

AIM

International Association of Mutual Benefit Societies

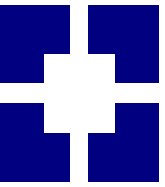
**Long Term Care:
trends and
challenges ahead**

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**Assoprevidenza & AEIP joint Conference
Rome, 25 March 2011**

What is Long Term Care?

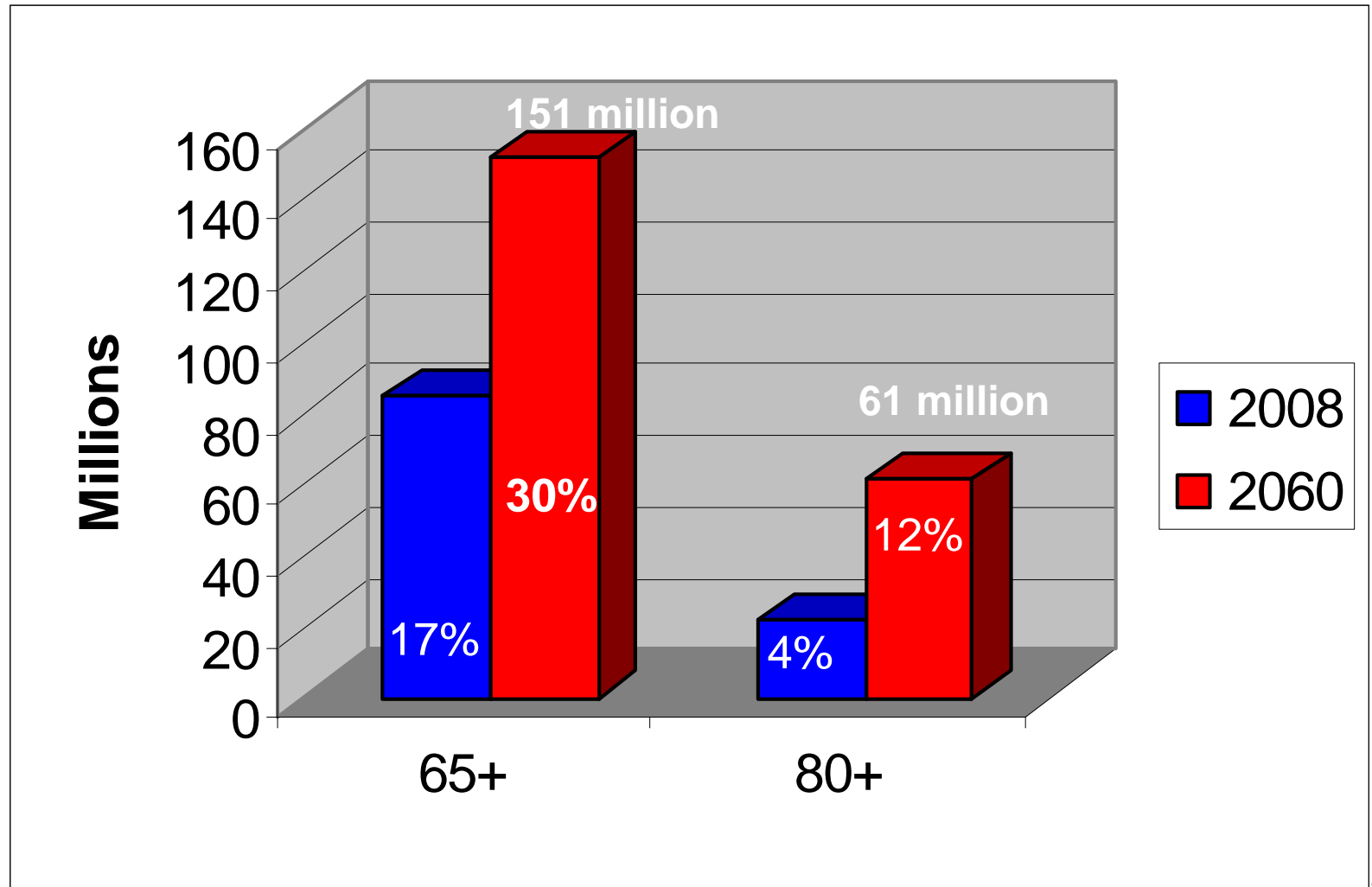
- Range of services for people who need **assistance on a regular basis**
- for basic **activities of daily living** (ADLs), like bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, ...
- because of chronic disease, physical or mental disabilities.
- These needs are most prevalent in the **oldest age groups**.



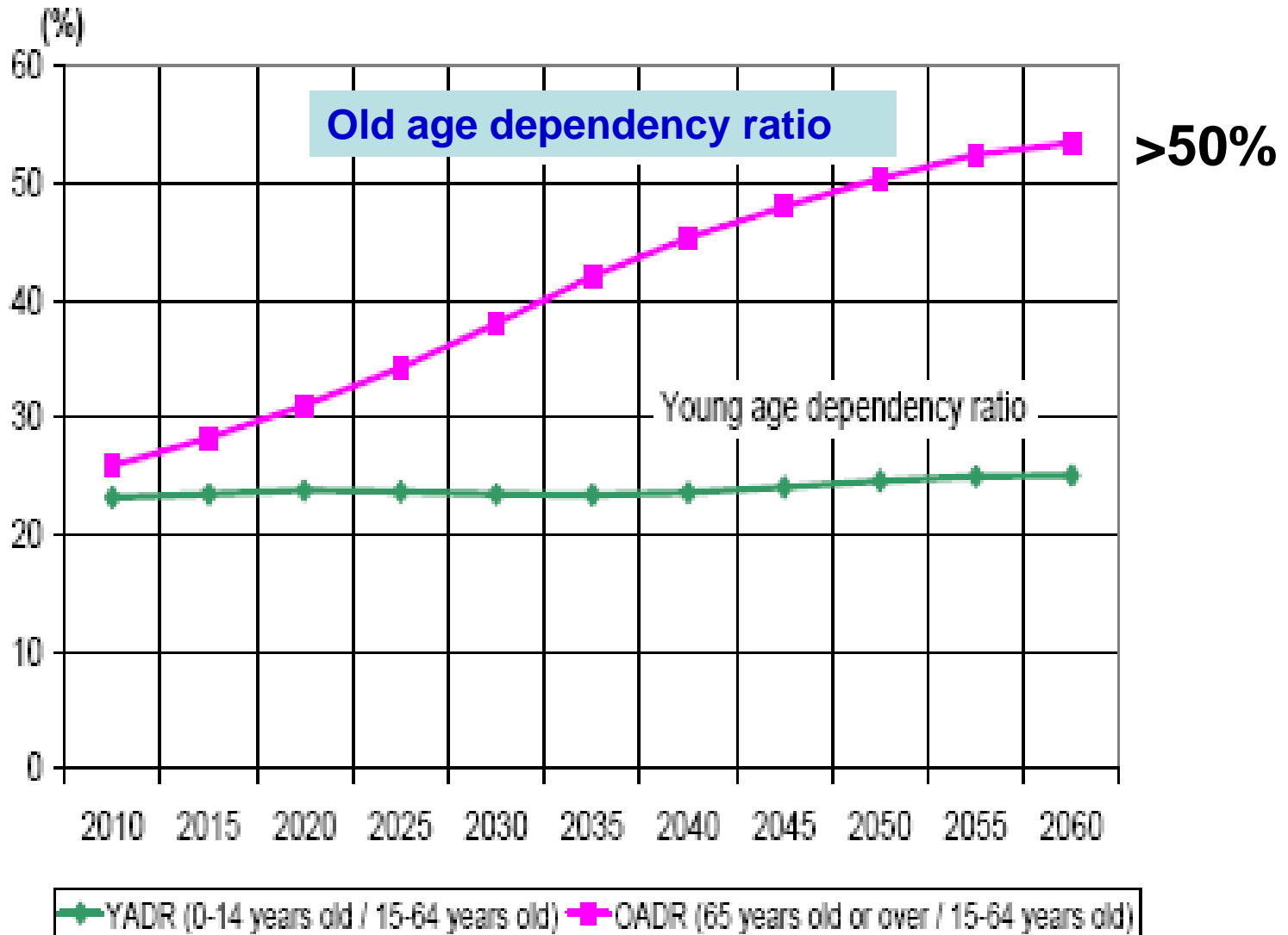
I. Some known changes

Ageing of the population

65+ projected to increase to 30.0% in 2060
80+ projected to almost triple to 12% in 2060

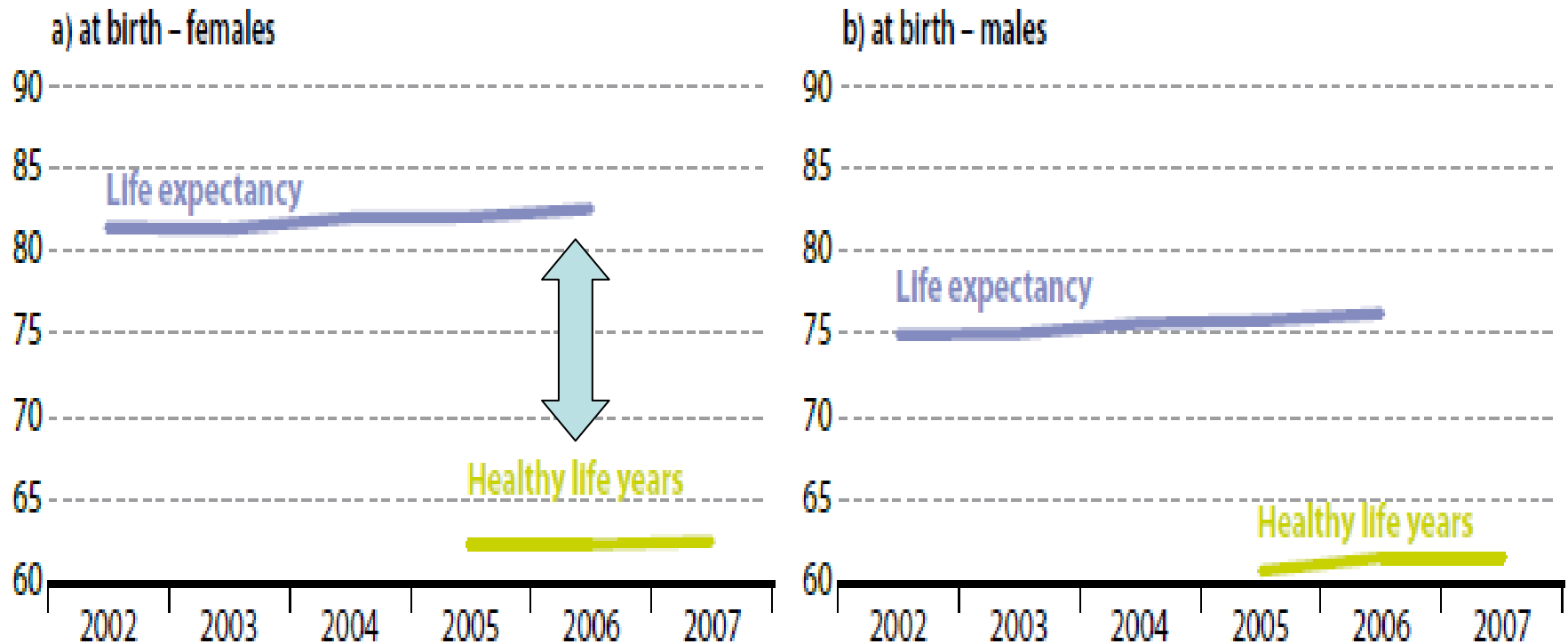


Old age dependency ratio (the 65+ over the 15-64) to double from 28.1% in 2009 to 58.5% in 2060



Source: Eurostat, EUROPOP2008 convergence scenario

Life expectancy is growing, = 82 years (female), healthy life years are also growing, but = 62 years

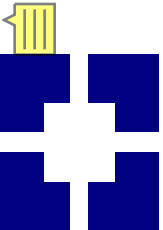


- It is due to:
- **socio-economic factors**, leading to health inequalities
 - **environmental factors** of health, as well as
 - **lifestyle determinants** (like smoking, alcohol, bad nutrition and excessive weight, physical inactivity, ...)

Epidemiological change: Chronic diseases are growing

- **Chronic diseases represent**
 - **70% of mortality**
 - **70-80% of the expenses**
 - the 4 main types of chronic diseases:
cardiovascular diseases, cancer, diabetes
chronic respiratory diseases
- **Many comorbidities**
 - **80% of the 65+ people have 1 chronic disease**
 - **50% have 2 chronic diseases**
- **Shortage of health
and social professionals**



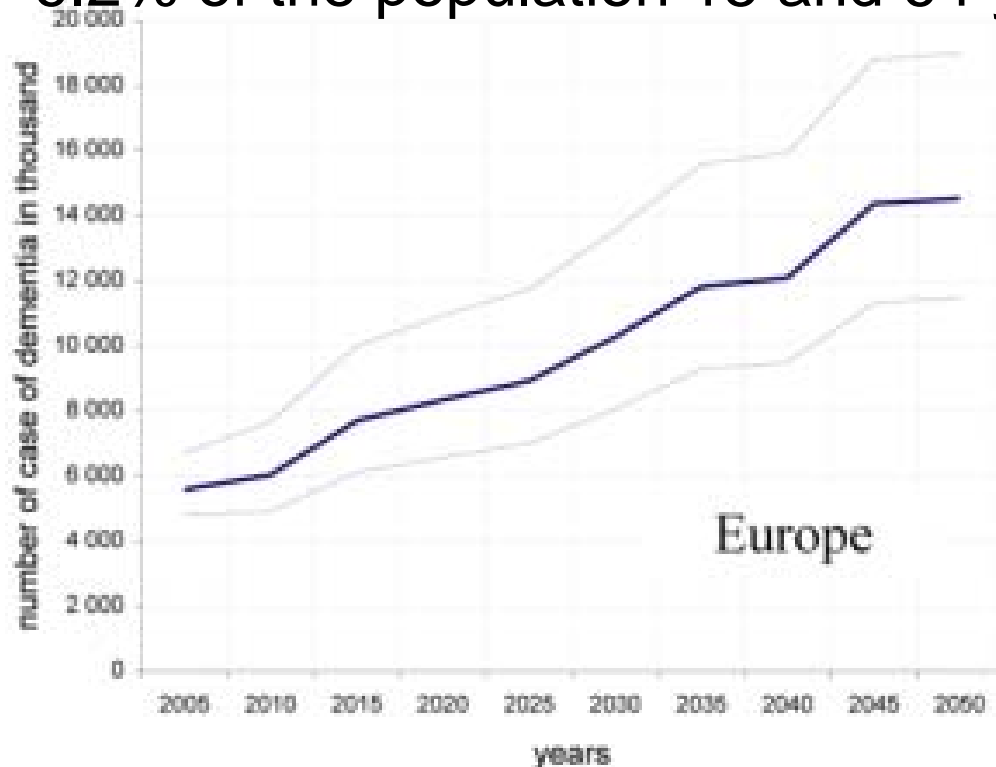


Big growth of dementia cases in Europe

In 2050, **14.5 million dementia** cases are expected representing **3.3 % of the total population**

10.1% of over 65 years

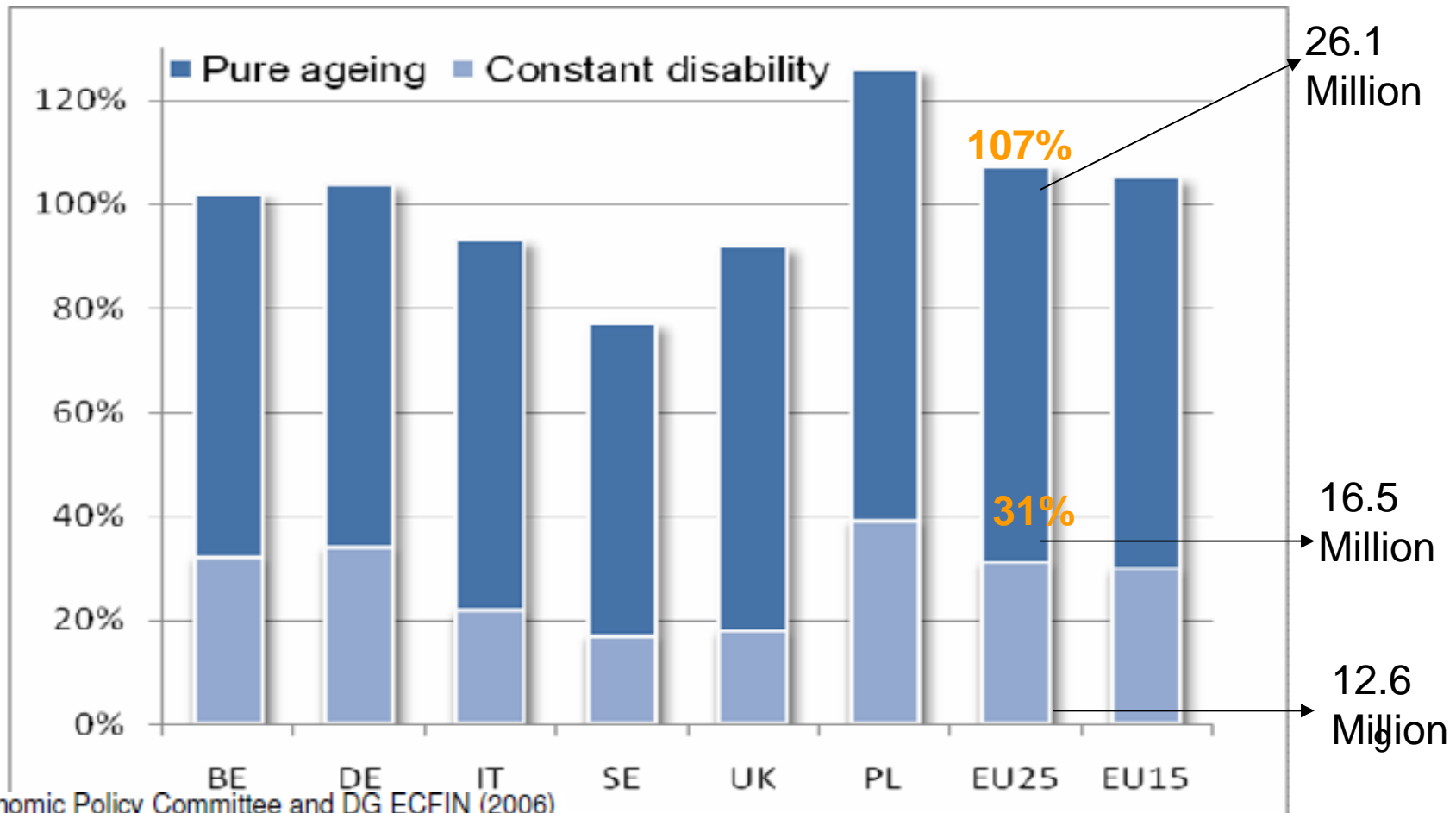
6.2% of the population 15 and 64 years



Number of dependent people will grow in 2040

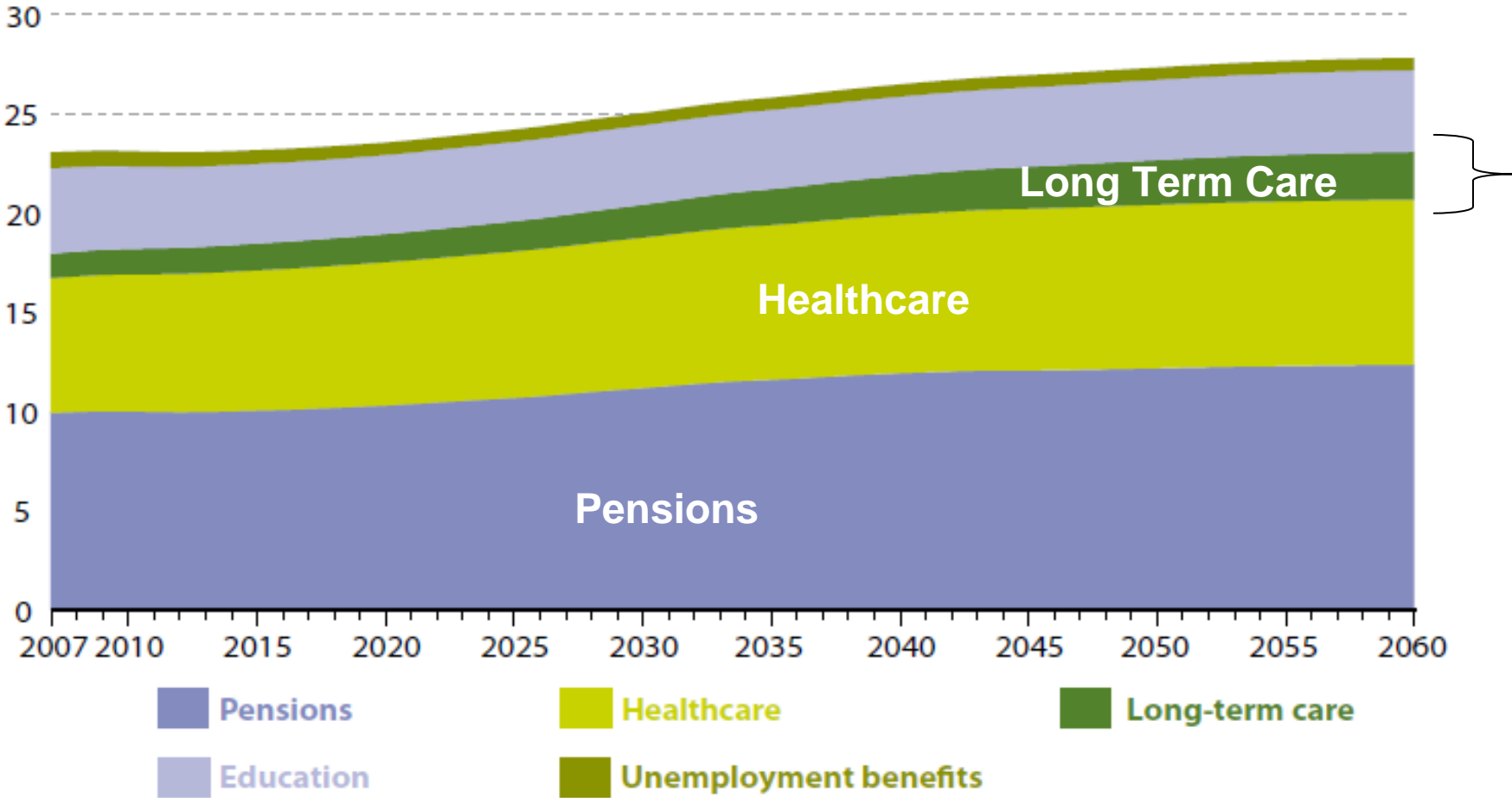
- Scenario 'pure ageing': health remains = in 2040 as in 2004: 107% increase of dependent people
- Scenario 'constant disability': health improves in 2040, only 31% increase

% increase from 2004 to 2040





LTC is only a small % of public spending, but it will grow in the future

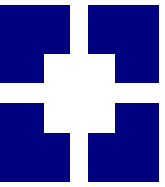


Evolution of EU-27 age related public spending (baseline scenario) in % of GDP – Econ Pol Com 2009

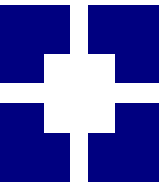


Projected LTC spending as % of GDP

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



II. General trend in LTC financing and organisation in the OECD

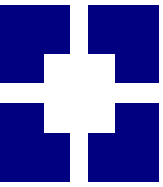


General situation in LTC in OECD

- **Public funding** is predominant
- **Private LTC insurance negligible**
(except US, Israel and to a lesser degree, Germany)
- **Private households share the burden:**
 - informal unpaid care
 - co-payments
 - out-of-pocket spending
- Many countries: **correlation** between **structure of public health and LTC systems**

Models of LTC financing

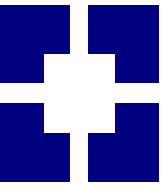
	Financing	Benefit	Eligibility	Private Insurance
United States	General revenue	Service/ Limited cash	Means-tested	<10%
France	General revenue	Cash only	Universal/Steep income-related coinsurance	25% of those 60+
Germany	Payroll tax	Cash or service	Universal	<10%, optional for high-earners
Japan	Payroll tax/ General revenue/ Income-related premium	Service only	Universal for 65+	None
Netherlands	Income-related taxes/Means-tested copayments	Cash or service	Universal	Mandatory, managed by private insurance
United Kingdom	General revenue	Service or cash	Means-tested	Very limited



Some figures

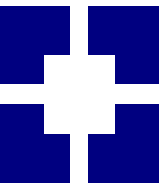
In most European Member States

- around **20%** of the elderly population **aged 65+** is **dependent**.
- % estimated dependent population receiving LTC:
 - on average **3.3% formal care in an institution** (between 5-9% in Nordic countries)
 - about **30% formal care at home**
 - hence some **50-60%** of people considered dependent receive no formal care and instead rely on **informal or no care**
- Differences across States are wide and reflect :
 - the variety of institutional arrangements
 - the **cultural differences**



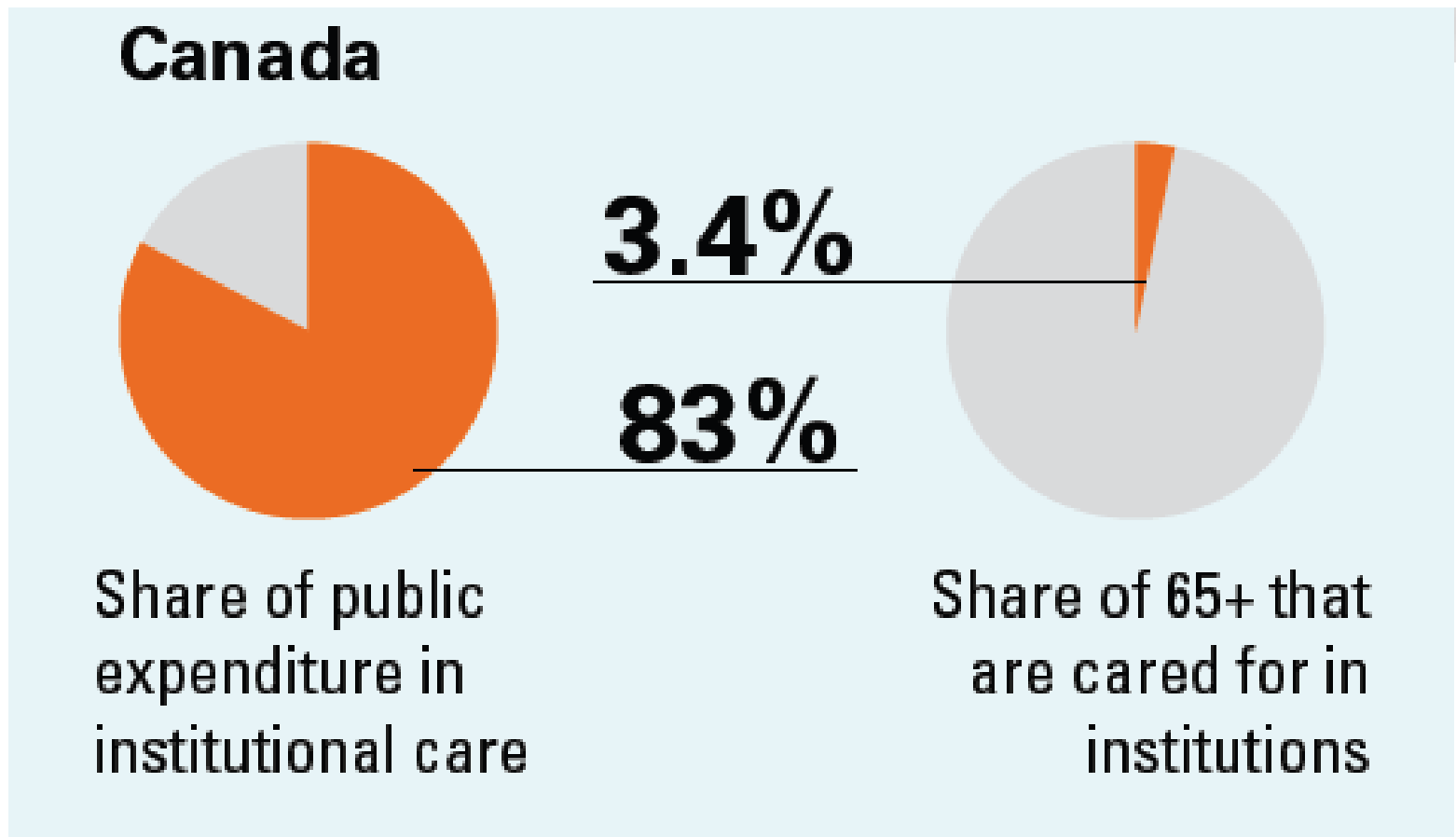
Four Types of LTC “Systems”

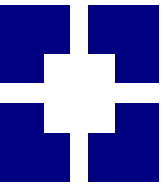
- **Universal and comprehensive coverage** for health and LTC
(Australia, Austria, Denmark, Finland, Norway, Sweden)
- **Public Social Insurance Programs**
(Germany, Japan, Luxembourg, Netherlands)
- **Part of Health care coverage**
(Belgium, Canada, Ireland, New Zealand)
- **Fragmented LTC benefits and services**
(Greece, Israel, Italy, Portugal, Spain, UK, US)



Most beneficiaries are cared for at home, but it is not where most public money goes to

There is a shift trend from institutional to home care.





III.

What are the challenges ahead for Long Term Care?

1. It is all about society

The societal perspective

- Putting respect for **human dignity at the center** of the social paradigm
- means accepting laws and social practices that **protect the weak and vulnerable** from domination, exploitation, or neglect.
- It is a **fundamental right and a duty**.

2. States should commit to universal accessible, high-quality and sustainable health care and long-term care

- Long term care like health is not an ordinary good.
- It is impossible for anyone to predict his care needs.
- What is more certain is that:
 - all human beings have periods in their lives - whether in infancy, old age, or illness - when they must depend on others to provide care.
 - most women, as well as many men, will at some point step into the role of care provider.
- It is a social risk and you are not 100% responsible when you need Long Term Care, just like when you become ill.

3. Solidarity is the key principle

- The principle of solidarity should be applied, with non selection.
- The **states should commit to 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.
- States are responsible for anticipating the needs associated with LTC, which extend beyond the provision of health care services, and for ensuring that resources are available and are distributed efficiently and equitably.
- Of course in an environment of **resource limitations** and the **debt crisis**, needs inevitably compete against one another as priorities are established and choices are made.
Tradeoffs are necessary.

4. No place like home

- To **stay at home and independent** as long as possible is what most want.
- And it is **cheaper than institutions**.
- A key factor is to have a **broad range of support services** available for home care and prevention.
- Other sectors should adapt for the older people: **housing and urban development, transport ...**
- **Solidarity between generations** is a key strategy (see brochure)

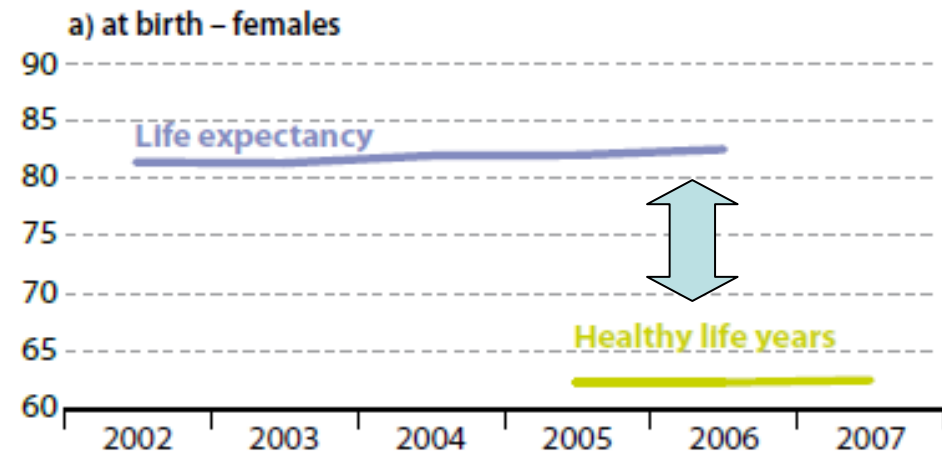
INTERGENERATIONAL SOLIDARITY
THE WAY FORWARD

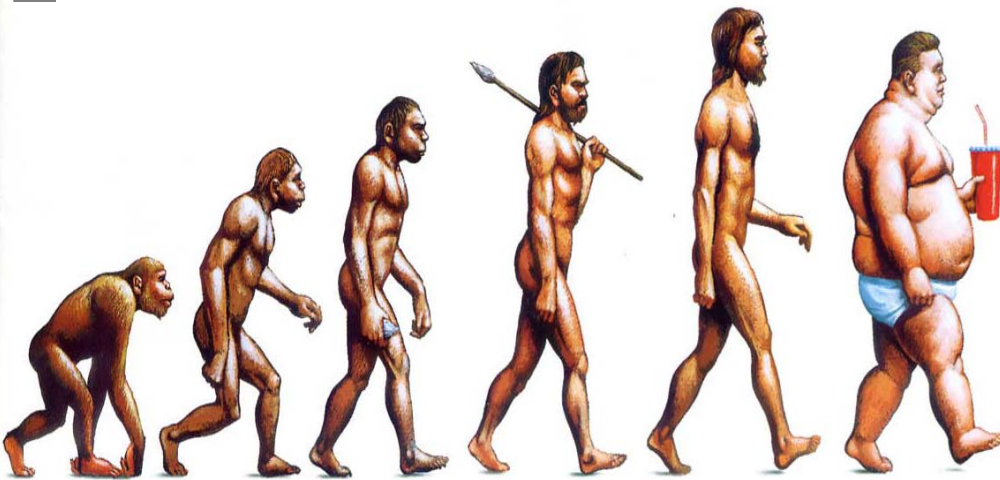
Proposals from the NGO Coalition for a 2012
European Year for Active Ageing and Intergenerational Solidarity



5. Healthy ageing is paramount

- We need to **raise** the number of **Healthy Life Years** which lie below the Life expectancy
- Healthy ageing is paramount and should be **mainstreamed** in all policies.
- Healthy ageing means:
 - maintaining the elderly in **good health**
 - and keeping them **active, autonomous** and independent over a longer period
 - increasing the potential **labour force**
 - **avoiding or delay chronic diseases**
 - **diminishing the burden** on family and informal carers
 - limiting pressure on health and social care budgets.





- **Promotion of healthy lifestyle** should be done throughout the life time (nutrition, physical activity, avoiding addictions..) but even beginning at an older age could give benefits
- Among the many programs of **mass and individual prevention and promotion**, intended to **modify the life styles** screening (to detect hypertension, diabetes, ...)



it is important to **invest in those which are cost-effective** (example of the tobacco control)

**But there are other sectors and determinants...
where is it worth to invest also like:**

- **Environmental health policies**
- **Adaptation of the housing for the elderly**
- **Urban development**
- **Transport**
- **Socio-economic factors, sustainability and age of pension, etc....**

6. Active ageing

- That means **mobilising the potential** of the rapidly growing population in **their late 50s and above**, who are, on the whole, healthier and better educated than any such cohort before them.

How?

- By **creating better job opportunities and working conditions** for the growing numbers of older people in Europe
- helping them take an **active role in society**, promoting life long learning and encouraging healthy ageing.
- creating a **society for all ages and fostering solidarity and cooperation between generations**, and gender equality,



29 April 2009

European Day of Solidarity
between Generations

(due to campaign of NGO where AIM and AEIP were active)

- **2012 as “European year of active ageing”** (EU Council)

7. Need for change of mentality

- A 65 years old man now is different from the 60' where the life expectancy was only 65. Just like 60 is an "expiration date".

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- Although aging is a normal part of life, it is feared, hated, and misunderstood.
- Largely because we have a **pervasive anti-aging philosophy**; there is a culture of "looking 30 for the rest of your life".
- The society has to accept the **role and richness of different generations**: "Just be yourself".



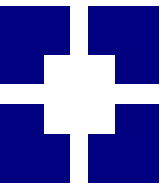
8. Ensuring quality is vital

- **Ensuring dignity and respect for older people**
Example of the German “**Charter of the rights** and responsibilities of older people in need of long-term care and assistance”
(**avoiding abuse and violence** against older people)
- Defining, monitoring and **improving quality of services** of LTC (quality insurance):
need to integrate Human right indicators, like the German charter does, in order to **evaluate the quality at all levels**
- Tailored-made care services for dementia patient
- Freedom of **choice for the elderly**:
to improve empowerment and autonomy of the older people
Example: through **personal budget** for choosing and paying services (cash benefit)

Using technology as a tool, can also help for the autonomy

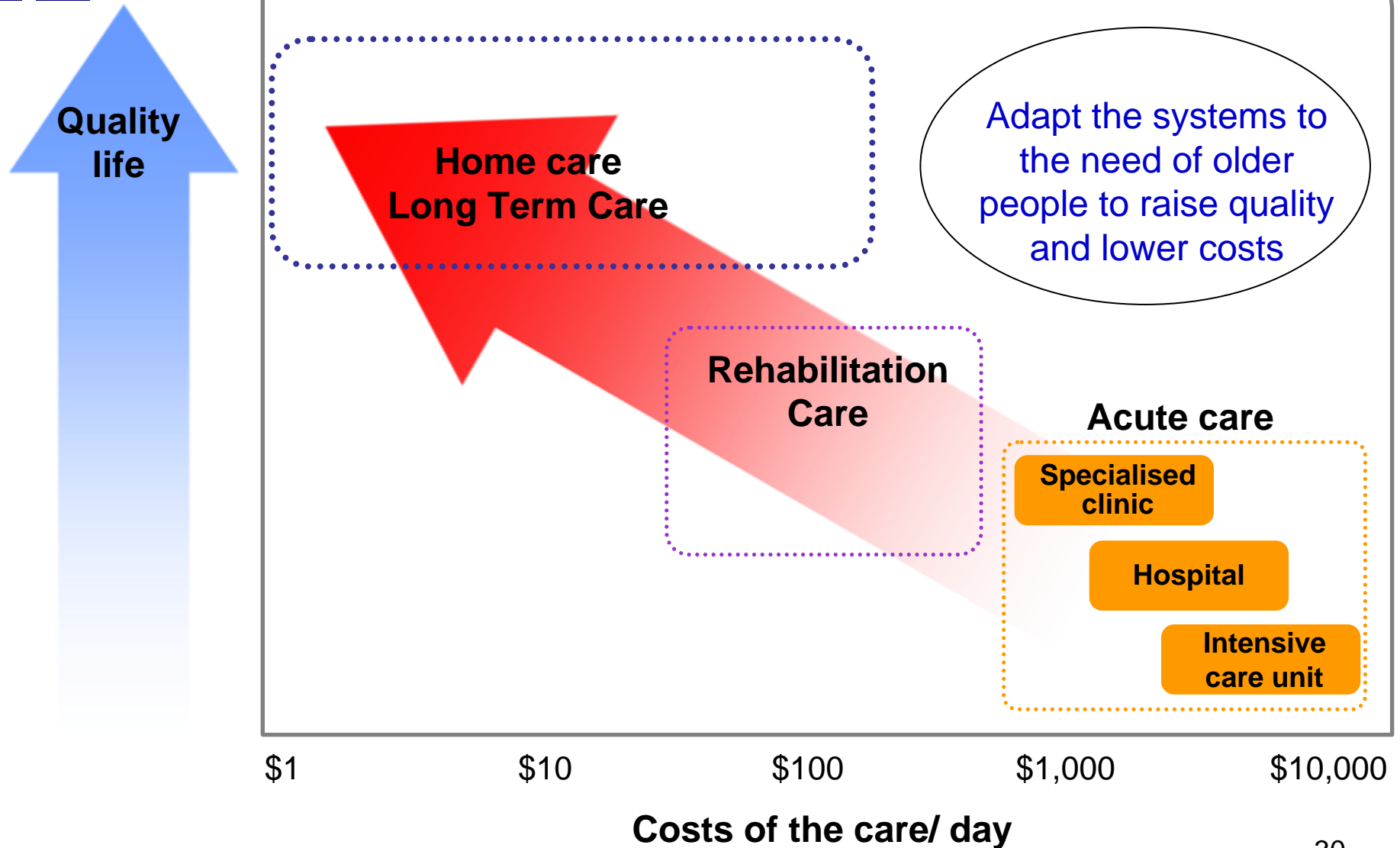
- Social alarms
- Sensors to monitor movement, temperature of the room...
- Remote Monitoring of Chronic Patients
- Contact by tele/video
- GPS for dementia people
- Wireless Monitoring
- Vacuum cleaner robot
- Smart houses





Enhance (LTC-Health) care coordination

in a complex system to provide a continuum of care

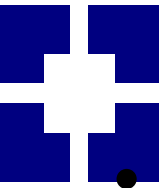


9. Ensuring quality workforce

- LTC sector is **labour intensive** with **staff costs** accounting for the **majority of the overall costs**.
- Balance between informal and formal care differs from country to country and changes over time (South vs North Europe).
- **In fact, the majority of care is given by informal carers** (difficult to get reliable data): number of informal carers exceed by far the number of formal carers

Table 1. Number of formal and informal LTC workers, selected OECD countries, 2006 or latest year available

Countries	Formal LTC workers	Informal LTC workers
Italy (1)	125 717	4 034 696
Netherlands (2)	100 000	1 193 000
Spain (3)	10 856	2 709 305
England. & Northern Ireland (4)	92 133	5 062 126
United States (5)	4 385 600	44 443 800

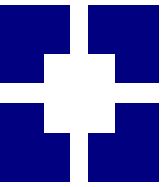


Informal carers

- Caring is overwhelmingly a **female** responsibility
- **Largest share of informal carers belong to middle - age groups (over 50)**
- Carers provide limited hours of care

Formal carers

- Predominantly **women** (up to 90%)
- Diverse educational backgrounds
 - low in Hungary and Spain
 - high in Australia, Canada, Denmark and Netherlands
- Middle - aged in some countries: Australia, Canada
- **Younger in others:** France, Japan, Netherlands, Spain, Sweden and United Kingdom



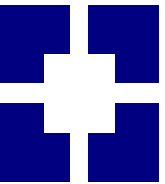
Shortage in the future?

Currently

- Vacancy rates are already high in Austria, Finland, Japan, Netherlands and USA
- **Retention difficulties** because of:
 - Low status , Low pay, Low retention, Low productivity, High turnover, High migration, High physical and mental stress

In future:

- **Fewer people of working age** (old age dependency ratio)
- **Informal care become older**
- More women work
- Decline in size of low-skilled workforce



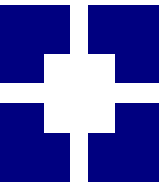
Solutions

1. Promote attraction of the job for formal carers

- Improve training and skills
- Raise salary
- Better consideration

2. Use the existing workforce more efficiently

- Redefine skill - mix and job tasks (case manager)
- ICT and LTC
 - More efficient organisation
 - Better co - ordination of care
 - Remote monitoring
(but few evidence on cost-effectiveness)



Solutions

3. Reliance on migrants?

- More than 20% of formal LTC workforce in Australia, Canada and the US are migrants... and it is increasing (e.g., Canada, Germany, Greece, Italy, NL, USA)
- Managed migration ??
Unmanaged” migration? (informal sector): Aut, It, Gr

4. Better coordination between formal and informal care systems

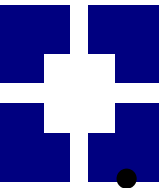
5. Incentives for informal/family carers

- **Financial benefits:** carer allowances, guaranteed income/tax and pension credits during care leave
- **Non - financial:** respite care, care leave, counselling/training and short stay care services

10. How to ensure a financial sustainability of the LTC system?

- All states are concerned with this question in a context of growing needs due to ageing and of budgetary constraints?
- No matter of benefits-in-kind, cash allowances, earmarked budgets, or a mix of the two in the provision of long-term care services,
- the core principles should remain
 - **solidarity and equitable financing**
 - through a progressive financing through **income-related taxation** and/or
 - **mandatory social insurance** with risk pooling and no risk selection or
 - a **mixed system**

to ensure **universal and high quality access** that **does not depend on ability to pay** and that the need for care **does not lead to poverty** and financial dependency.



- The remaining question is to find the **right mix between public and private sources?**
- In any case, a **social insurance or tax-based system appeared to be more efficient** than left entirely to the private initiative (2005 Luxembourg Presidency Conference on LTC).
- **Budgetary savings** on health-care may be realised if the projected increase in life expectancy over the long-term is accompanied **by an increase in healthy life years**.
- Thus, **prevention and an integrated and coordinated provision of health and long-term care** services, enhanced by the use of ICT and **new technologies**, could **bring savings** in terms of the ageing-related costs and an improvement in the health status of the elderly population.

Conclusion

Towards a solidarity based LTC system

Demographic change (and LTC)

- should be looked at as an **opportunity**,
- which can bring **innovative solutions** to many current economic and social challenges,
- but this will require
 - a **reworking** of several economic and social policies within society (be creative)
 - a **change of mentality** towards **solidarity between generations**



Solidarity should remain the **key principle** for LTC and Healthcare, as they represent a fundamental right.

