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Services for older people in Europe

Facts and figures about long term care services in Europe.

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European Social Network

Social Services in Europe

ESN is the independent network for social services in Europe. Our mission is to help change the lives of the most vulnerable in our societies through the delivery of quality social services. With Members in local public social services across Europe, we bring together the people who are key to the design and delivery of vital care and support services to learn from each other and contribute their experience and expertise to building effective social policy at European and national level.



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About this document

This report was compiled by Daniel Molinuevo as a working paper for the ESN policy and practice group on long term care for older people. It focuses on the situation in the countries represented in the working group: Belgium, Germany, Iceland, Poland, Romania, Sweden and the United Kingdom. More information about this working group can be found at: <http://www.esn-eu.org/long-term-care-for-older-people/index.htm>

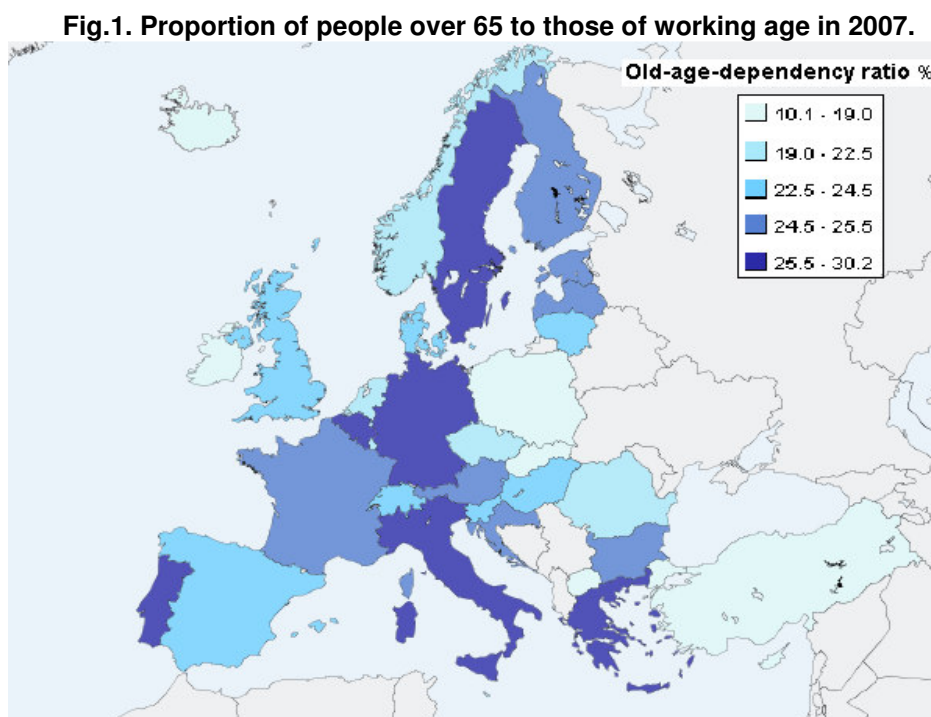
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An ageing Europe

“In the coming decades, the size and age-structure of Europe’s population will undergo dramatic changes due to low fertility rates, continuous increases in life expectancy and the retirement of baby-boom generation.”¹

Although long term care services are provided to all age groups, the large majority of its recipients are in retirement age. Consequently, supply and demand of long term care are largely determined by the demographic balance between the elderly and the working age group. This balance between generations can be expressed as the old age dependency ratio², which is the proportion of the oldest age segment (aged 65 and over) in relation to the economically active age group (from 15 to 64).



Source: Eurostat.

Figure 1 shows the balance between generations in Europe in 2007. Italy (30.2%) and Germany (29.9%) had in 2007 the highest proportion of old people in relation to the working age population: for every person older than 65 there were only about three people aged 15 to 64. Sweden had the fourth highest dependency ratio in Europe that year (26.4%), but was closer to the EU 27 average, which is four people in working age per person in retirement. Belgium (25.9%) and the UK (24.1%) had also a proportion of old people similar to the European average (25%). In Poland and Romania the proportion was five people in working age per old person, whereas in Iceland there were almost six people of working age for every person of retirement age.

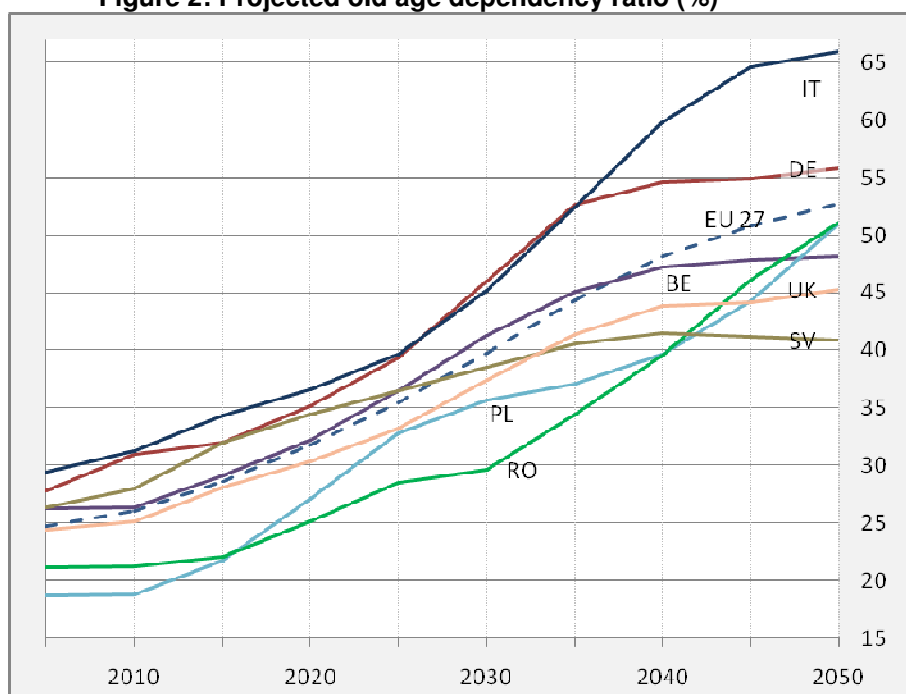
¹ *The impact of ageing on public expenditure*. Economic Policy Committee and DG ECFIN (2006).

² This indicator is calculated dividing the total number of elderly persons of an age when they are generally economically inactive (i.e. aged 65 and over) by the number of persons of working age (from 15 to 64). It is normally expressed as a percentage: a ratio of 25% means that number of elderly people is a quarter of the population of working age (i.e. for every person in retirement age there are four people of working age).

Projections on future demographic trends

Projections of future demographic trends can be useful to anticipate changes in the shift of resources between generations and to assess the financial sustainability of long term care services. According to projections made by Eurostat (see figure 2 below), by 2020 there will be only three people of working age per person aged over 65 in Europe. The ratio will reduce to two people economically active per retired person in 2045, a proportion that will be reached in Germany and Italy a decade earlier.

Figure 2: Projected old age dependency ratio (%)

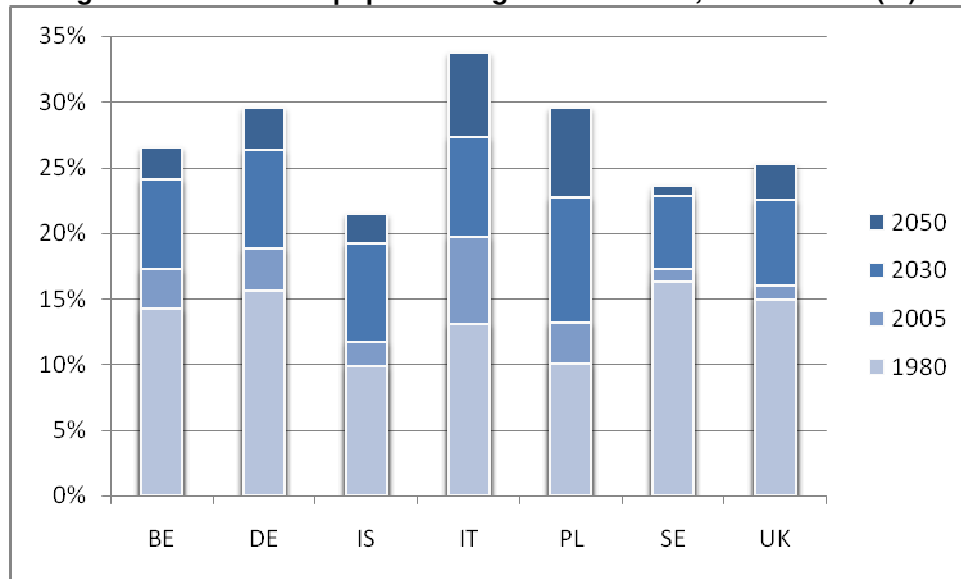


Source: Eurostat (2004).

Demographic change happens at a different pace in each country. The highest acceleration in the ageing process takes place in Poland and Romania. Whereas the current proportion in both countries is around five people of working age per old person, by 2050 the ratio will reduce to two workers per old person. Dependency ratios in both countries are expected to increase about 150% in the next 40 years, an increase higher than the other European countries and three times more the growth foreseen for Sweden.

Data displayed in figure 3 shows the demographic changes according to the OECD. It is estimated that by 2050 one third of the population in Poland, Italy and Germany will be over 65. The share of the elderly population in Belgium, Sweden and the UK by that time will be around 25% of the total population, whereas only one out of five Icelanders will belong to the oldest segment by that time. However, it is estimated that the current number of old people in Iceland (about 35,000) will double by 2050. This increase is much higher than in the rest of Europe and is only partially decelerated by a slight increase of the rest of the population.

Figure 3. Share of the population aged 65 and over, 1980 to 2050 (%).

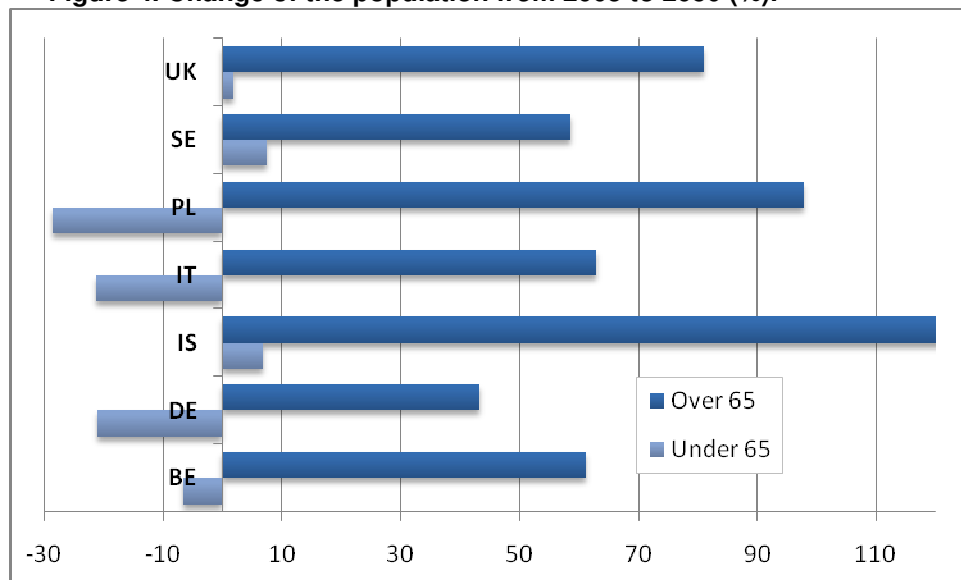


Source: OECD Demographic and Labour Force database (July 2006).

Therefore changes in the demographic structure are caused largely by the steep increase of the elderly population, but also by trends in the other age cohorts (see figure 4 below). Although in Germany and Sweden there is a similar increase of the elderly population (30%), the rest of the population decreases one quarter in Germany, whereas in Sweden this age group doesn't experience major changes.

In Poland the doubling of the proportion of older people is caused not only by the growth of these age segment (from 5 to 10 million people in the next 40 years), but also by a decrease of almost half the current population under the retirement age.

Figure 4. Change of the population from 2005 to 2050 (%).



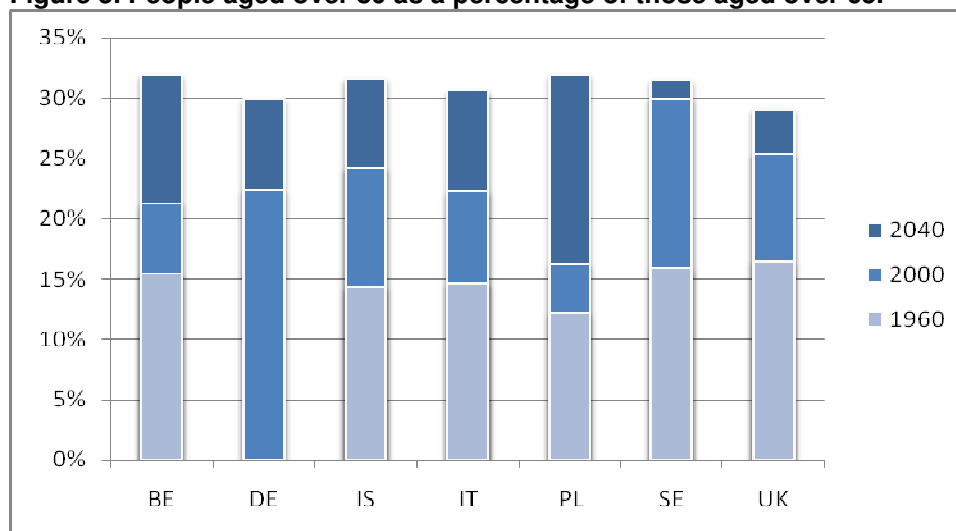
Source: OECD Demographic and Labour Force database (July 2006).

Composition of the elderly population

When it comes to population projections, it is important to focus on those groups that receive a larger share of long term care services: the “oldest old” (i.e. those aged 80 and over) and those with functional disabilities.

It is expected that by 2040 those aged more than 80 years old will constitute a share of the total population which will be more than twice the current proportion. By that year one third of the elderly population will be aged 80 and above, with gentrification taking place faster in those countries where this age group currently represents a low proportion of the population (see figure 5 below).

Figure 5. People aged over 80 as a percentage of those aged over 65.



Source: *Long Term Care for Older People*, OECD (2005).

The Survey of Health, Ageing and Retirement in Europe (SHARE)³ is the main source of comparable data on the number of old people that cannot perform activities of daily living due to physical limitations. On the basis of the data gathered in this survey, DG ECFIN⁴ has estimated that approximately 17% of the men and 23% of the women aged 65 and over experience physical limitations. This difference between men and women is due to the fact that women live longer than men and physical limitations increase with age (see table on the next page).

³ <http://www.share-project.org/>

⁴ Economic Policy Committee and DG ECFIN (2006), op. cit.

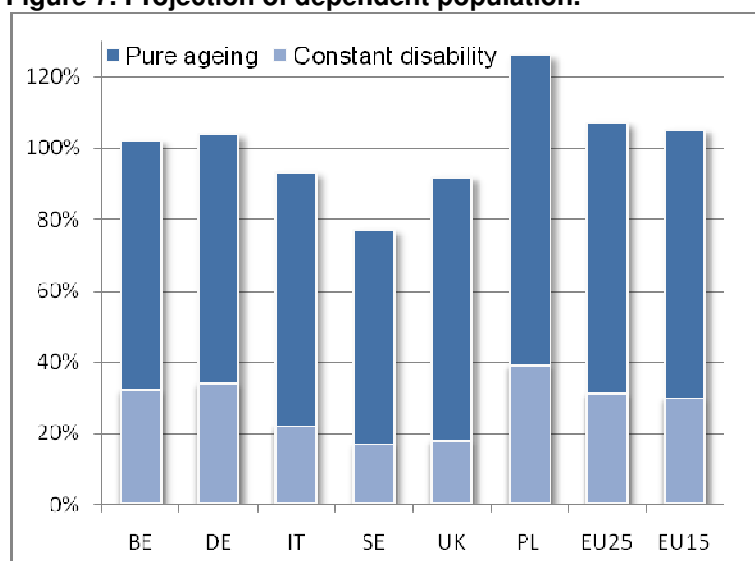
Figure 6. Estimated elderly population, in thousands (2004).

	75-79		80+		Total	Dependent population aged 65+			% of the total population aged 65+	
	Men	W	Men	W		Men	W	Total	Men	W
BE	33	55	132	284	416	18	27	23%	53	159
DE	174	414	873	1917	2790	15	22	19%	390	980
IT	201	337	741	1473	2214	16	23	20%	299	702
PL	71	136	284	601	885	15	20	18%	84	251
SE	17	36	104	218	322	16	25	21%	62	154
UK	231	356	1088	1811	2899	27	33	30%	361	841
EU25	971	1745	4214	8411	12631	16	23	20%	1628	4216

Source: Economic Policy Committee and DG ECFIN (2006)

Projections of the number of physically impaired elderly enable us to know to what extent increases in lifespan entail a higher demand of long term care services. ECFIN estimates are based on two scenarios. In the *pure ageing scenario*, the proportion of disabled amongst population remains unchanged (i.e. health conditions will be the same as now) and the number of elderly people that requires long term care due to physical impairment soars dramatically. In the *constant disability scenario*, disability rates are assumed to evolve in line with mortality rates (i.e. extended lifespan entails the deferral of age-related disabilities) and consequently the projected number of elderly disabled is lower than in the previous scenario.

Figure 7. Projection of dependent population.



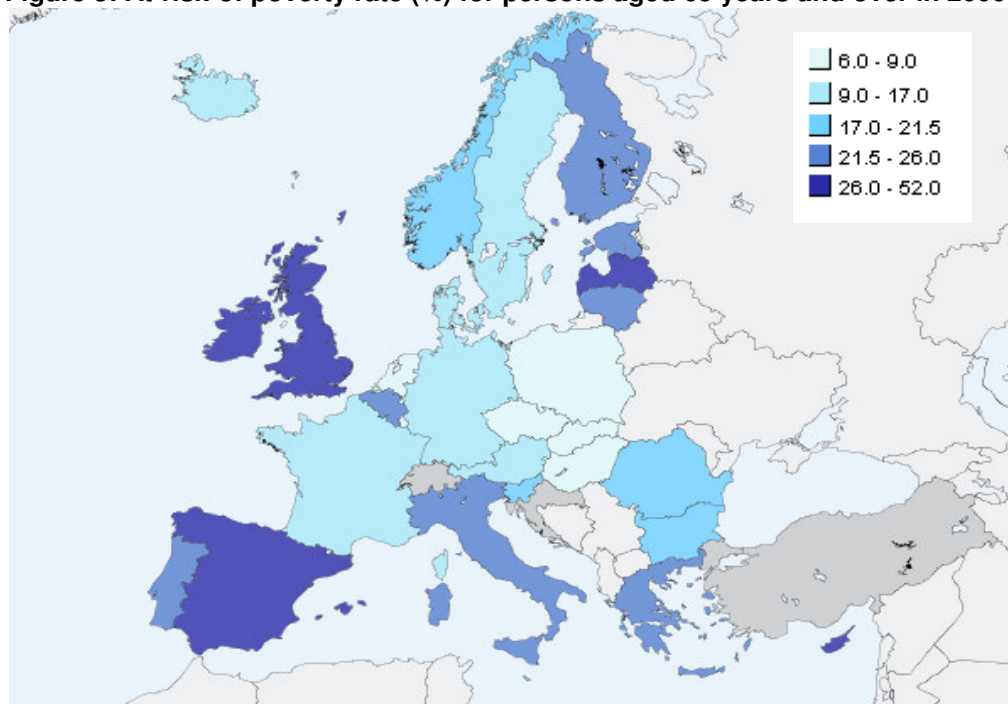
Source: Economic Policy Committee and DG ECFIN (2006)

Poverty and wellbeing of the elderly.

Aside from improving the health conditions of the elderly, public expenditure on long term care contributes to decrease their risk of being poor. About one out of five elderly people are below the risk of poverty threshold in Europe, with the risk of being poor increasing after retirement age in Western

Europe, especially in the UK. The map below shows the differences in the economic situation of those aged over 65.

Figure 8: At-risk-of poverty rate (%) for persons aged 65 years and over in 2006⁵.



Source: Eurostat.

The share of elderly people at risk of being poor ranges from nearly 10% in Iceland, Sweden, Germany and central Europe to almost one old person out of three at risk of being poor in the UK. In all European countries elderly women face a higher risk of experiencing poverty than men: women over 65 in Sweden are at a risk of being poor that is twice the risk faced by men.

The impact of social transfers on the risk of being poor is shown in the graph next page. Social transfers reduce from 23% to 19% the risk of the elderly of being poor in Europe. This reduction is higher in Sweden, where social transfers cut almost by half the risk of being poor at an old age. Social transfers have also a big impact in Iceland and Poland, where the risk of being poor decreases one third. Alleviation of poverty is lower than the European average in Italy (-8%) and Romania (-9.5%).

⁵ Percentage of elderly people with an equivalised disposable income (before social transfers) below the risk-of-poverty threshold. The *risk-of-poverty threshold* is set at 60 % of the national median equivalised disposable income after social transfers. *Equivalised disposable income* is defined by the European Statistical Office as the household's total disposable income divided by its equivalent size. *Social transfers* include social assistance and benefits related to unemployment, family, education and housing. Retirement and survivor's pensions are counted as income before transfers and not as social transfers.

Figure 9. At-risk-of poverty rate (%) of the population aged over 65 before and after receiving social transfers.



Note: retirement and survivor's pensions are counted as income and not as a social transfer. Therefore they are already included in the before social transfers scenario. Source: Eurostat (2006).

The role of health and social care services.

Long term care services are provided by both health and social care services. The allocation of tasks amongst these services depends on the availability of resources and the welfare arrangements in each country. The way demands are met has an impact the financial incentives of care recipients, given the fact that similar services can be provided at different fees or according to different eligibility criteria. It also influences the nature of services provided: care provision may be too medicalised or specialist treatment underprovided⁶.

The boundaries between health and social care also need to be taken into consideration when it comes to the international comparison of long term care expenditure. It must be noted that long term care is not a specific category in the European database on social expenditure (ESSPROS), but it is included as a subcategory⁷ in the "health", "old age" and "disability" expenditure chapters. Furthermore the category "old age" includes expenditure not related to long term care (such as pensions). Moreover, Eurostat uses national definitions of old age, whose disparities can distort international comparability. Therefore Huber⁸ argues that long term care spending cannot be compared between countries solely on old age related expenditure. Figure 10 shows the share of social protection expenditure devoted to old age care⁹.

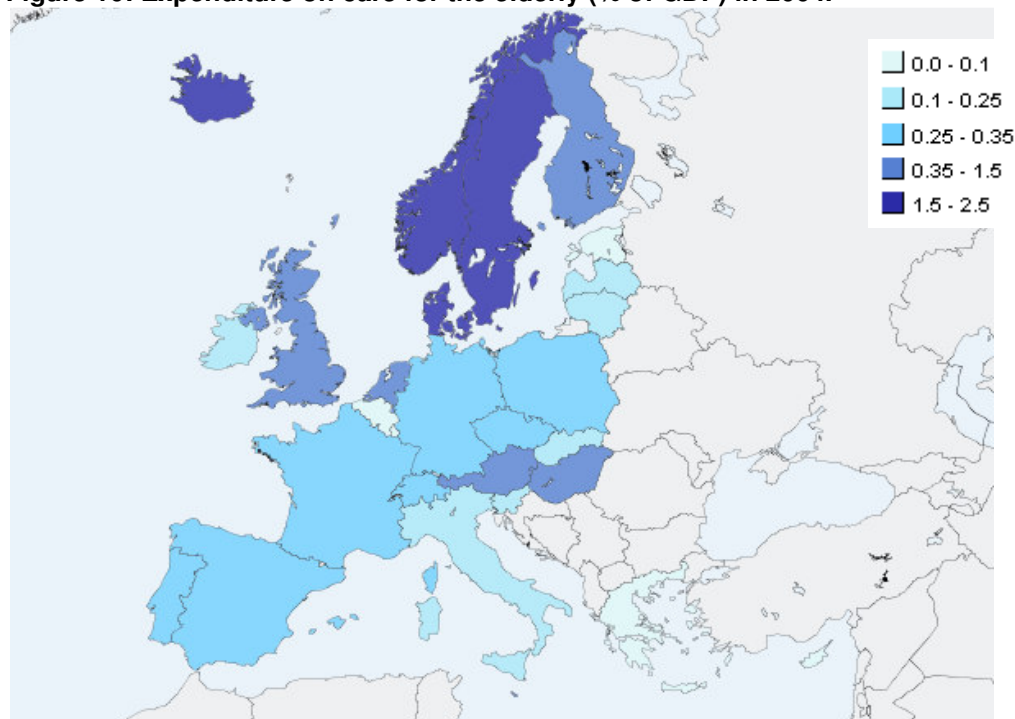
⁶Wittenberg, R., Sandhu, B. and Knapp, M. (2002) 'Funding long-term care: the private and public options', in E. Mossialos, J. Figueras and A. Dixon (eds) Funding Health Care: Options in Europe. Maidenhead: Open University Press.

⁷ More concretely, it is included in the subfunctions "accommodation", "care allowances" and "home care".

⁸ Huber, M. (2007): Monitoring long-term care in Europe. Background paper on care indicators, Mainstreaming Ageing: Indicators for Monitoring Implementation, European Centre for Social Welfare Policy and Research, Vienna.

⁹ *Old age care* can be income maintenance and support in cash or kind. It covers care allowance, accommodation and assistance in carrying out daily tasks and excludes health care expenditure.

Figure 10: Expenditure on care for the elderly (% of GDP) in 2004.



Source: Eurostat.

Data on long term care as a share of health care expenditure has been extensively collected by the OECD¹⁰. Long term care is a specific category in the System of Health Accounts, which was established in 2000 by Eurostat, the OECD and the WHO with a view to create common definitions that enable the collection of data that is comparable between countries.

The *OECD Health at Glance 2007* report shows that personal medical services account for 80% of the total health care expenditure in Scandinavia, whereas in Central and Eastern Europe it ranges from 50% to 60%. Expenditure on medical services is principally allocated to curative and rehabilitative¹¹ care. Long term care represents a higher share of expenditure than ancillary services in most countries, constituting about 10% of the total health expenditure in Europe, with expenditure being much lower in Southern and Eastern Europe.

¹⁰ Further information about OECD research activities in the field of long term care can be found at: <http://www.oecd.org/health/longtermcare>

¹¹ According to the System of Health Accounts, curative care aims to relieve symptoms of illness or injury, to reduce the severity of an illness or injury or to protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function. *Rehabilitative care* comprises services where the emphasis lies on improving the functional levels of the persons served and where the functional limitations are either due to a recent event of illness or injury or of a recurrent nature.

Figure 11: Health expenditure by function (% of health expenditure) in 2005.

	Personal medical services	of which:			Medical goods	Collective health	of which:	
		Curative-rehabilitative	Long-term care	Ancillary services			Prevention and public health	Health administration and insurance
Belgium	72	53	15	4	19	8	2	6
Germany	71	54	12	5	20	9	3	6
Iceland	82	65	17	0	16	2	1	2
Italy	78				21	1	1	0
Poland	64	53	7	4	32	4	2	2
Sweden	83				15	1		1

Source: OECD Health at Glance 2007.

Figure 12 below shows that most (or all) of long term care expenditure calculated as a share of health care expenditure are services of long term nursing care¹². Again, harmonisation of data is an issue and not all long term care services are included in these accounts, especially lower care tasks such as household work¹³. Therefore long term care expenditure should be compared between countries using both health and social care figures as an orientation and taking into account each country's particular welfare arrangements.

Figure 12: Health care expenditure on Long Term Care in 2004.

	Services of long-term nursing care				Long term care			
	Euro per inhabitant	Share of GDP (%)	Share of total current health expenditure (%)	Millions of euro	Euro per inhabitant	Percentage of GDP	Share of total current health expenditure (%)	Millions of euro
BE	381,09	1,37	14,06	3971,42	381,09	1,37	14,06	3971,42
DE	338,61	1,26	12,43	27941	527,59	1,97	19,36	43535
PL	20,64	0,39	6,51	787,95	20,64	0,39	6,51	787,95
RO	0,54	0,02	0,39	11,8	0,54	0,02	0,39	11,8

Source: Eurostat.

Long Term Care expenditure by recipient.

Age related expenditure evolves differently in old and new Member States and it also differs according to gender. Old Member States allocate an average of €13.000 to female beneficiaries aged 90 to 94, whereas this group only receives 380€ in the New Member States. There are also huge differences in Western Europe: expenditure in the 90-94 age cohort is equivalent to 60% GDP per capita in Sweden and 20% in Germany.

¹² According to the definition given by the OECD, *long term nursing care* includes care provided to in-patients who need continued assistance due to chronic impairment when performing their daily activities, day cases of long-term nursing care for dependent elderly patients and medical and paramedical nursing care delivered at home.

¹³ Huber 2007, op. cit.

Spending on women is substantially higher than for males in the same age cohort. Belgian women aged 80-84 receive twice more spending than males of the same age. Differences in expenditure according to gender are bigger in New Member States: in Poland males aged 90-94 receive 27€, whereas females receive twice that amount.

Figure 13: Age-related expenditure profiles for long-term care in GDP per capita

	60-64	70-74	80-84	90-94
Belgium	0.4	1.1	3.7/(6.7 women)	12.6/(20.8 women)
Germany	0.4	1.4	6.4	22.4
Italy	1.1	2.1/(2.6 women)	6.9/(11.5 women)	13
Sweden	1.5	3	29.7	62
UK	2	2.6	9.1	19.6
Poland	0.1	0.2	0.3/(0.6 women)	0.5

Source: ECOFIN (2006: 147)

A large share of expenditure is concentrated in those who are physically impaired to carry out daily tasks. Table 14 shows the number of dependent¹⁴ people aged 65 and over. It has been calculated on the basis of the numbers of ADL dependent population estimated in the SHARE survey and the number of people in institutions provided by Member States. About one fifth of the dependent elderly population receive long term care in institutions. Belgium, Malta and Sweden have the highest proportion of dependent elderly in institutions, whereas the lowest proportion being that of Italy and Latvia. There are more elderly dependent people (about 30%) receiving formal care in all countries except Belgium and Poland. Therefore almost half of the dependent population aged 65 and above receive no care, informal care or other forms of care that are not public funded. This proportion is substantially higher in Poland (83%) and the UK (75%).

Figure 14. Estimates of dependent population, in thousands (2004).

	Dependent population	Dependent population receiving formal care in institutions	Share of dependent population	Population receiving formal care at home	Share of dependent population	Population receiving informal or no care	Share of dependent population
Belgium	416	147	35%	114	27%	154	38%
Germany	2790	535	19%	975	35%	1280	46%
Italy	2214	193	9%	933	42%	1088	49%
Sweden	322	102	32%	142	44%	79	24%
UK	2899	278	10%	440	15%	2181	75%
Poland	885	105	12%	44	5%	737	83%
EU25	12631	1850	15%	3312	27%	7038	56%
EU15	11075	1585	14%	3151	28%	5909	53%

Source: ECFIN (2006:152), op.cit.

¹⁴ The term *disability* refers to functional impairment, whereas *dependency* implies a disability which requires the provision of a care service. *ADL-dependency* refers to difficulties in performing at least one *Activity of Daily Living (ADL)*. These activities are listed in the Katz ADL scale and include bathing, dressing, feeding etc. See http://ec.europa.eu/health/ph_projects/2000/monitoring/fp_monitoring_2000_annexe15_04_en.pdf p.29 .

Projections of long term care expenditure

The Economic and Financial Affairs Council (ECOFIN) requested the Economic Policy Committee (EPC) to provide age-related public expenditure projections. The projections draw on estimates carried out previously¹⁵ and they are based on several possible future scenarios¹⁶. In all cases long term care expenditure increases more than that of health care. This is due to the fact that the segments of the population that grow more are those that most in need of long term care services. Table 11 shows the developments estimated in the “reference scenario”¹⁷. According to projections for this scenario, long term care expenditure will increase 0.5 percentage points as a share of the GDP in 2050. This increase is higher in those countries where there is already a well developed system of formal care provision (i.e. Belgium, Germany, Sweden and Finland) and vice versa (most of the countries that became EU members in 2004).

Figure 15. Projected spending on Long Term Care as % of GDP

	2004	2010	2020	2030	2040	2050	2004-2050
Belgium	0.9	0.9	1.1	1.3	1.6	1.8	1
Germany	1	1	1.2	1.4	1.6	2	1
Italy	1.5	1.5	1.6	1.7	1.9	2.2	0.7
Sweden	3.8	3.7	3.7	4.9	5.2	5.5	1.7
United Kingdom	1	1	1.1	1.3	1.5	1.8	0.8
Poland	0.1	0.1	0.1	0.1	0.2	0.2	0.1
EU25	0.9	0.9	0.9	1.1	1.3	1.5	0.6
EU15	0.9	0.9	1	1.1	1.3	1.5	0.7
New Member States	0.2	0.3	0.3	0.3	0.4	0.5	0.2

Source: ECOFIN 2006 op.cit., p.162. (AWG reference scenario)

Community care networks and long term care expenditure.

An OECD study¹⁸ on long term care expenditure reveals that countries with different demographic trend or public programmes can have similar levels of expenditure on long term care and vice versa. Eligibility criteria and the type of benefits granted are different in United Kingdom, Germany and the United States, whereas their total level of expenditure is between 1.2% and 1.4% of their Gross Domestic Product. With reference to the share of the population aged over 80, in Spain this group is almost 40% higher than in Ireland, two countries with a similar level of expenditure. Although this age group is larger in Norway and Sweden, their high levels of expenditure are due to generous public provision of amenities. Furthermore, the public and private expenditure are not correlated, but they are mainly determined by copayment regulations. Therefore it is essential to analyse community care networks as they determine the level of expenditure on long term care in each country.

¹⁵ The EPC carried out a similar study in 2001, which was based solely on demographic changes, with no reference to possible developments in other areas such as care costs or institutional changes.

¹⁶ Projections are made on the basis of five different scenarios, with different assumptions in the future numbers of elderly people, changes in health and disability and changes in care provision and its costs. See Appendix for further information.

¹⁷ The “reference scenario” brings together the underlying assumptions of the other scenarios. Age-related disability rates fall by half of the projected increase in age specific mortality rates. Therefore half of the increase in lifespan will be of years in healthy conditions. In this scenario the probability of receiving care remains unchanged.

¹⁸ OECD (2005): Long-Term Care Policies for Older People.

Community care networks comprises the different providers of the whole set of services for the elderly. They can be classified according to these features¹⁹:

- The balance between residential and home care.
- The nature of public subsidies, especially the balance between support in cash and support in kind.
- The balance between the formal and informal care sectors, i.e. the role of, the state, families and non-state institutions.

Care at home or in institutions.

Long term care funding in Europe is mostly allocated to care institutions, except in the UK, where formal care delivered at home is allocated three times more funding. Formal care at home receives more funding in Western Europe than in the New Member States. ECFIN²⁰ estimates of the cost per beneficiary are shown in the table below. The average cost in EU15 per person receiving care in an institution is about 24.000€, whereas this amounts to 3750€ in the New Member States. In the case of Sweden, the unit costs in institutional care are about 63.000€ and they exceed 200% of the GDP per capita. Cash benefits amount an average of 4640€ per beneficiary in EU15, a figure ten times smaller in the New Member States. Benefits in cash are the main form of expenditure in Italy.

Figure 16: Total public expenditure on long-term care, all ages, 2004, as a % of GDP

	Institutional care			Home-based care			Cash benefits		
	Nominal Euros in billions	Unit cost	% GDP per capita	Nominal Euros in billions	Unit cost	% GDP per capita	Nominal Euros in billions	Unit cost	% GDP per capita
BE	1.43	9067	33%	0.85	6520	24%	0.14	1106	4%
DE	11.65	18517	70%	5.04	3886	15%	4.38	3740	14%
IT	5.50	19352	83%	6.69	3717	16%	8.63	6589	28%
SE	7.57	62972	203%	3.12	16579	53%			
UK	4.20	12824	45%	12.80	21856	76%			
PL	0.11	1160	23%	0.00	91	2%	0.10	823	16%
EU15		23935			9373			4619	
NMS10		3745			739			430	

Source: ECFIN (2006: 153)

With reference to institutional care, the tables next page show that there has been a shift in the provision of institutional care, with an increasing creation of places in nursing homes, where the supply of services is less costly²¹. This shift takes place in a context of deinstitutionalisation of health services for the disabled in favour of community-based services²². The number of LTC beds²³ has been reduced in both

¹⁹ Wittenberg et al. 2002, op. cit.

²⁰ ECOFIN 2006, op.cit. The *Economic and Financial Affairs Council of the European Union* is composed of the Economics and Finance Ministers of the Member States. The *Economic Policy Committee* provides support to the ECOFIN Council and is composed of two members of each Member State, generally senior officials from national ministries of finance or economics and from national central banks. A *Working Group on Ageing Populations (AWG)* was established to examine the economic and budgetary consequences of ageing.

²¹ OECD 2005, op. cit.

²² Mansell J, Knapp M, Beadle-Brown J and Beecham, J (2007): *Deinstitutionalisation and community living – outcomes and costs: report of a European Study. Volume 2: Main Report.* Canterbury: Tizard Centre, University of Kent.

hospitals and nursing homes in Sweden, where long term care is increasingly being provided at home. In Iceland, the decrease of long term care beds in hospitals is accompanied by an increase in nursing homes. Germany follows a similar pattern, with the number of beds increasing in nursing homes after the introduction of a new insurance programme²⁴. The cost of long-term care beds in nursing homes has also risen, probably due to the increase of elderly disabled that require more costly services.

Figure 17: Long-term care beds in hospitals and nursing homes, per 1 000 population aged 65 and over, 1995, 2000 and 2005.

	Hospitals			Nursing homes		
	1995	2000	2005	1995	2000	2005
Belgium	1.1	1.1	1.2	2002
Germany	22.9	46.7	1999 47.8
Iceland	17.4	1996 12.7	7.5	46.4	1996 51.4	61.0
Italy	..	1.0	2001 0.9	2003 ..	13.0	2001 14.8
Poland	..	3.2	2003 3.0	..	18.2	2003 18.3
Sweden	3.6	2.1	1.5	84.2	82.7	69.9
UK	0.6	1997 0.5	0.4	2004 24.3	1997 22.0	18.7

Note: In Iceland since 2000, the number of LTC beds in hospitals does not include beds in geriatric units, which have increased in recent years. Source: OECD Health Data 2007.

Figure 18: Number of Long term care beds in nursing homes

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Belgium						125720	125720	125720	125720	126722	129060
Germany	301961	344732	363878	363878	645456	645456	674292	674292	713195	713195	757186
Iceland	1419	1433	1398	1452	1557	1672	1702	1823	1921	2114	2116
Italy				134107	134107	134107	134107	155426	154585	154585	154585
Poland						89257	89257	89257	89257	90506	92180
Sweden	129843	127012	130725	118715	124062	126689	127124	124604	119791	113826	109106
UK	211300	220200	224400	221400	213200	204800	196800	187500	186200	179300	175200

Source: OECD Health Data 2007.

Benefits in cash or kind

Introducing choice in long term care provision empowers the elderly because it gives them a say in the provision of welfare. It can also lead to an increase in the quality of services as welfare recipients because they can choose the provider and the type of service that in their opinion suits their needs more satisfactorily. As “ageing in place” is the preferred option, introducing flexibility in the provision of welfare usually takes the form of support for home-based formal care or payments to informal care providers. Financial support to the informal care sector can have negative effects in countries with high unemployment benefits and low replacement rates. The combination of informal care allowances and generous unemployment benefits can become a disincentive to enter the labour market. Lundsgaard²⁵ categorises payments to the informal care sector in the following schemes:

²³ Long-term care beds are defined as beds allocated for people who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence in activities of daily living (OECD 2007: Health at Glance).

²⁴ OECD 2007, op. cit.

²⁵ Lundsgaard, J. (2005): Consumer direction and choice in long-term care for older persons. How can it help improve care outcomes, employment and fiscal sustainability? OECD Health Working Papers, Paris.

a) Personal budgets and consumer directed employment of care assistants:

Granting a personal budget can be used either to purchase care from competing agencies or to hire directly the services of a personal care assistant. In some countries it can also be used to acquire physical aids such as special beds or chairs. The Swedish Carer's Salary is used mostly in remote areas, with about 0.1% of Swedes over 65 being covered by this scheme. Carers paid with this scheme (which can be used also to pay relatives) receive a salary and social security benefits equivalent to those paid in the public sector. In the UK, the Direct Payments scheme was extended to those aged over 65 in 2000. This scheme can also be used as an alternative to services in kind, even though this scheme was initially introduced as a complement that municipalities could offer.

b) Payments to the person needing care to spend it as he or she prefers:

Old people needing long term care receive cash payments. In Germany, the Cash Allowance for Care (*Pflegegeld*) can be used as an alternative to services in kind. About one fifth of Germans aged 65 and over receive this kind of support, whose payment levels are adjusted to health conditions, which are reviewed every 3 or 6 months.

c) Payments to informal care givers as income support:

The aim is to compensate the loss of income that entails providing long term care. The difference between this scheme and personal budgets is that whereas the former aims to provide a minimum level of income the latter constitutes a remuneration for the services provided.

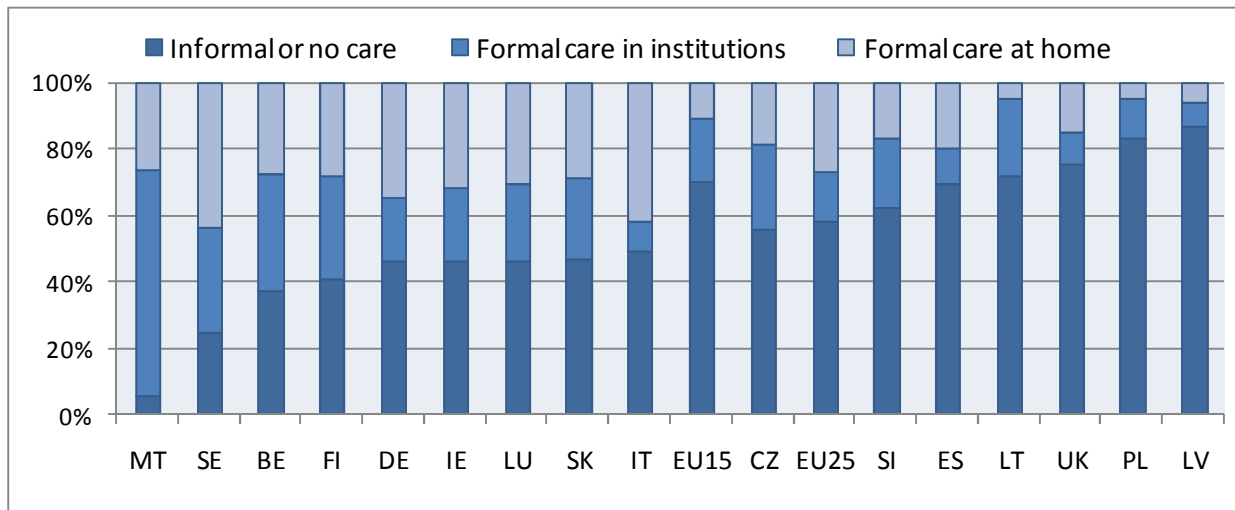
Non-financial support can constitute an incentive as important as those mentioned above. To this respect provided counselling, training and recreational activities in the framework of the earmarked grant Anhorige 300 from 1999 to 2001.

Formal and informal care.

Figure 17 shows the number of dependent²⁶ people aged 65 and over. It has been calculated on the basis of the numbers of ADL dependent population estimated in the SHARE survey and the number of people in institutions provided by Member States. About one fifth of the dependent elderly population receive long term care in institutions. Belgium, Malta and Sweden have the highest proportion of dependent elderly in institutions, whereas the lowest proportion being that of Italy and Latvia. There are more elderly dependent people (about 30%) receiving formal care in all countries except Belgium and Poland. Therefore almost half of the dependent population aged 65 and above receive no care, informal care or other forms of care that are not public funded. This proportion is substantially higher in Poland (83%) and the UK (75%).

²⁶ The term *disability* refers to functional impairment, whereas *dependency* implies a disability which requires the provision of a care service. *ADL-dependency* refers to difficulties in performing at least one *Activity of Daily Living (ADL)*. These activities are listed in the Katz ADL scale and include bathing, dressing, feeding etc. See http://ec.europa.eu/health/ph_projects/2000/monitoring/fp_monitoring_2000_annexe15_04_en.pdf p.29.

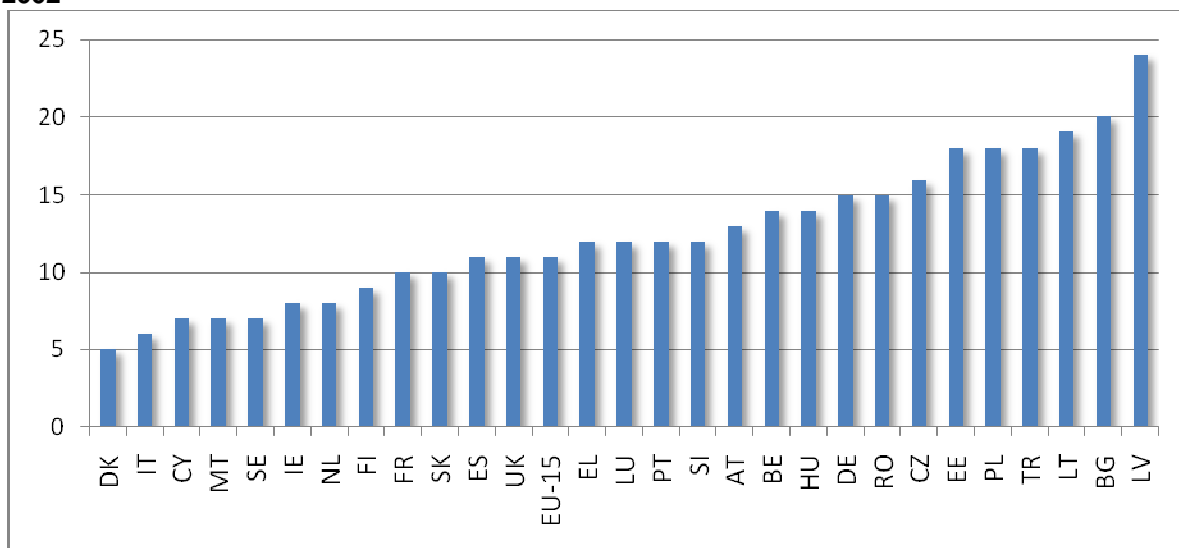
Figure 17. Estimates of dependent population, (2004).



Source: ECFIN (2006:152)

Figure 18 below shows that informal care is mostly provided by close relatives, with women doing most of the work. Men are more likely to be involved in domestic tasks and provide care mostly for their spouses (OECD 2005).

Figure 18: Proportion of people in the working age (16-65) caring for ill, disabled or elderly in the home, 2002



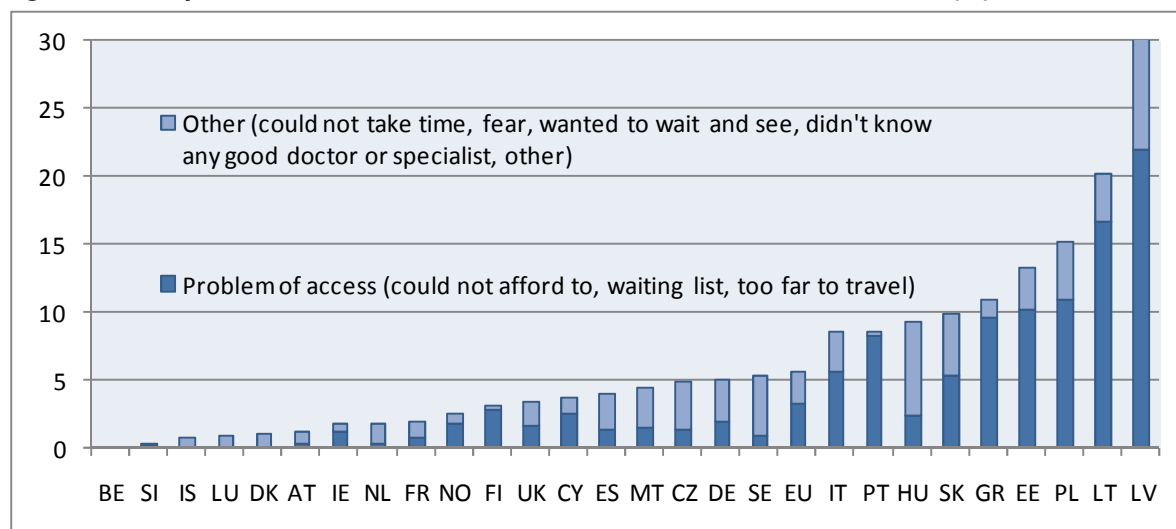
Source: Eurobarometer

Aside from financial incentives, culture determines to what extent families are involved in the provision of welfare. There are several typologies that classify European countries according to the role of the family on the provision of welfare. Daly and Lewis²⁷ consider that all the Scandinavian countries are characterised by strong institutionalised care both for children and the elderly, whereas Mediterranean

²⁷ Daly, M. and Lewis, J. (2000) 'The concept of social care and the analysis of contemporary welfare states', British Journal of Sociology, 51, 2: 281-98.

countries tend to rely more on the informal care sector. The involvement of the voluntary sector in the delivery of social care is particularly strong in Germany, as opposed to the case of the United Kingdom. However, it is conceivable that reliance in the informal care sector is due to problems accessing formal care provision. Figure 19 below shows that access to medical examination is more in New Member States and in the Mediterranean countries.

Figure 19: People over 75 with unmet needs for medical examination, 2006 (%).



Source: Eurostat.

Appendix: Long term care expenditure projections

Expenditure projections carried out by DG ECFIN in 2006 aim to identify the impact of non-demographic factors. It includes five possible scenarios regarding the evolution of dependency rates, care costs and policy changes:

- 1) A *pure ageing scenario* is built on the assumption that there will be no improvement in health conditions and that therefore disability rates will not change. The share of the elderly population receiving care is also held at the current level. It is therefore a demographic driven scenario that can be labeled as pessimistic as it doesn't foresee any improvements on health conditions.
- 2) A *unit costs scenario* that adds to the previous one an increase of care cost that evolves in line with GDP per capita.
- 3) A *constant disability scenario* in which disability rates decrease in line with changes in age-specific mortality rates.
- 4) A scenario including an *increase in the prevalence of receiving formal care* due to the increasing burden of the informal care sector. More concretely, it is based on the assumption that the proportion of dependent elderly people receiving formal care shall increase 1% yearly up to 2020.
- 5) A *reference scenario* which combines the factors mentioned above and where disability rates decrease half of the decrease in age-specific mortality rate

