

Long-term care for older people: The future of Social Services of General Interest in the European Union

Discussion Paper

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1. Introduction

Long-term care brings together a range of services for people who depend on ongoing help for an extended period of time with the activities of daily living, due to chronic conditions of physical or mental disability. These services can include help with everyday activities of housekeeping, transport, self-management and social activities but have usually a focus on more intensive personal care such as bathing, dressing, getting in and out of bed or chair, moving around and using the bathroom.

The emergence of comprehensive long-term care as topic for national social policy: the main issues at stake

In terms of time spent on long-term care, the majority of services is provided in private households by informal care givers (family and friends), with or without the support of publicly provided services. This is the case for all (European) countries, even for a country with rather generous public service provision like Sweden (OECD, 2005).

There is, however, a general tendency to put public programmes in place that help people who are in need of care to stay in their homes, or in the community as long as possible (e.g. in assisted housing), as this is the preferred form of living for most of them. But at the other end of the long-term care spectrum, a substantial number of people receive intensive care in an institutional setting (nursing homes or specially adapted wards in other institutions), which is often the last resort for persons who are living alone, are bedridden or suffer from severe dementia.

Persons in need of long-term care frequently also demand services along the full range of health care services, but problems at the interface between health and social services prevail in many cases, and surprisingly little systematic research has been done and too few is currently known about the cost-effectiveness of improving care along this boundary, including on prevention of dependency or on how to shorten the time spent in severe disability.

There is, however, evidence that the quality of long-term care is often not up to the growing expectations of users and their families. The need to improve the quality of services and to reach out to an increasing number of people has been among the main drivers of public spending growth for long-term care in recent years. This has raised the question of the financial sustainability of public programmes in coming years, when the proportion of the “oldest old” in the population (aged 80+) will grow faster than any other segment in the population, when staff shortages may become even more problematic and a broader scope of more sophisticated and higher quality services is requested by an ageing electorate (OECD, 2005).

The recent Commission project of a “Study on Social and Health Services of General Interest in the EU” has among four other sectors of social services studied in depth long-term care for a sample of eight countries: Czech Republic, France, Germany, Italy, the Netherlands, Poland, Sweden and the United Kingdom.¹ National experts answered a broad range of questions based on a uniform questionnaire and template for country studies. Figure 1 shows the results from this questionnaire on the question about the main issues at stake for long-term care in national policy discourses.

<Figure 1: Main issues at stake for long-term care services>

As Figure 1 shows, these country studies confirm that concerns about the impact of demographic trends, financial constraints, and quality of services and the need for better adapting them to users’ needs are at the top of social policy agendas for long-term care services. Figure 1 also shows that staff shortages and improving staff qualification is one of the major concerns and issues currently at stake in national debates on the further development of long-term care in countries, although this seems to be more an issue for countries where public supply of services and their public funding is already further developed (Germany, the Netherlands, Sweden and the UK).²

A recurrent theme from the country studies under this project is a concern about current staff shortages that are likely to become even more acute in the mid- to long-term perspective (5 to 20 years). This is not only driven by new demand, but also due to concerns about low pay, high staff turnover and difficult working conditions. Moreover, the work force is reported to age as well, so that a large number of persons will retire in the coming years (e.g. in France). In general, there is growing competition from the health care sector, where staff shortages (in the nursing professions) are a growing concern as well (OECD, 2005).

There seems to be some awareness about potential frictions with EU-law and the implementation and/or repercussion from European Court of Justice (ECJ) jurisprudence in Germany, France and Sweden, and to some extent in the Netherlands, but overall, these concerns currently rank much lower compared to other topics in long-term care policy. A common view among experts is that this is mainly due to the current absence of rulings of the European Court of Justice that concern the organisation of long-term care services in Member States.³

Long-term care in the framework of the Open Method of Coordination

Long-term care is a recent topic of the Open Method of Coordination (OMC) that was developed by the European Council and European Member States. Together with health care, it was included in the OMC in 2004. The concept of “long-term care systems” that brings together the complexity of services and actors sketched below is in itself a quite recent concept for many European Member States where the responsibility for providing and financing of these services

¹ See Annex 3 for a list of forthcoming reports in 2007 under the SHSGI project. A brief overview is available at: http://www.euro.centre.org/detail.php?xml_id=652

² The later concerns were also ranking high in a questionnaire sent to 18 OECD countries under the OECD Long-term care study, OECD, 2005.

³ See, however, below the discussion about ECJ rulings on the possibility to “export” benefits of long-term care systems.

often lies with different levels of government and for different target group, such as for “elderly care”.

The OMC promotes a closer cooperation among Member States on the modernisation of long-term care systems, which face similar challenges across the EU Member States, which however are currently at very different stages of developing coherent and more comprehensive policies and care provisions for persons in need of long-term care.⁴

This cooperation takes place mainly within the Social Protection Committee (SPC) that developed the OMC originally in the areas of social inclusion and pensions. In March 2006, the European Council adopted a new framework for the social protection and social inclusion process together with a new set of Common objectives: Three overarching objectives and individual objectives for each of the three policy areas of social inclusion, pensions and health and long-term care (see Box 1). The Open Method of Coordination is also based on the agreement of Common indicators that, however, are still largely lacking for the monitoring of public long-term care in a comparative perspective when it comes to service provision (number of recipients), expenditure or quality of care.⁵

Box 1: Objectives of the OMC for social protection and social inclusion

The communication “Working together, working better: proposals for a new framework for the open co-ordination of social protection and inclusion policies” set forward detailed proposals for the streamlining of the Open Method of Co-ordination (OMC) in the field of social protection and inclusion. The existing OMC’s in the fields of social inclusion and pensions, and the current process of co-operation in the field of health and long-term care, were brought together under common objectives – in continuity with the Nice and Laeken objectives - and simplified reporting procedures.

The overarching objectives of the OMC for social protection and social inclusion are to promote:

- (a) Social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies;
- (b) Effective and mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs and greater social cohesion, and with the EU's Sustainable Development Strategy;
- (c) Good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring of policy.

The following objectives apply to health and long-term care⁶:

Accessible, high-quality and sustainable healthcare and long-term care by ensuring:

- (d) Access for all to adequate health and long-term care and that the need for care does not lead to poverty and financial dependency; and that inequities in access to care and in health outcomes are addressed;
- (e) Quality in health and long-term care and by adapting care, including developing preventive care, to the changing needs and preferences of society and individuals, notably by

⁴ See http://ec.europa.eu/employment_social/social_protection/index_en.htm.

⁵ Long-term care relevant indicators are currently limited to health and disability data, see Tables 1 and 2.

⁶ In their original numbering.

- developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients;
- (f) That adequate and high quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions. Long-term sustainability and quality require the promotion of healthy and active life styles and good human resources for the care sector.

Source: Communication Working together, working better: A new framework for the open coordination of social protection and inclusion policies in the European Union;

http://ec.europa.eu/employment_social/social_inclusion/objectives_en.htm

Besides being now part of the OMC process, the debate about the future of long-term care services in Europe has during the past three years also increasingly been discussed in the context of the European Union legal and regulatory frameworks for service industries and social protection schemes that are derived from the principles of competition law and the internal market more generally. The core concept in this discussion is that of “services of general interest”, introduced in the next Chapter.

The Belgian Peer Review on “Long-term care for older people: The future of Social Services of General Interest in the European Union” is a novel approach to bring discussions on the social policy of long-term care together with the objective of spreading the knowledge of the possible implications of the EU-level regulations on the future of long-term care services.

This thematic background paper has a focus on trends in long-term care in a comparative perspective, including trends in modernisation of service provision that are relevant from a EU legal perspective. This paper does not analyse the underlying legal aspects in any detail because there are currently no concrete rulings of the European Court of Justice (ECJ) in the field of long-term care. For reference, there is additional information on legal aspects presented in Annex 2. This Annex also recalls how the European discussion on SSGI has evolved during the past four years.

Chapter 2 starts with an introduction of the notion of “social services of general interest” and the implications for long-term care in Europe. Chapter 3 provides an overview on the growing demand for long-term care, and presents a novel model of the interplay between long-term care services at the boundary between informal care in the family, health and social services. The next two Chapters discuss the wide variations in the organisation of publicly funded long-term care in Europe, such as in the number of care recipients and trends in modernisation for these services, before Chapter 6 addresses the difficult question of what we currently know about spending trends in international comparison. Chapter 7 finally brings all elements together to draw conclusions on strategies to make financing of long-term care sustainable for the future. Chapter 8 complements this with an overall summary and conclusions.

Much of the statistical material and international comparative information that is discussed in this paper is based on three sources: (1) latest data from both Eurostat and the OECD Health Data collection, (2) a major *Study on Social and Health Services of General Interest in the European Union* (in the following in short “Study on SHSGI in the EU, 2007”, and (3) the *OECD Long-term care study* published in 2005 that compared long-term care trends and policies for 19 OECD countries, among which are 12 European.

2. Long-term care as social services of general interest

In response to the challenges discussed above, but also as a result of a general trend in Member States to improve public sector management, and to foster “value for money” in public services, long-term care services are undergoing important changes in Member States. In many instances, there is a trend towards a more important role for private initiatives and of marketisation. For example, when countries have introduced new public programmes to finance long-term care, or have expanded existing programmes, this has sometimes been coupled with explicit policies to increase the role of private (voluntary and for-profit) providers and to create mixed markets in which public and private providers compete for clients, and for public and private funds.⁷

The expansion of long-term care services was consequently often accompanied by the introduction of a broad range of new steering mechanisms in response to these shifting shares in the mixed economy of welfare that might best be illustrated by the emergence of new stakeholders in quasi-markets. Provider and other stakeholder organisations, including public authorities, in this area are increasingly perceived as hybrid organisations guided by a mix of competition, concepts of solidarity, and public interest. Furthermore, networking, co-ordination and integration between hitherto divided areas and actors has contributed to the growing complexity of social service systems. The need to target services under tight public budgets on those most in need and a trend towards decentralisation in many countries, have also contributed to a growing complexity of organising and financing long-term care.

As a result of these reform trends, but also because the role of EU legislation has gradually increased, the influence of EU Community rules and legislation on the way social and health services operate in Member States has become more important over recent years and there is an increasing concern among stakeholders and policy makers about legal uncertainties and about lack of knowledge and understanding of the complex legal issues at stake.

The legal term of “services of general economic interest” refers to Art.86(2) in the Treaty which allows for certain exemptions from EU law, in particular from the rules on competition, for those services that are recognised by public authorities as fulfilling a task or mission of “general interest”. Much of the discussions on this concept, as well as initiatives of the Commission, and its dialogue with Member States, initially had a focus on services of general economic interest of the big network industries (such as transport, water, gas and telecommunication).

Social services of general interest (SSGI) are distinguishable from other services by specific missions of general interest defined by public authorities and public service obligations that providers have to fulfil. This is in particular the case for person-oriented services like long-term care that are subject to special public regulations, including quality and safety criteria in order to protect users and their families. Social services of general interest are a relatively new concept in the EU policy debate, which considerably accelerated and deepened since 2003.

The discussion on “services of general interest” (SGI) had initially a focus on network related industries and services (such as transport, water, gas, electricity, telecommunication, and postal services).⁸ Social services as “services of general (economic) interest” have only recently

⁷ An example is the introduction of social long-term care insurance in Germany and the effect it had on the public-private mix of providers.

⁸ See the Green paper on Services of General Interest.

become a topic of increasing attention in the European debate. The following provides a brief overview of the main elements of the legal and political background of this discussion.⁹

It was only in recent years that social services have increasingly played a role in this discussion. This was both driven by reforms in Member States that granted a more active role to (quasi-) markets and private sector involvement more generally, and by an increasing body of European Court of Justice (ECJ) case law, of which a majority had a focus on health care provision and on social security programmes. There is now the concern among service providers and public authorities that these cases might only show the tip of an iceberg of potential wider applications of EU-level regulation and ECJ case law to a broad range of social services in the future. There is in fact much uncertainty about the full extent to which this might be the case, as well as about the consequences this might have for the organisation and financing of social services at various levels of government.

What are the main issues at stake?

How to defining missions of general interest clearly in the context of accreditation and authorisation agreements but in compliance with EU-level regulations has increasing become a challenge. This can include the following elements:

- Defining the regulatory framework for service delivery and provision; delimitating the market (for example reserving some provision to specific providers),
- Regulating quality ex ante or providing for a possibility to introduce ex post verification of quality requirements,
- Controlling the access to the market,
- Limiting the provider types that may have access to public financing, (partial) re-funding,
- Controlling through ex ante territorial planning the financial consequences of the service provision, etc.

The main question with respect to EU legislation is the one of compatibility of such authorisations and agreements - that can be found in all Member States under one form or another with respect to providers of long-term care - with EU competition and state aid rules, as well as with public procurement rules and with internal market law.

In France, for example, the authorisation modes for elderly homes use tax advantages (reduced VAT rate and tax cuts). The question is the whether such advantages are also (or would be) given to non-national providers established in France or offering services on a temporary basis. This is explained in the following box.

⁹ See Annex 2 for a more detailed overview and the forthcoming study by Bernd Schulte (for further references see Annex 2 and 3)

Box 2: Consequences of authorisations and accreditation mechanisms in the EU legal context – An illustration from France

To receive a possible authorisation and approval to provide home services for the elderly, a registered project must respect a set of strict conditions. It needs to:

- Be compatible with the objectives and meet the social and socio-medical needs based on the social and socio-medical organisation schedule elaborated by each department and programmes of development between departments established by the Prefects of the Region;
- Have running costs which are not out of proportion with the provided service or with the costs of the institutions and services providing similar services;
- Have operational costs compatible with the budget of the public sector;
- Satisfy the rules of organisation and functioning and plan an evaluation process and information systems.

In comparison, the greater flexibility introduced by the new approval procedure (law n° 2002-2 *rénovant l'action sociale et médico-sociale*) of 2 January 2002 – that softens the agreement criteria – may have a negative impact on the quality of services.

As far as users rights are concerned, the arrangements planned in the Law of 2002 concerning the care booklet (*livret d'accueil*) are the only ones applicable. This means, for instance, that users of authorised services will not be allowed to ask a qualified person to help them to make their rights enforced. Moreover, users will not be allowed to be associated to the functioning of the service since it is not planned to create a Council of social life or whatever other form of participation. It is neither required to define objectives into a service project to obtain the agreement.

On the other side, the approval to provide home services is conditioned on respecting the schedule of conditions. This schedule defines the required documents, tariff information, the organisation of the telephone reception, the continuity of the service or the solutions to emergency situations. The approval suggests to the service provider to make some proposal of individualised or tailored intervention, that takes the demands of the beneficiary and of his/her relatives into account, and also to establish a clear contractual and financial relationship with the beneficiary. The manager has to guarantee the follow-up of the service provided through internal control, answering complaints and the evaluation of the interventions. Few constraints are imposed concerning the qualification of the professionals since no diploma is required as soon as the professional follows a training in the field or if the professional is hired under a subsidised contract to which a programme of professional or on-the-job training is associated.

Source: Study on SHSGI, Box 15.1

The Commission Communication “Implementing the Community Lisbon programme – Social services of general interest in the European Union” of April 2006 has addressed these uncertainties and announced to establish a monitoring and dialogue tool in the form of biennial reports from 2007 onwards in order to improve the knowledge of both service providers and stakeholders on the one hand and of the Commission on the other, of the situation of social and health services of general interest in the EU and the application and impact of Community rules on the development of these services. As a dialog tool this instrument will establish an ongoing

consultation with Member States and stakeholders, following earlier consultations in the year 2004.

The need for further clarification of these complex legal questions also stems from the fact that health and social services have been exempted from the range of services that are covered in the current version of the Service Directive.

Countries are currently at different stages of explicitly defining the “general interest” characteristics of long-term care services in national law and regulations. This can be all the more challenging in systems where part of the responsibilities for long-term care are delegated to provincial or local level, where know-how on the design of rules and regulations in compliance with the EU-level legal framework might only be emerging.

3- The growing demand for long-term care services

The prevalence of severe disabilities (at least one or more ADL restrictions) grows exponentially with old age. This has been observed both from data on care uptake, such as for residents in nursing homes, and for self-reported disability, as shown in Table 1. It should, however, be noted that disability in the sense of declining functional limitations is not necessarily perceived subjectively as “bad or very bad health”, as becomes evident from the replies to surveys on health status Table 2 that shows that the proportion of people aged 85+ that rate their health as “bad or very bad” is for a number of countries substantially lower than the proportion rating themselves as “strongly limited”.

<Table 1. Limitations in daily activities by age group - % of respondents answering strongly limited>

<Table 2. Self Perceived health by age group - % of respondents answering bad or very bad>

For both tables it is important to be aware of the severe limitations of comparability of the results from these and similar survey data between countries: Populations of different countries use different subjective scales for reporting in response to self-perceived health and disability questions, and survey results would consequently need for purposes of international comparisons to be standardised with the help of scale transformations, such as those based on actual measurement and case vignettes. This is methodologically very demanding and expensive. For the numbers shown in Table 1 and 2, unadjusted results are presented.

Data on care recipients also confirm that demand for long-term care on average increases exponentially in the highest age groups that are currently the fastest growing segments of the population (OECD, 2005, Long-term care for older people). With the increase in the number of the oldest old in the population (Figure 2), the level of dependence and the poly-pathologies of the elderly and the needs for long-term care and adapted social housing (to avoid residential care) are likely to increase strongly in the coming years.

According to the latest Eurostat demographic projections, the number of very old people (80 years of age or older) will increase over the next two decades by over 50% in most EU countries

and will have more than doubled in all of the EU25 countries, with the exception of Sweden that already today has the highest share of older people in the world.

<Figure 2. Population aged 80 years and over, 2005 – 2050>

By the year 2050, the number of very old people will have almost tripled or grown even more in 12 EU countries (Figure 2). In Italy, the share of persons aged 65 and over was 16% of the total population in 1995 and it grew to 19% in 2005, compared to EU15 and EU25 averages of 15% and 17%, respectively. Italy, together with Germany (19%) and Greece (18%), is the Member State with the highest proportions in 2005, while those with the lowest were Ireland (11%), Cyprus and Slovakia (both 12%). According to Eurostat projections for 2050, the share of persons aged 65 and over should rise to 30% both in EU15 and EU25 and to 35% in Italy (Eurostat).

At the same time, age-dependency ratios will have increased steeply, which poses limits on the growth of public budgets that will be available from contributions of the working-age population (Table 3). In Sweden, for example, the years between 2020 and 2030 are estimated to be especially tough when the large generation born in the 1940s gets older at the same time as the working-population is decreasing. The share of the population aged 85+ is forecasted to reach 2.2 million by 2026 (see SHSGI country report on Sweden, as quoted in Annex 3).

<Table 3. The ageing of the population in Europe>

What do we know about disability trends among older people?

Older people are not only living longer lives, there is also some evidence for at least a few countries that people stay healthy for longer, and that the onset of severe disability is more and more postponed. This means that people can live independently for longer, which would mitigate the demographic effect of higher absolute and relative numbers of very old persons in the population.

But the evidence on this trend is currently mixed (Box 3). As a recent OECD study puts it *“it would not seem to be prudent for policy-makers to count on any further reduction in the prevalence of disability among older people to offset the rising demand for long-term care that will result from population ageing”* (Lafortune et al., 2007).

Box 3: What do we know about disability trends among older people?

There is still much uncertainty about disability trends among elderly people, as a new study by the OECD has recently revealed (OECD, 2007, forthcoming). These findings have partially cast in doubt earlier, more optimistic, findings (e.g. Jacobzone et al., 1999). Of the sub-sample of eight European countries studied in this new report, there was evidence of a reduction in severe disability among people aged 65 and older for only about half of these countries (Denmark, Finland, Italy and the Netherlands). Disability rates have been stable in France over the past ten years, and been reported to be rising for Belgium and Sweden.

The picture for the UK is currently inconclusive, with contradicting results from two different surveys, which illustrate the severe data problems in this field of analysis. It is important that countries step up investment in surveys that allow for valid comparisons over time in order to better monitor disability trends in the population, in particular for older people.

Source: Study on SHSGI in the EU

The reported life-time risk for receiving nursing home care depends not only on the age-structure of the population but to a larger degree also on the design of national care systems (such as available supply and the division of labour with informal family care). In Germany, for example, this lifetime risk is about 35%. However, the age of entry has increased over time, while the average length of staying in a nursing home has decreased. Of the age group 70 to 74 years, only 5% need help, while in the age group above 90 years, dependency on help reaches 57%. Similar trends have been observed in other countries, however, not uniformly.

Moreover, there is some evidence that there is room for improving prevention strategies that could help postpone or mitigate health and disability problems among the elderly. These uncertainties alone, together with the well-documented risks of future life-expectancy estimations, make the business of projecting future long-term care a difficult task (see the section below on expenditure projections).

Long-term care: a complex array of services in response to changing needs

In addition to demographic changes, the needs for care are also changing more profoundly. Twenty years ago, institutions and services were mainly addressed to people experiencing social difficulties (insufficiency of resources or absence of family environment). Today, long-term care services are requested to provide more professionalised and often more medicalised services to a broader and more differentiated segment of the population.

Long-term care services have consequently changed substantially in many countries. Their function is no longer to only help people at risk of poverty but to offer social protection against potentially catastrophic expenditure on long-term care ("catastrophic" in the sense that these may consume the bulk of both a pensioners' income and household assets, in particular when care in a nursing home is needed). In addition, changing needs have led to the development of new types of services that are tailored to meet evolving and differentiated medical and social needs, at home and in institutions (Study on SHSGI in the EU).

This section sketches a comprehensive model of long-term care services that brings together the most important elements and individual services that have been implemented in individual countries – albeit perhaps not full comprehensive in any one. Long-term care services are presented in their interplay with health care and broader social services (such as income protection and social housing) and with the family situation.

<Figure 3. Long-term care: a complex array of services>

Figure 3 suggests multiple ways in which the interplay of care and service needs can be improved in many countries, or help to identify gaps in current service provision in the way the many actors in the system work together. The following list provides only some of the more important examples and strategies that countries have followed recently.

1. Care assessment and counselling should allow the full assessment of the social, health and functional situation of a person with care needs;
2. Health care can contribute to stabilising the functional status of dependent persons by providing adequate primary care services and by removing barriers to access, such as might be due to lack of (public) transport to reach services, or in the form of age discrimination.
3. Access to a broad mix of allied health professionals can prevent that chronic problems (such as diabetes) result in functional limitations.
4. Universal access to prevention (e.g. vaccination), screening or adequate diagnosis (diabetes, blood pressure, mental health) can work in similar ways.
5. Decent housing and adequate minimum income in old age can help prevent that people become institutionalised for other than health reasons.
6. A continuing of living arrangements from group housing to service departments with flexible care components can help avoid the “shock” of admission to a nursing home when people are very old.
7. Removing gaps in the full range of services to support informal care giving can enable people to stay longer in their homes and mitigate health and social risks for care givers.

Family care and living arrangements of older people

It is generally recognised that long-term care very much relies on the participation of private households that still provide the largest share of care hours in all countries and in many cases have also to shoulder a large burden of financing in case formal services are needed. Informal care-giving is consequently an indispensable component of care for older persons with long-term care needs, in particular because informal carers also provide for many older persons with the highest care needs, such as for dementia patient, for whom informal care is often the most important source of support (Moise/Schwarzinger/Um, 2004).

Women provide the greatest share of informal care, although with marked differences across countries (Table 4). Men are more likely to take over the role of caregiver for their spouses than in other family roles. Because more elderly people are living as couples and for a longer time, this has led to some increase in the participation of men in informal care giving over time (OECD, 2005). There are, however, gender differences in the care levels provided, which are not shown in Table 4. Women are predominant among informal caregivers with the heaviest commitments. They are more likely to be the main carer rather than an additional carer. The more demanding personal care services become, the more likely it is that women provide them. The share of domestic help rather than personal care is correspondingly higher for male carers (OECD, 2005).

<Table 4. Relationship between care recipient and informal care giver>

For countries where data are available, there seems to be a peak in care giving by those aged 45-65 (Table 5). This is a critical observation because this is the age group that frequently has multiple care responsibilities for elderly parents or for a spouse or partner with age-related health problems. In addition, fiscal and labour market policies for ageing populations have been targeting this age group to encourage higher labour market participation, such as by reversing trends towards early retirement. It will be important to ensure that caring responsibilities can be combined with employment in this age group (OECD, 2005).

<Table 5. Age distribution of care givers>

Although concerns have been expressed about declining care potential from children, in some countries, research in the United Kingdom, research has shown that the proportion of older people with at least one surviving child will be at a historic high level for the cohort reaching late old age over the next two decades (Comas-Herrera and Wittenberg, 2003). This suggests that, other factors remaining equal, the supply of informal care by children relative to demand is likely at least to be sustained over the coming two decades. The prospect for later in the century is less optimistic.

Moreover, the growing life expectancy of men, also relative to their spouses may result in a larger number of surviving couples, including a larger number of men who will be able to support their spouses in case of care need, and such a trend has been observed in Australia, where good data for monitoring these trends are available.¹⁰ Already now, the age groups of those aged 65 and over accounts in at least two countries (USA and Japan) for more than half of all family caregivers (Table 5).

4. How is publicly funded long-term care organised across Europe?

Long-term care systems in European countries have undergone major changes during the past decade in terms of financing, planning, provision and quality developments. New schemes such as the LTC insurance in Germany or personal budgets in the Netherlands were introduced.

But the findings from a number of recent studies confirm that Member States still differ widely in the ways long-term care is organised and funded, and in the total public expenditure made available (see Study on SHSGI in Europe, 2007, OECD 2005, MISSOC-Info 2006/2). This is the case for all the core aspects of long-term care: access to services and their financing, the role of families and of informal care, as well as the quality of care. Better integration of or cooperation between health and social services remains an important challenge in most countries.

Organising and funding long-term care is often complex, not least because regulating, financing or provision of these services is in most cases a shared responsibility (Figure 4) across different levels of government and administration. Framework legislation is often enacted at the national

¹⁰ It seems indispensable for countries with ageing populations to put surveys in place that are able to monitor trends in living arrangements and informal care giving, for example in 3 or 5 years intervals.

level, while detailed regulation and the organisation of services is frequently delegated to the regional and local level.

<Figure 4: Competent public authorities in long-term care services>

The devolution of competencies of organising long-term care to the local level has as a consequence created in many countries differences in the way care assessment is implemented, as well as differences in the generosity of services, also in response to what local budgets can afford. It is a common theme of the country studies under the recent Study on SHSGI in the EU that the experience of users and of their families often depends on the community in which they live, and this needs to be taken into account when aggregate statistics are analysed. This is, for example, the case for Italy and Sweden. There are also fundamental differences in the way long-term care is provided and funded in the constituting countries of the United Kingdom, where England and Scotland have recently departed in important policy choice, which resulted in a more universal system in Scotland, whereas the UK continues to rely more on means testing.

The public-private mix of care provision has undergone significant changes in a number of European countries. There is now considerable competition among different types of suppliers of long-term care in many European countries, which has in some instances helped to drive the agenda of assuring internal quality management and increased reporting to the public. But value-driven competition (linked to quality of services) is currently underdeveloped, which is a problem conceived in a number of countries (see the German country report under the Study on SHSGI in the EU).

<Table 6: Organisation of service provision in long-term care>

Who gets services? (Home versus institutions)¹¹

This section briefly reviews the evidence on the size of long-term care provision in international comparison, based on information from an emerging OECD data set that is the most comprehensive that is currently available. This is complemented by a comparison of the latest available projections for long-term care expenditure in the future. Long-term care expenditure is expected to increase steeply in future decades, but the drivers behind currently observed differences in the number of people receiving care and in expenditure are mainly due to differences in the state of development of publicly-funded long-term care, and to a lesser degree to differences in demography or health status (OECD, Long-term care or older people, 2005).

The numbers of dependent older people that receive long-term care in institutions ranges across Europe from below 2% (in Italy and Ireland) to more than 7% in Sweden and Hungary. But, the mix of services typically received in countries and the type of institutions that are behind the aggregate numbers of Figure 5 are clearly not the same between countries.

¹¹ This and the next section of the paper has mainly be borrowed from the Chapter 4 of the Study on SHSGI in the EU.

<Figure 5: People receiving long-term care in institutions, 2004>

Intensity of care, for example, will be on average higher in Sweden than in Hungary, and the comfort of living conditions is much higher in Sweden or Norway, where practically all nursing home inhabitants have a choice of a single room or service-apartment, whereas many nursing home inhabitants will have to share rooms in most other countries. With the exception of Sweden and Norway where choice of a single or double room in care in institutions ranks as a social right, the average number of persons per room in a nursing home typically ranges from 1,4 (Germany, UK) to 2 (in the Netherlands) or more in other countries (OECD, 2005).

The factors that explain why some countries have lower numbers of reported older people living in institutions are manifold. Caring for frail older persons is still predominantly a family responsibility in some countries (Italy and Ireland), and public policy has only recently become more active in complementing family care with more publicly available care alternatives in these countries. For other countries, there is a combination of a continuing family tradition in care and an increasing supply of home care alternatives, sometimes also supported by public programmes that allow families to decide on how to spend publicly provided funding for long-term care (e.g. the care allowances in Austria and Germany).

There is also greater disparity between countries in the share of older people who receive care in the community (where people who are cared for at home and that receive social benefits in the form of care allowances are included in the care ratios shown in Figure 6). Comparing aggregate care ratios between countries, and interpreting differences between countries correctly, is even more challenging in the case of home care than it is for care in institutions. In Austria, for example, the large number of care recipients includes many people that receive relatively modest monthly payments, whereas the entitlement conditions (combination of functional restrictions and number of hours of minimum care needs) in Germany result in fewer people getting over the threshold of the entry category of care allowances (or, alternatively, of professional home care services).

<Figure 6: People receiving long-term care in the community (including care allowances), 2004>

The boundary between “institution” and “home” is increasingly getting blurred where public long-term care programmes have aimed at creating “home-like” environments for persons who need long-term care. In Denmark, for example, many “nursing home places” have been converted to “service apartments” that are now served by the same providers that are also active in home care. These now show up in statistics either under “institution” or under “home” (see also the expenditure statistics in Figure 7).

There is also a general trend towards integrating health and long-term care provision, and of “continuing of care” across living at home with or without services, towards more intensive services, including short stay in institutions, or longer stay in nursing homes. These trends that aim at improving the quality of care and of the care experience at the same time make it increasingly difficult to draw the boundaries, such as between residential homes for older people, assisted living arrangements and service departments, and “nursing homes” (which increasingly are integrated as care wards in other institutions). Integrating care options in independent-living

environments that are specially adapted to the needs of older people also has the advantage that the social and health risks of the transition to more intensive care (such as that needed for bed-ridden persons) are mitigated.

Alternatives to care in a nursing home: the role of the informal sector

Families of frail older people that cannot get all the care needed from public programmes, and that are no longer able or willing to provide by themselves the – often extensive- care needed, increasingly are looking for care alternatives on a growing informal market where care assistance offer their services at very low prices, often without formal working relationships and frequently as migrant workers, with or without a legal work permission in the country where they provide these services. Informal (and in a strict sense illegal) employment in home care is increasingly an issue in other countries that provide benefits in cash (care allowances) to dependent older people and their families. Examples are Austria and Germany.

Cross-border issues: export of cash benefits

The question of whether cash benefits related to long-term care can be exported to other countries has been answered by the ECJ differently ways depending on the organisation of the underlying social programme (social insurance-type health-bound cash programme: Austria, Germany) versus means-tested tax funded systems (UK carer allowance).

Can care allowances be claimed while living in another EU country?

The German long-term care insurance is obliged to finance cash benefits from Germany to, for example, France if the care need is estimated by the Medical Service of the health care insurance (MDK) and the conditions for entitlements (in Germany) were met. In some cases the long-term care insurances now has even made direct contracts about in-kind transfers with providers of nursing and social care in other countries, such as in Spain.

For the case of Italy, the “Indennità di accompagnamento” can also be exported. In Sweden, the question whether it is possible to receive elderly care abroad has been discussed in several municipalities: Spain and Spanish islands is the main focus at present. No national guidelines in these matters seem currently to exist. But for certain municipalities, for example in Huddinge (a suburb of Stockholm) such financial help would be granted. The UK carer allowance, however can only be claimed within the country, and this has been confirmed by a case that had been brought up to the ECJ.

The strict application of existing EU-level regulation had consequently the result that people in need of long-term care and their families can be faced with different situations and possibilities to export care allowances across Europe, even in cases where their objective social and health conditions are the same from a patient perspective.

Box 4: EC Court of Justice rulings on long-term care

The Court of Justice of the European Communities has been confronted with question on national long-term care provisions, especially with difficulties to “export” acquired rights on long-term care benefits within the frame of regulation 1408/71 on coordination on basic social security systems. In the Molenaar judgement (C-160/96)¹² the CJEC classified one of the two benefits of the German care insurance (Pflegeversicherung) as a “sickness benefit” to which Regulation 1408/71 was applicable, because under the German law everybody insured against sickness has to contribute to the care insurance scheme. In the Jauch case (C-215/99)¹³, the CJEC declared that the Austrian care allowance had to be considered as sickness benefit in cash (traditional benefit) which cannot be entered into Annex IIa and therefore had to be exported.

The Austrian care allowance (Bundesplegegeld), a non-contributory benefit, had been listed in Annex IIa of the Regulation 1408/71 and granted to recipients of pensions who need care. The lack of definition could be explained by historical considerations – when the regulation was adopted long-term care was not a social risk as such - but it could also be that the court has difficulties to name this new benefit. Thus, it is interesting that the new regulation 883/2004 does not include the long-term care benefits in the list of matters covered by its article 3 but the concept of long-term care appears in the frame of sickness benefits; article 34 speaks about “long-term care benefits in cash” without giving a definition of long-term care. This “imperfect recognition” of long-term care shows at least that the question is very controversial at the European level, especially concerning the nature of these benefits and their status for the coordination of legislations (exportation, accumulation rules,...).

Source: MISSOC Info 2006/2

5. Trends in modernisation of long-term care services

Modernisation within the field of long-term care is driven by the socio-economic transformations sketched above that affect both the needs for care and the needs for financing. The following list is complemented by additional national examples, provided in Box 9 below.

Reform of long-term care systems can be grouped in a number of strategies:

- Increasing coverage and removing of financial barriers for publicly provided services;
- Introducing personal budgets and other cash programmes that give more choice to people with care needs and of their families on how to organise a bundle of services, including informal care or paid care assistants outside of the professional care market (see Box 6);
- Increasing the supply of support services for family care and care in the community: e.g. respite care and counselling;

¹² ECJ 5 March 1998 Case C-160/96 : Manfred Molenaar, Barbara Fath-Molenaar v. Allgemeine Ortskrankenkasse Baden-Württemberg. Point 19 refers to the German national legislation when stating “care insurance benefits are designed to develop the independence of persons reliant on care, in particular from the financial point of view. The system introduced is aimed at encouraging prevention and rehabilitation in preference to care and at promoting home care in preference to care provided in hospital”.

¹³ ECJ 8 March 2001 Case C-215/99 : Friedrich Jauch v Pensionsversicherungsanstalt der Arbeiter.

- Improving the care assessment process at the boundary between health and long-term care (such as with multi-disciplinary assessment teams);
- Better targeting of services and expenditure on those most in need (e.g. in Sweden);
- Improving cooperation between health and long-term care by better integrating health promotion and prevention strategies into care management;
- Quality management and assessment, including making information on care supply and its quality public (e.g. over the Internet);
- Decentralisation from national to local organisation of services.

The introduction of care allowances, personal budgets and other models of consumer choice

In a growing number of European countries, there is now a trend to give more individual choice for older persons and their families for the ways in which they can receive publicly funded long-term care, in particular for care provided as a joint responsibility between informal (unpaid family) care, professional services and publicly supported case management. These schemes have been introduced to provide more flexibility and self-determination to care recipients and their families, which can empower older persons as consumers (such as in their choice of providers) but ultimately can strengthen the role of households in the care-management process. Choice can also help address quality aspects that are difficult to quantify but easy to experience for users, such as the personal interaction between the older person and the care giver.¹⁴ Moreover, maintaining informal care is seen as key to the financial sustainability of public funding of long-term care systems.

Personal budgets, supplemented by professional case management, as it is the case in Germany, the Netherlands, the UK (England), appear increasingly to be a way of empowering the users. In England for example, the government introduced in 1997 direct payments which involve cash equivalents of care-packages for clients to pay for home-based care so that the care user becomes the direct 'purchaser'. More recently the Government has set up 13 pilot schemes of individual budgets.

Focus on user empowerment is accompanied in most countries by the introduction of market-based regulatory mechanisms that entail usually a move from public provision of institutional or home-based care towards the privatisation of professional provision of care. Private sector involvement of both non-profit and for-profit providers now exist in all countries and plays more important role in many cases.

The implications of cash-programmes such as care allowances and consumer choice are, however, even more complex. For example, it can create incentives to quit the labour market for women at a critical age of 50+, when reintegration in the labour market is very problematic. In addition, there is now evidence that care allowances have increasingly been used to employ migrant workers from low-wage countries at the borders of the European Union (e.g. in Austria, Germany, and in Italy), which raises important questions about lack of labour protection of the care workers, and about the safety and quality of care provided.

¹⁴ See Lundsgaard, 2005.

Integrated approaches to long-term care provision

Health and social services are increasingly seen as a joint responsibility between health and social services, and this is already implemented in a number of cases to varying degrees. From the perspective of long-term care as SSGI, this raises the need for any possible future legal or regulatory clarification on EU-level to establish rules that seem to apply across the health versus social care boundaries.

In most European countries the separation of health and social care leads to difficulties in co-ordination of care packages for dependent people. Measures have recently been introduced to favour integration of health and social care services in some cases.

Service integration refers to the process by which a range of social services is delivered in a co-ordinated way to individuals. The need for such coordination arises from the interfaces illustrated in Figure 3 that long-term care has with health care (both in primary care, but also in secondary care and for prevention) and with other social services, such as with social housing. This calls for close cooperation, first in the comprehensive evaluation of service needs for individuals, and then throughout the care process.

There is growing awareness among service providers and other stakeholders that more could be done to prevent or postpone the onset of disability in old age that results in severe functional limitations through better cooperation between acute care and social care. Better managing the costly “revolving door” between health and social interventions for people that live in social isolation is a particular challenge in this respect.

For long-term care, the better integration of health and social care services can take the form of integrated planning, funding and delivery of primary, secondary, residential care and community support services to provide flexible responses to people’s varied and changing needs. The importance of providing integrated, holistic, and cohesive care for older people is an important modernising trend within the field of long-term care. Historically, health and social services have been organised by different institutional actors, provided by different professionals, and even fragmented into specialised services. The integration of health and social services is however a complex process where professional histories and practices as well as cultural contexts are confronted (see e.g. Billings & Leichsenring, 2005).

Examples for country experience with integrated care

Italy: Attempts to integrate social and health services in long-term care have been made in Italy through the use of an integrated (social and health) home care voucher recently introduced in the Lombardy Region. This instrument establishes an administrated market of social and health care provision.

In the Netherlands, within the field of long-term care, a discussion about the need for integration of services and the necessities to cope with increasingly complex clients with multiple care needs is going on. One of the means to enhance integration is to share services, or even for organisations to merge. This has increasingly been implemented over the last years. This aims at better integration of services in order to deal with increasing complex needs for care and has

resulted in a wave of mergers between home-care providers, between home-care providers and institutional care (elderly homes, nursing homes) providers, as well as between institutional providers themselves.

For the UK, e.g., difficulties of delayed hospital discharge were reported, where older people could not be discharged from hospital because there were no alternative long-term care services in place. Following a model introduced in Sweden in 1992, in 2004 the government introduced a strategy to reduce the number of delayed discharges from acute trusts, which arise when hospital discharge is prevented by lack of suitable social services. Under the Community Care Act 2003, Local Authorities are now obliged to reimburse NHS hospital trusts if delays are caused by inadequate or delayed social care assessments and services, and acute trusts must notify social service departments of in-patients likely to need community care services. Initiatives have been taken to promote the development of intermediate care. These services are intended to prevent hospital admission, assist discharge from hospital and prevent avoidable admission to residential care. They have a strong emphasis on rehabilitation and comprise a short-term programme of rehabilitation in residential or home-based settings.

In Germany the question of developing of modern integrated care arrangements is still unresolved. Here, the planned development of integrated health care provision will be potentially influential for long-term care as well. The problem of integrating both sectors also reflects an asymmetry in the political economy between health care and long-term care. New social living and lifestyle arrangements are subject of many experimental projects. However, these have been rather short-lived and consequently they had so far no impact in terms of innovations on the benefit structure and the regional distribution of care.

More examples on modernisation from the Study on SHSGI in the EU

Box 5: Examples of modernisation and the quest for good governance

CZ

Benchmarking of costs for performance in state administration; Introduction of national quality standards.

DE

Introduction of market mechanisms Personal budgets (supplemented by professional case management); Integration of services for the care for disabled persons with long-term care and medical services (integrated care); Spatial governance (strengthening the municipality level); Governance modes empowering the users.

FR

Residential care: Reinforcement of users' rights, information of the beneficiaries, contract between supplier and beneficiary, council of social life; Universal voucher ear-marked to pay employment related to care and support services. Setting up of plans and co-ordination mechanisms to support the availability of measures for disabled and dependent persons without big regional differences.

IT

Introduction of market mechanisms involving delegation and tendering by public authorities in order to ensure the provision of home care services thus externalising tasks to non-profit organisations, especially to (social) cooperatives. Introduction of care allowance for severely dependent elderly people in difficult economic conditions and living at home introduced by some regional authorities (with a negligible effect on the development of an administered care market up to now, however). Integrated (social and health) home care voucher (Lombardy). Participative procedures in local programmes.

NL

Personalised budgets (clients managing their own care).

PL

Deinstitutionalisation of public long-term care; development of community-based care occupations; Improving standards; Monitoring and evaluation of policy initiatives.

SE

Collaboration of governmental agencies; countries and NGOs aiming at developing competencies and availability of personnel (competence ladder; focus on elderly care and nursing).

UK

Innovation in service delegation: Low level of responsiveness to service users' preferences, lack of continuity of services. Strategy: introduction of cash-equivalents and care-packages known as "direct payment" for clients to pay for home-based care

Source: SHSGI Country reports; Study on SHSGI in the EU, Table 12.1

6. How much does long-term care cost?

The international comparison of long-term care expenditure is confronted with massive data problems that are now well documented and generally recognised (see OECD, 2007, SOCX – An interpretive guide). This section reports on numbers from the ESSPROS database that in this form have been calculated and been analysed for the first time. Under ESSPROS, long-term care related social expenditure is part of at least the following three sub-functions of spending:

1. Accommodation
2. Care allowances, and
3. Home care.

These can be found as part of both spending under the "old age" function (which brings together services for people aged 65 and older) and under "disability", which reports for expenditure for people below the retirement age. ESSPROS is the only data source that currently has LTC-related data on social spending for 28 European countries (Figure 7).

The results from the calculations shown in Figure 7 confirm the wide variation of spending levels across countries that are much more pronounced than is the case for health care, for example. Although some long-term care expenditure may for a number of countries be reported to varying extent also under the health care function rather than under "old age" and "disability", Figure 7

nonetheless clearly illustrates that a number of countries have currently only very little public spending on long-term care related functions of social protection.¹⁵

A group of Nordic countries (Denmark, Sweden, Iceland and Norway) are the highest spending countries, although at least some of the high spending on the accommodation function will likely be on residential care without substantial long-term care provision. This confirms findings of other international comparisons (see OECD, 2005). On the other end of the spectrum, a number of southern European countries have rather modest long-term care expenditure reported (in the definition of functions used in Figure 7). Care-allowances play an increasing role in Europe, and these account now for substantial shares of long-term care related expenditure in a number of countries: Germany, France, Luxembourg, Austria, Poland, Sweden and the UK.

<Figure 7: Different components of LTC related social expenditure as percentage of GDP, 2004 >

Countries also differ widely in the relative shares between the accommodation function on the one hand, and care provided in private homes, and in the form of care allowances, on the other, although reporting is not uniform here: some countries count care allowances as home care (Luxembourg), while Denmark now reports much of the spending in assisted living and in service departments no longer as “accommodation” but under “home care” (in the sense of community care). Overall, there are, however, currently severe limitations in comparing the patterns shown in Figure 7 between countries (see Box 7 for further methodological remarks).

Box 6: A note on long-term expenditure estimates

In the main European data collection on social expenditure, the ESSPROS database, “long-term care” is not a separate category at the basic level of classifications. Social expenditure on long-term care is found in ESSPROS under three main sub-functions: “accommodation”, “care allowances” and “home care” for the two one-digit (top-level) social functions of “disability” and “old age”.

Countries differ currently widely in the way they “report long-term care” expenditure (for the range of services described above) to the ESSPROS database.

The main differences are:

- Besides under “old-age” and “disability”, there can be a considerable share of long-term care expenditure reported under the “health” function of ESSPROS.
- Expenditure under the “Accommodation” sub-function often contains some public spending on residential homes for older persons without, or with only very little long-term care needs.
- For some countries, the expenditure on long-term care programmes (that typically cover the population irrespective of age) have been split correctly among the “65 and above” age limit used by ESSPROS, whereas for other countries all spending under one programme is in total allocated to either “old-age” or “disability”.

For the latter reason, it is not advisable to compare long-term care related spending under the “old-age” function separately between countries.

¹⁵ However, much of long-term care expenditure for the Netherlands is not reported in Figure 7, because this is included in the AWBZ scheme under health.

Another potential data source is the joint data collection on the System of Health Accounts that OECD/Eurostat/WHO have recently undertaken, and that is partially documented in the OECD Health Data 2006 database. These numbers, however, include only part of all spending on long-term care. Many of the lower care levels of services, such as help with household work, are not included and therefore much of home care spending is excluded. The OECD estimates are consequently usually substantially lower than other estimates.

Moreover, harmonisation of reporting on this spending category is currently low, which casts the results partially in doubt (for example it is implausible that the expenditure in Sweden are much lower compared to Norway, as is reported in OECD Health Data 2006. In addition, the numbers reported in OECD Health Data 2006 can differ substantially from those estimated in the framework of the OECD Long-term care study, which in turn are similar, but not the same as those used as start values for the expenditure projections shown in Table 7 of this paper.

There is consequently much more investment on European level required to improve the data situation on long-term care expenditure substantially for the future monitoring of long-term care policies, such as in the framework of the OMC:

Private participation

In all EU Member States, private households heavily share the burden of care, first by providing the majority of hours of care that people with long-term care needs receive, second by making substantial co-payments or out-of-pocket payments for care provided under public programmes. Unfortunately, aggregate information on private spending is even scarcer than information on public programmes (see, e.g., OECD 2005 for private expenditure estimates).

Private households are in many cases requested to make substantial contributions to the financing of long-term care, either in the form of co-payments to publicly provided care, or as out-of-pocket spending for care for which no or only very little public funding is provided. This can also be the case for systems, where access is universal, but where funding is restricted to only part of the total care needs. In Germany, for example, long-term care insurance only insures the risk of spending on personal services for nursing home residents and these have to pay for the cost of boarding and lodging out of their own pocket.

As there are many pensioner households in all countries that do not have the financial means to cover considerable monthly payments to care providers, social assistance remains in many cases an important source of funding. The share of private funding in total long-term care can also be high for some countries where long-term care provision is currently small (e.g. Portugal, Spain).

Spending trends

The total of the long-term care related expenditure components from the ESSPROS database that this paper analysis has been growing over the last decade (as share of the economy) in all countries for which data are available (Figure 8). Rapid growth of expenditure relative to GDP was reported in the OECD Long-term care study mainly in periods when governments substantially expanded the publicly funded benefit package or changed eligibility criteria, for example by shifting to a universal system (e.g. in Germany and Luxembourg).

<Figure 8: Growth of LTC related social expenditure was uneven, 1995 - 2004>

The OECD reports that for some countries, public expenditure ratios to GDP remained remarkably flat over the past years (after the phasing in of public programmes), mainly due to the fact that public spending was capped in various ways, for example by not adjusting the level of care allowances to inflation or to increasing salaries in long-term care less than in other industries (Austria, Germany). As a result, over an extended period of time, this reduces service availability, affordability, and might put pressure on increased private spending (OECD 2005)

Against this background it is a remarkable finding that spending following the ESSPROS approach suggested in this paper shows growing spending share on long-term care for all European countries with available data.

The country reports under the Study on SHSGI in the EU provide additional evidence on recent expenditure trends and their current drivers, including changes in policy. In France for example, expenditures of the health insurance for the elderly in institutions and at home increased at an annual rate higher than 9%, in current €, between 2000 and 2005. In England, net expenditures on social services for older people have risen steadily in recent years, increased by 114% (in nominal terms) during the period 1994 to 2004. Similarly, total expenditures on health services for older people increased by 50% (in nominal terms) between 1999 and 2003.

The SHSGI study also argues that expenditure growth went for some countries hand in hand with strong job growth in the sector – both in institutions and in home care services. Budget constraints and decreasing employment in community services was, however, observed in several new Member States, for example, in the Czech Republic.

Expenditure projections

All estimations of future long-term care spending seem to agree that substantial additional investment in long-term care will be needed in response to the growing number of very old persons in the population. By 2050, spending (relative to overall growth of the economy) in EU15 may almost double from currently around one per cent of GDP to almost two according to recent OECD projections, and increase by two third in the reference projections for the Commission (Table 7).

<Table 7: Estimated expenditure on long-term care and projections until 2050>

These projection exercises also illustrate that more investment in basic data will be needed to better monitor the development of long-term care expenditure in the future, also to improve international comparability. As Table 7 illustrates, the uncertainty about current spending levels in international comparisons can be of the order of magnitude of the expenditure growth projected in the future (e.g. for Austria, where the 2004/5 number in the AWG reference projection is around 50% below the number used in the OECD projections).

In interpreting these projections correctly, it is important to keep in mind that these are mainly driven by demographic changes and by changes in the relative prices of care services compared to overall economic growth. Likely “catch-up” effects of countries that currently start at relatively

low levels of public expenditure such as for countries that have joined the EU in recent years have not been modelled in these projections. Box 11 reviews a number of other likely drivers of spending growth in the future.

Box 7: Drivers of long-term care spending growth in the future

There are many factors other than demographic ageing that will determine growth in long-term care expenditure under public budgets in the coming decades. Among these are (see, e.g., OECD, 2005, 2006, ECFIN 2006):

- The availability of informal care by family, friends, and the voluntary sector;
- Cost-containment versus more generous public funding of long-term care;
- Public pressure to put public long-term care programmes in place, where these are currently rudimentary, with some convergence in options available and living standards of older people to be expected in Europe;
- The cost of increasing quality of care, both for better trained and paid staff, more attention to quality strategies, and improved infrastructure (including more amenities in nursing homes and substantially better life-style of people living in institutions).
- Cost-pressures that will arise from staff shortages;
- Trends in disabilities, which are currently uncertain (e.g. will the increasing number of people with obesity become more dependent in old age – or will they die before they become frail older persons?);
- Trends in living conditions of older people, such as income levels, the increasing share of older people living as couples, where partners are able to support each other in case of care needs.

Source: Study on SHSGI in the EU, 2007, forthcoming

7. How to make financing of long-term care sustainable?

As this paper has argued, social policy in Member States confronted with a number of challenges for long-term care policies. How will additional investments and further improvements that are certainly necessary in this sector be financed and distributed to guarantee equal access and sustainability? How should the mix of available long-term care services evolve and which roles will the users of these services and their families play?

From the overview in this paper a number of conclusions on the future sustainability of long-term care services emerge:

1. Improved and continuing cooperation of formal care services with informal care provision by families and friends will be key for financial sustainability. No country would be able to provide all or most of care needed by formal, professional services. Where care allowance are now in place (German, and Austria), these “pay” for only a (smaller) part of the officially assessed care needs (in terms of hours of informal or formal care needed).
2. Putting today the right mix of services (between professional services and support services for family care) in place will be crucial for the financial sustainability in the future (OECD, 2005).

3. Staff shortages have started to pose important risks on the future (financial) sustainability of care systems in some countries. There is a “window of opportunity” to address these staff shortages now in order to avoid expensive shortages in the future (see also OECD, 2005).
4. While some countries have started to target public resources more on those most in need, it has been argued that more could be done to support private contributions in the form of specially tailored private insurance or savings contracts (OECD, 2005). There may, however, also be the need for better taking into account the overall income and wealth situation of older people in the future, which calls for closer cooperation between pension, long-term care and public assistance policies. Poverty in old age poses risks both to the health of the oldest age groups, and to the financial sustainability of long-term care and social assistance programmes (that are often financiers of “last resort”).
5. Finally, more investment in the (cost-)effectiveness of prevention strategies and in combating certain age-related diseases, such as Alzheimer, could potentially have a large impact on (reduced) cost for long-term care in the future, but this is currently under-researched.

8. Summary and conclusions

Recent studies have confirmed that the availability of services for older people who experience functional limitations in their everyday life and with basic tasks of self-care varies greatly between, and sometimes also within countries. There is evidence that the quality of services is frequently not up to the expectation of users or of their families.

Moreover, there remain many challenges of better integrating care for older persons between health and social services. Frail older persons have complex service needs that often combine acute health care (in particular for chronic conditions), rehabilitation, nursing care and other social services. Provision across this range of services is typically fragmented. Services of prevention and rehabilitation that could contribute to preventing or postponing dependency and functional limitations that lead to the need for long-term care are still underdeveloped.

Home-care services are in many cases less developed than care provided in institutions such as nursing homes. Dementia patients face in many cases particular problems of access to care than people with long-term care needs that are of a somatic nature.

Part-time inpatient and short-term care facilities (e.g. respite care to relieve caregivers during holidays or illness,) are also underdeveloped in many countries. They may be almost non-existent in other cases, namely in new Member States, and in Southern European countries.

Demographic trends and the need to improve the supply of better quality services that are affordable to users and their families are currently more important drivers of modernisation than the EU legal framework. But this may change in the future with the ongoing modernisation and a changing public-private mix of providers in this sector.

Acknowledgements

The author is indebted to the many experts that have contributed to the recent Study on SHSGI in the EU (see also Annex 3 on this study) and grateful to Carmen Georgi and Fabian Bahr from the European Centre who helped with preparing tables and graphs, and for help with final editing.

The author has, however, the sole responsibility for the selection of the contents and the presentation in this paper and for any errors in the current text. Moreover, this report does not necessarily represent the view of the Commission or of the Directorate General for Employment, Social Affairs and Equal Opportunity.

References

Billings, J/Leichsenring, K (eds) (2005) Integrating health and social care services for older persons. Evidence from 9 European countries. Aldershot: Ashgate.

Commission of the European Communities (1996) Communication from the Commission: Services of general interest in Europe, COM(96)443, Brussels.

Commission of the European Communities (2000) Communication from the Commission: Services of general interest in Europe, COM(2000)0580, Brussels.

Commission of the European Communities (2001) "The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability, Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions, COM 2001/723 final, Brussels.

Commission of the European Communities (2003) Communication from the Commission: Green Paper on services of general interest, COM(2003)270, Brussels.

Commission of the European Communities (2004a) Communication on patient mobility and healthcare developments in the EU, COM(2004)301, Brussels. (http://eur-lex.europa.eu/LexUriServ/site/en/com/2004/com2004_0301en01.pdf).

Commission of the European Communities (2004b) Communication from the Commission: Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the "open method of coordination", COM(2004)304, Brussels.

Commission of the European Communities (2004c) Communication from the Commission: White Paper on services of general interest, COM(2004)374, Brussels.

Commission of the European Communities (2004d) Commission Staff Working Paper: Report on the Public Consultation on the Green Paper on services of general interest, SEC(2004)326, Brussels. (http://ec.europa.eu/services_general_interest/docs/comm_2004_0326_en01.pdf).

Commission of the European Communities (2006a) Communication from the Commission: Implementing the Community Lisbon programme: Social Services of General Interest in the European Union, COM(2006)177, Brussels.

Commission of the European Communities (2006b) Consultation regarding Community action on health services, Brussels. (http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/comm_health_services_comm2006_en.pdf).

Commission of the European Communities (2006c) Report on Social Protection and Social Inclusion, Brussels. (http://ec.europa.eu/employment_social/social_inclusion/docs/2006/cs2006_7294_en.pdf).

European Commission (2006) Long-term care: MISSOC-Info 2006/2, Brussels.

European Commission (2006) Commission Communication: The demographic future of Europe – from challenge to opportunity, COM(2006) 571, Brussels.

European Commission (2006) Commission Staff Working Document, Annex 2 (SEC(2006) 516) to the Communication from the Commission “Implementing the Community Lisbon programme: Social services of general interest in the European Union” (COM(2006)177) of 26 April 2006.

European Commission (2006) Communication from the Commission (2006) First-stage consultation of European Social Partners on reconciliation of professional, private and family life, SEC (2006), Brussels.

Eurostat (2006) Social protection - Expenditure and receipts, European social statistics, Data 1995-2003, 2006 Edition, Luxembourg.

Eurostat (2007) Living conditions in Europe, Statistical Pocket Book, Data 2002 – 2005, Luxembourg.

Huber, M (2005b) Long-term care in OECD countries: current trends in services and progress towards a routine indicator system, Presentation at the UNECE & IIA (UN-Malta) Workshop “Care Provision in Ageing Societies: Policy Challenges & How to Address Them”, 19-20 Malta.

Huber, M. (2005a) The need to improve the comparability of long-term care expenditure data: recent estimates from a selection of OECD countries and follow-up work, Presentation at the Workshop on Trends in Disability and Future Costs of Health and Long-term Care organised by the European Commission, (Working Group on Ageing) and the OECD, 21-22 February 2005, Brussels. http://ec.europa.eu/economy_finance/events/2005/workshop0205/7en.pdf.

Huber, M. (2007 forthcoming) 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.

Institut für Sozialarbeit und Sozialpädagogik (ISS) (Ed.) (2003) Soziale Dienstleistungen als Dienstleistungen von allgemeinem Interesse in der EU – Ziele, Zuständigkeiten, Rahmenbedingungen/Social Services as Services of General Interest in the EU – Objectives, Responsibilities and Conditions/Les services sociaux en tant que services d'intérêt général dans l'UE – Objectifs,

responsabilités, conditions générales, Frankfurt am Main: ISS. (http://www.soziale-dienste-in-europa.de/Anlage25245/Soziale_Dienste_als_DAI_in_der_EU.pdf).

Institut für Sozialarbeit und Sozialpädagogik (ISS) (Ed.) (2004) Gemeinwohlbezogene soziale Dienste in der EU – ihre besonderen Charakteristika, ihre Leistungsfähigkeit und Rahmenbedingungen der Dienstleistungserbringung/Social Services of General Interest in the EU – Assessing their Specificities, Potential and Needs/Les services sociaux d'intérêt général dans l'UE – leurs particularités, leurs performances et les conditions cadre de leurs prestations, Frankfurt am Main: ISS.

(<http://www.soziale-dienste-in-europa.de/Anlage25563/gemeinwohl2004.pdf>).

Lafortune, G. et al. (2007) Trends in Severe Disability Among Elderly People: Assessing the Evidence in 12 OECD Countries and the Future Implications, OECD Health Working Paper No.26, Paris.

Leichsenring K/Alaszewski A (eds) (2004) Providing integrated health and social care for older persons. A European overview of issues at stake (ed. with A. Alaszewski). Aldershot: Ashgate.

Lundsgaard, J. (2005) Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care: How Can it Help Improve Care Outcomes, Employment and Fiscal Sustainability? OECD Health Working Papers No.20, Paris.

Maucher M (2005) Analysis of the replies of all European Union member state's governments to the questionnaire of the Social Protection Committee preparing the Communication on Social and Health Services of General Interest, Observatory for the Development of Social Services in Europe, Frankfurt am Main.

Maucher, Mathias (2005) Analysis of the replies of all European Union member state's governments to the questionnaire of the Social Protection Committee preparing the Communication on Social and Health Services of General Interest, Frankfurt am Main: Monitoring Unit of the Observatory for the Development of Social Services in Europe. (<http://www.soziale-dienste-in-europa.de/Anlage25573/auswertung-antworten-ms-mitteilung-sgdai-ed.pdf>).

Mc Kee, Martin/Mossialos, Elias/Baeten, Rita (Eds.) (2002) The impact of EU Law on Health Care Systems, Brussels: P.I.E.-Peter Lang (Work & Society No. 39).

Moise, P. et al. (2004) Dementia Care in 9 OECD Countries: A Comparative Analysis, OECD Health Working Papers, No.13, Paris.

OECD (2005) Long-term Care for Older People. Paris: OECD.

OECD (2006c) Society at a Glance: OECD Social Indicators, Paris.

OECD (2007) The Social Expenditure database: An interpretive Guide, SOCX 1980-2003, Version February 2007, Paris.

Acronyms

ADL	Activities of daily living
CIRIEC	Centre International de Recherches et d'Information sur l'Economie Publique, Sociale et Coopérative
ECJ	European Court of Justice of the European Communities
EU	European Union
GDP	Gross domestic product
IADL	Instrumental activities of daily living
IT	Information technology
LFS	Labour Force Surveys
LTC	Long-term care
MS	Member States of the European Union
NAPs	National Action Plans for Social Inclusion
NGO	Non-governmental organisation
OECD	Organisation for Economic Cooperation and Development
OMC	Open Method of Coordination
PPP(s)	Public-private partnership(s)
QM	Quality management
SGI	Services of General Interest
SHSGI	Social and Health Services of General Interest
SPC	Social Protection Committee
SSGI	Social Services of General Interest
WHO	World Health Organisation

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TABLE 1: LIMITATIONS IN DAILY ACTIVITIES BY AGE GROUP - % OF RESPONDENTS ANSWERING STRONGLY LIMITED

country	AT	BE	EE	ES	FI	FR	GR	IE	IT	LU	NO	PT	SE
16_24	1,5	4,7	2,6	1,6	3,1	1,2	0,6	1,5	0,9	1,7	2,1	2,6	6
25_34	2,1	6,6	3,4	4,1	4,8	1,8	1,1	2,3	1,5	4	3,4	4,3	7,4
35_44	3,8	9,1	5,1	5,7	8,5	3,1	1,6	4,1	1,7	5	7,3	5,5	11,9
45_54	10,3	11,8	9,8	8,8	11,3	5,8	3,7	6,6	3,3	7,3	9	10,8	16,8
55_64	13,4	14,7	14,9	13,4	12,6	8,1	7,5	10,1	6,3	13,1	10,9	17	22,5
65_74	20	21,4	29,3	16,2	19,1	13,5	13,3	13,3	10,2	16,1	11,6	29,1	17,2
75_84	34,7	29,6	43,4	25,6	31,3	26,3	19,6	20,5	18,4	28,3	17,8	39,3	30,3
85+	47,3	45,4	61,9	31,2	31,6	36,2	25,8	35	33,9	43,9	23,5	48,5	38,5

Source: Eurostat

TABLE 2: SELF PERCEIVED HEALTH BY AGE GROUP - % OF RESPONDENTS ANSWERING BAD OR VERY BAD

	AT	BE	DK	EE	ES	FI	FR	GR	IE	IT	LU	NO	PT	SE
16_24	0,9	2,3	1,6	2,5	1,9	1,2	1,4	0,4	0,6	0,9	1,9	2,5	2,6	4,2
25_34	2,7	3,7	3,1	2,3	3,7	2,2	2,9	1	1	2,1	3	4,5	5,5	3,1
35_44	2,9	5,1	4,2	4,9	5,1	4,7	4,1	1,9	1,9	3,3	4,7	8	8,2	6,6
45_54	8,1	9,5	7	11,6	11,1	7,9	10,3	4,1	4,1	6,3	11,4	9	18	9,5
55_64	10,8	12,2	9,1	21,6	20,4	12	14,9	11,9	5,9	13,3	16,5	12	32	10,4
65_74	17,2	16,3	10,7	37,1	30,4	18,3	21,6	20,7	8,4	23,6	16,6	12,5	51	8,2
75_84	31,6	22,6	18,5	49,9	41,7	32,3	32,3	33,6	12,8	35,2	28,5	17,5	62,3	18,1
85+	36,6	26,1	22,7	51,9	46,7	38,1	35,5	47,3	25,2	41,7	39,6	24,3	63,5	19,9

Source: Eurostat

TABLE 3: THE AGEING OF THE POPULATION IN EUROPE

EU-25	Retirement age to working age population (in %) 1)			Life expectancy at birth (in years)	
	1970 2)	2005 2)	2050 2) 3)	Males	Females
				2004 2) 4)	
EU-25	18,4	:	52,8	75,6	81,7
BE	21,2	:	48,1	75,9	81,7
CZ	17,9	19,8	54,8	72,6	79,2
DK	18,9	22,7	40,0	75,4	80,1
DE	21,4	27,8	55,8	76,5	82,1
EE	17,7	:	43,1	66,1	77,2
EL	17,2	:	58,8	76,6	81,4
ES	15,2	24,4	24,4	77,2	83,8
FR	20,6	25,2	47,9	76,7	83,8
IE	19,3	16,4	45,3	76,4	81,2
IT	16,7	:	66,0	76,8	82,5
CY	:	17,3	43,2	76,6	81,7
LV	18,0	24,1	24,1	65,9	76,2
LT	15,9	22,3	44,9	66,3	77,7
LU	19,1	21,3	36,1	76,0	82,2
HU	17,0	22,7	48,3	68,7	77,2
MT	:	19,3	40,6	76,7	80,7
NL	16,2	20,8	38,6	76,9	81,4
AT	22,7	22,7	23,5	76,4	82,1
PL	12,6	18,7	51,0	70,6	79,2
PT	14,9	25,2	58,1	74,9	81,4
SI	14,8	14,8	21,8	73,5	80,7
SK	14,4	16,3	50,6	70,3	78,0
FI	13,6	23,8	46,7	75,3	82,2
SE	20,7	26,5	40,9	78,3	82,6
UK	20,7	:	45,3	76,2	80,7
BG	14,0	24,8	60,9	69,0	76,2
HR	:	:	:	72,0	79,0
MK	:	:	:	:	:
RO	:	21,1	51,1	68,2	75,5
TR	:	:	:	68,8	73,6
IS	15,0	17,9	:	78,9	82,8
LI	12,3	15,6	:	78,6	84,2
NO	20,4	22,4	:	77,5	82,3
CH	17,3	23,3	:	78,5	83,6

Notes:

1) Population aged 65 years and over related to the population between 15 and 64. These are rough approximations of the real retirement and working ages.

2) 1 January.

3) 2050: Eurostat, 2004 based population projections. Trend scenario, baseline variant.

4) Belgium, Estonia, Italy, Malta, United Kingdom: 2003.

Source: Eurostat (2007: Table 1.3)

TABLE 4: RELATIONSHIP BETWEEN CARE RECIPIENT AND INFORMAL CARE GIVER

Country (source)	Year	Relationship	Total	Male	Female
Austria (Microcensus 2002)	2002	Partner	18	7	11
		Child	38	14	24
		Other	43	12	32
		Total	100	34	66
Sweden (Survey of aged care, 2000)	2000	Child	46	13	33
		Other	53	..	..
		Total	100	..	..
Ireland (Survey of older persons, 1993)	1993	Partner	22	5	17
		Child	48	13	35
		Other	30	..	..
		Total	100	..	..
Germany (Schneekloth and Müller, 2000)	1998	Partner	32	12	20
		Child	28	5	23
		Other	40	3	37
		Total	278	20	80
Spain (Survey on impairment, disabilities, and handicaps)	1999	Partner	23		
		Child	38	6	32
		Other	39		
		Total	100		
United Kingdom (General household survey, 2000)	2000	Partner	15	..	..
		Child	43	..	..
		Other	42	..	..
		Total	100	..	..

Note: The definition of carers and care recipients may differ between countries. The number of informal carers is usually higher than the number of carers receiving support under public long-term care programmes (e.g. as cash allowances)

Source: OECD, 2005, Table A.6

TABLE 5: AGE DISTRIBUTION OF CARE GIVERS

Country	Year	Under 45	45-64	ab 65
Austria	2002	27	48	25
Canada	1995	35	42	23
Germany	1998	15	53	33
Ireland	2002	46	43	11
Japan	2001	4	42	54
United Kingdom	2000	35	45	20
USA	1994	12	37	51

Canada: British Columbia only

Germany: main caregivers only, age groups refer to -39, 40-64, 65+

Japan: age groups refer to -30, 40-59, 60+

United Kingdom: age groups refer to 16-44, 45-64, 65+

TABLE 6: ORGANISATION OF SERVICES PROVISION IN LONG-TERM CARE SERVICES

	Country							
	CZ	DE	FR	IT	NL	PL	SE	UK
Approximate "market" shares								
Public	80%	5%	42%	30%	0%	na	70%	10%
Non-profit	15%	50%	51%	50%	80%	na	10%	10%
For-profit	5%	50%	7%	20%	20%	na	20%	80%
Mode of governance								
Market				x		x	x	x
Quasi-market (competition between providers and purchasing by a public agency based on regulations)		x			x	x	x	
Planning	x		x	x	x		x	
Other (please specify)								
Service cheques for purpose of services							x	
User and worker's cooperatives								
Type of regulatory mechanism								
Related to authorisation regimes for service providers	x		x					
• Accreditation	x				x	x	x	x
• Certification	x						x	x
Related to service provision requirements		x					x	

Source: Study on SHSGI in the EU, 2007, forthcoming, Table 4.1.

TABLE 7: ESTIMATED EXPENDITURE ON LONG-TERM CARE AND PROJECTIONS UNTIL 2050

Country	AWG reference scenario (ECFIN)			OECD projections				
	2005	2050	Change (2004-2050)	2005(*)	Cost-pressure	Change (2004-2050)	Cost-containment	Change (2004-2050)
BE	0,9	1,8	1	1,5	3,4	1,9	2,6	1,1
DK	1,1	2,2	1,1	2,6	4,1	1,5	3,3	0,7
DE	1	2	1	1	2,9	1,9	2,2	1,2
GR	na	na	na	0,2	2,8	2,6	2	1,8
ES	0,5	0,8	0,2	0,2	2,6	2,4	1,9	1,7
FR	na	na	na	1,1	2,8	1,7	2	0,9
IE	0,6	1,2	0,6	0,7	4,6	3,9	3,2	2,5
IT	1,5	2,2	0,7	0,6	3,5	2,9	2,8	2,2
LU	0,9	1,5	0,6	0,7	3,8	3,1	2,6	1,9
NL	0,5	1,1	0,6	1,7	3,7	2	2,9	1,2
AT	0,6	1,5	0,9	1,3	3,3	2	2,5	1,2
PT	na	na	na	0,2	2,2	2	1,3	1,1
FI	1,7	3,5	1,8	2,9	5,2	2,3	4,2	1,3
SE	3,8	5,5	1,7	3,3	4,3	1	3,4	0,1
UK	1	1,8	0,8	1,1	3	1,9	2,1	1
EU15	0,9	1,5	0,7	1,3	3,5	2,2	2,6	1,3
CY	na	na	na	na	na	na	na	na
CZ	0,3	0,7	0,4	0,4	2	1,6	1,3	0,9
EE	na	na	na	na	na	na	na	na
HU	na	na	na	0,3	2,4	2,1	1	0,7
LT	0,5	0,9	0,4	na	na	na	na	na
LV	0,4	0,7	0,3	na	na	na	na	na
MT	0,9	1,1	0,2	na	na	na	na	na
PL	0,1	0,2	0,1	0,5	3,7	3,2	1,8	1,3
SK	0,8	1,3	0,6	0,3	2,6	2,3	1,5	1,2
SI	1	2,2	1,2	na	na	na	na	na
EU25	0,9	1,5	0,6	na	na	na	na	na

(*) estimated start value for projections

Source: ECFIN 2006 and OECD 2006

FIGURE 1: MAIN ISSUES AT STAKE FOR LONG-TERM CARE SERVICES

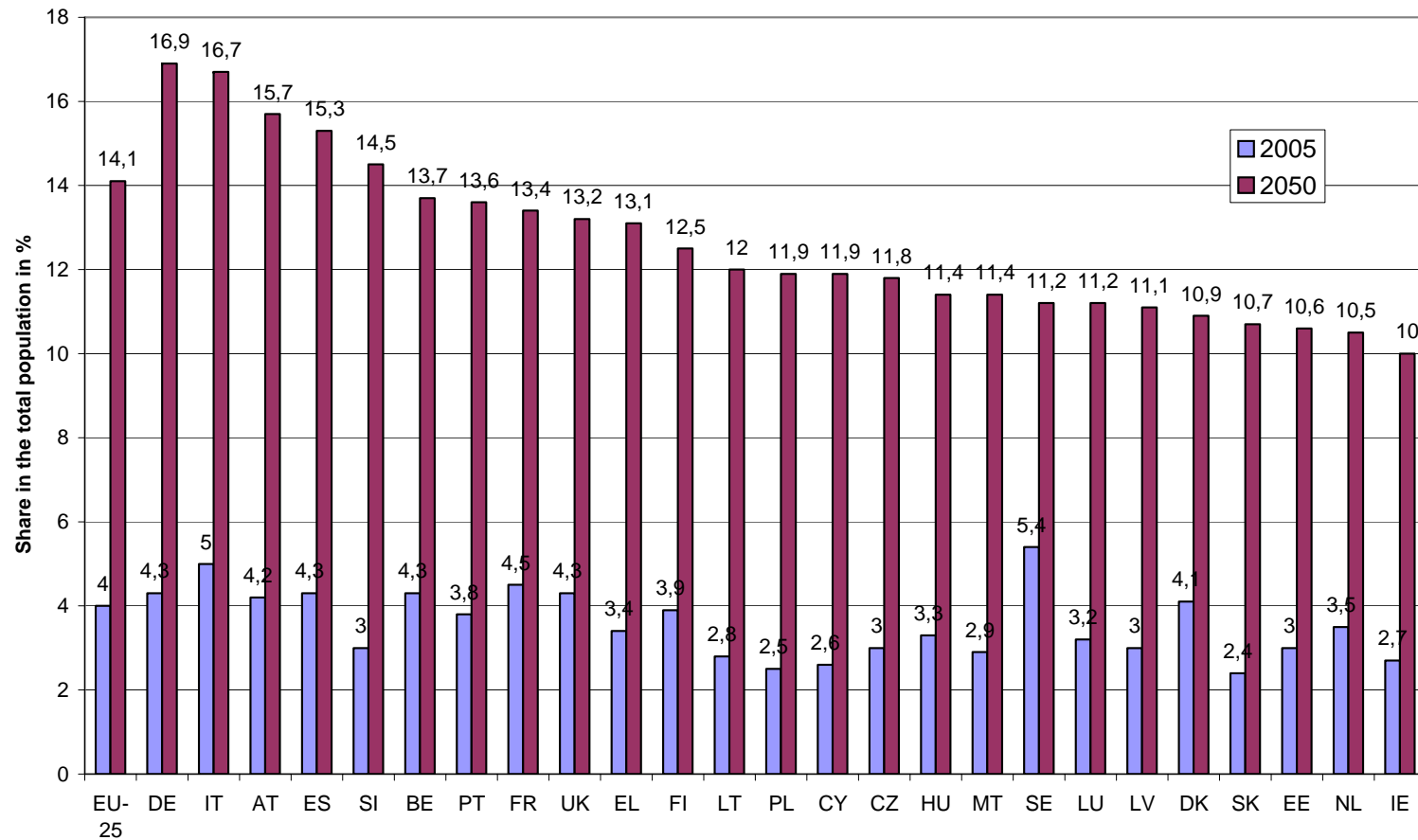
Main issues at stake	Country						
	CZ	DE	FR	IT	NL	SE	UK
Demographic trends and other (macro) socio-economic developments	1	1	1	1	1	1	2
Financial constraints on budgets of public territorial authorities (on national, regional, local level)	1	1	2	1	3	3	1
Availability of a sufficient quantity of good quality services	1	3	2	1	1	2	2
Need to adapt to the evolution of users' needs or to better tailor the supply of services	2	1	1	4	2	2	1
Structural reforms in view of organisation, regulation, financing	2	2	1	4	1	2	2
Problems with low-quality services	3	2	3	3	1	1	2
Availability and qualification of personnel	4	2	3	4	1	1	1
Co-existence of different types and status of providers	1	1	3	2	2	3	5
Concerns about financial sustainability of service provision	1	3	5	4	1	2	1
Affordability of services for private households (e.g. avoiding high cost-sharing requirements)	2	2	3	1	3	3	3
Introduction or extension of new regulatory or administrative measures	4	2	1	4	2	2	3
Implications of introduction of (quasi-) market or of competition from private for-profit providers	3	2	2	4	2	3	3
Cost cutting and/or effects of measures to increase efficiency	3	2	4	4	3	4	1
Potential frictions with EU-law and the implementation and/or repercussion from ECJ jurisprudence	5	3	3	5	4	3	5

Note: Rating from 1 (Very important) to 5 (Not at all important)

1	2	3	4	5
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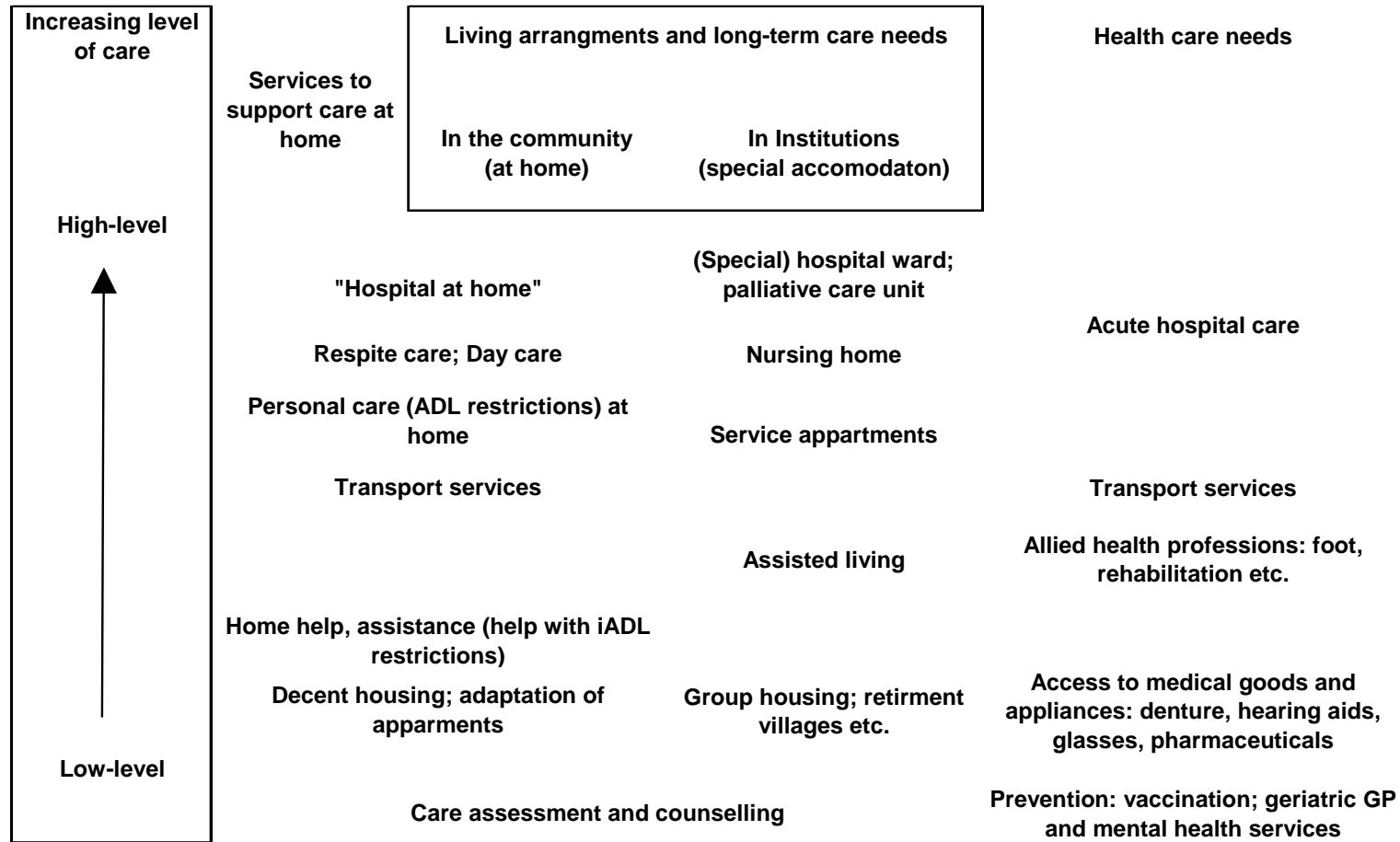
Source: Study on SHSGI in the EU, 2007, forthcoming, Figure 4.1

FIGURE 2: POPULATION AGED 80 YEARS AND OVER, 2005 - 2050



Source: Eurostat (2007: Graph 1.2)

FIGURE 3: LONG-TERM CARE: A COMPLEX ARRAY OF SERVICES



Source: author's graphic

FIGURE 4: COMPETENT PUBLIC AUTHORITIES IN LONG-TERM CARE SERVICES

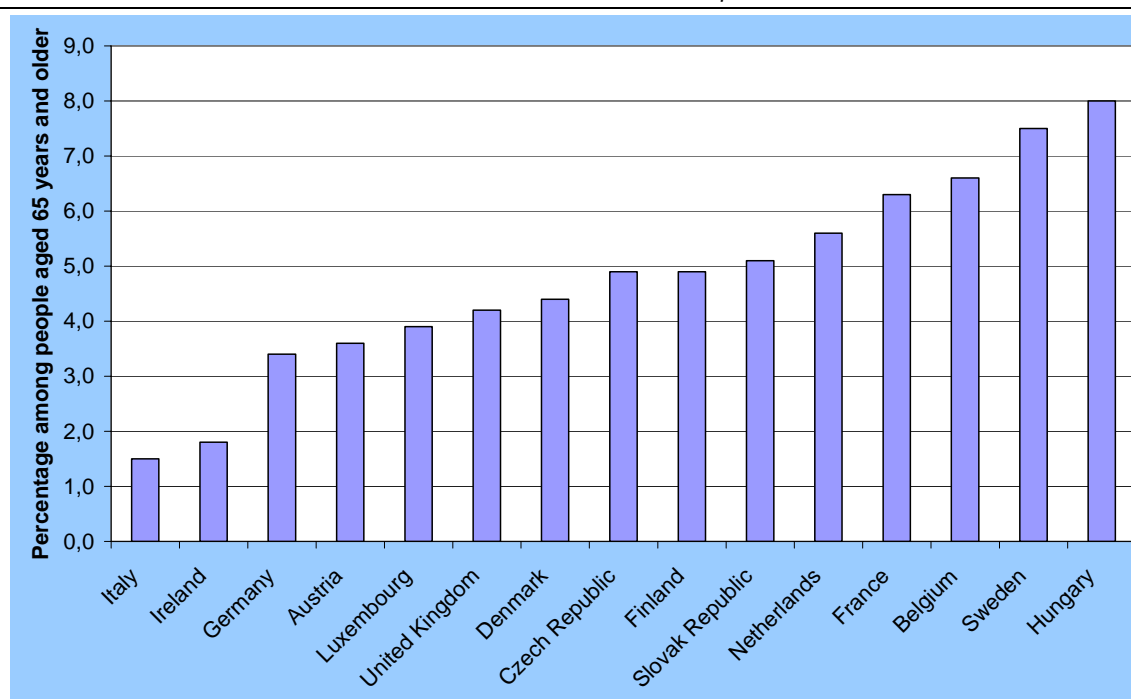
Competent public authority	Country							
	CZ	DE	FR	IT	NL	PL	SE	UK
National government	4	3	1	5	1	3	2	3
Regional territorial authority (state; province)	1	1		1		2	2	4
Local territorial authority		1				1		1
• District			2	4			2	5
• Municipality	2			3		1	1	1
Social insurance agency		1			2		2	5

Note: Ranking from 1 (Most involved) to 5 (Least involved)

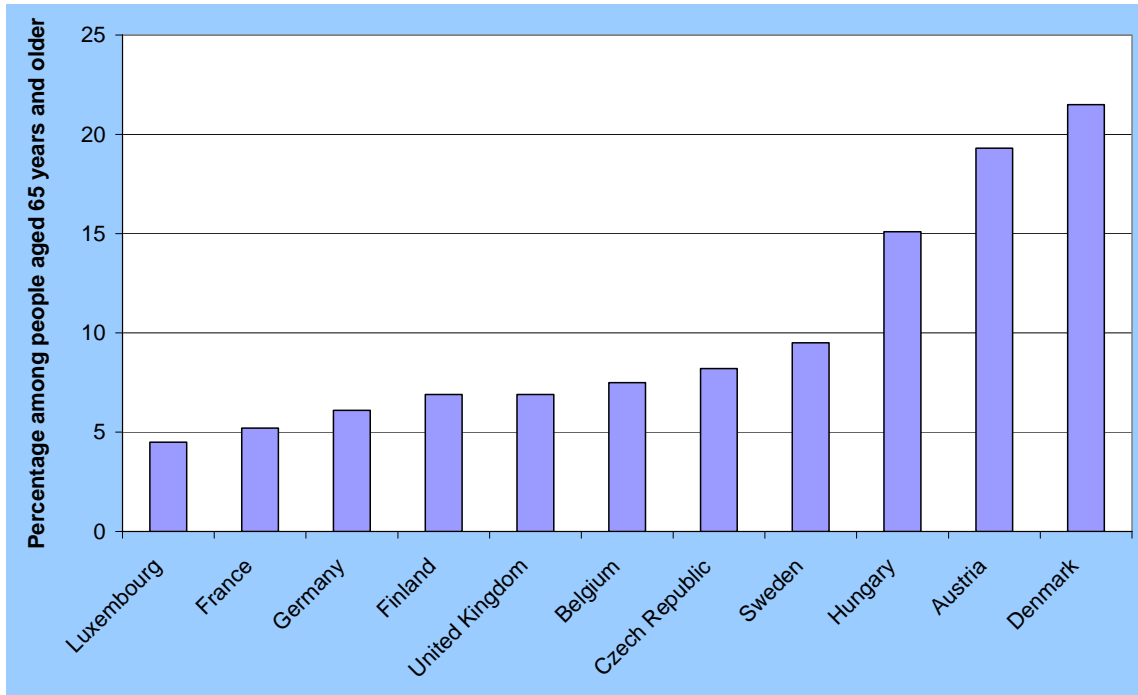


Source: Study on SHSGI in the EU, 2007, forthcoming, Figure 4.3.

FIGURE 5: PEOPLE RECEIVING LONG-TERM CARE IN INSTITUTIONS, 2004

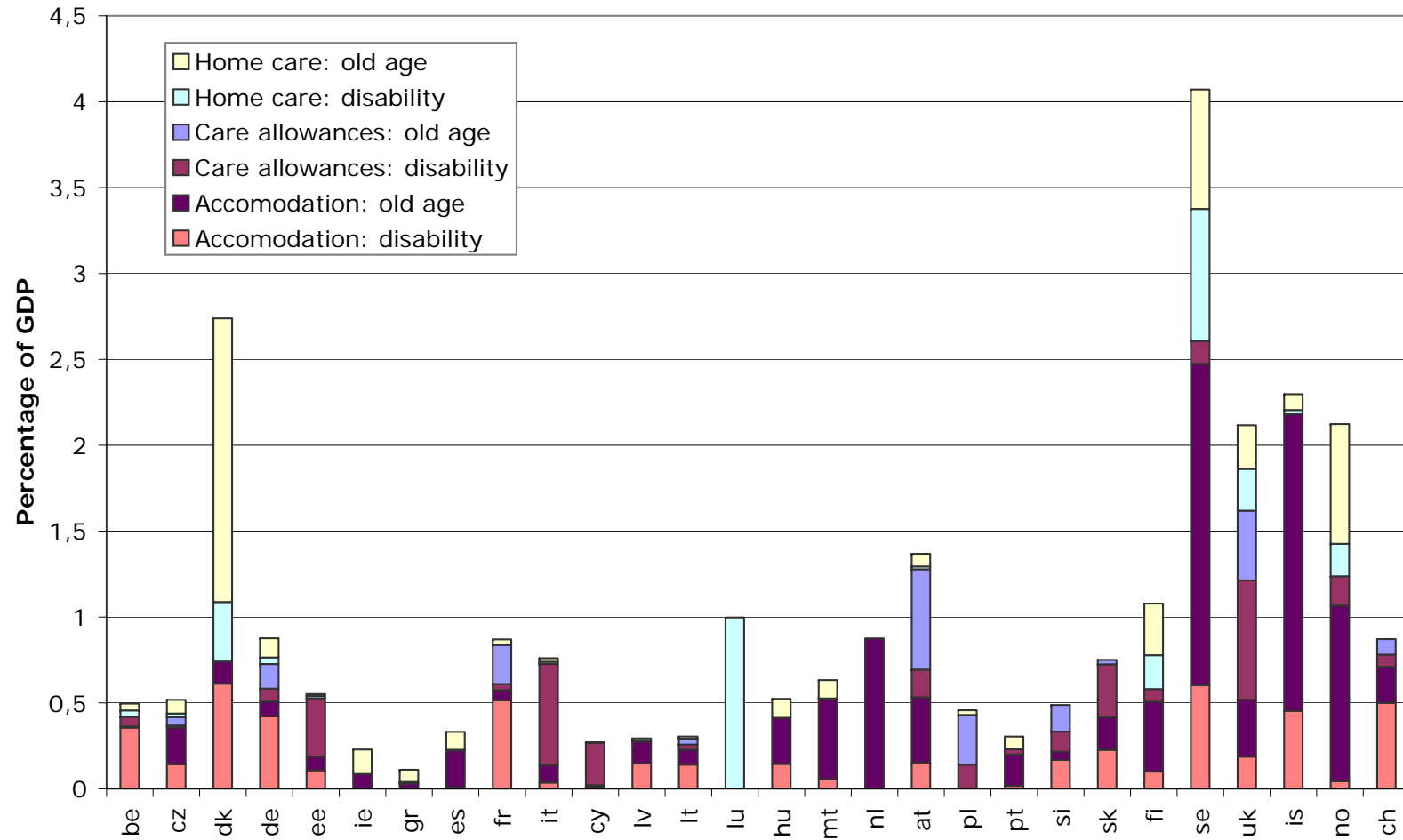


Source: OECD Health Data 2006

FIGURE 6: PEOPLE RECEIVING LONG-TERM CARE IN THE COMMUNITY (INCLUDING CARE ALLOWANCES), 2004

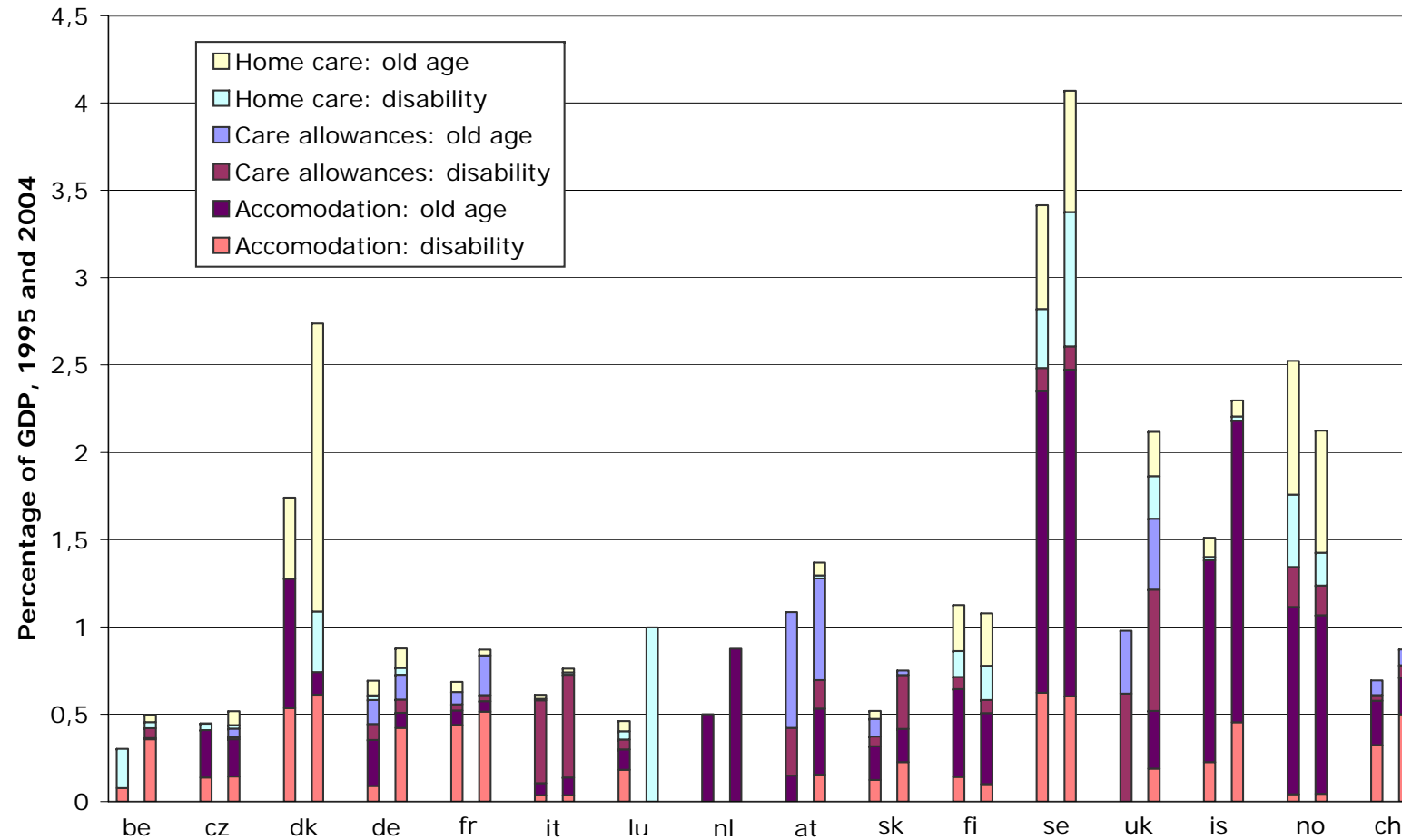
Source: OECD Health Data 2006

FIGURE 7: DIFFERENT COMPONENTS OF LTC RELATED SOCIAL EXPENDITURE AS PERCENTAGE OF GDP, 2004



Source: ESSPROS (accessed May 2007), own calculations

FIGURE 8: GROWTH OF LTC RELATED SOCIAL EXPENDITURE WAS UNEVEN, 1995 - 2004



Source: ESSPROS database (accessed May 2007), own calculations

Annex 2. The application of the Community rules in the area of social services

The following box recalls the “history” of the discussion on SSGI in European policies. The following sections are taken from the Annex to the recent Communication on Social Services of General Interest that was published on April 26, 2007.

Box 8: SSGI – an emerging EU policy topic

In spring 2003, the Green Paper on SGI¹⁶ put a clear emphasis on network-related industries and services (such as transport, water, gas, electricity, telecommunication, postal services). Social and health services are mentioned, but not dealt with separately and/or in detail.

The successive White Paper on SGI¹⁷, published roughly one year later, again mainly focused on network-based industries and services and on Community principles, regulation and framework conditions for their functioning. A core Community notion developed in this regard is the universal service concept which can be understood as a set of general quality guidelines for SG(E)I, such as universality, accessibility, affordability, continuity, security, transparency, user and consumer protection.

In this document, the European Commission, however, devoted a specific chapter to the social and health sector and introduced the concept of social and health services of general interest (SHSGI). It also announced a Communication on SHSGI to describe the way in which they are organised and financed and to further systematise approaches on Community rules and the contribution of these rules to the modernisation process of social and health services and to improve knowledge of the actors in this field on their organisation, regulation, delivery and financing.

Linked to the two documents mentioned above, the European Commission launched a broad debate on the future of SG(E)I in Europe, contributing to a comprehensive review of its policies in this field. The stakeholders at European and national level were and are being involved in the reflections. The Green Paper on SGI was followed in 2003 by a questionnaire-based consultation process, resulting in a large number and range of replies, statements and opinions elaborated by stakeholders at EU and national level¹⁸. The White Paper did not lead to a second comparable broad consultation process.

For the field of social and health services, the Commission, in 2004 and 2005, used a different double-track strategy to prepare the communication on SHSGI announced in the White Paper on SGI. On the one hand it co-organised a conference which provided a forum for national and European stakeholders, especially governments and non-governmental organisations from the

¹⁶ Commission of the European Communities, 2003

¹⁷ Commission of the European Communities, 2004c

¹⁸ For results see the report on the public consultation, Commission of the European Communities, 2004d, with section 4.4.3, “An interest in the clarification of the situation of organisations providing social services”, p. 15, being devoted to the field of interest of this study.

social and health policy areas, to voice their positions, fears and expectations related to the communication itself, but also to various questions concerning the legal and political framework for services of general economic interest and services of general interest at EU level. On the other, in order to gain additional information concerning policies and approaches, a questionnaire was distributed by the Social Protection Committee (SPC) to the Member States, to be answered by December 2004.

The 2004 SPC questionnaire on SHSGI

The SPC questionnaire proposes a rather broad concept of “social services” which is not confined to any of the terms “social protection”, “social security” or “personal social services” or to other common concepts as used in the Member States. SPC and DG Employment and Social Affairs had proposed to delimit the scope of the 2004 SPC inquiry on social and health services of general interest to the following fields and systems: statutory social protection schemes, supplementary social protection schemes, health and social care services, support for families (e.g. childcare facilities or services), services to promote social integration and to provide personal support (e.g. in cases of homelessness, drug dependence, disability, mental or physical illness), social housing and other services with similarities to social and health services or active labour market measures (e.g. access to placement services or education and training).

The insight gained from the analysis of the replies to the questionnaire by all 25 Member State governments and of a series of European-level and national stakeholders as well as first conclusions were summarised in the feedback document “Social services of general interest and health and long-term care services within the European Union”¹⁹ (18 March 2005). This paper served as a background document for a seminar (1 April 2005) to discuss the issues with all Member States’ governments and selected European umbrella organisations representing the social partners, the social economy and the civil society (NGOs in the social and health policy field), in order to “conclude” the consultation process launched by the White Paper on SGI.

Source: Study on Social and Health Services of General Interest in the European Union (2007 forthcoming), Final Synthesis Report, Vienna, Frankfurt and Liege.

Applying the subsidiarity principle and the distinction between economic and non-economic services of general interest.

In general, the case law of the Court of Justice (“the Court”) indicates that the EC Treaty gives Member States the freedom to define missions of general interest and to establish the organisational principles of the services intended to accomplish them.

However, this freedom must be exercised transparently and without misusing the notion of general interest, and the Member States must take account of Community law when fixing the arrangements for implementing the objectives and principles they have laid down. For example, they must respect the principle of non-discrimination and the Community legislation on public contracts and concessions when organising a public service.

¹⁹ Cf. http://www.europa.eu.int/comm/employment_social/social_protection/docs/background_en.pdf

Moreover, when it comes to services of an economic nature, the compatibility of their organisational arrangements with other areas of Community law must be ensured (in particular freedom to provide services and freedom of establishment, and competition law). In the field of competition law, the Court has established that any activity consisting of supplying goods and services in a given market by an undertaking constitutes an economic activity, regardless of the legal status of the undertaking and the way in which it is financed²⁰.

With regard to the freedom to provide services and freedom of establishment, the Court has ruled that services provided generally for payment must be considered as economic activities within the meaning of the Treaty. However, the Treaty does not require the service to be paid for directly by those benefiting from it²¹. It therefore follows that almost all services offered in the social field can be considered “economic activities” within the meaning of Articles 43 and 49 of the EC Treaty.

The public authorities and the operators in the field of social services of general interest perceive the constant evolution of Court jurisprudence, in particular for the notion of “economic activity” as a source of uncertainty. Whilst the case law and Community legislation¹⁴²² have endeavoured to reduce this uncertainty or clarify its impact, they cannot do away with it completely.

Specific situations encountered today by the social services

To properly understand the specific conditions for the application of the Community framework to social services, this Communication deals with the most frequent situations.

Delegation

Deciding whether to delegate a social mission in whole or in part If the public authorities decide to delegate the mission to an external partner or to form a public-private partnership, Community law on public contracts and concessions may come into play.

In such cases, the public body delegating a social mission of general interest to an external organisation must, at the very least, respect the principles of transparency, equal treatment and proportionality. Moreover, in certain cases, the public contracts directives impose more specific obligations. For example, Directive 2004/18/EC concerning, inter alia, public service contracts requires contracting authorities to establish technical specifications for contract documents such as contract notifications, specifications or complementary documents. Certain Member States and service providers have pointed out the difficulty of establishing in advance a precise description of the specifications for social services, which must be adaptable to the individual circumstances of persons in need.

To overcome this difficulty, technical specifications may be established on the basis of performances and functional requirements. This means that the contracting or awarding

²⁰ See, for example, cases 180/98 to 184/98, Pavlov and others.

²¹ Case 352/85, Bond van Adverteerders.

²² See Annex 2 to Commission working document SEC(2006)516

authorities may decide to define just the aims to be achieved by the service provider. This way of defining technical specifications should guarantee the necessary flexibility and, at the same time, sufficient precision to identify the subject of the contract.

- Management of a social service under a public-private partnership Public-private partnerships (PPPs) are being used increasingly to provide social services of general interest.

In this context, the term “concessions” and the rules concerning their award, as well as the application of the provisions of public contracts relating to the creation of mixed capital entities whose objective is to provide a public service (institutionalised PPPs), should be clarified. Consultation has shown that clarification is required for institutionalised PPPs.

Significant clarifications on the distinction between “internal” and “third party” entities were brought by the Court of Justice’s judgment in the *Stadt Halle* case²³¹⁵. According to this ruling, the procedures for awarding public contracts apply as soon as a public authority intends to conclude a contract for pecuniary interest with a legally distinct enterprise in whose capital it has a holding with one or more private enterprises.

Use of public financial compensation

A public authority may decide to pay compensation to an external body for the performance of a social mission of general interest. This financial compensation is intended to make up for any expenditure involved in accomplishing this mission which would not have been incurred by an enterprise operating solely according to market criteria. Following a judgment of the Court²⁴, the Commission²⁵ took a decision pertaining to State aid which has already considerably simplified the requirements on financial compensation received by social service providers and provided the necessary legal certainty. This decision established the thresholds and criteria in such a way that the compensation received by the vast majority of social services is automatically considered to be compatible with the competition rules and therefore exempt from the obligation of prior notification. Compensation will still have to be communicated to the Commission for the small number of social services, which do not meet these thresholds and criteria²⁶.

However, these simplifications can apply only if the services in question have, in advance and by legal act, been attributed a mission of general interest. The Commission’s decision therefore encourages Member States to make the missions they delegate to social services explicit, thus leading to transparency which is useful for everyone, both the services in question and their users.

²³ Case 26/03, judgment of 11 January 2005.

²⁴ Case 280/00, judgment of 24/07/2003, *Altmark Trans*.

²⁵ OJ L 312 of 29.11.2005, pp. 67-73.

²⁶ See Annex 2 to Commission working document SEC(2006)516.

Regulation of the market

Where private operators provide a social service, Member States may decide to support the operation of the market to ensure that certain objectives of general interest are met. In so doing, they must respect Community law, in particular the rules and general principles of the Treaty pertaining to the freedom to provide services and freedom of establishment. It should be remembered in this context that services excluded from the scope of the Directive on services in the internal market will continue to be subject to these rules and principles.

Freedom of establishment (Article 43 of the EC Treaty) allows an operator to perform an economic activity through a permanent base in another Member State for an indefinite period.

This will often be the case for social services frequently requiring the use of infrastructure in practice (social housing, homes for elderly people).

Freedom to provide services (Article 49 of the EC Treaty) means that an economic operator may provide services temporarily in another Member State without being established there. It also allows a consumer to use services offered by a provider established in another Member State. Articles 43 and 49 of the EC Treaty rule out not only discriminatory national rules but also any national rule applied indiscriminately to national and foreign operators which makes exercising these fundamental freedoms more difficult or less attractive. However, according to the case law of the Court, social policy objectives are overriding reasons based on the general interest which may justify the application of measures intended to regulate the market, such as the obligation to hold a permit in order to provide a social service. The Court ruled that such measures must be based on objective, non-discriminatory criteria which are known in advance so as to support the exercise of the national authorities' powers of appraisal. To be compatible with Community law, these measures must also be proportionate. Moreover, the opportunity for access to an adequate recourse has to be guaranteed.²⁷

Compatibility with the rules on access to the market

An analysis of these examples illustrates the flexibility in the application of the Treaty when it comes to recognising (in particular in the spirit of Article 86(2)) the inherent features of these services' missions of general interest. When the compatibility of the modalities of accomplishing a mission of general interest with the rules of access to the market is assessed, these specific features are therefore taken into account. The Community rules encourage the public authorities to be clear about the correspondence between the burdens or obligations associated with the mission and the restrictions on access to the market they consider necessary to allow these organisations to perform properly, beyond the definition of missions of general interest attributed to a social organisation.

²⁷ See for instance the judgment of 20.02.2001, Case C-205/99, *Anilir*.

Annex 3. List of forthcoming reports under the SHSGI project

SHSGI Policy papers

These are reports submitted under the SHSGI project to cover in-depth a range of transversal or sectoral topics.

Schulte, Bernd (2007) *The European Legal Framework*, Max-Planck-Institut für ausländisches und internationales Sozialrecht, *SHSGI Policy Paper No.1*, Munich.

Herrmann, Peter (2007) *Social and Health Services of General Interest A Wider Perspective*, European Social, *SHSGI Policy Paper No.2*, Organisational and Science Consultancy (ESOSC), Aghabullogue (Ireland).

Czischke, Darinka and Nikolova, Mariya (2007) *Sector Report: Social Housing in Europe*, European Social Housing Observatory at CECODHAS, *SHSGI Policy Paper No.3*, Brussels.

SHSGI Country studies

These are reports submitted to the SHSGI study by expert teams in charge of in-depth country studies for the following eight country cases

Potuček, Martin, Hanušová, Pavla, Kopecká, Petra and Scháněl, Martin (2007) *Czech Republic*, SHSGI Country Studies, No.1, Praha.

Richez-Battesti, Nadine, Priou, Johan and Petrella, Francesca (2007) *France*, SHSGI Country Studies, No.2.

Schulz-Nieswandt, Frank, Sesselmeyer, Werner, Wölbert, Saskia, Meyer-Rigaud, Remi, Nätke, John F. und Toellner-Bauer, Ulrike (2007) *Germany*, SHSGI Country Studies, No.3.

Kazepov, Yuri, da Roit, Barbara, Sabatinelli, Stefania, Arlotti, Marco and Barberis, Eduardo (2007) *Italy*, SHSGI Country Studies, No.4.

Tjadens, Frits and Meinema, Thea (2007) *Netherlands*, SHSGI Country Studies, No.5.

Balcerzak-Paradowska, Bozena, Golinowska, Stanisława and Krzyszkowski, Jerzy (2007) *Poland*, SHSGI Country Studies, No.6.

Fröbel, Lisa, Jönsson, Per-Olof and Sundén, Eva (2007) *Sweden*, SHSGI Country Studies, No.7.

Spear, Roger Garth, Wittenberg, Raphael, Aiken, Mike, Davey, Vanessa and Matosevic, Tihana (2007) *United Kingdom*, SHSGI Country Studies, No.8.