Health and Social Care Committee

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Residential care for the elderly in EU member states

Following on from the Health and Social Care Committee meeting on 25 January 2012, further information on:

- **Further information on whether there is a definition of 'not for profit' provision or whether this varies between countries**
- **Further details of provision in Holland and Germany in terms of ownership models, the ways in which provision is made (e.g. at local/federal state level).**
- **Clarification on whether 'England' actually refers to England only in figure 1 of the paper for the meeting on 25 January 2012**

This paper provides further information on the relative contributions of the public, private and non-profit sectors to the provision of residential care for older people in EU member states. It also provides more detailed information on arrangements in Holland and Germany. Colleagues and their contacts in the Assembly's Brussels office have contributed to the paper and may provide further information which will be forwarded to Members.

The mix of providers of residential care across EU member states

There is considerable variation in the composition of the residential care sector across EU member states, as shown in table 1 which is taken from a paper by Allen et al (2011)[1]. The same paper makes the following observations:

> While in central European countries the role of private non-profit organisations as providers of care has a long tradition, private for-profit organisations are on the rise everywhere. This development includes the Nordic countries where, however, a majority of services are still publicly provided.
>
> […]
>
> It should be underlined that the emergence of private for-profit providers has been a phenomenon of the past 20 years only.
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> (p18)

Not-for-profit residential care provision across EU member states

There are a number of different providers of not-for-profit residential care for the elderly across EU member states; the most common types of providers across 11 member states are summarised below in Table 1.

[1] Allen, K. et al, *Governance and finance of long-term care across Europe*, page 19, September 2011 [accessed 1 March 2012]

Table 1: Long-term care provider mix and level of provision, by country

Country	*Public*	*Non-profit sector*	*Private*	*Expectations of Informal carers to provide care*
Slovakia	High	Medium (Church)	Medium	High
Finland	High	Low (NGOs)	Medium	Medium
Switzerland	Medium	Medium	High	Medium
Austria	Medium	High (charities and other non-profit organisations – traditionally affiliated to churches and political parties)	Medium	Medium
Netherlands	Low	High (non-profit organisations, mutuals)	Low	Medium
France	Low	High/medium (non-profit organisations)	Medium	High
Sweden	High	Medium (trusts, co-operatives)	Medium	Low
Greece	Low	Low (NGOs, church)	High (migrant care workers) Low (residential care)	High
UK (England)	Low	Medium (social enterprise, voluntary, non-profit organisations)	High	Medium
Denmark	High	Low	Medium	Low
Germany	Low (in-patient and out-patient services)	High (in-patient) and medium (out-patient services)	Medium (in-patient services) High (out-patient services)	Medium

Source: Allen, K. et al, Governance and finance of long-term care across Europe, page 19, September 2011 [accessed 16 February 2012]

It can be seen from Table 1 that there are a number of different care providers in the not-for-profit sector across EU member states, including mutuals, co-operatives, charities and non-governmental organisations. However, the authors add the caveat that countries may define different stakeholders in different ways.

Provision of residential care for older people in Holland

There has been a mandatory system of long-term care insurance in the Netherlands since 1968. Everyone who lives in the Netherlands is insured under the Exceptional Medical Expenses Act (the AWBZ in Dutch), which covers all chronic care especially concerning large expenses where insurance on a private market would not be feasible. This includes residential care for the elderly.[2] Institutional care plays a major role in Holland by comparison with other European countries; in 2007 6.8% of the elderly population were in

[2] Mot, E., The Dutch system of long-term care, page 9, March 2010 [accessed 16 February 2012]

institutional care, although Dutch government policy in recent years has been to promote care at home[3].

The Dutch government determines budgets for long-term care over a four year period, and the Department of Health, Welfare and Sport controls financial expenditure on long-term care. The government also bears overall responsibility for the provision of long-term care system, however many responsibilities lie with individual care providers.

Institutional long-term care for the elderly is regulated by the Dutch Healthcare Authority, which makes rules and supervises compliance in these areas. In regulated areas such as residential care for the elderly, **currently only non-profit providers are allowed to operate.**[4] These rules include determination of the maximum tariffs that can be charged for these services, and also outlines what care must be offered by providers.

In Holland for most types of care covered by long-term care insurance patients can choose whether to buy their own care through personal budgets, or for their regional care office to organise and purchase care for them. However, **for residential care, including that for the elderly, the regional care office organises and purchases care for the patient, although the patient can specify which provider delivers their care.**[5]

Regional care offices are affiliated to one of the health insurers in an area. In 2009 there were 32 regional care offices in the Netherlands operated by 12 health care insurers.[6] The remaining health insurers in a region voluntarily give a mandate to this health insurer to carry out the organisation and purchase of care for the people that they insure. Most health insurers in the Netherlands are not-for-profit organisations. This health insurer runs a regional care office as a separate legal entity, and it has to meet certain conditions set out by the Dutch Government to be able to perform the role.

The budgets that the regional care offices have to operate within are calculated by the Dutch Healthcare Authority. Regional care offices are expected to keep within this budget, although if they experience difficulties in doing so they can try to solve this through redistribution of money between providers within a region, or between regions.

There has been criticism within Holland that this model of operation provides few incentives for efficiency, and the previous Dutch Government planned to make changes by 2012 to improve this, however they were delayed by the fall of the cabinet in 2010.[7]

Not-for-profit providers of residential care for older people in Holland

Mutuals and other non-profit organisations provide residential care for the elderly in the Netherlands.[8] These organisations require a permit to operate from the Dutch Ministry of Health, Welfare and Sport. Historically, such providers were allied to religious (Catholic or

[3] Mot, E., The Dutch system of long-term care, page 11, March 2010 [accessed 7 March 2012]
[4] Ibid, page 17
[5] Ibid. page 10
[6] Van der Veen, R. et al, Governance and financing of long-term care: Dutch National Report, March 2010 [accessed 16 February 2012]
[7] Mot, E., The Dutch system of long-term care, page 23, March 2010 [accessed 16 February 2012]
[8] Allen, K. et al, Governance and finance of long-term care across Europe, page 19, September 2011 [accessed 16 February 2012]

Protestant) or political organisations. However such ties have weakened as providers have become more professionalised and business-like. In some cases providers have merged to meet the requirements of the Dutch welfare state, with which they are intimately connected[9].

Provision of residential care for the elderly in Germany

There has been a mandatory and universal system of long-term care insurance in Germany since 1994. Members of the public health insurance system become members of the public long term care insurance (LTCI) scheme, and those who have private health insurance are obliged to buy private, mandatory LTCI providing the same benefit packages. The LTCI does not cover all expenses incurred by long-term caregiving. All insurance benefits are capped. The aim is to provide insurance covering basic long-term care needs, but not for board and lodging.

The German long-term care system is based on three institutional levels of governance and financing and is embedded in the fundamental state principles of federalism and subsidiarity. The Federal Government and the Governments of the States (Länder) have a legislative function while the local authorities are responsible primarily for executive implementation. Local authorities in particular have a duty to avoid disparities in support and to ensure a regular supply of long-term care in every region of Germany. This takes into account the contribution of all local, state-owned, and non-profit-making care institutions and private enterprises.[10] **In Germany in 2010, 55 per cent of residential care services were provided by not-for-profit organisations, 40 per cent were provided by profit-making private sector organisations, and 5 per cent were provided by the public sector.**[11]

The Länder have regulation and inspection functions and responsibility for financing investments in premises for long-term care services. Regulations vary greatly among the 16 provinces. Some Länder directly finance investments in nursing homes, while others only provide subsidies for dependent older persons living in nursing homes who currently rely or who would otherwise rely upon social assistance.[12] While capital investments are considered the responsibility of the Länder, regulations on the amount of subsidies for such costs differ greatly among the Länder. In practice, these costs have often been passed on to residents, at an estimated average monthly amount of €347 in 2007.

In Germany the organisation of health care and therefore long-term care is based on self-administration. Each health insurance fund has an affiliated care insurance fund. In 2009 seven types of statutory long-term care insurance funds existed, with around 200 single funds. They are self-administrating corporations under public law, meaning that

[9] Dekker, P. in Evers, A and Laville, J. *The Third sector in Europe* (2004) chapter 7 The Netherlands: private initiatives and hybrids, pp148 & 160.
[10] Schulz, E., The long-term care system for the elderly in Germany, page 3, March 2010 [accessed 17 February 2012]
[11] Allen, K. et al, Governance and finance of long-term care across Europe, page 18, September 2011 [accessed 16 February 2012]
[12] Schulz, E., The long-term care system for the elderly in Germany, page 3, March 2010 [accessed 17 February 2012]

they carry out legally mandated tasks under government supervision but are organisationally and financially independent. In addition, around 40 private LTCI funds exist.[13] The insurance funds negotiate services to be provided and prices with the care provider, and funds operate collectively to negotiate rates with each individual care facility.

Not-for-profit providers of residential care for older people in Germany

According to Bode and Evers[14] voluntary welfare associations in Germany provide approximately two thirds of homes for older and disabled people and about 40 per cent of all hospitals (p108). The sector comprises various local agencies and non-profit enterprises organised into six nationally organised welfare federations:

> two are linked to the churches, one to the Social Democratic Party, one is not aligned and the remaining two are aligned with the Red Cross and a small Jewish agency
>
> (pp107-8)

Welfare associations are therefore culturally and politically embedded in German society although this is said to have weakened in recent years, in part due to the increasing professionalisation of welfare associations. Nevertheless, charitable donations and voluntary work make significant contributions to their work[15].

There has been a significant growth in private sector provision in recent years: private facilities increased by 50 per cent between 1999 and 2009. In the same period non-profit facilities increased by 27 % whereas the number of public facilities decreased by 17 per cent[16].

Do the graph and tables in the previous paper refer to England or the UK?

The tables and graphs in the paper discussed at the Committee's meeting on 25 January 2012 refer to long-term care for the elderly in England rather than the United Kingdom. They are based on research into long-term care for the elderly in England conducted as part of the *Assessing Needs of Care in European Nations*[17] (ANCIEN) research project, which has looked at different long-term care systems for the elderly in 21 EU member states. **The contribution for the UK is from the Personal Social Services Research Unit at the London School of Economics and looks at the English care system;[18] therefore the tables and graphs refer to England**.

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[13] Schulz, E., The long-term care system for the elderly in Germany, page 6, March 2010 [accessed 17 February 2012]
[14] Bode, I. and Evers, A. in Evers, A and Laville, J. *The Third sector in Europe* (2004) chapter 5, p108 [accessed 1 March 2012]
[15] Ibid, pp108-110
[16] Dr. Caroline Vöhringer, Brussels office, personal communication
[17] Assessing Needs of Care in European Nations, Home [accessed 17 February 2012]
[18] Comas-Herrera,, A. et al, The long-term care system for the elderly in England, page 17, March 2010 [accessed 17 February 2012]