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

Minutes



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



# Long-term care: How to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities The Netherlands, 10-11 February 2009

*The Peer review was hosted by the Dutch Ministry of Health, Welfare and Sport*

## Day 1 - morning session

### Welcome addresses

In her welcoming speech, **Iris van Bennekom**, Director for Long-term care, Ministry of Health, Welfare and Sport, the Netherlands, said that it was a pleasure for her to make this opening address on behalf of the State Secretary of Health, Welfare and Sport of the Netherlands, Mrs. Dr. Jet Bussemaker who would join this Peer Review in the afternoon to participate in the discussions and to enjoy the opportunity to exchange ideas and visions with this company of high level experts. The Netherlands had high expectations in this Peer Review and hoped that the results of this meeting would also be favourable for the peer countries. The intention was to make an assessment, an appraisal. Not verdicts, but opinions and advises was what was sought. How to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities? She expressed her hope that the advice and comments received during this meeting would enable them to gather all the information and material needed to prepare decisions of the Dutch government and parliament about the future.

Bennekom concluded her welcome speech with a question: is it possible that a part of the solutions we seek for our problems lies in the attitude of our peoples? In the way they live, in their lifestyles, in what they expect from themselves and what they expect of the collective. Does it make a difference for the long term care, if almost everyone in a society tries to be as independent and self-supporting as possible, and if people believe in helping each other and if voluntary work is esteemed as something pleasant, something that increases someone's prestige? Or should these attitudes be considered as commodities that don't matter? After this **Iris van Bennekom** gave the floor to Ruth Paserman of the European Commission.

**Ruth Paserman**, DG Employment, Social Affairs and Equal Opportunities, European Commission, said Peer Reviews were organised in the framework of the Open Method of Coordination (OMC) in Social Protection and Social Inclusion. The OMC is an agreement between Member States to share common objectives and to monitor how they are being put into practice, with an annual report on progress.

'Sustainable long-term care' can seem a vague objective, she said, because while everyone agrees that quality long-term care (LTC) should be accessible to all, it can be achieved in different ways. During 2008 and 2009 the OMC is highlighting three issues:

1. finance – how to ensure financial sustainability for the future;
2. coordination – how to coordinate provision between the health care and social sectors and between different levels of government;

3. workforce – how to organise the different types of carers: those working in formal or informal care, and caring for people in their homes.

The Peer Review would be examining these three aspects, and she hoped all the participants would benefit from each other's experiences.

### Introduction of the Dutch policy by means of figures

**Hans Broere**, Division Manager at the Department of Long-Term Care in the Ministry of Health, Welfare and Sport, the Netherlands, responsible for the financing of long-term care, said the policy focus is up to the year 2040, to ensure people retiring at that time will still have access to good quality care. The credit crunch is an accelerator, raising pressure to re-examine the sustainability of the system.

He outlined the three key challenges –

1. ensuring the system is **sustainable** -
  - a system has to be affordable over the coming years, up to 2040. Dutch citizens – particularly the elderly – need a “crystal clear insurance factor” so they are clear about their entitlements,
  - the labour force must be large enough to cope with growing demand, and measures must be taken to improve efficiency and innovate, using new technology;
2. maintaining a high **quality of care** - through making the system transparent and setting core quality indicators and benchmarks for different types of care;
3. **building a client-centred approach** – by shifting the focus of financing and providing health care from institution-based to client-focused schemes. This may be done through no longer making payments to institutions, but directly to individual clients, for example through the system of 'personal budgets'.

In addition to these challenges the system has come under political pressure to cut bureaucracy and create more diverse living conditions for those needing long-term care.

These challenges are acute given the Netherlands' demographic picture: the population stands at 16,5 million: a large population for a small country. Average life expectancy is nearly 79 years, and the fertility rate is below the level needed for national replacement. By 2030 over 20% of the population will be over 65 - around average for European countries, but much lower than Japan, for example. While there are now four working people for each person over 65, by 2050 there will be only two.

This will exert a heavy burden on the economy. If nothing is done to revise the system of long-term care, particularly for old people, projections suggest that by 2040 public expenditure on health and the old age state pension could be more than 20% of GDP. On the other hand, if growth is strong this could be cut to just below 10% of GDP. Much depends on future economic conditions.

According to the 'worst case scenario', by 2040 21% of the Dutch labour force would be needed to operate the health care sector, but changes in productivity, working hours and labour

participation could bring this down to 14% of the labour force.

Dutch health care is divided into three 'pillars':

1. The 2006 Health Care Insurance Act (Zvw) that set up mandatory private health care insurance, covering general practitioners, therapists, medication, hospital care and all the auxiliary needs.
2. The act to insure long-term care is called Exceptional Medical Expenses Act (AWBZ). It was introduced in 1967 and covers all mandatory public long-term care insurance for nursing homes/homes for the elderly, home care and institutional care for frail elderly people and those with psychiatric disorders or physical disabilities. The cost and number of clients has grown considerably since 1967.
3. The 2007 Social Support Act (WMO) run by local authorities and supported by national government to provide services for those in need.

These are supplemented by laws on price controls, accreditation, quality and rights of clients.

Clients find this system very complex to operate, said Mr Broere, when they need to receive services from all *three* sources, and are unclear about which agency is responsible.

The Exceptional Medical Expenses Act/AWBZ is implemented by health insurers. The assessment office, with regional branches, assesses the level of care a client needs and is entitled to according to nationwide criteria. The regional health care office is responsible for contracting the relevant care provider. There are 1300 institutions providing care for elderly people.

Clients then choose how they want to receive the care: in an institution, administered at home, or they can opt for a 'personal budget' scheme, in which they are given funds (based on a financial assessment of the care needed) which they can spend as they wish.

The Dutch authorities now actively encourage people to receive care in their own homes, rather than in an institution. The large majority of older people under 85 lives at home. Beyond that age, about 30% are in institutions and here the government is encouraging the use of smaller-scale nursing homes, rather than larger institutions, particularly if clients require special types of care.

Almost 600,000 people (3% of the population) receive long-term care funded by the AWBZ either in institutions or in their own homes. Over half of these are elderly people with physical problems, 113,000 are mentally or physically disabled and 72,000 suffer from dementia. Most dementia sufferers live in institutions, with about 17,000 coping at home, while a majority of older people with physical problems can also stay in their homes.

### **How is this financed?**

The total cost for institutional care in 2006 was €14.8 billion, which averages €58,500 per client. The total cost for home care was €5.9 billion, averaging €22,000 per client. Spending on the increasingly popular personal budget scheme totalled €1.3 billion, an average of €14,500 per person, but this has risen to €2.1 billion in 2009 – a fast rise over a short period, given that residential care costs are also increasing. The authorities are currently researching what kind of

people choose the personal budget, as this is a large ingredient of future LTC thinking.

A total of €22 billion is available for the AWBZ, of which 92% comes from premiums paid by the taxpayer - averaging about €320 a month per person, and 8% from co-payments by clients. €18 billion of this is spent on targeted care for the elderly or disabled, and the remainder on preventive programmes such as vaccinations.

### Questions and discussion

Participants were particularly interested in the personal budget scheme, and also about the need for a “crystal clear insurance system”, and integrating long-term care and health provision. Other questions focused on whether the cost of housing should be included in long-term care, and whether there are many migrant carers.

**Mr Broere** explained that under the personal budget scheme people are free to choose whatever form of long-term care they wish – they can pay a relative, or someone from a care agency, but as this care is not inspected it is not possible to guarantee quality. This is currently a topic of political debate, given a growing number of small commercial companies offering services. The scheme is very popular among elderly people and among parents of children who need long-term care, as the latter prefer their children to be cared for at home. Reasons for its popularity include a greater freedom for people to choose their own form of care, especially among the growing number of well-informed and highly educated older people, and problems of waiting lists and trust in institutions.

The personal budget is assessed depending on the client’s needs – for example how many hours of personal care and of nursing a week they require, and this has been found to be more efficient and some 25% cheaper than institutionalised care. What they don't spend is refunded. There is no upper limit on the individual personal budget, and with a growing number of disabled people needing large amounts of care opting for this solution, it could rise to €70-125,000 p.a., but this would be very exceptional.

Home care is distinct from the personal budget arrangements. The current average cost is €22,000 per person p.a., but at what point does it become too expensive if the policy of enabling people to remain in their homes results in long hours of home care over many years? Everybody receiving LTC has to make a co-payment, but this varies according to income etc.

There is also a move towards small-scale residential accommodation for dementia sufferers, elderly people and handicapped children, for example. The government is encouraging this trend, although it can be more expensive, and vulnerable, if just two or three carers are responsible.

The role of migrant workers in care services is under debate across the EU. However, although the Netherlands does employ some carers from Eastern Europe, this is not a large-scale issue.

There is a growing debate about needing a “crystal clear insurance system” because of the confusion between public/private financing schemes and disagreements about whether care should be provided collectively, or whether people should choose individually the care they want. The AWBZ is one of the fundamentals of the Dutch healthcare system, based on the principle that the money should guarantee a good quality of care, but some people want to 'top up' their support to pay for better long-term care if they wish to, leading to fears of a two-tier system

developing, although the number of totally private nursing homes is currently quite small.

As to the issue of whether the cost of housing is automatically included in residential care, Mr Broere said that before people move into residential care, they make a contribution of about €6.400 on average per annum, but accommodation in a home is covered by the long-term insurance act. This has sparked public debate about whether one should separate paying for 'rent' and 'care' in an institution. Changing the current set-up where everything is paid for by the AWBZ, would affect the amount each person paid in an institution, as it would be means tested. There is an ongoing discussion about whether housing is simply the first and most basic ingredient of care, or whether some groups should be expected to pay rent.

Peer Review participants also debated the boundaries between LTC and healthcare, with regard to 'crystal clear insurance'. The Dutch national health care budget is slightly below the European average, while the AWBZ premium (12.15% of earnings) that people have to pay is very high in comparison to other countries. This suggests that a lot of medical care is covered by LTC insurance. Should it be transferred to the Health Care Insurance Act (Zvw)?

Mr Broere explained that the long-term care insurance act was just meant to cover care for conditions that could not be insured against, such as mental or physical handicaps or frailty as a result of old age. While the current system makes a theoretical distinction between care provided out of the health care budget (funded through health insurance and provided by insurance companies), and premiums for long-term care, most people need both forms of care simultaneously.

In addition, as the national budget for long-term care is larger than the national medical insurance budget, and it is unclear which of the two budgets should cover medical treatment, money from the AWBZ budget is often used to pay for clients' medical care as well as for their long-term care.

The AWBZ had originally been designed only to cover care for exceptional medical expenses – not normal health expenditure. He wondered whether an integrated health system might work better, as the Dutch AWBZ pays the costs of older people needing care and those who have physical and mental disabilities, which can be quite different, but this would not be as clear for patients who would prefer the two systems to be separated.

In the context of the Open Method of Coordination, Member States are asked to consider whether to maintain the separation between medical and non-medical care and between long-term and acute care.

Mr Broere wondered which financial structure would prevail in an integrated Dutch system – the medical insurance model based on regulated competition between insurance companies, or the long-term care insurance system, which is publicly organised and financed?

## **Presentation of the Discussion Paper**

### **Long-term care: How to organise affordable, sustainable long-term care**

**Dr Heinz Rothgang**, the thematic expert from the Centre for Social Policy Research, University of Bremen, began by describing the demographic changes which determine the need for 'dependency' or long-term care. German statistics show that people's need for long-term care is directly related to their age, as it only increases substantially once they reach 80. More than 50%

of all beneficiaries of social long-term care are over 80, so the amount of care needed nationally will depend on the percentage of the population over 80 years of age.

Figures from the Organisation for Economic Cooperation and Development (OECD) show that between 2005 and 2050 there will be an 83% rise in the proportion of the population aged 65+, and a 247% rise in the share of the population over 85, thus considerably increasing the numbers of those needing long-term care.

But there is some hope, he went on. Age-related health may improve, and since proximity to death is itself an important indicator, the number of dependent people may increase more slowly than predicted. While people's need for long-term care is directly related to their age, those who are closer to death need more care than those of the same age who are in good health. Thus even though life expectancy increases, the need for care is less dependent on a person's age, and this could reduce the increase in numbers by up to one third.

Turning to the question of how to **finance** long-term care in a sustainable way, Dr Rothgang pointed to four possible funding sources:

- personal savings;
- private insurance with risk-related rates;
- contributions within a social insurance system; and
- tax-financed benefits, with or without means testing.

Looking at the various options for providing long-term financially sustainable care, Dr Rothgang said that in order to provide universal coverage and an adequate benefit package, he believed it necessary to have a public-funded system, topped up with additional private finance if desired. This could be financed either from insurance contributions or from taxes.

In moving towards such a system, countries which have an existing national health service try to integrate long-term care services into it, while those with insurance schemes have to create a new system. He gave a word of warning on both counts: tax-based systems have to secure adequate funding when competing with other demands – possibly through earmarking a budget, while a social insurance system must ensure everyone pays contributions, and not allow 'good risks' to opt out. All income sources must be included, not just income from labour to avoid fiscal problems if the wage share declines.

In order to be sustainable any system needs **boundaries** to control the cost of long-term care, but they may undermine integrated care provision. Countries with a separate and narrow LTC system, such as Germany, tend to worry about insufficient integration, whereas countries such as the Netherlands, with a more encompassing system, want to set clear boundaries to control costs.

If we want an integrated system for health and long-term care we have to unify services, but is this a good idea? He believed that integrating medical and social care would provide the most sustainable long-term care. However we warned of two dangers: Health service professionals (doctors) could dominate LTC professionals (nurses), who are just beginning to define a professional role for themselves; and a healthcare-led system would be likely to undervalue the crucial role of families and informal care. In view of this, he was sceptical about 100% integration of health and long-term care.

Boundaries are one way of controlling costs. Other options relate to criteria for entitlements, including the definition of 'activities of daily living' (ADL); thresholds (minimum requirements); assessment procedures, waiting times, means tests, capping of benefits, and pricing systems.

Turning to the problems of falling **labour supply** in the face of growing demands, Dr Rothgang outlined measures needed to encourage people to enter the caring professions:

- improve pay and conditions, with greater job satisfaction and recognition;
- instigate a proper career structure;
- introduce job differentiation between trained professionals and less qualified personnel;
- put more emphasis on recruitment;
- encourage more men to enter the profession which would indirectly improve pay, job status and working conditions;
- introduce a framework for more mixed-care arrangements in which formal carers, informal carers and those in the voluntary sector work together;
- tackle the supply and demand side by giving more support to family care and the voluntary sector, thus reducing the demand for professional care workers.

Improving LTC requires a multi-dimensional approach taking many different factors into account, said Dr Rothgang. It must have a sound financial base, provide universal coverage, give an adequate benefits package and ensure labour supply in the formal, informal and voluntary care sector.

## Discussion

**Jozef Pacolet**, Head of the Welfare, State and Housing Sector at the Catholic University of Leuven, **Belgium**, said the demographic shift and the composition of the labour force in 2050 had to be taken into account in planning future services. It is sometimes difficult to distinguish different forms of care, and perhaps it would be better to look at a means of grading rather than linear boundaries. According to the OECD the distinction between medical and non-medical care depends on the profession providing it. He believed that an integrated system could offer a continuum from health to long-term care. There should not be a cap on funding for health care or LTC since this would leave people unprotected. The need for public funding is fundamental.

One dimension of the economic crisis is that it may mean a bigger supply of workers if the care industry expands while others shrink. If the estimated cost rise for LTC is from 0.9% to 1.5% of GDP in 2050, he wondered what the problem was. In the US, the huge market in private health care spending is 50% higher than in Europe, even though it does not cover the whole population, and could rise from 15% to 20% of GDP by 2050.

**Ruth Paserman** suggested that some statistics should be "taken with a pinch of salt". Budgets are at risk of "exploding", and while the current situation may offer an opportunity, how do we exploit it in a sustainable way?

**Henk Nies** from Vilans in the **Netherlands** was concerned that the continuing debate about setting financial boundaries for care is driven by supply issues, not outcomes. The Netherlands is experimenting with contracting across boundaries. It is complicated, but in the same way that a customer buying a tomato is concerned only with the final product, so the system should move towards contracting outcomes. He asked for examples of good practice.

**Max Rubisch** of the Federal Ministry of Labour, Social Affairs and Consumer Protection, added that **Austria** is encountering considerable difficulties with boundaries between federal and provincial competences. Therefore, in nationwide projects it is necessary to conclude an agreement between the federal and the provincial level.

**Anne-Sophie Parent** of the European Older People's Platform (**AGE**) emphasised the importance of improving the number of 'healthy life years' older people live, as additional years in ill-health will merely increase the demand for LTC. She was concerned that countries which are implementing drastic reforms are expecting women to shoulder the responsibility of caring for relatives at home. The trend to cut down the time spent in hospital after operations also leaves families responsible for intermediate care. Yet at the same time women and older people are expected to participate in the labour market. She queried why, since 50% of the population will need LTC during their lives, the Netherlands' legislation is entitled the 'Exceptional' Medical Expenses Act (AWBZ). She warned against the principle of charging older people on the basis of their assets, giving examples of patients leaving hospital to find their homes mortgaged.

**Floris de Boer** from the Dutch Ministry of Health, Welfare and Sport said women already combine work and care, and that women's employment will not automatically mean the end of informal care. However, part-time working is a more important element. If everyone were in full-time employment this might pose problems, but that is not currently the case.

**Mr Broere** said there are some five or six large private insurance companies in the Netherlands that would be capable of taking on the task of administering the AWBZ, and there are proposals to introduce regional health care offices run by private insurance. The drawback would be that each insurance company would only cater for its own clients. While this would offer more integrated care, it raised several questions: Would long-term care be subject to the same eligibility rules as medical care? How would private insurance companies assess the risks of insuring people for long-term care?

The Dutch government will take a decision about the position of care insurance offices in long-term care by 2012, and this is likely to come down on the side of a system based on individual schemes carried out by insurance companies. While this will ensure that care is more client-based, it will give private insurance firms, which are often part of large multinational companies, more influence in determining policy. He recognised the problems inherent in the private insurance market. He gave examples of parents of disabled children having to use the value of their houses to secure care, or older people selling their homes to their children to avoid losing them. The Netherlands used to have such a system, and got rid of it.

**Caroline Glendinning** from the Social Policy Research Unit at York University said in the **UK** health and social care are funded by different funding streams and are the responsibility of different organisational structures. This can create co-ordination problems, for example when people are discharged from hospital. Policies since 1997 have made a major effort to improve collaboration between the two services at local level. She noted that evidence from Flanders shows that 'personal budget' arrangements which allow relatives to be employed as carers can increase the supply of paid care workers, for example by bringing newly retired people into paid care. However, Flanders and other research has also pointed to the danger of exploitation that can arise from paying relatives through personal budgets, since they can find it hard to say 'no' to additional duties.

**Niclas Jacobson** from the Swedish Ministry of Health and Social Affairs commented that given **Sweden's** increasing trend to care for people in their homes, home carers should be better trained. Medical advances mean people can survive longer with more complex conditions.

**Phil Madden** from the European Association of Service Providers for People with Disabilities (**EASPD**) urged governments to listen more closely to the people who receive services, and family carers. Many families successfully undertake complex tasks, if they have enough support. The way forward must be through an integrated family policy.

**Carmen Manu** from the Romanian Ministry of Labour, Family and Social Protection, the Directorate for Social Services and Other Rights, said **Romania** does not have a coherent system of long-term care. The current services are funded from taxation, from state and local budgets, the provision of care services being the responsibility of social assistance public services set up at community level, by local authorities. Due to the lack of funds and trained personnel, care services are not equitably developed all over the country and the access to long term care is limited in certain communities, especially in rural areas. Therefore, the last debates are more and more focused on the possibility to establish an insurance scheme to cover part of the costs of long term care. The Ministry has set up a national programme to help local authorities train and employ carers. The program evaluation put in evidence not only good results, but unexpected ones such as the migration of part of the trained carers to other countries where they can earn more. ( Italy, Germany, etc).

As long-term care is covered by the local-authority-run social protection scheme, rather than health services, there is a problem integrating the professionals involved into one team, although introducing an integrated insurance scheme might resolve this.

**Piotr Błędowski** of the Warsaw School of Economics said **Poland** spends twice as much money on social long-term care, which employs a large workforce, as on health care, and the two systems are run separately. Spending in new Member States is much lower than in old Member States, and it will take time for them to reach the same levels of quality and funding. Poland also has problems with the emigration of carers.

Asked about the evidence that private insurance cannot supply LTC, **Dr Rothgang** pointed to the US example, where health insurance is voluntary, 46 million people (16% of the population) have had no insurance over the last year. If you want universal coverage it cannot be achieved through voluntary private insurance, since premiums are related to risk, and therefore people who are poor or unhealthy do not get insured. On the other hand, once the insurance becomes mandatory, risk-based premiums have to be subsidised, and it turns into a form of social insurance.

Regarding the best method of funding care, Dr Rothgang insisted on a mandatory scheme. Comparing social insurance and a tax-based system, a social insurance system has one major advantage: the insured are entitled to benefits, which therefore cannot be cut as easily when the economy declines.

Following questions on the use of personal budgets outside the Netherlands, **Mr Broere** said recipients must live in the country, but can spend money on short trips abroad. **Matthias von Schwanenflügel** from the **German** Federal Ministry of Health noted that a decision of the European Court of Justice (the case Moleenaar in 1998) relates to the right to benefits abroad. This could be a very dangerous development. An EU Directive on patients' rights is being prepared which may deal with this question. **Mr Pacolet** said growing mobility in the EU could

create complex legal questions.

### **Long-term care assured: How to manage the shortage of care workers in long-term care**

**André Wendt** and **Bert Gotink**, from the Mondriaan School in the **Netherlands** said the school's Social and Health Care Division has 6800 students: 3000 in health care, 3200 in social care and sports, and 600 on security courses. Health care education covers assistant domestic care takers (Level 1), basic level care takers (Level 2), care takers /assistant nurses (Level 3) and nurses/social workers (Level 4). Most courses are full time, but there are 1240 level 3 students and 105 at level 2 on 'day release' once a week, paid for by their employers.

Unfortunately there has been a sharp drop in the numbers of those wanting to take up a career in domestic and residential care or long-term mental health. This, coupled with the growing proportion of people over 65 compared to those under 65, means that staff shortages in domestic care could reach 11% by 2011.

Schools like Mondriaan have problems encouraging students to take courses in long-term care because of the profession's poor image, compared to the "sexy" medical profession, so colleges and employers are taking joint responsibility for boosting recruitment by turning to other groups as a possible source of students. These include people over 21 who "follow their heart" in choosing a career in care and are able to study full time. Young people are often influenced by their peers in rejecting care work, but from their early twenties may become disillusioned by office jobs and look for a change of direction. Another group consists of people over 35 who want to embark on a career – particularly women whose children are growing up and who want to return to part-time study and work.

While these potential recruits over 35 must have the necessary accreditation from their previous education, their experience of raising children or caring for family members has equipped them with the skills they need to be able to complete the course in a shorter time, particularly if they enter a scheme which has been specially adapted to their needs.

In The Hague, Mondriaan worked with the authorities to mail all women over 35, 40% of whom were not in employment, and in cooperation with the care organisations designed a tailor-made course combining work experience with studying three days a week. There was a big response and in two years 320 students graduated. Most prefer to begin with part-time work, three to four days a week, possibly moving to full-time work as their children grow up. This shows the benefits of recruiting students over the age of 35.

The Hague has a large number of students at level 2 (basic care work) and a shortage at level 3 (assistant nurse). This is partly because they come from ethnic minorities and lack the confidence to study higher grade courses, and partly because students are from lower social classes and lack the requisite entry requirements. Mondriaan overcomes this by encouraging students completing level 2 to move on to level 3 to become better qualified, and has achieved a 42% success rate in doing so. The school is targeting second and third generation ethnic minorities, but one complication is that ethnic minority women are sometimes reluctant to work with men. Around 20% of long-term care workers have level 4/5 qualifications, and most are employed in hospitals.

Mondriaan is also working with the government and employers on projects to prepare those with limited access to the labour market to develop skills so they can embark on a career in care, and offering language training to workers from other countries.

### Questions and discussion

Participants asked the following questions: Is Mondriaan offering courses for informal as well as formal workers? Why do students decide to study for a career in care? Do students learn “on the job”? How does one maintain standards in home care? As towns such as The Hague have a high immigrant population, is a special effort made to encourage immigrants to train?

**André Wendt** and **Bert Gotink** said Mondriaan offers courses in response to demand from national or local government, so given the expected growth in informal or home care, the school is likely to design courses to meet this need. It also offers shorter courses which combine extensive practical ‘hands-on’ training by employers with studying. A further 800 university students are taking healthcare courses, and some will go on to do Masters’ diplomas.

Many students start the courses without a clear motivation, and can easily drop out, so Mondriaan is working to improve the image of long-term care to make it an attractive profession. Young students who come straight from school at the age of 16 often start out with low motivation, but once they are at Mondriaan it is possible to change their attitude. However there is no exact research in this area and it is not really the school’s responsibility to carry it out. Unsuccessful level 4 students who started with the aim of working in hospitals would be qualified to work in LTC, but unfortunately they often do not want to. That is why Mondriaan is looking to recruit older people.

As to the numbers of migrants in The Hague, more second and third generation immigrants want to work in care than before and there are some long-term care homes which are geared to ethnic minorities, making the work more attractive to these groups.

On the topic of quality in the care services, **Floris de Boer** said the Health Care Inspectorate carries out inspections of homes and will close those where the quality of care is considered poor. Although home care is not monitored in the same way, the Social Support Act has a charter for quality in informal care. Local authorities can also organise support for example through respite care.

**Caroline Glendinning** pointed out that a grown number of local authorities in **England** offer home care ‘re-ablement’ services that help older and disabled people regain the skills and confidence to care for themselves. These services are relatively short and intensive, and after six weeks have been found to reduce the need for home care services; however it is not yet clear how long the effects of this re-ablement last in reducing needs for home care services. Many home care reablement workers are retrained home helps who need a different mindset directed towards helping people to do things for themselves rather than doing things for them.

### Dutch strategies to deal with labour market problems in the long-term care sector

**Ina Bakker**, a Dutch expert in long-term care, said the **Netherlands** needs a ‘Deltaplan’ – a large scale and multi-comprehensive approach combining different strategies – to provide sustainable care for its ageing population and shrinking workforce. It is estimated that by 2030

and beyond 22.4% of the population will be 65 and over and 2.3% over 85. By 2050 the percentage of over 85s will rise to 3.7%, while the numbers of those with diseases of ageing like Alzheimer's could more than double.

If policies remain the same, the health workforce will not be able to cope: today about 13% of the total Dutch workforce are in the health care sector but by 2020 it will take an estimated 25%.

There are three possible solutions:

- *Reduce the need for care*

Prevent diseases of ageing that require care, such as heart disease or high blood pressure by encouraging a health lifestyle. Give more support to informal care and with a growing number of people (mainly women) combining caring for an elderly relative and a career, introduce legislation to make it financially easier to combine work and family care.

Expand the use of new technologies, such as ICT, to aid caring at a distance and for research into diseases such as Parkinson's. Decentralise administrative and executive policies, using the example of the Dutch Social Support Act (WMO) which transferred social support responsibilities from national to local level, simplifying the administration and cutting costs.

- *Improving labour productivity – 'Work smarter, not harder'*

Promote new technology, and follow the example of the Dutch Ministry of Health, Welfare and Sport, which in 2008 set up a commission to promote this via the *Zorg Innovatie Platform*. Innovate at work by introducing new work routines, dividing tasks between medical professionals and health care workers and introducing job differentiation to make work more interesting.

- *Enlarging the health workforce*

Recruit more workers by improving the image of the sector; offer practical learning and work experience for students in care institutions ('*stages*'); make special funding available for health care specialists so they can rise up the career structure and target new groups – such as less educated youngsters – to consider health care as a career.

Keep people at work and stimulate them to work more, by enhancing the attractiveness of the sector, reducing work pressure, offering more flexible work schedules for those with children or older relatives, and an inspiring work climate, with opportunities for job advancement. Research indicates that work pressure is by far the strongest factor leading to drop out. The Dutch government has introduced policies to discourage female health care workers over 50 leaving, which has happened in the past, seriously depleting the work force. Reduce the 'part-time factor' in care work and encourage more full-time work.

- *Working until retirement and pension*

In the past people were encouraged to retire before age 60 to create jobs for young people. Today the Dutch government is creating financial incentives to encourage people to continue working, is redesigning work patterns to accommodate older people - for example reassigning physically strenuous work to younger people and is increasing job differentiation and creating more senior position for older workers. At the same time the Dutch pension age is being raised from 65 to 67, although some employers complain that older workers are more expensive.

While each of these three strategies is useful, said Ms Bakker, none of them on their own is enough - a broad spectrum approach is needed to bring the strategies together.

### Questions and comments

New technologies are evolving, such as a suit that enables women to lift greater weights (developed in Japan). The Danish Finance Ministry is launching a funding programme for research. Will the Netherlands do something similar? Are there enough on-the-job training places available? If the 55+ age group is thought too expensive, this reflects a lack of finance rather than a staff shortage. To encourage older workers, why not simply withdraw incentives for early retirement? Would a minimum wage be helpful? Will the current crisis mean strategies must be modified?

**Phil Madden** pointed out that new technologies could be dangerous if used to replace workers and reduce labour costs. Isolated people need real human contact. What was needed is an Ethical Code such as the one currently being produced by EASPD with EU funding

**Gert Alaby** from the National Board of Health and Welfare in **Sweden** said only 10% of LTC workers have university education. He suggested raising the level of skills needed, to make LTC work more interesting, and recruiting more trained nurses and social workers to the sector.

**Ms Bakker** replied that any measures to make care work more attractive are welcome. ICT can help, but cannot replace social contact. It is paradoxical but true that there is a shortage of 'stages' at care agencies and institutions. A minimum wage already exists in the Netherlands, but does not help enough. Educational levels are also being raised to higher educational standards, but expected staff shortages are in the lower level 3 grades.

**Bert Gotink** explained that employers claim it takes too much time and effort to supervise students, so the government is considering funding to overcome this.

### Discussion on the three sub-themes of the Peer Review:

- balancing collective and individual arrangements;
- boundaries between the long-term care and related schemes;
- securing sustainability and enough well-qualified personnel.

**László Pattván** from the University of Debrecen Health Faculty in **Hungary** said the government has brought in many reforms but this has been so costly that it is now being forced to cut back the welfare budget. Funding care is a hotly debated issue, as social services are funded from taxation, and health care by an insurance system, creating uncertainty about which department is responsible, with the risk that some groups, such as elderly, might not be covered by either budget.

In 2008, health care reforms cut treatment stays in hospital. LTC departments are covered by health care services, while residential homes come under social care. More and more activities are covered by the social sector, but costs are rising and funding is inadequate.

The state and local authorities are the main service providers. The state sets the budget and regulates the system. Currently only 5% to 4% of the population receives care, and only 2% of people over 65 receive long-term care. There are a huge number of people with special needs who do not get anything.

Government strategy is to train unemployed people to offer social care. But training is poor, as most care workers receive a rudimentary 18-months' training – as a result about 80% of care workers are lowly-skilled, and agencies are wary about assigning workers to home care. The remaining 20% of care workers who are educated in social work or nursing at university tend to leave for Western Europe where the pay is better. Universities market nursing training as an opportunity to find work abroad. In general social care is an unpopular, lowly paid career that attracts the less well-educated. Hungary's problem is that undereducated people stay at home, while qualified workers are eager to leave.

**Carmen Manu** was concerned about the number of trained health workers who are offered work abroad – and wondered whether it might be possible introduce a contract, which obliged them to stay in Romania after they completed their training.

**Tanja Amon** from the Ministry of Labour, Family and Social Affairs of the **Republic of Slovenia** said the country's social welfare system and health systems, which are responsible for care, are not well organised, and lack a comprehensive strategy for training enough long-term carers. The care profession depends on informal and non-professional providers, like voluntary organisations or family members.

Slovenia has four different types of training for long-term care: a) in schools/ university; b) short courses leading to a vocational certificate; c) private programmes targeted at special groups, e.g. Alzheimer's sufferers; d) education by the care providers themselves. Therefore there is no comprehensive strategy. There is also a category of 'family assistants' who are informal carers.

**Sirlis Sömer-Kull** from the Ministry of Social Affairs in Tallinn said in 2007 **Estonia** had a very low unemployment rate, and staff shortages in the social sector, which is not a popular one to work in. Now, unemployment is growing every day and people are calling care homes to ask for jobs. People who emigrated for work are returning as opportunities dry up. The situation is changing every day.

**Miia-Kersti Sultsmann** from the **Estonian** Association of Gerontology and Geriatrics said that care workers are trained at medical schools or private institutions, but the country lacks a unified system of training. LTC is offered in special hospital departments, employing nurses, or residential homes with unregistered carers. Staff are taken "off the street" and tend to leave once

they are qualified. So the quality of service is fairly low. In the future, the aim is to change the law to unify care work standards. There are moves to improve the profession by giving more responsibilities to nursing staff and integrating nursing and long-term care. LTC is financed by local authorities and service users. Unfortunately the government recently reduced support for local governments, which might result in a lower ability to buy LTC from care providers. Due to standardisation of care work some small residential homes will be closed. The future is hard to predict. She pointed out that there are few if any men working in LTC, although **Sirlis Sömer-Kull** pointed out that some young men are now taking work in care homes in order to substitute military service.

**Lucy Aarnink** of the Ministry of Health, Welfare and Sport, said the **Netherlands** wants to see more diversity in the labour force, with more people from different ethnic groups entering the profession.

**Aurelia Curaj**, of the Geron Foundation, felt that training for carers in **Romania** is too theoretical and distanced from the practical job. Medical schools are responsible for training in medical care, so most of those on the courses want to work in hospitals. Social care training takes place in universities, and graduates expect to become policy-makers, not care workers. Lack of back-up means dementia sufferers can be turned out of geriatric hospitals after two weeks, with only drugs to help them.

**Carmen Manu** said shortage of funding in **Romania's** health system means that resources do not stretch to cover all aspects of care, such as for people with mental or physical disabilities, so their family members have to undertake it. Alzheimer's sufferers are cared for in adult centres for the disabled but cannot be sure of LTC.

Social work was only recognised after the revolution, and social workers require a university degree and do not want to go into LTC. Negotiations are underway on a shorter, more basic training for people to work in rural communities where carers are needed. A measure to compel trainee doctors to spend some of their training time in rural areas could be a solution. Lifelong learning could help informal carers to qualify in the formal sector.

**August Österle** of the Institute for Social Policy, Vienna University of Economics, said **Austria** is a "receiving country" in care work migration. Incomers from Slovakia, Poland and other Central and South-Eastern European countries cover the need for trained care staff. A research project is underway to discover what makes people decide to move to another country. Pay is an important factor. Nurses from Slovakia can commute 50 km and may earn three times as much. Career prospects are also significant; health care reforms and cuts in hospital beds have created uncertainty in many countries. Evidence shows that people do not always move willingly, and many would be happy to work for less money in their home country, if they had good career opportunities.

### **General discussion in the presence of Jet Bussemaker, State Secretary of Health, Welfare and Sport of the Netherlands**

**Jet Bussemaker** told the Peer Review it was undertaking a very important debate. Before her election as a politician she did research on comparative welfare states at University of Amsterdam, so was quite well informed on different countries. However it was easy to overlook the care sector and focus only on social security and the labour market. All countries are now

confronting challenges related to LTC. She asked participants to describe their experiences and offer their advice on organising sustainable long-term care.

**Niclas Jacobson** said the **Swedish** experience has shown the need to professionalise long-term care, by insisting that it is very skilled work requiring a high level of competence. A new proposal could restrict elder care to qualified staff who have undertaken on-the-job training, but it would be costly.

**Jozef Pacolet** said current moves in the **Netherlands** risk adding administrative complexity and taking away clients' autonomy. Introducing competition into health and long-term care for the elderly would be looking for a solution that is not feasible, he insisted. The integrated AWBZ was a good starting point, and progress should continue down that road. If the country is seeking an integrated solution, housing costs, for example, should be included in care provision. Otherwise it would bring about a cut in protection, which runs contrary to the need for more LTC in the future.

**Ms Bussemaker** responded that the system aims to provide everyone with the same level of care, in an objective and transparent way and allow the client to choose what form of care s/he wants. There is a need for greater diversity in the way care is organised. Separating the cost of accommodation and care gives people more choice and is more to do with creating diversity than cutting services.

A big debate is underway about what should be covered by national government and local government (municipalities). While people complain about cuts in LTC, spending has doubled in 10 years. The most important question is how is the money being spent, is it reaching the people who need it, and are we avoiding excessive bureaucracy?

**Hanka Bendig** from the Central Association of Health Insurance Funds in **Germany** said that while proposed changes to the Dutch system of long-term care will give more autonomy in form of information and Consultation to the client, they will put a greater focus on family members.

**Caroline Glendinning** referred again to the English re-ablement scheme as an example of good practice. Robust research on the longer-term impact of home care re-ablement is currently in progress, but preliminary research shows it has an immediate impact in reducing the need for home care.

**Anne-Sophie Parent** was concerned about the number of companies opening care homes on the borders of neighbouring countries, where they can attract patients from across the border thanks to their lower cost, such situation often resulting in longer waiting lists for local older people in need of LTC. She also raised concerns about the fact that LTC care trained in some countries move to other EU countries to work. This means that the country who has invested in their training does not reap the benefits.

**Heinz Rothgang** believed that the future of long-term care lies in an interplay of the formal, informal and the voluntary sectors, which requires new rules governing formal work so that voluntary carers, such as relatives are integrated into the system.

In Germany, inspectors are now obliged to publish their findings, which will help to boost quality. Counselling facilities for families have been set up. "There are lots of options between caring for yourself or going into an institution," he insisted.

**Ms Bussemaker** recognised the risk of putting extra burdens on family carers, who could get ill themselves as a result. Yet the Netherlands is determined to help people stay in their own

homes. This means offering more support to informal carers, such as days off, training, or a contact network.

The personal budget is a popular system, but requires a lot of organisation and so is not suitable for everyone.

She thought the scope for creating a brain drain from other European countries was limited, since in the Netherlands most people want to be cared for by people who live near them and speak their language.

Employers in the care sector must invest in training for their workers, and the financial crisis may even be helpful in encouraging recruitment to a sector which always needs workers.

She concluded that the Dutch government is working to improve the quality of service and to give people more choice, creating a balance between voluntary, informal and formal care. She did not believe formal care to be the best option. Thinking of her own old age, she preferred the idea of informal and voluntary care. "I don't have a romantic view of how things once were, with everyone taking care of each other, but we have to find something in between," she argued.

## Day 2

The session opened with some remarks from **Matthias von Schwanenflügel** from the Federal Ministry of Health, **Germany**, regarding more perspectives for care nurses:

- In Germany, a new reform allows nurses or social workers to take on case management.
- Workers in nursing homes may be classified as 'dementia care workers', funded through LTCI. A low level of training is offered and workers are paid approximately €10-12 per hour.
- A trial project is underway to enable nurses to carry out tasks previously restricted to doctors. They require special training, and the scheme is funded by medical insurance companies. This allows for the rigid dividing line between doctors and nurses to be more flexible, but this is still a sensitive issue in Germany so the project is breaking new ground.

## NGO Statements

### AGE – the European Older People's Platform

**Anne-Sophie Parent** said there has been a recent shift away from services that used to be covered collectively, towards individual responsibility. AGE members understand that a better balance between individual and collective responsibility is needed in response to the rapidly ageing population, and that public authorities are no longer able to guarantee everyone's long-term needs. But older people are disoriented by some reforms. Member States should devote more effort to explain the reforms and provide information on alternative solutions to those who are no longer eligible for support, keeping in mind that older people applying for LTC are going through a difficult phase in their lives and are very vulnerable.

The stakeholders' main concern arises from the fact that many people don't understand what they

are committing themselves to. Services that used to be free are now partly charged, and people may find this out after they have started using them. They may then have to give up the services if they are too expensive.

Some countries, like France, are considering a cap on charges because all citizens have made contributions and should therefore be covered on the basis of solidarity rather than risk. For the over-65s, it is too late to buy private insurance, and some people are especially vulnerable, for example, women and immigrants. Individual budgets are useful but people with Alzheimer's are not capable of making decisions for themselves, and so the responsibility falls on carer who often do not get any support or counselling

### **EASPD – the European Association of Service Providers for People with Disabilities**

**Phil Madden** affirmed that it is essential for service providers' organisations (SPOs) to be involved in discussions of the sort taking place in the Peer Review since they play an important role.

Ageing is intertwined with disability, since age tends to bring disability and people with disabilities are living longer. Mr Madden called for society to stand back and ask itself 'what is desirable?' He suggested a move away from long-term care to long-term support since this principle is more active and participative. This means putting people first, and trying to provide individual person-centred services with the aim of maintaining maximum independence, so that people can 'age in place'.

**Assessment:** Assessments of needs must be participative and involve the people concerned, especially families.

**Eligibility:** If we make eligibility more strict, this does not mean the need goes away. Huge variations in definitions exist in different countries so a fair consensus must be developed.

**Boundaries:** he said the false distinction between social care and medical care makes things more complicated for those in need.

**Models:** There is no one-size-fits-all solution. The personal budget idea is very exciting, yet people do not necessarily want to have to control everything themselves. New technologies must also be introduced with respect for ethical principles.

**Personnel:** Mr Madden said the EASPD has major concerns about staffing. There are problems relating to training and image, but above all people must be able to work with better employment conditions of service.

### **Debate: balance between collective and individual arrangements of financing**

**Heinz Rothgang** said this issue is at the centre of the debate. It is not true that everything is getting worse. There is as yet no estimate of the value of informal care in Europe, and no clear definition of LTC, but there *is* more awareness of the issue.

**Alexandra Norrish**, Head of Social Care Strategy at the UK Department of Health, stated that **England** is developing a strategy that will move away from means-tested long-term care system

that is limited to those who are unable to pay for their own care, to one that has greater coverage. Traditionally, state support has gone only to those with high needs and low income, but demographic change is provoking a rethink because more people need support, and families can no longer offer the level of care they did in the past. The principles of the social care support system are unchanged since the 1940's, so 18 months ago the Prime Minister announced a Green Paper which will propose fundamental changes to the funding of the whole social care system; this will be published in 2009.

More and more of the wealthiest and healthiest are trying to opt out of collective systems because they do not want to pay for other people, warned **Anne-Sophie Parent**. More and more needs are no longer met collectively, but this does not mean they disappear. Private insurance companies are interested in 'filling the gaps'. She warned of the need to avoid a two-tier system where publicly funded care is deprived of income from healthier citizens, and universal access applies to a shrinking pot of services. She argued that the move backwards towards individual responsibility is based on an obsolete vision of the family since half of the ageing population will soon live alone and will have no one to care for them.

Do we mean collective funding or delivery? asked **Floris de Boer**. In the past, care delivery was like a supermarket with just two or three items available. The Netherlands is increasingly convinced of the need for increasingly personalised care.

In **Germany**, public funds cover 60% of the cost of LTC, said **Matthias von Schwanenflügel**, with the rest coming from the people themselves or social welfare for those in need. This expresses a social consensus.

Trends in **Sweden** are going in different directions, admitted **Niclas Jacobson**. It is a tax-funded system, with municipalities responsible for LTC. But scope of care is diminishing due to demographic realities, with resources redirected towards the more severe conditions. While costs for municipalities have gone down by 6% over the last five years due to staff cuts, expenditure on healthcare by county councils has increased.

In **Austria**, where LTC is widely regarded as a collective responsibility, there are three pillars, said **Max Rubisch**: first, the LTC allowance, which goes to 400,000 people (about 5 % of the Austrian population); second, supporting measures for caring family members and third, social services. About 77,5 % of people on the LTC allowance are looked after by family members, sometimes supported by social services, and about 17,5 % in nursing homes (70,000). The other 5% (20,000) are looked after by immigrant carers. Costs continue to rise, especially for social services, since family structures are changing. As people are trying to stay at home as long as possible, it will be increasingly important to support families in the future, for example by allowing for part-time working. At the moment, there is some staff shortage in Austria, as the wages in the LTC sector are low and the working conditions very difficult.

In **Romania**, LTC is funded by taxes, said **Carmen Manu**, but different criteria apply to disabled and elderly people. The health system covers people discharged from hospital for 45 days, but this aid is difficult to obtain. The Ministry of Labour, Family and Social Protection gives subsidies to NGOs providing LTC, but last year many organisations only offered domestic help, because it is easier. It is important to maintain a wide range of collective social support, she judged.

**Estonia** does not have a care insurance system, but responsibility is shared between healthcare and social care systems, said **Sirlis Sömer-Kull**. Social care is financed by local authorities and

health care from national sickness fund (insurance based system). Authorities cover 47% of the cost of residential care, and families 53%, which is a big burden. More services are needed, but when money is short local authority budgets are reduced. Service providers are sometimes small organisations that are economically inefficient.

Wide variations exist in different parts of **Hungary**, admitted **László Pattyán**. Local-authority-run homes can get 100% funding from the state, but church-run institutions get a large subsidy on top (167%). Private insurance is available, and wealthy people can avoid the state system. A needs assessment was carried out in 2008, leading to establishment of minimum levels of service, but social services are not well enough organised to meet the needs of people staying at home.

**Slovenia** is planning to introduce a collective insurance scheme, said **Mateja Nagode** from the Social Protection Institute of the Republic of Slovenia from Ljubljana. Local authorities are not well enough organised to guarantee services. For example, home help is still not accessible in all Slovenian municipalities under the same conditions (price, subvention, schedule etc.). For people needing more than 3 hours help a day, residential care is the only option.

There is a lack of coordination between social assistance and health care in **Poland** also, explained **Piotr Błędowski**. There is a balance between collective and individual arrangements. The country has 1.1 million people needing LTC. About 100,000 live in nursing homes, and a further 100,000 receive services at home. Some people are hospitalised unnecessarily, while many pay for care themselves, which is unacceptable. An LTC insurance system would be a possible solution.

## Prevention

**Floris de Boer** said the evidence in favour of ill-health prevention measures is building up. The 'Big Move' project in Amsterdam encouraged patients to improve their fitness, and doctors' visits fell by 50% in a year. The United Nations Economic Commission for Europe takes the view that measures to improve health would not cost too much and could be implemented locally and collectively.

**Sweden** has tried out a system of preventive home visits to elderly people before they need care, and found it to be very helpful, said **Niclas Jacobson**.

**Jozef Pacolet** pointed out that good social care can prevent the need for health care. In the Flemish province of Limburg, 9% of residents use home nursing compared with a general average of 6%. And whereas 4% on average are in residential care, in Limburg the figure is only 3%. This means one person in 100 staying out of an institution, and more people being supported. Providing services at an earlier stage can avoid increased costs later.

**Anne-Sophie Parent** agreed that cutting social care is likely to lead to more accidents and higher health care costs. Member States must consult and explain when making changes.

Other points raised: There needs to be a more positive approach to LTC based on what people *can* do, also taking account of friends and neighbourhood, not just family.

## Boundaries between long-term care and related schemes

In Austria there are clear boundaries between health and LTC. **Max Rubisch** was not in favour of combining services since there are many funding problems in the health sector and there would be a danger of siphoning money away from other services. At the same time, the need for close cooperation does not always function well, for instance after patients are discharged from hospital. More systematic care management is required in transition situations.

**Caroline Glendinning** pointed to a number of grey areas. For example in the Netherlands and England, domestic help is no longer covered by collectively-funded care arrangements. Secondly, LTC policies in some countries are universal and cover people of all ages, but there is a tendency to neglect their needs under an agenda driven by demographic change and population ageing. Evaluation of the recent individual budget pilot projects in England showed that it is cost effective and popular with younger disabled people, but the outcomes were worse for older people. In England, current policies are emphasising the importance of flexibility, choice and control over the content of long-term social care services. There is also currently a great deal of pressure, particularly from disabled and older people's organisations for funding and services to have wider coverage, with some degree of universal coverage.

The total volume of resources for LTC are fragmented between the National Health Service, local authorities and social security. Ten years ago the law was changed to relax the funding boundaries at local level. Local authorities and health organisations can now pooled budgets to fund specific services (for example after hospital discharge). The experiences of many other countries shows that a single funding stream for LTC (including both social and health care elements) is easier for central government to manage; however, there is always a danger in such situations of healthcare getting a bigger share.

**Mireille Goemans** from the Federal Public Service "Social Security" in **Belgium**, explained that a few years ago the Federal Government decided to limit the number of places in rest homes for the elderly, while increasing the quality of care and staff. Therefore, in 2005, it decided to devote a budget equivalent to the upgrading of 28 000 beds in rest homes to beds in nursing homes over the period 2005-2011. However, in order to maintain frail or dependent elderly persons at home, 20% of this budget must be devoted to the financing of alternative forms of care in support for the elderly at home, such as day care, short stay, but also to the financing of new structures of care such as crisis' care facilities, new care functions such as case management or counselling, new synergies or new housing schemes. These projects were to start on October 1, 2008, but they have been delayed to one year for institutional reasons.

In **Poland**, until 2004, care homes were funded by the state and home services by local authorities, explained **Anna Prekurat** from the Polish Ministry of Labour and Social Policy. This meant local authorities put people into homes, to reduce their costs. After 2004 a co-payment rule applied, leading to a rise of 10,000 in the number of people living at home, between 2004 and 2007.

**Phil Madden** was concerned that by redefining needs and tightening criteria, authorities make it harder to obtain services, especially for the less articulate and people with language problems. Some people who should receive support do not get it – how can this be addressed?

**Jozef Pacolet** felt that European economies are rich enough to afford to expand services. Domestic help is the first line of need when people become dependent. The UK is discovering that you cannot maintain two systems: one means-tested and the other free at the point of

delivery (the NHS). Fifteen years ago, it would have been unthinkable to expect people to work all their lives and then sell their houses to pay for care. Unless social insurance for LTC is improved, it will create a market for private insurance which will not meet needs.

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

and [http://www.coe.int/t/dg3/socialpolicies/socialrights/default\\_en.asp](http://www.coe.int/t/dg3/socialpolicies/socialrights/default_en.asp)).

### Impact of the economic crisis

Regarding the problem of recruiting care workers, several speakers noted that in the short term the economic crisis may lead to an increase in people seeking jobs in the care sector as other forms of employment become scarcer. However, this extra demand could fall again when economies start to recover.

In the **Netherlands**, the financial crisis is accelerating the debate on where to draw the line between services paid for by care insurance, and normal living expenses (e.g. accommodation). A working group in the Dutch Ministry of Finance is putting this on the agenda for review of future sustainability.

In **Estonia**, emigrants are returning home because the financial crisis is reducing job opportunities in other parts of Europe, and creating a demand for work in the care sector, so it may have a positive effect on LTC.

The crisis may not last long, said **Jozef Pacolet**. However, if it goes on for 10 years, it will weaken opportunities to enlarge social protection, and in **Belgium** social policy will become more difficult. For example, subsidising early retirement will be unaffordable in future. Belgium has introduced a system of vouchers, taken up by 600,000 people over the last five years. They can be exchanged for home help (80% of total cost), are not means tested or taxable, and are therefore even more beneficial for people on higher incomes. This sort of scheme will not be affordable in the future, either, but cutting it back is not easy.

**Max Rubisch** said that costs of long-term care are increasing in **Austria**, especially for social services. Local authorities, who are responsible, have tight budgets and are asking for assistance from the Austrian federal state. The budget for 2009-2010 is currently under discussion, and in the crisis there is doubt whether a new plan for the state to subsidise services will be put into effect.

In the **Netherlands**, according to **Floris de Boer**, it is widely expected that there will be cuts in public spending which will affect LTC. However some people are optimistic. For example the Phillips company is switching manufacturing from televisions to medical devices and ICT for the elderly, indicating that industry detects a market in this area.

**Anne-Sophie Parent** said income from both direct and indirect taxation is falling. How can local authorities sustain their budgets? Prevention helps to keep people in their homes, and it is important to avoid them ending up in the wrong place – i.e. costly residential or health care. Belgium is planning a pilot project to get people out of residential care. The French Health

Ministry has a health counselling scheme for 50-70-year-olds. In Sweden, a prevention campaign showed older people how to avoid risks, e.g. how to decorate a Christmas tree without falling. Even in a crisis, laws guaranteeing people's entitlements remain the same, she insisted.

In **Poland**, said **Anna Prekurat**, the government has put €285 million into a 'social solidarity reserve' to help local authorities bear social expenditures. Taxes have been lowered this year so it will be impossible to find extra resources for LTC.

The national budget in **Hungary** is in a bad condition, largely due to tax evasion, explained **Ákos Erdélyi**. Out of 10 million people, 4 million pay personal income tax, of which 1 million contribute 90% of personal income tax revenue. The government is taking steps to counter this problem and if they are successful there would be no need to cut spending. Charges are already high and so cannot be increased.

**Romania** has not felt the full impact of the crisis yet, judged **Carmen Manu**. The minimum wage has increased, and the state is continuing to subsidise NGOs. Child and family allowances, funded by the state, have been substantially increased (ex. the allowance for raising a child 0-2 years aged represents 85% of the parent wage, being delivered during 2 years of parental leave). The health system reimburses up to 90% of the cost of medicines for chronically ill persons and elderly people.

**Phil Madden** was concerned that the social consensus is fragile in every country, making it important to defend the integrity of people's rights. It could be argued that countries have talked themselves into the economic crisis, and there is a danger that they might equally argue themselves into accepting cuts in social protection as a result. This would be dangerous.

In the **UK**, the majority of people who were consulted as part of a Government engagement exercise said that, they wanted a collective solution but people were less willing to support options which would have required them personally to make a contribution. Two options exist: bringing in more funding through higher taxation or prioritising those most in need. But there is a risk that room for decision-making could become much more limited as a result of the economic crisis, said **Alexandra Norrish**. She pointed out that people over 65 own nearly £1 trillion worth of housing equity. How can they be persuaded to invest in adapting their homes, for example? £22,500 is the threshold beyond which people must pay for their own care, but questions are being raised about using a proportion of this housing wealth to create an insurance pool, for example.

Some other participants were critical of this trend. **Jozef Pacolet** said if people have to use up their assets to secure care, they have no insurance at all. **Heinz Rothgang** agreed that people who have worked all their lives should not have their assets taken away. Under the UK system, people have to help themselves, and the state only steps in for the very needy. He believed there were many better ways of raising money than using up part of the individual wealth. **Anne-Sophie Parent** wondered how universal access could be reconciled with means testing. Some older people would be frightened to claim support for fear of losing their home. She suggested a cap on the amount of money or the property authorities could claim. But **Roland Bladh** saw the proposal merely as a way of encouraging wealthy older people to make a contribution.

Other points raised: collective services are easier to cut or ration at times of stringency, without society being aware of it, than cash benefits which people regard as a right. Tax-funded schemes are also more vulnerable than social insurance at times of economic crisis. Prevention may not

be an answer to the crisis since it helps people to live long and potentially incur more costs.

### **Relevance and key learning elements for peer countries and stakeholder representatives**

**Heinz Rothgang** said that the host country had posed three principal questions, concerning:

1. The role of professional care workers and how to tackle shortages;
2. The funding of long-term care;
3. Where and how to set boundaries between health and social care and collective and individual responsibilities.

### **Care workers**

In the Netherlands, projections for the number of care workers required up to the year 2040 vary from 14% of the workforce, to a worst case scenario of 21% of the workforce, influenced by variables such as productivity and working hours. In other countries the time frame differs – not all Member States have problems yet. However, demographic change will lead to increased demand for workers, creating problems in the future.

It is possible to influence both demand and supply:

- Demand – through prevention, better healthcare, special measures such as the 're-ablement' scheme in England which helps people to recover skills and be more self-sufficient in their own homes. Informal care and the voluntary sector also have an important role. Some countries rely heavily on family members, others – such as Sweden – depend more on professional workers. But family patterns are changing, suggesting challenges in future. Getting families and the voluntary sector more involved diminishes the problems.
- Supply – referring to the previous day's presentations, Mr Rothgang recalled proposals for raising productivity, getting more people into the services and keeping them there. In the Netherlands, there are efforts to market careers in the care services better, and to 'head-hunt' by writing directly to women who may be interested in working as carers. Most significant is the 'image problem', and steps are needed to make the job more attractive, especially to young people, through boosting social recognition, career opportunities and pay, and above all lessening pressure on workers.

He turned to the question of migration of care workers, and the interests of both 'receiving' and 'exporting' countries. There is evidence that not all countries are eager to import workers from outside their borders – and he referred to the Netherlands Secretary of State having refused the offer of immigrant labour because Dutch residents prefer local people, and there could be language difficulties. In this context, however, the regulation of working conditions is very important.

Austria, another receiving country, has found that incoming workers do not leave their home country from choice, but from necessity. Therefore, exporting countries could consider offering incentives to encourage qualified workers to stay, such as student loans during training that could be written off if the individual stays on to work in the home country for a specified period of time.

It was noted, also, that the current economic crisis might have a beneficial effect on care work by attracting people who lose jobs in other sectors.

### **Public/private financing**

There is no one-size-fits-all solution, said Mr Rothgang. However, he believed there was consensus in favour of universal coverage and equal access and opposition to two-tier arrangements. He sensed the overall view that private insurance cannot be the backbone of the system: if it is risk-related it does not offer universal care provision, and if it is compulsory it thereby becomes a form of social insurance. Another option is tax-financing. But the general tendency was in favour of some form of social insurance system, which to be sustainable must include the whole population, with everyone paying premiums levied on all kind of income.

Social insurance also gives greater protection at times of financial crisis since services are not so vulnerable to spending cuts. Although laws may offer legal entitlements to care, such laws can be changed.

Mr Rothgang queried current trends. Are services declining because of re-privatisation? There are, however, some positive signs of greater collectivity. Problems may also arise from the exclusion of certain benefits such as domestic help from care provision. What is the role of means testing? Should public funding only step in once personal wealth has been spent? He noted that different countries have different attitudes to means-testing.

### **Setting boundaries**

In the Netherlands, AWBZ spending has increased rapidly, and the government is interested in what measures other countries are taking to avoid such rises and to control budgets within specific areas (healthcare, long-term care, housing support etc.). How can 'crystal clear' boundaries to entitlements be established? However, Mr Rothgang noted that the Peer Review had tended to discuss how to erode boundaries that obstruct integrated care, in effect reversing the theme as set out. Participants had also warned of the danger of health care taking precedence over and attracting funds away from long-term care.

He drew attention to the personal budget scheme operated in some countries, including the Netherlands, where payments may be made to family members. On the other hand a German pilot project excluded payments to family carers. Some important questions remain, including: who can receive payments? Should they be restricted to trained carers? How does society control the system? And most of all, how can quality of service be measured and guaranteed?

### **Closing remarks**

**Roland Bladh** said the Peer Review had three objectives:

1. to respond to the demand from authorities in the Netherlands and other Member States for a debate on the three core questions on the agenda;
2. to allow for an exchange of information between the participants;
3. to offer information and guidance to the Commission which will in turn feed into its ongoing work on social protection and social inclusion, and the Joint report on Social Protection and

Social Inclusion prepared with the Member States. Since the 2009 report will appear shortly, the current review will form part of the document to be published in early 2010.

He highlighted a series of forthcoming events that will carry forward the debate:

**25-26 May**, in Prague, the **Czech Presidency conference** will focus on elder care, fostering dignity and avoiding abuse.

**5-6 May, in France**, there will be a Peer Review on the topic of dementia, Alzheimer's, and how to provide care, following on from the French Presidency conclusions suggesting that Member States need to develop action plans in this area.

A further Peer Review in **Brandenburg, Germany**, will look at health care services in rural regions with declining populations.

**15-16 September** in Sweden, a **Swedish Presidency conference** on *Healthy and Dignified Ageing* will address the questions of elder care and setting boundaries.

Mr Bladh said the question of the care workforce is a difficult one, but the Commission has started working on it through a *Green Paper on the EU Workforce for Health* and an open consultation launched on 10 December 2008. ([http://ec.europa.eu/health/ph\\_systems/workforce\\_en.htm](http://ec.europa.eu/health/ph_systems/workforce_en.htm)). He urged anyone with opinions on the problems and potential solutions to take part via the website, adding that short, concise contributions are most effective. The deadline for responses is 31 March 2009.

**Niclas Jacobson** explained that the Swedish conference reflects the priorities of the Swedish Presidency. It will discuss the issue of bringing health and social care together and developing better cooperation and integration. The Swedish Presidency would like to make the issue of elderly care and ageing more prominent on the European agenda. Discussions have taken place, but always on an ad hoc basis. It could be useful to set up smaller groups of experts to meet regularly.

The conference will be looking for solutions to the questions raised by integration and boundaries. There will be different workshops focusing on healthy ageing, staffing, and many of the other issues covered by the Peer Review.

**Iris van Bennekom**, closing the meeting on behalf of the Dutch Ministry of Health, Welfare and Sport, said that she and her colleagues had had high expectations of the Peer Review, and that the input from participants had been of such high quality that they were more than satisfied.

Although the meeting had not set out clear guidelines for reform, that was not necessary. It is evident that long-term care must be affordable and sustainable, but that does not mean that everything must be governed by a single system. It is more important for different sectors and services to communicate, with the aid of good coordination and collaboration, than for everything from domestic help to residential care to be brought together into one system.

She said the meeting had heard interesting examples of good practice, such as the German scheme for nurses to be trained in case management, the British programme of re-ablement at home, and examples from Romania, Poland and other countries. She promised that the Dutch ministry will evaluate the Peer Review, together with the Commission and the thematic expert. Some aspects deserve to be examined more closely, in particular personal budgets, financing of prevention, and matters of empowerment.

“Let's not forget there is no one-size-fits-all solution and we don't need a universal, European long-term care system,” concluded Ms Van Bennekom. Each system has its own values, and comparison can be a stimulus for improvement.

She thanked all the Peer Review members for their active participation and promised to keep in touch. The gathering could be the basis for an informal EU network on long-term care, and information exchange will be especially necessary throughout the economic crisis.