

Assessing Needs of Care in European Countries

Policy implications and recommendations

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WP1: HOW EUROPEAN NATIONS CARE FOR THEIR ELDERLY

- Still very difficult to collect precise quantitative information on LTC according to predefined definitions for a large selection of European countries.
 - setting up an international database on organisation, provision and use of long-term care or putting effort into the improvement of an existing one, possibly based on OECD SHA methodology
- The cluster analyses (LTC typologies) indicate large differences between European long-term care systems
 - Since these differences do not necessarily translate into outcomes, and have a cultural (historical) dimension, it does not seem appropriate to aim for a unified system, but rather to adapt existing systems based on performance measures.

WP 2: Demographic epidemiologic projections of long term care needs in selected European countries: DE, ES, NL and PL

- The scenarios show the overriding influence of demographic change on future disability
- The effects of changing risk factors (obesity and smoking) on disability prevalence are surprisingly small
 - Policy interventions to change lifestyle are not likely to have substantial effects on LTC needs and use, but may be desirable for other reasons (good news for anti-smoking policies, bad news for anti-obesity)
 - The numbers of disabled elderly persons can be robustly forecast, so there is enough time to plan and organize the required LTC capacity

WP 3: Availability and choice of care

- Formal and informal care are neither perfect complements nor substitutes, but are task-specific
- There are limits to the expansion of formal LTC at home:
 - not practical for severe disability
 - low efficiency?
- Informal care is already heavily used in some countries, presumably with a high burden of caregiving (physically, mentally and economically)
 - Aim for a balanced system with sufficient formal and institutionalised care and support for informal carers, including measures to reconcile labour and care

WP 4: THE INFLUENCE OF TECHNOLOGY ON LONG-TERM CARE SYSTEMS

- Technology has the potential to increase the effectiveness of LTC systems by improving:
 - Reduce incidence or impact of chronic diseases (medical tech)
 - Autonomy of elderly persons with limitations
 - Productivity of formal care workers
 - (lowering) burden of caregiving by informal caregivers
 - Efficiency of LTC provision, especially through better coordination with health and social care systems
- Potential gains will be greatest if technology is integrated in care model, rather than supplementary to existing model
 - Not just assistive devices, monitoring etc., but also information and communication optimisation

WP 4: THE INFLUENCE OF TECHNOLOGY ON LONG-TERM CARE SYSTEMS (cont'd)

- Increase awareness of existing tech opportunities
- Define paths of organisational change to enhance successful implementation
- Support integration of technology in LTC processes
- Remove barriers to introduction of technology (legal/privacy, fragmentation of decision power, ...)

WP 5: QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EU

- Dimensions of quality assurance policies:
Integration, Transparency, Quality of informal care, Monitoring, Education
- Policy options to improve LTC quality
 - Step up efforts to collect comparable information on integration
 - Step up efforts to promote integration (countering fragmentation within LTC and improving coordination with health and social services)
 - promote/recommend transparency on information about the results of quality assessments (such as online publication, diffusion of best practices)

WP 5: QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EU (cont'd)

- Step up efforts to assure quality of informal care. This is probably a weak spot in many countries.
 - promote networking among local authorities, volunteer organisations and families
 - Diffusion of best practices and provision of training
 - Step up efforts to support informal caregivers (facilitate care/work combination, respite care, diffusion of information on technological support options)

- Promote or impose monitoring efforts on a regular basis

- Invest in education and research (developing national curricula for LTC professionals, promote research on best practices for the training, hiring and retention of geriatric nurses and other LTC staff)

WP 6: PROJECTIONS OF USE AND SUPPLY OF LONG-TERM CARE IN EUROPE: POLICY IMPLICATIONS

- Demographic dynamics will inevitably cause a care gap, both in formal and informal care
 - Growing numbers of ADL-disabled people (care demand)
 - Insufficient growth in numbers of formal (at current LTC workforce participation rates) and informal caregivers (especially adult children at working age) (care supply)
 - Devise incentives to attract workers into LTC jobs (better pay, immigrant workers?)
 - Step up informal care support, especially concerning work/care combination
 - Expand the provision of formal care, especially in countries where the burden on informal carers is already high

WP 6: PROJECTIONS OF USE AND SUPPLY OF LONG-TERM CARE IN EUROPE: POLICY IMPLICATIONS (cont'd)

- Secure the financing of the increasing LTC cost
- Boost LTC efficiency by:
 - Organisational change (better coordination, integration, information exchange, aided by ICT solutions)
 - Technology to increase the productivity of formal and informal caregivers (assistive devices, monitoring systems etc.)

WP 7: The performance of LTC systems

- Differences in the level of LTC use among countries are to a large extent determined by different patterns of care use and -to a smaller extent- by differences in disability levels. Demography plays a limited role.
 - In countries with generous LTC systems, changing the care use pattern may be a powerful way to control costs (but at a price).
 - In countries with rudimentary LTC systems, a possible development towards a more average care use pattern will lead to a much larger formal burden of care.

WP 7: The performance of LTC systems (cont'd)

- LTC systems are organised in very different ways, especially regarding the responsibility of the individual and the family compared to the state. The role of informal care and private funding differs widely among countries. In these very different systems the probability of older persons with limitations receiving help can still be comparable. But there is a trade-off among quality of life and care and equity on the one hand and the total burden of care on the other hand.
 - Improving the quality and equity will in many cases lead to a higher burden of care, especially a higher formal burden, as a large role of informal care has a negative impact on equity.

WP 7: The performance of LTC systems (cont'd)

- There are some problems with assessing LTC systems. First, we do not know the strength of the preferences for the different dimensions in different countries. Secondly, for some dimensions it is very difficult to find internationally comparable data. An important example is the quality level of care.
 - Promote research into the weights that societies place on quality, equity and the burden of care.
 - Collect internationally comparable data on the quality of care and other aspects (e.g. integration and simplicity of systems).

Summary: options for Europe's LTC systems in the face of ageing populations

- Solutions for a growing care gap
 - a) Do nothing
 - Growing unmet needs and/or
 - Lower care quality
 - b) Lower care intensity (# of caregivers per care user)
 - Only possible when intensity is relatively high (ex. FC in NL)
 - c) Increase supply
 - Formal care: make profession more attractive (higher wages)
! Substantial cost increase
 - Informal care: only possible in countries with low current use
 - d) Improve efficiency
 - Technology (1): reduce LTC needs (advances in treatment of chronic diseases)
 - Technology (2): improve productivity of LTC system
 - Change setting: formal home care versus institutionalised care

Summary: estimated effects of various policies on care gap (thousands of users)

Policy option	NL	DE	ES	PL
a) Do nothing				
Formal care gap (K users)	553	1598	1132	87
Informal care gap	25	691	1176	-
b) Lower FC intensity (DE level: 0.45)				
	404	1600	984	-
c) Increase supply				
Formal (30%): FC gap (Δ wages: +23%; $\epsilon_w = 1.3$)	445	1258	933	72
Cost % GDP	> +1.1%	> +0.4%	> +0.3%	> +0.02%
Informal (20%): IC gap	-1	14	846	-
d) Technology				
Reduce needs (10%): FC gap	461	1325	953	73
Reduce needs (10%): IC gap	9	284	894	-
Improve productivity (10%): FC gap	517	1484	1066	82
Improve productivity (10%): IC gap	12	353	1011	-

Policy mixes required to eliminate care gaps

	Policy mix	Boost supply	Lower intensity	Increase productivity	Care gap
NL	FC	53%	45%	10%	57
	IC	10%	59%	0%	-59
	Cost: > +2.1% GDP (4.7%), lower quality				
DE	FC	119%	45%	10%	1
	IC	10%	59%	0%	-1
	Cost: > +1.4% GDP (1.8%), higher IC burden				
ES	FC	101%	45%	10%	2
	IC	3%	59%	0%	2
	Cost: > +0.7% GDP (1.1%), lower quality				
PL	FC	270%	45%	10%	0
	Cost: > +0.15% GDP (0.1%), higher quality				