 3. Total number of adult social care jobs by sector, service type and job role group, 2011 (England)

Job role group	Sector -> Type of service	All sectors	Local Authority	All Independent	NHS	Direct payments recipients
All job roles	Residential	674,900	38,100	636,800	0	0
	Domiciliary	830,700	23,100	387,600	0	420,000
	Day	95,600	16,300	79,300	0	0
	Community	251,500	82,000	95,300	74,200	0
	Total workforce jobs	**1,852,600**	**159,400**	**1,199,100**	**74,200**	**420,000**
Direct care	Residential	444,000	27,100	417,000	0	0
	Domiciliary	776,200	19,800	336,500	0	420,000
	Day	65,500	11,900	53,600	0	0
	Community	151,000	30,300	66,200	54,600	0
	All Direct care	**1,436,800**	**89,100**	**873,200**	**54,600**	**420,000**
Managerial / supervisory	Residential	57,800	4,200	53,600	0	0
	Domiciliary	31,700	2,000	29,700	0	0
	Day	13,100	1,800	11,300	0	0
	Community	29,100	14,700	12,600	1,900	0
	All managerial	**131,800**	**22,700**	**107,200**	**1,900**	**0**
Professional	Residential	49,200	400	48,800	0	0
	Domiciliary	4,300	300	4,000	0	0
	Day	1,600	200	1,500	0	0
	Community	37,400	18,800	800	17,800	0
	All professional	**92,600**	**19,800**	**55,000**	**17,800**	**0**
Other	Residential	123,900	6,300	117,500	0	0
	Domiciliary	18,400	1,000	17,500	0	0
	Day	15,300	2,300	12,900	0	0
	Community	34,000	18,200	15,800	0	0
	All other roles	**191,500**	**27,800**	**163,700**	**0**	**0**

Source: Skills for Care estimates using various sources; available at http://www.skillsforcare.org.uk/research/latest_research_reports/Size_and_structure_2012.aspx, accesssed September 11, 2013.

The state provides carers with a carer allowance of currently £59.75 per week, if they provide care for more than 35 hours and do not earn more than £100 per week. People providing care for 20 hours or more are entitled to carer's credit, protecting their pension entitlements towards the Basic State Pension and the State Second Pension.

Formal carers: According to official government statistics, public social care services in England employed 120,300 persons (on a full-time equivalent; FTE) in 2012, 5 percent fewer than in 2011. Women held 82 percent of adult public social service jobs and the average age of employees was 47.88 percent of these jobs were permanent and 6 percent based on fixed-term contracts. 51 percent of the workforce was employed on a part-time basis. Care Workers earned an annual gross salary of £17,100 (median FTE salary) and Senior Care Workers earned £22,600 per annum. Taking into account all providers, the sector employed approximately 1.85 million carers. Accordingly, the public sector employed only a very small fraction, whereas the overwhelming majority (69 percent) were employed by the independent sector (49 percent private and 16 percent voluntary). Table 3 provides an overview of the various sectors and type

of service. As is shown in Table 4 the hourly wages differ significantly between the various sectors.

Remuneration: According to Annual Survey of Hours and Earnings data for 2011, 7.9% of the adult social care workforce 22 years of age and over are paid at or below £5.93, with 11.9% paid below £6.08 and close to a quarter (23.6%) paid below £6.50 an hour. About 32 percent of the adult social workforce employed by statutory local authorities have no qualification, which is the case for 38.5 percent of employees in the private adult social care sector. Based on the uneven distribution of occupational pensions, it is very likely that only those employed by statutory local authorities and other (quasi) governmental agencies accrue entitlements to an adequate pension. The auto-enrolment into occupational pensions is currently rolled out, but has not yet reached small employers.

Table 4. Adult social care workforce by job role and sector (hourly pay, 2011)

	All Sectors	Statutory Local Authority	Private Sector	Voluntary Sector	Other
Manager	£14.40	£30.01	£13.00	£18.68	£13.82
Nurse	£11.96	£14.01	£11.88	£12.53	£8.50
Senior Care Worker	£7.15	£10.46	£7.00	£8.20	£8.50
Care Worker	£6.65	£8.32	£6.50	£7.00	£7.10

Source: Skills for Care (2012b)

4. POLICY AND RECENT DEVELOPMENTS

The quality of adult social care is not always of the highest standard. Moreover, the provision of care was plagued by a series of scandals, among them those at a private care home operated by Castlebeck, which were revealed by a BBC documentary. However, the noncompliance with quality standards is not limited to institutional care homes. As an investigation by the Equality and Human Rights Commission concluded the poor quality of home care for many older people was breaching their human rights. After a number of investigations into the work of the Care Quality Commission, which was only established in 2009 to oversee the quality of care within the NHS and social care, its Chief Executive, Cynthia Bower, resigned in February 2012. A report by the National Audit Office (2011) concluded that the Care Quality Commission had had a difficult task in establishing itself, and had not achieved value for money in regulating the quality and safety of health and adult social care in England.

The UK Parliament recently enacted legislation, which will comprehensively reform the system of long-term care in England. It will be implemented over the next couple of years. The legislation includes the following: A cap on care costs will be introduced from April 2016. If someone is assessed by their local authority, as having eligible care needs, they will be informed how much it will cost the local authority to meet those needs with local services. These costs count towards their cap. So, however great a person's costs become, once they have reached the cap the state will step in and provide financial support. The Government is introducing a cap that

is equivalent to around £61,000 in 2010/11 prices227. This is equivalent to £75,000 in 2017/18 prices. We expect up to 16% of older people to face costs of £75,000 or more.

People of working age who develop care needs before retirement age will benefit from a cap that's lower than £75,000. People who have care needs before they turn 18 will effectively have their cap set at zero.

Currently only those with assets of less than £23,250 get help with paying for their care costs. The government's changes will mean that those with property value and savings of £100,000 (in 2010/11 prices) or less will start to receive financial support, with the Government paying a proportion of their residential care costs on a sliding scale[228]. Systematic prevention, rehabilitation and independent living policies for elderly people with long-term care needs are underdeveloped in the United Kingdom. The current government has promised significant improvements in the context of the recent legislation reforming the provision and financing of adult social care in England (cf. Department of Health 2012).

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227 This was above the £25,000-£50,000 range originally recommended by Andrew Dilnot, who chaired a commission on long-term care reform (Dilnot Commission).

228 £100,000 was the amount recommended by Andrew Dilnot, and is equivalent to around £123,000 in 2017/18 prices

5. BACKGROUND STATISTICS

United Kingdom (UK)																		
Demography																		
Elderly population as % of total population [1]	**2013**			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	17.2	15.6	18.7	21.2	19.7	22.7	23.4	21.6	25.3	24.8	23.0	26.6	7.6		7.4		7.9	
80+	4.7	3.6	5.7	6.5	5.6	7.5	8.5	7.2	9.7	9.5	8.0	10.9	4.8		4.4		5.2	
85+	2.3	1.5	3.0	3.1	2.4	3.7	4.4	3.5	5.3	5.7	4.6	6.9	3.4		3.1		3.9	
80+/65+	27.3	23.0	30.7	30.8	28.2	33.0	36.2	33.5	38.4	38.1	34.8	41.0	10.8		11.8		10.3	
85+/65+	13.2	9.9	15.9	14.4	12.3	16.3	18.7	16.3	20.8	23.1	19.8	25.8	9.9		9.9		9.9	
Elderly population as % of total population [1]	**EU-28**																	
	2013			**2030**			**2045**			**2060**			**P.p. change (2013-2060)**					
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**		**M**		**F**	
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2		10.2		10.2	
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7		6.2		7.3	
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7		4.0		5.3	
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7		14.8		13.1	
85+/65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7		11.8		12.1	
Old-age dependency ratios, % [2]	**United Kingdom (UK)**									**EU-28**								
	2013			**2060**			**P.p. change**			**2013**			**2060**			**P.p. change**		
	Total	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**
20-64	29.1	26.2	31.9	47.5	43.0	52.1	18.4	16.8	20.2	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	18.4	16.0	20.8	33.5	29.7	37.5	15.1	13.7	16.7	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status																		
Life expectancy [3]	**United Kingdom (UK)**									**EU-27**								
	2010			**2060**			**Change (years)**			**2010**			**2060**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at birth	78.3		82.4	85.2		89.1	7.0		6.7	76.7		82.5	84.6		89.1	7.9		6.5
years at 65	18		20.7	22.8		25.7	4.8		5.0	17.2		20.7	22.4		25.6	5.2		4.9
Healthy life expectancy [4]	**2005**			**2012**			**Change (years)**			**2005**			**2012 (EU-28)**			**Change (years)**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
years at 65	10.4		11.4	10.5		10.6	0.1		-0.8	8.6		8.9	8.4		8.5	-0.2		-0.4
Healthy life expectancy as % of the life expectancy	**2005**			**2011***			**P.p. change**			**2005**			**2011 (EU-28)***			**P.p. change**		
	M		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**	**M**		**F**
at 65 (%)	61.2%		57.9%	59.6%		56.4%	-1.6		-1.5	52.1%		44.5%	48.3%		40.4%	-3.8		-4.1
Expenditure on long-term care																		
Total public expenditure on long-term care as % of GDP [5]	**2010**			**2060**			**P.p. change**			**2010**			**2060**			**P.p. change**		
	2.0			2.9			0.9			1.8			3.6			1.7		

Notes:

M - Males; F - Females; : - not available; * - data for 2012 - not available

Sources:

1) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

2) Commission services. DG EMPL calculations based on data from EUROPOP2013, Population at 1st January by sex and single year age [proj_13npms]

Old-age dependency ratio (20-64) - the ratio between the total number of elderly persons aged 65 and over and the number of persons of age from 20 to 64.

Old-age dependency ratio (20-69) - the ratio between the total number of elderly persons aged 70 and over and the number of persons of age from 20 to 69.

3) Commission services, EPC. The 2012 Ageing Report

4) EUROSTAT, Healthy Life Years (from 2004 onwards) [hlth_hlye]

5) Commission services, EPC, The 2012 Ageing Report. Base case scenario

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