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Care services in crisis? Long-term care in times of European economic and financial crisis

Anna Waldhausen

Federal Ministry for Family Affairs, Senior Citizens, Women and Youth

Deutscher Verein für öffentliche und private Fürsorge e.V.

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Office Address: Zeilweg 42, D-60439 Frankfurt a. M.
Postal Address: POB 50 01 51, D-60391 Frankfurt a. M.
Phone: +49 (0)69 - 95 78 9-0
Fax: +49 (0)69 - 95 789 190
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Agencies responsible for the Observatory are:
German Association for Public and Private Welfare
Michaelkirchstraße 17/18
D-10179 Berlin
Phone: +49 30-62980-0
Fax: +49 30-62980-140
Internet: http://www.deutscher-verein.de
Institute for Social Work and Social Education
Office Address: Zeilweg 42, D-60439 Frankfurt a. M.
Postal Address: POB 50 01 51, D-60391 Frankfurt a. M.
Phone:+49 (0)69 - 95 78 9-0
Fax: +49 (0)69 - 95 789 190
Internet: http://www.iss-ffm.de

Authors:
Anna Waldhausen (anna.waldhausen@iss-ffm.de)

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Summary

In the EU Member States, the ratio of senior citizens to the total population is on the increase. Developing policies for long-term care and elderly services has therefore taken on a growing importance in the last decades. However, Europe is currently going through a severe economic crisis that many countries are combating with austerity programmes that in some cases affect social spending. The question now is whether these developments will also impact on long-term care policies and elderly services in EU Member States. Will services and benefits be curtailed? The present working paper analyses public expenditure for long-term care on the basis of three case studies (ES, UK, FIN). Our main sources of information were publications of the competent ministries in each country as well as media reports. Our conclusion is that public expenditure for long-term care has developed much along the same lines as other areas of "social expenditure policy". Countries cutting back on social spending also try to save in the area of long-term services. Savings not only take the form of explicit cuts in financial or other benefits: sometimes they are more indirect, for instance when access to social services is made more difficult.

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1. Introduction

In all Member States of the European Union, the ratio of older people to the total population has increased steadily in recent decades due to a combination of low fertility and rising life expectancy (Rechel et al. 2013, p. 1). Because society is ageing, existing social protection systems have been facing rising expenditure for age-related services (cf. for instance Lipszyc et al. 2012 with respect to long-term care).

Independently of a purely expenditure-based analysis, Pavolini and Ranci came to the conclusion in 2013 that long-term care is one of the fastest growing policy areas in the last two decades (Ranci and Pavolini 2013). The OECD has observed that over the past ten years, most OECD countries have had to expand their long-term care services (Colombo 2011, p. 57ff).

At the moment, however, the issue of how expenditure has been evolving is being re-examined. Indeed, in the last few years Member States of the European Union have had to deal with negative economic development. Although slight growth had been recorded in 2010 and 2011 – after a sharp economic downturn in 2009 – (average growth in EU Member States in 2011: 1.5%), real GDP sank by 0.3% in 2012 (Dauderstädt and Keltek 2013, p.1).

In the last quarter of 2012, Member States' GPD fell again by an average of 0.5% (EU COM - European Commission 2013, p. 5f).

On average, 2009 had witnessed a clear increase in EU expenditure for social protection, in terms of both unemployment benefits and health, disability and age-related spending. The increase was lower in 2010, and in 2011 and 2012 there was, on average, a decline in social spending (EU COM - European Commission 2013, p. 39f). This is due to efforts at fiscal consolidation and to measures taken to reduce debt. Social protection expenditure has been the worst hit area (EU COM - European Commission 2013, p. 5).

Given these developments, the present paper examines whether policies for long-term care and elderly services have also been affected by policy reforms and/or by the reduction of state funding. The following pages will analyse examples of state funding in the area of long-term care.

We have restricted our analysis to three EU Member States: Spain, the United Kingdom and Finland. These countries were selected because of the differences in their welfare state contexts. The welfare state typology proposed by Sigrid Leitner (Leitner 2013) was adopted as a selection aid, because the selected countries correspond to different categories of this typology: "optional familialism" (Finland), "explicit familialism" (United Kingdom) and "implicit familialism" (Spain).

2. Country 1: Spain

2.1 The socio-political context

Spain is one of the EU countries to have suffered most from the consequences of the economic and financial crisis. If we consider the social situation in Spain, for instance by examining indicators of the risk of poverty or social exclusion, we note that the social situation in the country deteriorated significantly between 2008 and 2011 – as a direct result of rising unemployment (Minty and Maquet-Engsted 2013). Social expenditure in Spain has developed much like the EU average (cf. Introduction). At the beginning of the 2008/2009 crisis, social expenditure in Spain increased; however, spending fell again in 2010, earlier than in most other EU countries, and declined even further in 2011 and 2012 (Bontout and Lokajickova 2013, p. 13ff).

After the electoral victory of the Popular Party (PP) in 2011, the government of Prime Minister Mariano Rajoy announced far-reaching austerity measures. These measures have had a drastic effect on the household incomes of Spanish citizens (Minty and Maquet-Engsted 2013, p. 45ff).

2.2 Spanish long-term care policy and current developments

In Spain, the concept of a universal right to care services is still relatively new. The statutory care system (Sistema para la Autonomía y Atención a la dependencia) was adopted in 2006. Benefits under the system were introduced gradually from 2007 onwards. Arguably, the biggest challenge is ensuring "system sustainability", i.e. providing secure financing for the care benefits offered under the system. With the ongoing impact of the economic crisis, a number of reforms have been introduced – reforms which, as we will now show in detail, have consisted mainly of cutbacks.

For instance, the original intention of the Spanish Care Act [Ley de dependencia] was for services and benefits for patients in need of care to be introduced in annual steps on the basis of need. Patients with the highest care requirements were to be the first to be integrated into the system. It was initially planned that patients with average requirements would be considered from 2011 onwards. However, in December 2011 the new government issued Decree 20/2011, which postponed the entry of this group into the care system to the year 2013 (Patxot 2012, pp. 17, 18).

RD-ley 20/2012 enacted even further cutbacks. Payments to informal carers were reduced by 15%. The obligation to pay social security contributions for caregiving relatives was abolished. Furthermore, the inclusion of patients with low care needs into the system has been delayed in order to focus the services and benefits now being offered on high-need patients (Reino de España 2013, pp. 23, 115).

The period of time granted to the autonomous regions for processing a case and deciding on a patient's need for assistance has been extended from six months to two years. And whereas assistance was originally granted retroactively at the end of this period, this right was abolished by Decree 08/2010 for the six-month period (Moran 2012).

With the introduction of the Care Act, the budget for care services expanded continuously between 2007 and 2011. This changed starting in 2011 with a cutback of expenditure on care by 5.2% (EUR 1,498 million) (Patxot 2012, p. 18). The "National Reform Programme for 2013", which the Spanish Government presented to the European Commission, estimates the savings generated by the reforms at EUR 599 million in 2012 and approximately EUR 1,108 million in 2013 (Reino de España 2013). This represents a significant proportion of the annual expenditure for the Care Act, which totals approximately EUR 6,000 million (Sust 2013).

In the National Reform Programme, the government announced further changes that would enable it to achieve the savings planned under the programme for 2013. For instance, co-payments to be made by the recipients of social services will rise by some 5%. This increase will be phased in progressively over the next three years. For the current year, the government estimates that this change will already generate savings of EUR 339 million. Additional

savings of EUR 289 million will be achieved by “adjusting benefits to the real care needs of users” and by “prioritising the provision of professional services instead of financial benefits” (Reino de España 2013).

This latest announcement of new austerity measures in the care system has been met by a wave of protests: “The Government deals a final blow to the Care Act” is the title to the front-page article of “el Periódico” (Sust 2013). The organisations CERMI, CEOMA and UDP1 have criticised the cutbacks. Several press articles have also called attention not only to the explicit cutbacks but also to a practice of “simplifying the care needs assessment test”. The spokesman for the national platform for the defence of the Care Act2, José Luis Gómez-Ocaña, speaks of a “re-evaluation” of the care needs of patients entitled to care services. He explains that persons in need of care are being forced to undergo new medical assessments, which often enough lead to a downgrading of benefits that had already been granted (Sust 2013).

2.3 Conclusion

The Spanish policy of spending cuts has had a significant impact on the range of services and benefits for the care of patients requiring long-term care. The austerity measures – reductions in benefits for caregivers, access restrictions (explicit and implicit) to care, fee increases – hit the new care system, which had been introduced only in 2007, hard. This not only has a direct impact on the quality of life of elderly people, but also hinders the development of the emerging care market (Patxot 2012, p 18).

[1] Organisations representing the rights of potential beneficiaries (the elderly and people with disabilities): Unión Democrática de Pensionistas (UDP), Confederación Española de Organizaciones de Mayores (CEOMA), Comité Español de Representantes de Personas con Discapacidad (CERMI)
[2] http://coordinadoraestatalplataformas.jimdo.com/quienes-somos/ (last accessed on 23 August 2013)

3. Country 2: the United Kingdom

3.1 The socio-political context

According to the European Commission, the United Kingdom is not among the countries hardest hit by the developments resulting from the crisis (Minty and Maquet-Engsted 2013). Nevertheless, and in view of the country's poor budgetary situation3, David Cameron, Prime Minister since May 2010, has announced significant reductions in welfare benefits. The coalition agreement signed in 2010 between the Conservative Party and the Liberal Democrats set reducing the national deficit as a target (Her Majesty's Government 2010). This is also reflected in expenditure on social benefits. The financial plans presented by the conservative-liberal coalition in 2012 provide for cutbacks in social spending by EUR 10 billion by 2017 (Watt and Jowit 2012). In 2009, and once again in 2010, expenditure on social benefits increased in response to the crisis, but then declined again in 2011. While spending continued to decline in most EU countries in 2012, the United Kingdom, however, was one of a group of countries where absolute numbers increased slightly again (Bontout and Lokajickova 2013, p. 17f).

As a target group, the elderly are particularly at risk of poverty. According to the Office for National Statistics, two million British pensioners are among the poorest in Europe, placing the United Kingdom in fourth position among the 27 EU Member States behind Cyprus, Bulgaria and Spain (Cassidy 2012). The "National Social Report 2012" (Lewis 2012, p. 17) also mentions the high percentage of over-65s who are at risk of poverty after social transfers. There is also public discussion on the fact that each year more than 20,000 retirees die as a consequence of insufficiently heated apartments (James Banks 2012, p. 1). Savings that impact mainly on the elderly therefore deserve special attention.

3.2 Long-term care policy in the United Kingdom and current developments

Overall, there have been a great number of activities between 2010 and today in the areas of long-term care and elderly services. In addition to the fact that these services are viewed as becoming fragmented, public discussion has focused primarily on the financing of care benefits, on unfulfilled care needs and on the poor quality of care services. A number of deficits in the medical and social care system have been revealed with regard to the quality of care, but also in the legal framework (Seeleib-Kaiser 2012, pp. 3, 13). A series of "care scandals" have been uncovered by the media in recent years (Seeleib-Kaiser 2012, p. 14).

Benefits and care services for the elderly were important issues even during the election campaign and in the coalition agreement that was then signed between the Liberals and Conservatives in May 2010. In the 2010 election campaign, David Cameron promised that

[3] The national debt of the United Kingdom is one of the highest in the European Union (Seeleib-Kaiser 2012, p. 3).

there would be no cuts in state benefits for pensioners (Her Majesty's Government 2010, p. 26). For the coming legislative session, however, services such as the winter fuel allowance for the elderly will become the subject of special scrutiny (Woodcock 2013).

The coalition agreement of the conservative-liberal government called for a study on the funding of care and an overall reform of the social care system (Her Majesty's Government 2010, p. 30). The government appointed a commission chaired by Andrew Dilnot (the "Dilnot Commission") and entrusted it with drawing up an analysis of the current situation and exploring different financing options for care costs in England (Department for Work and Pension 2010).

In July 2011, the Dilnot Commission suggested that the asset threshold beyond which no state benefits are granted should be increased from the current £ 23,250 to £ 100,000. In addition, lifetime care costs should be capped at an amount between £ 25,000 and £ 50,000 (Commission on Funding of Care and Support, 2011).

In a next step, the government submitted a White Paper ("Caring for our future: reforming care and support", July 2012) founded on the findings of the Dilnot Commission. A draft law was then published ("Draft Care and Support Bill") merging previously existing legislation into a single legal text (Secretary of State for Health 2012). In 2013, the government revised the proposal and introduced a cap on care costs. The bill provides that the individual asset threshold of a patient above which no state benefits can be granted will be raised to £ 123,000. The government plan therefore expands the potential target group even more in comparison to the Dilnot Commission. However, it would cap the maximum contribution for care costs at £ 75,000 only (Department of Health 2013, Joint Committee on the Draft Care and Support Bill 2013, p. 10). This part of the reform is expected to enter into force in April 2017. According to estimates made by the government, 100,000 more people than in the past will thus be eligible for assistance in the future. The additional costs of approximately £ 1 billion per year for the reform will be generated by changes in inheritance tax and in National Insurance contributions in the course of the introduction of the single-tier state pension (Hilary Osborne 2013).

Most municipal councils allow only people with substantial or even critical care needs to receive government benefits (Comas-Herrera et al. 2010, p. 4). Several newspaper articles have in recent years reported that access requirements to local government services have been tightened. Both the Guardian and the Independent quote the organisation "false economy", according to which more than 5,000 disabled and elderly people have completely lost their care services in the last two years, while a further 2,000 have experienced cuts. Nowadays, less than 14% of local councils grant care services to people whose needs the council has estimated as "moderate" compared to 40% six years ago (Sarah Morrison, 2012). This shows clearly where savings of public services for the elderly are being realised. In 2012, 4.5% of expenses were reduced compared to the previous financial year. Even before the

cuts, AgeUK reported that 800,000 from a total of two million elderly people with support needs due to care requirements receive no formal support from public or private bodies. The Health Committee of the House of Commons has also reported increasing indications that funding pressures for social care services are leading to a reduction of services (Seeleib-Kaiser 2012, p. 16).

A study quoted by the Guardian on co-payments for home health care in England shows the differences evolving in recent years between the various local councils in terms of fees charged for social care measures and their development. On average over the last two years, average fees for an hour of home care have increased by 10% (Ramesh 2012).

3.3 Conclusion

A reform of the long-term care system in the UK has been on the political agenda for some years. The “Draft Care and Support Bill” was not published until July 2012, after some delay. The bill would give more people a right to support services in the field of long-term care. The individual asset threshold above which state benefits are no longer paid is being be increased to £ 123,000, which expands the circle of beneficiaries. For the first time, individual contributions for long-term services are being capped. However, some parts of the reform are not as extensive as had been hoped for or previously proposed by the Dilnot Commission. Moreover, reform efforts stand in contrast to spending cuts in the social care system, which become obvious through implicit cutbacks in services.

4. Country 3: Finland

4.1 The socio-political context

Finland suffered a severe economic and financial crisis in the early 1990s and responded by restructuring – particularly in the banking sector. According to Saltman, these adjustments saved the country from having to make major financial cutbacks during the ensuing crisis of 2008 (Saltman et al. 2012, p. 24). Although Finland recorded a decline in gross domestic product after 2008 – at 8% it was even the sharpest decline of any OECD country – the country bounced back relatively quickly. Moreover, tax revenues (and thus the financial basis of the Finnish health and social care system) remained nearly constant due to a relatively low unemployment rate. The country's fairly good starting position before the crisis also helped it quickly overcome the brief period of recession after 2008 (Lehto et al. 2012, p. 1; Kangas and Saari 2008, p. 245).

Like in other EU Member States, Finland's expenditure for social protection increased in 2009. In the following years, while spending rose less strongly than it had, it did not drop as much as in most other EU countries (Bontout and Lokajickova 2013, p. 18). In this respect we can identify a clear difference between Finland's saving and spending behaviour and that of other EU Member States.

4.2 Long-term care policy in Finland and current developments

The government programme presented by the coalition government of Prime Minister Jyrki Katainen includes several points that are intended to effect changes in the long-term care and elderly care systems (Vidlund and Kivelä 2012, p. 27). It announces changes in the fee structure for social services (without specifying what form these changes might take) as well as increased monitoring of current services (Vidlund and Kivelä 2012, p. 27; Prime Minister's Office Finland 2011, p. 101).

Important new features are included in the "Act on care services for older people". Following adoption by Parliament in December 2012, the Act came into force on 1 July 2013. It is intended to guarantee a need-based and nationally uniform support system for senior citizens. The objective of the Act is to ensure that local authorities are well-prepared to meet the anticipated increase in demand for services. Important elements of the legislation are the priority of outpatient versus stationary solutions, rapid determination of the needs of applicants, better planning of services and processes to ensure the quality of services.

The law prefers services that are provided in the home environment of the person in need of care. Long-term care should be provided in an institutional context only if it is medically or otherwise necessary to ensure that the person concerned can enjoy a dignified life and receive good quality care.

For each legislative period of the local councils, local authorities are invited to submit a plan of activities for the welfare of their ageing populations and an overview of the availability of social and health services for the elderly. Local authorities are obligated to consult local senior citizens' councils for the planning, implementation and monitoring of all activities that affect older people in the community.

The "Act on care services for older people" also supports the maintenance of quality standards in the services offered. The number of care personnel, their qualifications and their work duties must be proportionate to the number of elderly people to be cared for and their degree of need. Service providers are called upon to increase self-monitoring of their performance and to enhance their quality standards (Ministry of Social Affairs and Health 8 November 2012).

Many municipalities have raised municipal taxes and borrowed more money in order to provide health and long-term care services. In many municipalities, services such as cleaning the homes of patients being cared for at home and delivery of medications to these patients are no longer covered; these services are nowadays being carried out by private companies and patients have to pay these companies directly for the services they receive. (Vidlund and Kivelä 2012, p. 30). In some municipalities the fees for social services have been raised. These increases are linked to the economic and financial crisis. They reinforce already existing differences between municipalities (Vidlund and Kivelä 2012, p. 33).

4.3 Conclusion

The Finnish system of elderly care is currently undergoing major changes, including a trend towards encouraging informal care and growing competition in the care market resulting from a growing number of private providers. However, despite some economic losses and cost-cutting efforts during the financial crisis, no significant cuts in the health and care sector are being made (cf. also Lehto et al. 2012; Vidlund and Kivelä 2012). Nevertheless, local conditions seem to be implicitly adapting to the "external conditions" of the crisis. This manifests itself, for instance, in increasing fees for the social services provided by municipalities and in the decline of granted benefits.

5. Overall conclusion and outlook

In times of economic and financial crisis, Member States of the European Union cut back on their social spending. All three countries considered here as examples – Spain, the United Kingdom and Finland – have cut their spending to varying degrees. The cuts made by these countries in the area of long-term care are developing in parallel to what is happening to overall social spending. Spain, which has been severely hit by the crisis, has been making significant explicit cutbacks and thus following, among other recommendations, the financial guidelines of the European Union under the EU assistance programmes. The United Kingdom, too, has reduced social spending in the face of its significant budget deficit. Because a reform of the care system had long been on the political agenda, the Conservative government could not help but propose an expansion of benefits in a draft bill presented this year. It did so, however, with some delay, and also not to the extent proposed by the Dilnot Commission. In Finland, no obvious crisis-related savings measures could be identified, or at least such measures are not clearly distinguishable from general trends, for instance the increased preference for informal rather than formal care. But here too, there have been increases in the fees for social services provided by local governments.

Overall, it seems obvious that more and more cutbacks are being carried out, above all by local governments and especially with regard to the granting of benefits and the increase of private co-payments. This type of cutback is less transparent for the public and overall less visible than, for instance, the reductions in financial transfers that have been taking place in Spain. No figures are currently available to represent the extent to which access to social protection measures by people requiring care services has been changing.

If access modalities change, this certainly has consequences for the overall care context. Does access restriction cause a shift from formal to informal care? Or does it create new gaps in coverage?

This paper discusses short-term changes in benefits as a result of the economic crisis. It remains to be seen whether the measures described here are really only short-term in nature. Will the economic situation improve and will care-related services be expanded once again? If this is not the case, questions will arise as to the long-term impact of this situation on the quality of life of older people in Europe. Long-term care services are one of the factors that help compensate for social inequalities in old age. In many cases, they make a concrete contribution to poverty reduction and inclusion among the elderly. If, after a steady expansion in most EU countries since the 1990s, the field of long-term care now goes into a permanent decline, this will not fail to have social consequences. In the long run, permanent cutbacks in this area are bound to give rise to existential questions. They will also undoubtedly push the aim of the European Innovation Partnership “Active and Healthy Ageing” – to increase the average number of healthy life years of Europeans by two by 2020 – into the further distance.

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