CHAPTER 8

LONG-TERM CARE IN EUROPE

An introduction

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Abstract: A European overview of the situation of long-term care faces the problem that this type of care is mostly organized at local level. It is therefore rather difficult to make a comparison between countries and to give a European overview. Overall figures hardly exist due to this difficulty. On the other hand, the present challenges and future trends are rather similar in the various countries.
Keywords: long-term health care

INTRODUCTION

There is a strong relationship between long-term care and Farming for Health (FH). Most of the persons who benefit from FH are elderly people, persons with mental and physical handicaps and persons with psychiatric handicaps. Most of the clients belong to the target group of long-term care. It is not surprising that long-term care is one of the major sources of income of FH.

Long-term care is understood as a well-planned and well-organized set of services and care processes, targeted at the multi-dimensional needs/problems of an individual client or a category of persons with similar needs/problems. Elements are home nursing and long-term health care, social care, housing, and services such as transport, meals, occupational activities, empowerment activities, etc.

The exact meaning of 'long' differs from country to country. It is not so much defined by the length of the period as by the functions and services. If in The Netherlands you receive one week home help, it is still called long-term care.

What do we really mean when we talk about long-term care? Persons with physical or mental handicaps and frail elderly need support and help in their daily life activities; 80 % of their demands regard assistance with shopping, small repairs in the house, help in getting in or out of bed, help with dressing, help with all kind of forms, cleaning the house, help with putting on supporting stockings, social activities, support with finding and carrying out work, contacts with other people,

Jan Hassink and Majken van Dijk (eds.), Farming for Health, 101-106.

help in spending the day: activities that ask little technical but a lot of social expertise; activities that do not belong to the medical domain but the social one; activities that belong to the daily life domain.

DIFFICULT COMPARISON

It is very complicated to give a European overview, and hardly any facts have been aggregated at European level. Much is known for individual countries. The reasons for the lack of national and European aggregation are:

- Services are often divided between different public structures and budgets (national, provincial, regional, local), between health budget and services, and between social budget and services.
- Long-term care is highly influenced by different structures of informal and family care (Mediterranean countries have family care far above average and the number of long-term care beds is therefore far below the European average).
- Systems of long-term care are being reformed: reorganized and innovated (mostly with budget consequences) in northern and central countries and expanded in southern countries.
- Dealing with personal social services in the local context is far more important than in the national or European context.
- Nordic countries started to develop social care services already during the 1950s (undergoing marked differentiation between different types of services and institutions, professional concepts and approaches). Southern-European countries are still in a pioneering phase (difficulties regarding funding and staffing).
- There is a sharp contrast with general health care with its well-defined medical professions, differentiated competences, monitoring, registration, etc. Social services are often lacking even national regulations.

FINANCING SYSTEMS

There are two main systems of financing health care, working with public funding mechanisms, in Western Europe:

1. The Beveridge model, which is tax-funded with infrastructure of ownership and control of authorities (Denmark, Greece, Spain, Ireland, Iceland, Italy, Norway, Portugal, Finland, Sweden, UK).
2. The Bismarck system, which is social-insurance-funded and controlled by legal private organizations (Belgium, Germany, France, Liechtenstein, Luxemburg, Netherlands, Austria, Switzerland).

Some countries have a tendency towards a mixed system. Table 1 gives some examples.

FACTS AND FIGURES

Some of the most important figures are summarized below (see Table 1):

- Between 1995 and 2001 18 % of net job creation took place in this sector. Average health-care expenditure in Europe is 8.4 % of GDP (USA: 13%).
- Public expenditure on long-term care is 1.3 % of GPD, ranging from 0.7 % in France, Ireland, Austria up to 2.8 % in Sweden and 3 % in Denmark (Annex 1).
- Health care and social services are very labour-intensive. Employment in the health-care and social sector is approximately 10-13 % of overall employment; in long-term care approximately between 3 and 5 % of overall employment.

Table 1. *Health-care financing (primary, secondary and tertiary) in percentages*

	Taxes	Social insurance	Private insurance and contributions
Netherlands	5	73	22
Denmark	85	0	15
Norway	48	48	5
UK	64	20	16
Ireland	78	9	13
Italy	38	39	23
Greece	26	32	42

PRESENT CHALLENGES

- Long-term care is a rather young sector; laws and regulations regarding long-term care were only passed in the 1990s.
- All European countries meet the same difficulties: legislation and financing do not fit, there is no good link between cure and care, no good link between the sectors of care, welfare, housing, services and social security; responsibilities of different partners are not clear; there are gaps and overlaps where these sectors meet; sectors are divided into parts regarding the target groups (elderly, mentally and physically handicapped) and sectors are divided because professionals define their domain too strictly.
- The systems are so complex and have so many stakeholders that almost nobody has a total overview of the system. Care and services are orientated on supply, not on demand.
- Due to this complexity a new profession is arising: a whole layer of professionals ‘who know their way in the complex system’. Counsellors, guides, supporters, professionals who explain and clarify, professionals who translate the demand of a client into terms of the provider, who are helping the clients, and who are often working from a local ‘care and services information point’.

FUTURE TRENDS

- Hospital care is declining, which results in a bigger need for long-term care.
- A greater decentralization is taking place in almost all countries, which asks for a new coordination between stakeholders at national, regional and local level.
- It is to be expected that of the two larger streams in Europe within the long-term care discourse (one starting in the medical realm and the other starting in social services and social integration) the latter one will become more and more important. This will probably have a negative influence on regulations and funding but it will on the other hand give more freedom of choice to the individual client and the local level.
- In the future there will be changing relationships between the state, the for-profit market and the non-profit sector, with a growing share for the private and the for-profit sector. These changing relationships will give more opportunities to the entrepreneurial care and services provider.
- A greater desire for more choice and more individualized, tailor-made services will arise due to the further emancipation and assertiveness of clients.
- Ageing of the population will result in a larger demand for long-term care and on the other hand long-term care will more and more become a set of services for the elderly. At the same time there is an ageing of staff. Already in seven EU member states 40 % of the nurses are over 40 years old and in five states this is already over 50 %. There will probably be a shortage of care professionals in the near future.
- As a result of European regulations there will be more freedom of movement of personnel involved in services, and long-term care tourism will become a normal phenomenon. Some Dutch care providers have already set up care provisions in Spain, where elderly get their care and services while enjoying the climate. Insurances cover this care tourism under the same conditions as they apply in The Netherlands.
- There will be the introduction of social markets. These new organizational forms in long-term care are characterized by two innovations:
  - the insertion of competitive rules in the relationship between public financiers and private service providers, and
  - the encouragement of the capacity of self-organization of members of a given community.
- Citizens and families will be faced with more market and more choice, especially in the form of cash benefits and vouchers for users or client-led brokerage by local authorities.

CONCLUSIONS

The following conclusions can be drawn regarding the relationship between long-term care and FH:

- The future will be characterized by cooperation or competition between public and private providers at the local level; care farmers will have to deal with these new relations and will have to join cooperation or competition.
- Entrepreneurial behaviour and the promotion of this behaviour will enhance the breaking up of the traditional bureaucratic organization, of traditional provisions and traditional professions. This will give care farmers more opportunities.
- The stronger orientation of long-term care towards social services and the weaker bonds with the traditional medical realm open new possibilities for Green Care and FH.
- In view of the demographic changes and the ageing of the population it would be wise not to take mainly the handicapped (as it is done nowadays) but also the elderly as an important target group, not only because of the demographic trends but also because of their political pressure (45 % of the voters are over 55 years old and elderly are true voters) (Annex 2).
- Elderly will more and more use their capital (invested in houses) to buy care and services. The idea of leaving your possessions to your children is disappearing at a rather high speed.

AVAILABLE WEBSITES

http://publications.eu.int/index_nl.html
http://www.euro.who.int/observatory/hits/toppage
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Annex 1. *Total public expenditure on health and long-term care as percentage of GDP for the year 2000 (European Centre Vienna 2004)*

	Total health and long-term care		Health care		Long-term care	
	2000	Increase in % GDP, 2000-2050	2000	Increase in % GDP, 2000-2050	2000	Increase in % GDP, 2000-2050
Belgium	6.1	2.2	5.3	1.4	0.8	0.8
Denmark	8.0	3.1	5.1	0.9	3.0	2.3
Germany			5.7	1.7		
Greece			4.8	1.6		
Spain			5.0	1.6		
France	6.9	2.1	6.2	1.6	0.7	0.5
Ireland	6.6	2.5	5.9	2.3	0.7	0.2
Italy	5.5	2.0	4.9	1.6	0.6	0.4
Netherlands	7.2	3.5	4.7	1.2	2.5	2.4
Austria	5.8	3.0	5.1	1.9	0.7	1.1
Finland	6.2	3.5	4.6	1.5	1.6	1.9
Sweden	8.8	3.2	6.0	1.1	2.8	2.1
UK	6.3	2.2	4.6	1.2	1.7	0.9
EU-14	6.6	2.5	5.3	1.5	1.3	1.0

Private expenditure differs between countries, ranging from 1.3 % of GDP in UK and Sweden to 2.5 % in Austria and Belgium, 2.7 % in Germany and 3.3 % in The Netherlands

Annex 2. *Percentage of voters over 55 year in the EU*

	Year 2000	Year 2020
Austria	34	43
Belgium	34	43
Denmark	34	44
Finland	32	44
France	32	40
Germany	37	45
Greece	36	40
Ireland	26	31
Italy	35	44
Luxembourg	35	45
Netherlands	31	42
Portugal	31	38
Spain	32	39
Sweden	36	42
UK	34	41

The percentage of non-voters in the over-55 group is in all countries lower than the percentage of non-voters in younger age groups.