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Closing the gap – in search for ways to deal with expanding care needs and limited resources

Synthesis Report

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Executive summary

This paper summarises findings from discussions at and papers for a Peer Review held in Stockholm on 20-21 October 2011, hosted by the Swedish Ministry of Health and Social Affairs. In addition to the host country, seven peer countries were represented: Bulgaria, Cyprus, Denmark, Estonia, Germany, Luxembourg and Slovenia. Represented as stakeholders were Caritas Europa and AGE Platform Europe. Taking part for the European Commission were representatives of DG Employment, Social Affairs and Inclusion.

Increasing shares of the older population, changing societal models and labour markets will result in a considerable gap between demand for and supply of health and social care for the elderly unless major reductions in the care system can be achieved. On the demand side, the Swedish approach to close this gap builds on prevention, measures to increase self-sufficiency and reduce functional dependency, while the supply side is to be strengthened by workforce development and support as well as support for informal carers. Increased efforts in data collection, evaluations, and broader use of technological solutions including those based on information and communication technologies are expected to increase efficiency and quality of service provision. The discussions at the Peer Review supported this approach, and highlighted the necessity of a change of mind set towards a more holistic approach. Estimates for Sweden suggest that this approach to bridge the forecasted gap in long-term care service provision and financing has the potential to favourably affect four of the five Europe 2020 targets (75% employment rate, 3% investment in R&D, reduced percentage of cohorts without education and training, reducing people at risk of poverty and social exclusion).

Part A. Policy context on European level

Currently, **no common European model** for provision or financing of long-term care (LTC) can be identified. Nations differ along the lines of importance of and support for informal care, the shares of public vs. private finance and provision of care, the role of cash benefits vs. benefits in kind, and different degrees of generosity and accessibility of their care systems. Depending on the main variables chosen and the scope of the systems under consideration, national systems with similar characteristics can be grouped in different ways (see e.g. Kraus et al. 2010, Esping-Andersen 1990). There are, however, some common denominators for the **challenges** that all care systems for the elderly in Europe will face during the coming decades:

The European population is **ageing**, albeit to different degrees in individual Member States. The European Commission estimates the share of public spending for LTC in GDP to increase from 1.2% (EU27, 2007) to 2.4% (2060, reference scenario; see European Commission 2009). Changing societal models like declining family size, changing residential patterns and increasing female participation in the labour market will affect possibilities for informal care provision, while later generations might approach services with higher expectations regarding service levels and quality. Currently, between 1% and 2% of the total workforce is employed in LTC in developed countries. Existing projections for European countries suggest that this share will increase considerably during the next half of the century, with limits on its expansion on the supply rather than on the demand side. Without effective countersteering measures, these developments will open a gap in care provision which calls for efficient strategies to delay care needs while increasing the relevant workforce and their productivity.

Care for the older population is highly **labour** intensive. At the same time, this work is often and for most countries characterized as a low-pay, low-status but very demanding kind of work. Moreover, there is wide international as well as intra-country dispersion of wage levels and working conditions, e.g. between public and private sector or between home care and nursing care homes. Consequently, elderly care in many countries experiences high turnover rates and / or recruitment problems. (Simonazzi 2009, Fujisawa, Colombo 2009, OECD 2011)

In many European countries the current workforce in this sector can be characterized as predominantly female, somewhat older than the average workforce, and with higher shares of all three: low-skilled, foreign born, and part-time workers, compared to the average workforce. Additionally, in several countries there is a considerable number of immigrant workers with uncertain economic and legal prospects, mostly as domestic help. (Simonazzi 2009, Fujisawa, Colombo 2009, Geerts 2011)

The literature suggests basically three strategies to secure the availability of future LTC workers (OECD 2011):

- Improve recruitment efforts, including traditional as well as new recruitment pools;
- Increase the retention of successfully recruited LTC workers, by improving wages levels and working conditions in the care sector; and
- Seek options to increase the productivity of care workers.

Economic theory distinguishes basically five types of **financing models** for LTC systems (Wittenberg et al. 2002, Fernandez et al 2009): Private systems with or without government subsidies place rather high financial burdens on individual care recipients and their families and show a tendency for unmet need; they are usually not considered to suffice for the standards aspired by European social policy. Of the remaining options, the mere provision of a safety net can still place high financial burdens on larger population groups, but still requires considerable administrative efforts to steer resources to persons with highest need for the sake of low demands from public budgets. Total expenditure for universal funding systems are usually higher than in safety net systems, largely due to defined entitlements. Universal funding systems cover the entire population and should foster equality and social cohesion, ensuring that everyone who meets need criteria can access services regardless of their income or wealth. Funding is typically progressive and relies on a combination of earmarked contributions and payroll taxes. Often user charges play a role with certain services. In social insurance systems of this type, total expenditure is typically rather needs driven than budget constrained, while tax-funded systems more easily employ expenditure constraints and eligibility criteria. Progressive universal funding systems try to combine advantages of both system types: Entitlements cover the entire population, but means-testing ensures that individuals in highest financial need receive the largest amount of public support, thus relieving the demands on public expenditures. Compared to safety net systems, effects for social cohesion and stigma effects are preferable.

Part B: The situation in Sweden

Compared to other members of the European Union, Sweden is currently among the countries with the highest population share with 80 or more years of age. Projections show that in the next 30 years, the largest population growth in Sweden will occur among people aged 65 or older. In international comparisons the Swedish LTC system stands out as very generous, and as using / providing a high level of formal care which is financed predominantly with public rather than private money. There is an increasing role of informal care, with high support for informal carers.

Over the past 15 years, Sweden experienced a decreasing need for help among the older population while the incidence of health problems has been increasing; it is therefore unlikely that declining need for help can be explained by improving health. The more likely explanation for reduced need is seen in better housing standards and better access to assistive technology, making it easier for people to manage without help.

A key area for low care demands is improved possibilities for the elderly to stay living in their ordinary home, which can be fostered by introducing **intelligent and user-friendly technical support**. In the Swedish view, LTC is a far more promising area than health care for efficiency-enhancing application of technologies. Over a period of six years, the Swedish Government has been supporting the development of products and services which can assist older persons and their carers in their everyday lives. The initiative will continue until 2012 and supports 130 projects in the period 2007-2012. The programme builds upon a "24 hour perspective" and thus aims at keeping people independent in as many everyday functions as possible for as long as possible. A special focus is on a design enabling easy use also for special requirements of many older persons (e.g. diminished eyesight).

A similar purpose is served by a **tax credit for household services**, which makes household services cheaper by up to 50% and which turned out to be used most frequently by women aged 85 years or older.

Leverage effects as identified by demographic and medico-economic models are clear and decrease of morbidity should be a major objective for decision-makers (see LEV Project).

The Swedish Government has decided on an initiative for **active and healthy ageing**. Local authorities are to be inspired to cooperate with NGOs to create health promotion activities. Furthermore, health coaches should support individuals with small health problems to adopt a healthier lifestyle.

As elderly care is highly labour intensive, skills and good organisation and practice of care work are of major importance for efficient and high quality care. The currently observed shift towards more care provided in the private home changes demands placed on staff working in this setting of care. The Swedish Government therefore finances a four year **education initiative** to improve the competence among staff without formal education. There are national criteria for the components that need to be covered in courses. Municipalities are incentivized to procure education courses through a bonus.

New legislation from 2011 brought in elderly care by stipulating **national core values** for the dignified care of the elderly; this initiative applies to both, public and private providers. Elderly care shall promote participation, the feeling of well-being and choice. The Act on **Free Choice Systems**, introduced in 2009, aims at facilitating market entry for private providers and thus at

encouraging competition based on quality. It is up to municipalities to introduce the system of choice; one third of persons receiving home help live already in a municipality with this system.

The National Board of Health and Welfare cooperates with municipalities and county councils to develop **open comparisons** and public performance reports on health care and social services. Surveys on service provider and user level and official statistics are used to build a wide range of quality indicators which can be used to illustrate how municipalities and county councils are scoring in different quality areas. This provides useful information for prospective services users as well as for politicians seeking to improve local service quality and can raise the awareness of staff concerning quality of care. Additionally, two **quality registers** have been developed in the area of elderly care, building on modern IT solutions and enabling participating providers to compare their own results over time and with those of others. But for the time being, registers concentrate more on health care indicators than on social care. The introduction of a performance-based grant system has increased the input to registers dramatically and improved coverage and quality of data. The next step is to promote the use of the registers for local improvements in quality by strengthening analysis capacity on the local level.

In cooperation with stakeholders, the Swedish government has drawn up an **eHealth strategy** to ensure efficient and effective use of information and communication technology (ICT) in order to promote safer, more accessible and efficient health and elderly care services. Development of a common approach and nationally established guidelines and solutions are necessary and call for collaboration of all actors in the health and care sector.

Part C: Policies and experiences in peer countries and stakeholder contributions

In compliance with the Europe 2020 strategy, the **Bulgarian** government adopted a National Reform Programme (2011-2015) in 2011, translating European targets into national targets tailored to Bulgarian challenges. This programme includes e.g. the sub-target of reducing the number of persons aged 65 or above living in poverty by 52,000 which is to be achieved by a combination of measures: develop a national concept for active life of the elderly, create a network of LTC services, and increase the adequacy of pensions. Bulgarian activities to protect public health follow three general approaches: education and information of the population, prophylaxis of diseases and health protection. A noteworthy national prevention programme aims at limiting osteoporosis (2006-2010). The programme includes changes in reimbursement rates to the national health insurance fund, training programmes for densitometry staff along with a random community screening of 2500 Bulgarian women, and an epidemiological survey (2000 women) to investigate prevalence and risk factors in the general female population 50+. Currently, a second national programme against osteoporosis as well as a national concept for active ageing are in preparation. The Bulgarian Red-Cross in cooperation with relevant ministries started to implement a project "Home care towards independent and dignified life" (October 2011-March 2015), which is one of the measures aimed at improving quality and developing a home care sector.

A scheme to improve the quality and effectiveness of social work is currently being implemented; it builds, among others, on improved cooperation and interaction between institutions and on vocational training and upgrading of personal qualifications and skills. In the area of informal care there is a recent scheme enabling an unemployed family member to work, after some training, for minimum payment including social insurance as personal or social assistant to a disabled family member. One component of this model includes also other persons than relatives as care providers. The Bulgarian long-term care system is refocusing from mainly institutional to more community and home-care based by introducing more services of the latter kinds. The number of private providers has gradually increased. Furthermore, better cooperation between health and social services has been identified as one of the priority areas for the next few years. In terms of financing, a decentralization of financing accompanied by an introduction of some unified standards aims at increased private provision of services, thus increasing quality and choice opportunities for clients.

In **Cyprus**, elderly care is provided by public as well as by private institutions, but concentrates more on therapy than on prevention. In 2004, the Council of Ministers took the decision to elaborate and implement a 10 Year Action Plan for the development of health care services for the elderly. Five priority areas including health promotion and prevention were chosen, but since 2005 only a partial implementation of the action plan took place. Due to the economic crisis, revisions, new prioritization (e.g. use of e-Health, more targeted approach) and consequently reallocations of resources are under way. In order to foster care provision at home, there is continuous development and investment in community nursing; training of employees in the private sector, however, is not organised on a regular basis. There is no public provision of respite care or aftercare.

The system in **Denmark** shares several characteristics with the Swedish one, with home-care being at the core of Danish elderly care. Municipalities are obliged to offer personal care and assistance, but also support for necessary practical work in the home, regardless of the

recipient's type of accommodation. User charges can be applied only to users of temporary, not of permanent home-care, with the charge per hour depending on income. Since 2003, there needs to be choice between public and private providers of home-care services. As opposed to Sweden, Danish municipalities have to create the framework for this choice.

In recent years, several projects focused on enhancing monitoring of quality: Elderly care was chosen as the first area of attention of a project to improve, simplify and secure more coherent documentation on central areas of public service, initiated by the Danish Government and the association of Danish municipalities. Since 2008, this monthly data collection covers 7 indicators concerning effects and 16 background indicators on elderly care. The same initiators are responsible for an annual national survey of satisfaction among recipients of help, covering satisfaction with quality of services, with carers and stability of help. Additionally, municipalities should employ such surveys systematically in their management and development and are encouraged to publish results. Tools to carry out comparable surveys were developed and tested and can be used by municipalities. Furthermore, a national framework of mechanisms to monitor quality in elderly care has been developed.

Preventive and health-promoting efforts are made at both, national and local levels. 90% of the Danish municipalities offer training as an alternative to conventional, more compensatory home-care services in line with a focus on rehabilitation. One of the best known models is the ambient assisted living programme from Fredericia municipality, which focuses on everyday rehabilitation and reports positive consequences for participants as well as public finances. The two main initiatives to increase the productivity of the relevant workforce are flexible task performance and task relocation between health and elderly care and a focus on welfare technology. The latter programme covers all public services (not only social services) and was allocated 400 million € (3 billion DKK) for 2009 – 2015. Ten demonstration projects in the area of elderly care have been funded; tests and evaluations in cooperation with the National Board of Social Services focus on impact on services, work environment but also productivity and economic benefits.

Like in several other new Member States of the EU, also in **Estonia** the care system for the elderly is characterized by a segregation between social care (care homes, home care services, day care centres) which is financed by local governments, and health care (including home and inpatient nursing care, geriatric evaluation) which is financed by the national insurance fund. In addition to low overall service and capacity levels, differences in financial capacities of local governments, lack of integration between the two sectors as well as of a standardized and homogenous needs assessment framework are perceived as problems. The expected increase in life expectancy and consequently in the share of the older population will presumably aggravate these problems. Current discussions ask whether the local government should remain responsible for financing, organising and providing these services. As many municipalities have low numbers of inhabitants, not all local governments offer all the services they would be legally obliged to supply. It seems that not so much the appropriate training, but rather the scarcity of (human) capacities is perceived as a challenge, even though better and standardized needs assessment frameworks and services remain on the agenda.

German long-term care insurance is a social insurance of the pay-as-you-go type and almost entirely financed by contributions and premiums; in the public branch there are nationally uniform contributions of 1.95% of wages (2.2% for childless persons) subject to an income ceiling. All the population is covered; high-income persons may opt into the private system. There are three defined levels of need for care which determine the level of granted benefits, thus benefits are irrespective of age, income or wealth. All insurance benefits are capped; the aim is to provide

coverage for basic LTC needs, but not all expenses for LTC. The basic principle in LTC insurance is “rehabilitation before care giving, care giving at home before institutional care”; this principle is understood as preventive approach. Being already in a situation with declining overall and rising share of older population, Germany has already been collecting experiences with practices to attract and retain LTC workers like recruitment from specific target groups and measures to improve job status. The latter includes diverse measures like developing national curricula, new job categories and a minimum wage floor.

Informal care giving plays a significant role. Several measures to support informal care givers are in place; the reform 2008 introduced additional measures like improved counselling and support bases and a possibility to take an unpaid leave from the job for a period of up to six months.

Since the introduction of the LTC insurance, the number of professional home-care services has significantly expanded, with an even more expanding share of private services and an increasing average number of clients per institution. The 2008 reform included a raise of the contribution rate, but this step is not expected to ensure the long-term financial sustainability of the LTC system. Measures to avoid additional demand (like preventive home visits in Denmark), measures to improve cooperation between settings of care (LTC – health care, nursing home – home care), and last but not least continued if not increased efforts to attract and retain human resources are deemed necessary as well.

In **Luxembourg**, LTC insurance has been a branch of compulsory social security since 1998. It is financed from contributions (1.4% of active and retired persons’ incomes alike), and supplemented by a state contribution (30-35% of total LTC expenditure) and a contribution from the electricity sector. In accordance with the dependency level, a care plan is elaborated which contains the services the dependent person is entitled to. All those services are entirely covered by LTC insurance. Dependent persons are entitled to assistance with ADLs and, depending on the level of care needs, with household tasks and other support including support for an informal carer. For dependent persons at home, LTC insurance covers help and care provided by a so-called care network (a professional service under contract with LTC insurance, they may also cover health services, not only LTC) or by a semi-stationary centre, or covers pension contributions for informal carers who are not yet receivers of a pension.

The 2010 health care reform aims at improvements in service quality as well as reduced demand for health and LTC service needs. Improving the links, communication and cooperation between relevant actors are seen as major challenges. In this vein, a national e-Health plan (eSanté) was adopted which is going to support multiple projects; the first two of which involve radiologic imaging and laboratory analysis. Luxembourg is trying to respond to the future challenges by introducing new ways of delivery of health services, putting health professionals and their continuing professional and vocational education into the centre of efforts.

Regarding human resources, Luxembourg is in a somewhat different situation compared to other European countries. As Luxembourgish wages are above those of neighbour countries, it has been easy to attract non-resident workers from there, resulting in a large share of migrant workers in LTC, even though sometimes there seem to be language problems involved. These language problems hopefully will be mitigated soon: Several care providers including the largest (SHD) are working on implementing a software solution for the managing of care data, including a multi-user application customizable to different user groups which can be combined with a multi-language user interface. This solution is hoped to deliver a series of benefits, but will require additional training for health workforce. To ensure financial sustainability in the short term,

government contributions will be adjusted. For the long-term perspective, a revision of the respective law is planned for 2013.

Slovenia is currently lacking an integral system for LTC, with relevant regulation scattered over several fields (health, pension, disability, social assistance). Cash benefits and residential care are organised centrally while home care services are provided on a local level. A new law is in preparation but has not yet passed the legislative process.

Home care services are currently less developed, while a somewhat higher share of the 65+ population receives LTC in an institutional setting, compared to the EU average. There is already a considerable excess demand for services, notably residential care places, and more increases are expected due to the demographic development. Funding for LTC stems from public (75%; from compulsory social insurance and taxes) as well as private (25%) sources, 31% from public funds is paid in cash in various benefits, e.g. municipalities can provide some compensation for a loss of income of informal family carers. Benefits in kind are income-tested.

The **AGE Platform Europe** stresses that an adequate level of investment in health promotion and disease prevention over the life cycle as well as the mainstreaming of health in all policies are needed. For effective disease prevention, training of healthcare professionals and their knowledge about geriatric issues will be key elements. Increased efforts to form an age-friendly environment can serve to provide several positive aspects at the same time: prevent accidents and social isolation with possible positive side effects for mental health, reduce levels of dependency and possibly extend the duration of active labour market participation.

AGE Platform Europe corroborates the importance of measures like (European recognized) training, certification, continuing support programmes, and improved payment and working conditions to increase the status of formal carers. Development of more flexible (e.g. family friendly) working hours, better protection of carer's health and new job profiles and qualifications (enabling inter alia higher mobility between care sectors) additionally may increase the attractiveness of jobs in the care market for national and migrant workers alike. Introducing ICT and assistive technology could help attract more younger and male care workers.

For informal carers, AGE believes there is need for EU legislation to ensure carers' leave to better enable them to balance paid work and informal care. Current developments are underlining this need: The increasing age at which families are started means later generations of informal carers will be affected already in younger ages than current informal carers, and the economic crisis and resulting shortages in public budgets will leave more older persons with higher and more complex needs living at home. Adequate supply of child and innovative eldercare solutions are viewed as a prerequisite to reaching the 75% employment rate required in the Europe 2020 Strategy. With regard to quality of care, AGE refers to the voluntary European Framework for Long-term Care (WeDO Project), which encompasses quality of care as well as quality of work.

Caritas Europa draws attention to migration issues: In spite of the high share of foreign born LTC workers in many European countries, legal channels for migration into the EU are limited and/or complicated and prefer highly skilled workers, which only to a lesser degree corresponds to projected needs of the LTC sector. Migrants from poorer EU regions often end up working illegally, especially in informal domestic settings, despite their right to free movement and to work in another EU country. These areas should be addressed through policy interventions with an overall strategy aiming to improve access to the labour market, recognition of qualifications, recruitment and increased retention of LTC workers. Caritas Europa regards recent Swedish

rules in this context as an important step in this matter, and recommends to regulate transnational recruitment agencies in order to eliminate abuse and trafficking of workers. In a similar vein, eliminating precarious working conditions constitutes an important step in improving recruitment and increasing retentions of workers. This aspect applies most importantly to the domestic sector.

With regard to informal care, also Caritas Europa underlines the need for a right to leave to protect carers from the risk of unemployment and of reduced income both during their working life and retirement.

Furthermore, Caritas Europa sees favouring non-profit care providers over for-profit ones as a means to improve quality of care due to different business principles in both segments of the market. There seems to be potential, however, for non-profit providers to benefit from more business-like processes, like modern human resource management procedures or work organisation. Measures taken to strengthen financial sustainability need to support different income groups according to their means, i.e. the lowest income quintile should be reached first and foremost by welfare transfers.

Part D: Discussions at the Peer Review meeting

The discussions during the meeting focussed on **efficiency enhancement** within the current care systems in EU Member States, particularly through **prevention strategies, evaluation and data collection**, as well as on **workforce development and support, stakeholders' contribution** to the care system and **technological support** for the elderly. The **Swedish approach** found much support and encouragement, especially the approach to focus on prevention, quality care and an age-friendly society rather than on optimal financing of an isolated LTC system. However, the different position of countries due to different historical developments was called into consideration. The large and active role of the government is traditional and widely appreciated in Sweden. A similarly large role may be less appreciated by populations of countries with a very different national history. Populations of such countries may continue to feel more reluctance to put most or all regulation, monitoring and provision of personal care to national authorities. Differences in peoples' attitude and trust towards public authorities have to be taken into account when nations learn from the Swedish approach.

A lively discussed topic was **prevention**. The presentation on this topic highlighted, among others, the beneficial effects of an active life style and the need for prevention to start already while a person is in his/her forties. Peers from several countries reported on programmes or initiatives, like Germany on an intended strategy focusing on workplaces in small and medium enterprises, Luxembourg on a diabetes prevention plan for the young, or Bulgaria on the 2011 priority programme for persons aged 65 or above in poverty. The following discussion brought up a series of aspects:

- Rehabilitation is also possible at old age. This seems to be not sufficiently known and therefore leads to larger than necessary dependency.
- Prevention is often a process taking longer periods of time, which can make it a costly procedure. There is, unfortunately, still a large need for studies on cost-effectiveness of existing measures.
- Several cheap measures exist already, e.g. to reduce the risk of falls, which again often are the starting point of later dependency. There are e.g. positive experiences from France with automatic lighting fixtures to prevent falls during the night.
- Active ageing can be supported by very different measures, including special areas in public places (compare the attitude to common gymnastics of the elderly in China, and playgrounds for children around the world) as well as nursing homes for activity of older citizens, later retirement (paid work provides motivation, which is one of the most necessary prerequisites for activity), projects to link the old and the young generation (e.g. in a Slovene project young people from schools support seniors in IT use).

A recurrent topic in discussions was that we need a **change of the mind set**. We need to remind ourselves of the capacities and resources of the senior generation. (Severe) need for care or support is concentrated in a small share of a large population group, while large shares of the old population still can enjoy rather good health. Therefore, there will also be a growing number of more or less healthy persons, and already today by far more informal care is being provided by peers (mostly spouses) than by younger family members. More focus on the capacities of the older generation than only on their needs (and involved costs) would be appropriate in the care discussion: e.g. different forms of networking (from seniors cafés to informal senior ICT

communities) might still represent an underutilized but promising resource. As examples for possible prevention measures show, a limited focus on the “core” LTC sector grasps only parts of potential improvements and would not yet lead to the desired more age-friendly society. The European Commission emphasized the potential role of LTC as an employment opportunity, and as a possible entrance to the labour market, also for persons with low levels of formal education.

Current and prospective future **workforce** for care was another recurrent topic. The discussion corroborated the impression that informal care will continue to be the most important group of carers in many countries, even when declining family size, a rising age to start a family and rising retirement ages will increase difficulties to balance informal care and employment. Several forms of support, including education of informal carers, will have to gain much more attention.

The discussion showed consensus, that major improvements for job quality in the care sector (pay, reputation, education, other working conditions) are due in several countries. Education will remain a key issue not only in Sweden; there are already various education programmes under way (e.g. Bulgaria: for family carers, Germany: 3 year training programme, Slovenia: programmes focusing on different age groups). Modernized legislation may also come into play here.

The in some countries large role of illegal (mostly migrant) work especially in domestic care will also need attention and will need to be addressed in a proper labour migration policy.

There was, however, some discussion on two topics: One being the role of part-time employment (Is its extension desirable in order to recruit otherwise unavailable workers, or is current part-time work a “waste” which can be avoided by switching more workers into full-time employment?), the second concerns qualifications for low-skill care workers: How much skilled versus unskilled labour will be necessary, and how much education or training is sufficient to provide quality care in the realm of more basic tasks?

The problems of insufficient availability of relevant **data** resulted in strategies for more comprehensive, comparable and efficient data collection programmes, typically as part of an eHealth initiative. Due to the large gaps in information suitable for evaluations and forecasts, there still seems to be large room and necessity for further work, including proper dissemination of results on what works under which circumstances and what not.

A general feature of the discussions was the close **connection and interrelation between several key issues**, which corroborates the often repeated call for a holistic approach:

- Better education of (nursing) work force has a potential not only to increase quality of care, but also to increase retention of staff; both may contribute to reduce the cost of care.
- Active ageing may not only reduce the need for care, but may also increase the ability to support peers and thus contribute to close the gap in human resources.
- More wide-spread application of technical aids (simple mechanical as well as ICT use) may not only improve the efficiency of care, but also improve recruitment from other than the traditional recruitment pools, e.g. increase recruitment of younger and male workers.

Part E: Conclusions and key lessons

A number of **key lessons** emerged from the discussions:

- Micro-simulations based on administrative data - as in the Swedish case - can allow Member States to estimate the probable size of the future care gap. Such scenario building would also allow policy makers to test the relative importance of alternative strategies to reduce or close the gap.
- Estimations for Sweden found that no single instrument is capable of closing the gap and that concentrating on alternative financing forms offers particularly limited prospects. But the estimations also show that a combination of smaller but systematic effects can close the gap, including improvements in productivity (both capital substitution and better organisation), efficiency, healthy ageing, the recruitment, retention and training of carers, the ability of frail older people to manage their disabilities well enough to live independent lives thanks to assistive technologies etc.
- A clear **order of preferences** is needed when choosing possible ways of closing the gap between future care needs and scarce resources:
 - Efforts should first be made to **improve the efficacy of existing systems**. There is still some slack within them, due for instance to historical work organisation, or insufficient use of technical equipment and ICT. In some Member States like Sweden, models have shown that slight increase in productivity of existing systems have the capacity to meet the needs of the population without increasing the share of medicale expenditure in GDP (see conclusions of LEV Project).
 - At the same time, efforts should be made to **reduce the demand for services** through **increased prevention and health promotion** efforts.
 - **Modern support techniques** should be utilised more fully in order to improve the **self-sufficiency of older people** in need of care.
 - Only then should we think about **increasing public expenditure on long-term care**.
 - **Cutting services** or **increasing user charges** should be considered as last option.
- **Preventive measures** are urgently needed to reduce the incidence of diseases, which otherwise are predicted to become the major challenge in health care costs. There are currently only a few **prevention implementation studies** to guide selection of the most efficient way to reduce risk factors. Prevention needs to be implemented at different stages of life, depending on current health profiles of the different age groups in the existing population. Focus on pathologies must be designed accordingly. However, it seems that achieving full efficiency requires prevention plans to **start in middle age** in order to encompass the major groups at risk. It is also essential to act on relevant risk factors (diabetes, hypertension, obesity, etc.) to avoid further deterioration of health status and corresponding long-term care needs. It should, however, be borne in mind that **prevention also generates costs**, but there are still not many studies on their costs.
- We have only a small window of opportunity before the **demographic effects** of ageing are fully felt. So we need to **collect more evidence now** and **disseminate** the results on a very broad basis.

- The **cost-efficiency dimension** of existing projects (especially local and community-based) and also **technologies that meet long-term care needs** should be brought forward as a support for decision-making. Evaluations need to focus on specific pathologies, in connection with a specific technique or strategy. Low-cost techniques or strategies could be promoted more specifically, in a context of budget crisis.
- **Possible resources** of which more use could be made in elderly care:
 - The **supply of formal and informal carers** could be significantly enlarged through older people's involvement in care work, which could be made into one major form of **Active Ageing**.
 - The role of **voluntary work** is important at a time when a large share of the 65+ population is still healthy. With public support and maybe some training, many more resourceful people 65+ could be enticed to help older and frailer elderly people on a voluntary basis.
 - Some retirees (especially women) struggle with low pension levels and could use an extra source of income. Perhaps, with some training, a significant share of resourceful people in this group could be **incorporated into the waged care workforce**. **More flexible arrangements for combining other income with pension** as well as for **part-time work** would be required since few people above pensionable age can be expected to work a 40-hour week.
 - **Patients as providers** are a further potential resource. More modern techniques should be used to make use of patients' own capacities to tackle their care needs and manage autonomous lives amid frailties and some disabilities. This also involves **empowering patients** wherever possible. If people – such as diabetics - get used to the idea of tackling some of their care needs themselves at a younger age, it will be easier to continue later on.
 - Obviously, the relevance of these approaches will vary from one country to another.
- Even when making better use of the above mentioned resources, **informal care** will continue to play a major role in elderly care. Probable developments on the labour market will increase the necessity for efficient support particularly for those of them who are employed.
- There is a **need to raise the prestige of the caring profession** as a whole. This could, furthermore, also help to attract more men into this profession.
- **Education** is vital to the **quality of care**. However, there are still **inconsistencies between the content of education for care work and the demands made of employees** in everyday work situations. Continuing education and career development are incentives for **staff retention**. There are also strong indications that education helps to **contain costs**.
- **Developing and supporting age-friendly environments** is also an important point to underline, not only to limit or avoid possible costs but also to improve full integration of elderly people into society. If gains in life expectancy make us define the age corresponding to the notions of "old" and "retirement age" by distance from death (average life expectancy) instead of from birth (chronological age) we could better understand how old age is being redefined by the rising average age of the population now and in future.

- A **change of mind-set** towards elderly care will be needed, involving a **holistic approach**. Rather than being seen as a burden, it should be recognised that older people represent a **wealth of experience and potential resources** that should be put to good use. In that respect, ongoing experiences and projects focusing on intra-generational (i.e. between elderly people) and inter-generational solidarity (i.e. between elderly people and other age groups) should be supported and presented to demonstrate the benefits that society can gain from elderly people's commitment.
- Countries have to strike a **balance between national consistency and local responsibility for provision**. The right level of government for financing, organising, planning and providing services is still an issue in several Member States.
- **Rising expectations** may pose even greater challenges, in the form of increased demands for services, than might be supposed from the demographic or health-related needs per se. Governments must be **transparent and honest** with the public about this issue. They must make it clear what can be achieved in future and what (probably) cannot. They must also state what the costs will be.

Contribution of the Peer Review to the objectives of the Europe 2020 Strategy

- **Preparing for population ageing** is seen as one of the challenging issues in the Europe2020 strategy. Europe faces the risk that changing demographic dependency rates might affect public budgets so much that this in turn might hamper the potential for economic growth. The challenge will be to reform social systems and practice including long-term care in a way that minimizes such risk while simultaneously maintaining or even improving social standards.
- Member States' **ability to close the gap** between expanding needs and limited or declining resources for long-term care constitutes a major element of their capability to **respond adequately to the challenges from ageing**, in particular the increasing share of the oldest population groups.
- Finding ways to close this gap is an important part of adapting European societies to the **opportunities of new demographics** including the changes in needs and the composition of demand for goods and services which will form the basis for future economic activity.
- Thus, the long-term care gap issue has links to **four of the five Europe 2020 targets** (75% employment rate, 3% investment in R&D, reducing the percentage of the cohort without education and training, reducing people at risk of poverty and social exclusion) and **six of the seven flagship initiatives**.
- In terms of the need for **research and product development** it links to the 'Innovation Union', the 'Digital agenda for Europe' and the 'Industrial policy for the globalisation era'. In terms of **employment, skills and social inclusion** it links to the 'Agenda for New Skills and Jobs', 'Youth on the move' and the 'European platform against poverty'.

- The Innovation Union **European Innovation Pilot (EIP) on Active and Healthy Ageing** is of high relevance to develop Member States' capabilities to close LTC need gaps. The combined focus on prevention and strategies to raise the effectiveness and efficiency of caring systems through improvements and deployment of innovative organisation and assistive technologies puts this squarely at the centre of gap closing efforts. One challenge for this EIP is to get the balance right so that prevention and support for autonomous living receives sufficient attention and enough resources compared to care therapies.
- The EU's Europe 2020 strategy for growth does not contain a specific section on **social protection**. However, this issue is indirectly covered by the strategy's strong commitment to **reducing poverty**. Amongst other things, this means that elderly care should not give rise to poverty (of care receivers or care providers) and that poverty should not exclude anyone from care.
- Long-term care reform can help to **reduce poverty risks**. Becoming dependent on long-term care is a major poverty risk if co-payments or user charges are involved, as is the case in many EU countries. If the focus is on keeping older people in a position to manage their own lives, this poverty trap can be reduced. This necessitates effective **prevention strategies** and appropriate **means of support**.
- Closing the gap in long-term care also connects in important ways with the **employment target**. Women, notably those of middle age, are particularly subject to underemployment in many Member States. Long-term care can be seen as a **job motor** which could provide a considerable share of the un- and semiskilled jobs we will need in the future. This could be particularly useful for groups of special concern in the labour market context such as early school leavers and drop-outs from training. For **young people**, work in long-term care could be a low threshold way of entering the job market. It might also provide employment opportunities for **middle-aged** and **older people** who currently have difficulty in finding jobs – especially those with low levels of education or outdated qualifications. But if long-term care is to function effectively as a job motor, **easy access to training** will be required. Some **reorganisation of care work** may also be needed in order to match a **particular skills mix**, encompassing both highly qualified carers and those with lower skills levels. In addition to new jobs in the care area itself, also new jobs in supply sectors like technology are to be expected.

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