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Assessing Needs of Care in European Nations

THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN HUNGARY

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1. The long-term care system of Hungary

1.1 Overview of the system

The Hungarian long-term care (LTC) system still bears the marks of the central planning that was in effect in the country between 1950 and 1990. The organisational logic of the planner dictates centralisation (for it is easier to control fewer institutions) – a preference for institutionalised care over managing personal networks (such as home-based care) and a kind of organisational blindness that does not notice needs beyond its sphere of operations. The consequence, as in other fields of activities, is a dual structure: a centralised system of institutions and a wide range of household activities by which people adjust to the situation. A further feature of central planning, which in principle assumes the planner to be better informed than regulators of a market, is that the planning process is biased towards sectors that are easier to measure. Since the efficiency and output of human capital investments and lifecycle financing in general is more difficult to measure, and in addition its time horizon is much longer than the five-year plan, these fields are residual for the planner compared with sectors such as heavy industry.

This structure is still recognisable although it has changed significantly since 1990. New providers, in particular charities, have entered the scene; public administration has become more decentralised; much of the formerly informal activities have become formal; and much of the demand that used to remain unmet is now met by supply.

Universal coverage, based on the principle of social equity, is an expressed policy goal of the Hungarian LTC system. Until 2008, age was the only prerequisite for entitlement. Anyone reaching the age of 62, the retirement age, was entitled. No means test was required and the extent of lost physical or mental capabilities was not checked. Personal insurance history was not controlled until 2006. Although the National Health Insurance Fund (NHIF) introduced personal health accounts from 2007, this was not meant to restrict entitlement but to increase revenues from the active-aged population. As a major change, in 2008 an eligibility test was introduced, which evaluates the physical and social conditions of applicants.

The LTC system does not offer benefits for recipients to ease access to services. There is only one kind of social allowance for relatives who provide for a disabled family member. All other expenses finance in-kind services.

Services provided in health care are nursing care in nursing departments of hospitals and home nursing care. The three main types of services in social care are home care (including 'meals on wheels' services), day care and residential care. The number of authorised places in institutional care is just below 50,000 (excluding care centres for temporary care), with these

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being almost completely filled. The waiting list, of around 17,000 persons, is largely inflated by double or triple registration; we estimate the effective waiting list to be about 5,000-7,000.

1.2 Assessment of needs

There is no national definition of the need for care. In 2008 an assessment process was introduced but this applies only to home care and institutional care, and not to other segments of social care (such as meal provision) or to health care.

Since 1 January 2008 eligibility for institutional care has been restricted to those who need care for more than 4 hours a day. Individuals who need care 2-4 hours a day are entitled to home-care services. For needs that fall below 2 hours a day, no care is financed from public sources. Need is established by a complex assessment process. Applicants are evaluated in 16 various activities and resources grouped into 8 larger dimensions of assessment. These include independence in daily activities (eating, bathing, dressing and toilet use), self-reliance (dealing with household utilities and money, following therapy), walking, mental functions (orientation in space and time, communication), eyesight and hearing, the need for health care, the need for supervision, and social circumstances (social network, housing and financial background, with the last two only in assessing for institutional care). Abilities and resources are measured on a 0-to-5 scale and an algorithm translates the resulting values to time. These restrictions have diminished utilisation by about 10% among new applicants.

The assessment process is initiated by the general practitioner (GP) and carried out by an expert committee appointed by the local notary (in the case of home care) or the expert committee of the National Institute of Rehabilitation (NIR).

These criteria are national standards and they are binding, but as mentioned above, they apply only to a segment of social care and not at all to health care.

Eligibility for health care is insurance-based in principle but it is nearly universal. In practice, almost every citizen holds a social insurance card, which is the condition for access to health care.

1.3 Available LTC services

Which services?

Social care services are divided into three categories: basic services, institutions providing daytime care and institutions providing residential (long-term and respite) care.

Basic services: Home care (házi segítségnyújtás) *and meal provision* (szociális étkeztetés)

All local authorities are obliged to provide home care and meals for those who need assistance at home in their everyday life owing to their age, disability or bad health.

Institutions providing daytime care: Day care for the elderly (idősek klubja)

Institutions providing daytime care aim at serving as a daytime substitute for family care, by providing opportunities for the elderly to meet others, to have meals, to meet their health and hygienic needs and to guard against loneliness. These clubs provide meals, various services and leisure activities for those who live in their own home, but cannot fully look after themselves. In 2006, over 1,200 such clubs served 39,000 clients.

Institutions providing residential (long-term and respite) care: Home and respite care for the elderly (időskorúak otthona, gondozóháza)

Institutions providing residential (long-term and respite) care exist for those persons who are not able to look after themselves or need permanent help. Residential care centres serve meals three times a day, give clothes (if needed), and provide mental and physical health care.

Health care services are divided into two main types: nursing care in the nursing departments of hospitals and home nursing care. Most hospitals have some nursing beds for those who are in need of long-term nursing. These services include help in stabilising and improving health conditions, prevention of diseases and alleviation of pain, and the preparation of relatives for participation in home care.

Who is eligible?

Eligibility for home care and institutional care is settled by the assessment procedure described in section 1.2. Eligibility for health care is nearly universal.

1.4 Management and organisation (role of the different actors/stakeholders)

The LTC system is dual in that health care and social care are organised separately. The two institutional systems are not coordinated.

Health care legislation is in the hands of parliament; the government further specifies regulation. Local governments (about 3,200 in number) may issue local regulations within the framework specified by the national actors. The system is administered by the Ministry of Health (MoH) and the National Public Health and Medical Officer Service (NPHMOS), a licensing and supervisory agency. Since 2007, a new body, the Health Insurance Supervisory Authority (HISA), has controlled the quality of and access to health care services and releases evaluations of providers.

Finances are mostly managed by the NHIF, which contracts with providers for services, and the MoH, which supplements finances on a project basis. Services are provided at the local level mainly by local governments.

In social care, the legislation is structured the same way as it is for health care, with the qualification that local governments are more active in this field than in health care. They influence entitlement criteria within the limits drawn by the legal framework, the scope of assistance and care provided, and some other conditions. Social care is supervised by public administration offices (PAOs), operating under the authority of the Ministry of Local Governments (MoLG). PAOs are also responsible for issuing licenses. In addition, the Ministry of Social Affairs and Labour (MoSAL) maintains a regional (NUTS 2 level) network of methodology institutes, with the objective of the development of professional quality across the numerous local authorities (in 2006, before reorganisation, the network was operating at the NUTS 3 level).

Financing is in the hands of the MoH, which calculates the per capita and per case amounts of normative support to care providers. It also funds projects, much like the MoLG; the latter controls most of the funds of local governments. Services are provided mostly by local authorities, which are also responsible for investment decisions and determine the fees for services. The importance of non-governmental providers is secondary, although NGOs providing public services are entitled to the same amount of normative funding from the central budget (through contracting with local authorities) as the local governments themselves and, in addition to this, care centres maintained by churches receive additional financial support, which amounts to about 50% of the normative funding. This is counter-balanced by the availability (or lack) of properties for care centres. NGOs, in contrast to public providers, have no inherited real estate wealth, and they have less financial means to purchase property for the siting of services. The normative funding can be used only to cover maintenance costs but not investments.

1.5 Integration within the LTC system

LTC services are administrated in the health care system and the social care system separately. Both systems have their own distinct legislation, financing mechanism and services. The two systems maintain parallel institutional networks. This applies to institutional care as well as home care. There is no cooperation between the two systems and none of them applies, let alone coordinates, a system of case management. According to a recent report by the State Audit Office (SAO, 2008), the optimal division of labour would be to care for those who need special health services in the health care system, whereas those who do not need such services but whose physical and mental stability depends on special care, would stay in institutional care facilities. The report finds this frequently not to be the case.

2. Funding

Generally speaking, the financial system of public LTC subsidises supply. Services are funded directly and those in need of care do not receive cash grants to buy services. Private insurance schemes are not involved.

Operational costs are financed by the NHIF for health care and the government budget for social care. Local governments receive normative support from the government according to the number of beneficiaries they care for. It is set for each type of service by the government each year. It is meant to fund services, not tasks. There are services for which there is no normative support. Local authorities frequently supplement normative support from their own revenues depending mostly on the resources available. In total, local governments funded 39% of all public expenditure on LTC in 2006; this grew to 46% by 2008.

In addition, local authorities may charge user fees. The exact amount varies from service to service. Algorithms of its calculation are given by regulation, taking the user's personal income into account. Real estate assets are also part of the income calculation but other types of assets are not. Nor is the availability of informal family carers taken into account. The maximum fee is 80% of the monthly income for residential care, 60% for provisional residential care and 50% for rehabilitative respite care. Home-care charges are 2% for home care with a signalling device, 20% for home care proper, 25% for meal provision and 30% for combined home care and meal provision. The ceiling for day care is 15% of income or 30% if combined with meal provision. There is a difference in the amount of user fees in the governmental and in the non-governmental sector.

The ratio of the three sources, central government, local government and the beneficiary, can be different, depending on the type of benefit and the financial situation of the given local authority.

3. Demand and supply of LTC

3.1 The need for LTC (including demographic characteristics)

There are no official or administrative assessments of need. The only cost projection available is that of the standardised projection exercise by the European Commission. Information on disability of the elderly is not easily available. The last National Health Survey (NHS) was launched in 2003. The NHS contains extensive information on the independence of older individuals on a three-grade scale: independent, dependent and severely dependent. The next round of the NHS is to take place in 2010.

In Table 1, we show the key age-dependency rates in order to demonstrate the population ageing process. It reveals a slow pace of population ageing throughout the entire 20th century,

which will accelerate in the decades to come. Between 1901 and 1951, the population aged over 65 more than doubled from 304,000 to 739,000 (adjusted to territorial changes). Over the second half of the century (by 2001), it had doubled again, to reach 1,544,000 persons aged over 65. This age group grew much faster than the rest of the population. Over the same period, the population aged 19 or younger decreased sharply from 3,090,000 (1951) to 2,360,000 (2001).

Table 1. Various age-dependency rates, 1901-2050

	1901	**1951**	**2001**	**2050**
(-19 / total)	44.9	33.3	23.1	18.6
(20-64 / total)	50.7	59.2	61.7	54.7
(65+ / total)	4.4	7.5	15.1	26.7
(65+ /20-64)	8.8	12.7	24.5	48.8
(80+ / total)	na	0.9	2.7	7.2
(80+ / 65+)	na	11.5	18.0	27.0
Total population (in millions)	6.9	9.2	10.2	8.7

Source: Hablicsek (2004).

The baby-boom cohorts born between 1953 and 1956 will reach the age of 65 in 2018–21. Their children, whose number reached its peak between 1974 and 1978, will follow in 2039–43. By 2050 the total number of persons above the age of 65 is expected to grow by another 50% to over 2,340,000, to account for more than a quarter of the total population.

The number of the oldest old (the 80+ population) grew from 85,000 (0.9%) in 1951 to 278,000 (2.7%) in 2001. Projections indicate a significant increase to 7.2% by 2050. The share of the oldest old increased not only in proportion to the total population but also among the elderly (65+), from 11.5% (1951) to 18.0% (2001); it is expected to grow further to 27.0% by 2050.

The need for care can also be estimated from the NHS. The questionnaire of the survey contains several questions on dependence. It is measured on a three-grade scale: independent, dependent and severely dependent. In 2003, the proportion of dependent and severely dependent persons was 21.9%; 54.5% among the 65+ population and 71.5% among the 80+ population. Table 2 contains more detailed dependence levels by age group and gender.

Table 2. Dependence levels by age and gender (dependent and severely dependent)

	Men				**Women**			
Age groups	65-69	70-74	75-79	80+	65-69	70-74	75-79	80-84
Dependence (%)	31.6	44.9	39.7	52.6	52.5	53.4	71.5	83.0

Source: NHS (2003).

In total, the 2003 NHS definitions of dependency cover about 860,000 dependent and severely dependent persons in the 65+ population and about 230,000 dependent and severely dependent persons in the 80+ population.

The 2009 *Ageing Report* of the European Commission (2009) estimated the number of dependent older persons at 594,000 of whom 508,000 received only informal (or no) care.

3.2 The role of informal and formal care in the LTC system (including the role of cash benefits)

In 2007, 2.4% of the nearly 2.2 million persons at age 60 or older were in residential homes (CSO, 2008a), whereas 2.1% received home care from professionals (CSO, 2008b). Meals-on-wheels were provided for 4.7%; a quarter of those receiving meals-on-wheels received home care as well. Altogether, 8.2% of the 60+ population received some form of formal care in 2007 (CSO, 2008b).

In health care, the number of long-term nursing beds was 6,600, where 46,000 clients (mostly elderly) received care (CSO, 2008c).[1] Combined, these numbers reveal a considerable unmet need.

3.3 Demand and supply of informal care

The bulk of LTC activities is left to households or an informal market. This problem is further aggravated by the fact that the majority of elderly persons live in households either alone or with another elderly person (see Table 3).

Table 3. Household composition of the 60+ population (%)

	Single	Married	Widow/er	Divorced	Total
Male 60+	4	74	14	7	100
Female 60+	4	36	51	9	100

Source: Central Statistical Office.

The proportion of households where older persons can rely on the help of the younger generation is steadily decreasing even though the majority of older individuals have children and grandchildren. According to the Eurofamcare study (Szeman, 2004), 86% of those over the age of 60 have a living child. Among those who also have grandchildren, 14% have six or more, increasing the number of potential carers within the family. In the case of sickness and nursing, 88% of older persons can count on them, 85% could find help with household tasks, 88% in official affairs and 73% in financial matters.

While the average number of helpers upon whom a person can count on is 5.3–5.4 in cohorts in their 20s and 30s, it is only 3.7 for those in their 60s and declines further to 2.6 for those over the age of 70. Altogether, 34% of those interviewed could count on neighbours and 19% on friends. More specifically, 14% of the elderly could count on the help of neighbours in the case of sickness, 17% in household tasks, 34% in official affairs and 5% would also receive financial help from their neighbours. The help that could be expected from neighbours in nursing was the strongest in small towns.

Another 8% of the elderly look to friends for help in nursing. Their role is greater in Budapest and other cities.

There is only one form of help to family carers from the government. The 'nursing fee' is a social allowance; applications, based on the expert opinion of the GP, can be submitted to the local authority. The nursing fee can be claimed by relatives caring for a severely disabled or a permanently ill young (<18) family member. That is, the nursing fee is not specifically targeted at the long-term care of the elderly. Additionally, the social legislation provides an

[1] The exact age distribution of clients of long-term nursing beds is not known. A recent non-representative study of five nursing departments found the average age of patients to be 79; 88% of the clients were age 65 or older.

opportunity for local governments to give financial help to relatives caring for a family member aged over 18. In 2007, 19,000 family carers received this type of help, although this figure cannot be broken down by the age of the person cared for. The average value of the nursing fee was €87 a month in 2007.

3.4 Demand and supply of formal care

Introduction

In general, it is safe to say that the capacity of formal care does not meet the demand. Whereas over half the elderly has a certain level of dependence, some 8% have access to formal care. In Table 4, we show how many of those severely dependent persons have access to residential care.

The table reveals that even in the 80+ cohorts the access to residential care of individuals living with severe dependence is limited to a minority. The rate is higher among women than among men, in particular above the age of 70, due to household composition. Women are more likely than men to remain alone.

Table 4. Access of severely dependent persons to residential care by age and gender, 2003 (%)

	Women				**Men**			
	60-69	**70-79**	**80+**	***60+***	**60-69**	**70-79**	**80+**	***60+***
Residential home (social care)	13	32	41	*32*	13	13	28	*16*
Chronic nursing care (health care)	27	29	21	*42*	23	15	19	*19*

Source: Baji (2009) based on the NHS.

In Table 5, we display the access of a broader group, those living with dependence in general, to home care. The figures reflect an even wider gap of unmet needs.

Table 5. Access of dependent persons to home care by age and gender, 2003 (%)

	Women				**Men**			
	60-69	**70-79**	**80+**	***60+***	**60-69**	**70-79**	**80+**	***60+***
Home care	2.7	6.4	10.4	*6.2*	2.1	4.6	9.8	*4.4*
Meal on wheels	6.6	9.6	14.4	*9.9*	8.4	10.4	17.7	*10.8*
Home care with a signalling system	1.1	2.8	3.9	*2.5*	0.6	1.5	3.2	*1.4*
Home nursing care	2.0	5.1	12.6	*6.0*	3.2	4.5	9.2	*4.7*

Source: Baji (2009) based on the NHS.

In general, if demand is to be derived from the NHS data, more than 80% of the dependent elderly do not have access to home care, and about 60% of severely dependent persons do not have access to residential care. The rest of the elderly in need of care are forced to turn to relatives or neighbours. Most of the care provided for elderly persons is informal.

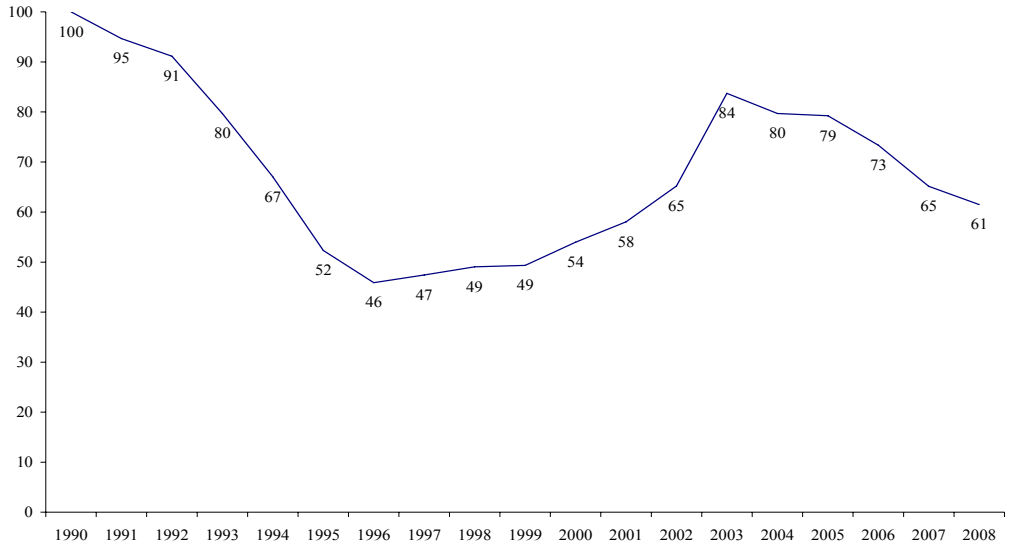
Institutional care[2]

The supply of residential care for the elderly has increased significantly over the past two decades. At the beginning of the 1990s around 30,000 beds were maintained in social institutions. By 2000 this had grown to 40,000, despite the rapidly diminishing government subsidies (see Figure 1). A rapid growth in subsidies between 1999 and 2003 led to a further increase in the number of beds, which was accelerated by development programmes by the central government. In 2006, the number of beds provided in residential homes reached 47,000, complimented by a further 4,000 beds in care centres, which gave temporary residential care up to one year in duration.

The average quality of the infrastructure in residential homes is rather low: 75% of rooms serve three or more clients and have no separate bathroom.

The number of nursing beds in hospitals was 4,000-5,000 until the 2006 health care reform. The reform doubled the number of beds. At the beginning of the 1990s, 27,000 persons were cared for with these beds annually; in 2006, the figure was 45,000. After the reform, the number of clients increased to 67,000.

Figure 1. Per capita government subsidy to residential homes, 1990=100



Home care[3]

Local governments are obliged to organise home-care services. Currently, there are 860 local governments (out of the total of 3,200) that do not maintain such services. After 1990 there was a sharp decrease in the number of clients (in 1990, 85,000; in 1995, 44,500; in 1999, 40,000). From 2000 onwards, the number of recipients slightly increased. In 2006, home-care services were provided to 48,000 elderly persons, 70% of whom were women. The number of caregivers, however, barely changed over the same period (in 1990, 4,900; in 2006, 5,100).

The social care reform in 2008 restricted eligibility for home care (see section 1.2). We expect a decrease in the number of applicants owing more to transaction costs (a long administrative

[2] Data in this sub-section are derived from CSO (2008b).

[3] Data in this sub-section are derived from CSO (2008b).

procedure combined with means testing) than to the eligibility conditions, which are not really demanding. It should be noted that the means test is meant for determining the level of per capita financing and not for determining eligibility.

Meals-on-wheels services are similar: local governments have an obligation to run such a service, which most of them do but 815 still do not. In 2006, 109,000 elderly persons were catered for. After 1990 there was a slight increase in the number of clients (in 1990, 91,000; in 2000, 98,000). A significant proportion of clients are provided with a combined home care and meals-on-wheels service.

The home signalling system is a complementary type of home care service. Local governments in settlements with 10,000 inhabitants or more are obliged by the legislation to organise signalling systems. In 2006, 165 local governments had such an obligation but only 94 of them provided a signalling system.

There are no data available on the waiting list for home care services.

Home-based nursing care services are largely privatised. In 2006, 46,000 clients were provided with nursing care in their own home, 47% of whom received some special form of therapy (such as physiotherapy and speech therapy). The number of cases was around 60,000; the number of visits was 715,000. The average number of visits per client has gradually increased over the last decade (in 2000, 21.9; in 2006, 24.7). The average number of visits per case has remained stable at around 12 over the same period (in 2000, 11.5; in 2006, 11.9).

A relatively new form of home nursing care is hospice care. This type of home nursing care has been financed by the NHIF only since 2004. The number of nursing days in hospice care was 51,000 in 2006, shared among 2,100 cases.

4. LTC policy

4.1 Policy goals

The policy goals of the Hungarian government with regard to the LTC system are summarised in the *National Strategy Report on Social Protection and Social Inclusion 2008-2010* (MoSAL and MoH, 2008). The report pronounces as the overarching aims the creation of a system that can adequately respond to the challenges of demographic changes, the consolidation of the institutional framework of long-term care and the establishment of standardised rules across the two systems of services, health care and social care. These overarching aims are spelled out in more specific objectives, such as to maintain and further develop the two separate systems but with an efficient coordination between them; to improve interoperability and cooperation between the two named branches; to eliminate inequalities in the access to care services; to introduce flexibility so that the system will meet individual needs in a flexible way; to take measures required for ensuring financial sustainability; to create the necessary mechanisms for the provision of services and for funding; and to create uniform standards and protocols.

4.2 Integration policy

The programme of improving cooperation between health and social care in LTC is nothing new. Earlier efforts, however, produced only preliminary results. The MoSAL launched a project on “Homogenous Care Categories”, with the explicit aim of surveying nursing activity in residential homes and social care in hospitals, in order to map the boundaries of social care and health care. Another project, ISHCS (“Integrated Social and Health Care System” or ISZER in its Hungarian acronym) has the objective of maintaining and promoting the independence of older individuals and the optimal utilisation of community, hospital and

institutional resources by coordinating services (Juhasz, 2008). Regulatory efforts have also been undertaken with regard to clearing the profiles of services, such as the withdrawal of permission for residential homes in the social care system to provide special nursing care activities from 2008.

4.3 Recent reforms and the current policy debate

The eligibility restriction, which is a recent development, has been described above in detail. Another reform, pertaining to the health care system, changed the distribution of beds in hospitals. More specifically, the government significantly reduced the number and changed the concentration of active beds in inpatient centres. This resulted in an overall increase in the number of chronic beds, which in turn affected long-term care capacities.

Current policy debates focus on the establishment of a uniform regulation of LTC services (Government Decision 2011/2007) and the improvement of professional conditions for nursing (i.e. the "Security and Partnership" government programme on health care development, 2008). In addition is the development of capacities in home-based care in order to halt the expansion of residential care (i.e. the "Changing Paradigm" government programme on social services development, 2007) and the setting up of a new branch of social insurance for nursing that would finance nursing care and social care for the elderly (i.e. the government's Green Paper on Health, 2007).

4.4 Critical appraisal of the LTC system

The most critical issue in the Hungarian long-term care system is the low level of access to services. The limited public resources that can be devoted to this purpose leave much of the need for LTC unmet. In addition, the employment of these resources is not efficient. Instead of focusing on cooperation and coordination with alternative providers such as households, the system focuses on funding institutions rather than tasks. The institutional system is emphatically dual, with limited to no coordination between social care and health care in legislation, funding and provision, although some recent initiatives may change that in the future. This duality leads to parallel financing of similar functions, thus reducing efficiency. With the lack of relevant data, which are a requirement for evidence-based policy, decision-making is frequently exposed to lobbying pressure. This could explain why recent regulations favour health care at the cost of social care, although the latter is more cost-effective.

The institutional net is sparse, making the chances of access asymmetric. Rural areas are particularly poorly covered. In contrast, some aspects of social care are over-decentralised, delegating responsibilities to more than 3,200 local governments in a population of 10 million.

List of abbreviations and acronyms

GP	General practitioner
HISA	Health Insurance Supervisory Authority
ISHCS	Integrated Social and Health Care System (Hungarian acronym: ISZER)
LTC	Long-term care
MoH	Ministry of Health
MoLG	Ministry of Local Governments
MoSAL	Ministry of Social Affairs and Labour
NGO	Non-governmental organisation
NHIF	National Health Insurance Fund
NHS	National Health Survey
NIR	National Institute of Rehabilitation
NPHMOS	National Public Health and Medical Officer Service
NUTS	Nomenclature of territorial units for statistics
PAO	Public Administration Office
SAO	State Audit Office

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About TARKI Social Research Institute

TARKI, founded in 1985, was the first independent research centre in Eastern Europe. The institute's profile consists of research on a wide range of issues related to social stratification, labour markets, income distribution, intergenerational transfers, tax-benefit systems, micro-simulation, consumption and lifestyle patterns and attitudes. TARKI's profile has recently expanded with the addition of a public health unit and the joint founding of a new institute of macroeconomic research, KOPINT-TARKI. Over the last fifteen years TARKI has moved in the direction of applied research and the provision of research-based policy advice. It now regularly advises international and national policy-makers, especially in regard to the impact of policies on social and income inequalities, and provides research evidence and analyses to inform draft legislation. Although based in Budapest and engaged with Hungarian social issues, TARKI puts a strong emphasis on comparative analyses and provides expertise on European social structure, income distribution, social mobility and attitudes as well as on the operation of national social welfare regimes.

TARKI is a member of various international research networks and consortia, like IFDO, ICPSR, ISSP, LIS, ECPR and ENEPRI. TARKI researchers publish in international and Hungarian scientific journals but are also often asked to present their research in different media, including television news programmes, and its researchers make a conscious effort to tailor their research results and conclusions to a broader audience. TARKI publishes a highly regarded *Social Report* every second year, which is widely referred to in scientific publications, reviewed in the press and regularly incorporated into undergraduate course syllabi. TARKI has its own fieldwork department with a nation-wide interviewer network and hosts Hungary's national social science data archive, which is part of the Council of European Social Science Data Archives (CESSDA). TARKI is an independent, non-partisan institute.

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).