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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN ESTONIA

GERLI PAAT AND MERLE MERILAIN

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The Long-term Care System for the Elderly in Estonia

ENEPRI Research Report No. 75/June 2010

Gerli Paat and Merle Merilain*

1. The long-term care (LTC) system in Estonia

1.1 Overview of the system

In 2001, the Ministry of Social Affairs (MoSA) prepared the Nursing Care Master Plan 2015 in order to provide nursing care targets to match the hospital targets set out in the Hospital Master Plan 2015. The main changes recommended by the Hospital Master Plan 2015 were to turn small hospitals (mainly owned by local governments) into nursing care homes and to develop non-institutional nursing care services that provide home nursing and day-care nursing.

Reforms in the health care system are closely linked to the social welfare system. However, the health care and social welfare systems are relatively separate from each other, which causes problems in terms of the transfer of individuals between the different systems. The availability and quality of long-term care (LTC) services is limited, due to the fact that the welfare and health care systems are financed from different sources – from the state budget and through the Estonian Health Insurance Fund (EHIF), respectively. Many residents of social care homes also need long-term care, but the amount of care provided is constrained by limited municipal budget resources. As the target group for long-term care and welfare services largely overlaps, integration and better coordination of services are required to respond more effectively to the varying needs of elderly and chronically ill persons.

Strategies to optimise integrated care in Estonia have been developed by interdisciplinary working groups, but at the time of writing these have not yet been implemented. For successful implementation, consensus among the various care sectors is required, along with legislative support from state bodies. In addition, changes are needed in financing, in terms of the combined financing from the EHIF, municipalities and personal resources; changes are also needed at the service organisation level, in terms of the descriptions of the minimum requirements and those pertaining to quality for all long-term and social care. A 2007 amendment to the Health Services Organisation Act (which entered into force in 2008) provides an opportunity to arrange long-term service provision through a family doctor. This should bring home-based nursing care services closer to the patient.

The strategic aim of the welfare system in Estonia is to increase decentralisation, focus on individuals and provide a flexible system of services. Since 1995 the Social Welfare Act (*Sotsiaalhoolekande seadus*) has regulated matters related to social care. The Social Benefits for Disabled Persons Act (*Puuetega inimeste sotsiaaltoetuste seadus*) of 1999 regulates matters related to disabled persons. The care system is person-/client-centred and the service package provided is put together based on the individual's needs with the objective of assuring the client relative independence and an opportunity to use general public services. Social insurance and

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social welfare both offer guarantees for the risks of illness, invalidity and disability. Benefits both in kind and in cash are granted to all residents in Estonia. Still, there is no specific LTC scheme in Estonia.

LTC is provided by the Social Welfare Act to residents of all ages (depending on their needs), but most of the services are provided to elderly persons and to those with permanent physical or mental handicaps. LTC services are financed by the local government and also by the person or his/her family.

LTC entails continuous health and nursing care given to persons who need assistance on a regular basis because of chronic impairments and a reduced degree of independence in their daily activities. Constant (24-hour) long-term care is available to all age groups; however, the majority of the service users are elderly persons.

On an individual level the objectives of the care system are to achieve the best possible quality of life for persons who require care, basing the assessments on individual needs, and to enable them to cope in their habitual environment (home) for as long as possible. LTC for the elderly includes both health care and welfare services, which can be financed from various sources. The services provided to the elderly with health and coping difficulties should ideally facilitate their chances of continuing to live a decent life and of actively participating in public, social and cultural life. The macroeconomic goals of integrated care are to increase the efficiency of care, the expedient use of expensive care services (institutional care) and the development of community-based care services.

LTC is provided as an in-kind social service and is organised regionally. It is provided as needs-based social assistance by the Social Welfare Act. Care services can be provided by the state, local municipal institutions, public or private legal entities. Ideally, individuals in need of care have family members who can look after them. There is also a caregiver's allowance paid by local municipalities to caregivers, although local municipalities are not required to pay caregivers' benefits. The services are financed by the local government and by the individuals and/or their families.

LTC is usually provided to elderly people with several chronic illnesses, who require help with treatment procedures and who cannot cope with the tasks of everyday life. It is also provided to adults with multiple conditions and a partial incapacity to cope with everyday life, such as geriatric patients. This type of care is often of insufficient quality and does not meet contemporary requirements and expectations because of inadequate premises, a lack of trained personnel (nurses and caregivers) and a lack of appropriate financing for the services. Many LTC hospitals and welfare institutions are faced with an acute shortage of space and the standards are relatively low. In addition, there is still a shortage of long-term care beds. In terms of future challenges, appropriate facilities are needed to support the development of new service delivery models. Financial support of €27.5 million from the European Regional Development Fund (ERDF) for the period 2007–13 should facilitate the development of LTC facilities and improve the quality of services.

1.2 Assessment of needs

The criteria for the determination of LTC requirements are the state of health and the need for personal assistance, guidance or supervision. Case managers have special training and they are competent to assess the condition and needs of individuals for any necessary welfare and nursing care services. The case management model is now being introduced. The assessment of the need for nursing care is done by a doctor (either a general practitioner or a medical

specialist). The assessment of the need for welfare services is done by a local social worker, who takes any necessary action considering the needs and wishes of the person and his/her family.

The assessment of care needs is a part of the case management process, which includes a full assessment of the person's condition and capability. Physical capabilities (eating, maintaining hygiene, doing chores, etc.) are considered as well as psychological (mental health) and social aspects (ability to work, communicate, etc.). There is a special questionnaire that must be filled in, accompanied by an interview between the person and a specialist or an observation (by a specialist who observes the person's daily activities) or both. A personal care plan will be set up. If a person has to cover some of the expenses of the care services (especially in the case of care homes), an income means test will be undertaken to establish the amount of payment required for that person. A means test is necessary only if a person needs welfare services, and is conducted by the local government. Nursing care services do not require a means test.

Since 2004, geriatric assessment has been offered. An interdisciplinary (geriatric) assessment team performs the assessment of the needs of clients and draws up individual plans of nursing care. The team includes a physician (geriatrician or an internist trained in geriatrics), a nurse, a social worker and other specialists if necessary. As a rule, the primary assessment of needs is carried out in the geriatric departments of hospitals, but also at daytime nursing care facilities or at the place of residence of the person with the referral of a family doctor, a specialist doctor or a social welfare worker. Thus, a more exact assessment of the needs helps to ensure the expediency and cost-efficiency of services.

The need for LTC is related to a person's degree of disability. Someone who has a need for constant personal assistance, guidance or supervision 24 hours a day is categorised as having a profound disability. Someone with a severe disability needs personal assistance, guidance or supervision in every 24-hour period and someone with a moderate disability requires regular personal assistance or guidance outside his or her residence at least once a week. At the end of 2008 there were 118,000 persons with a disability, representing 8.8% of the total population, among whom 61% were 63 or older, 34% were aged 16-62 and 5% were younger than 16 (MoSA data, 2009).

Benefits provided by the state are not means-tested, although at the local government level this depends on the decision of the local government. The Estonian system follows a principle whereby domiciliary care has priority over residential care.

1.3 Available LTC services

A person in need of assistance can receive various care services according to the needs and available resources. Long-term care services comprise welfare and nursing services. Welfare services, according to the Social Welfare Act, entail the following kinds of assistance:

- *care by relatives/informal care* – care or basic nursing care of an elderly or disabled family member or a relative in home conditions. Local governments offer supporting services to assist carers looking after their relatives, e.g. domestic help and respite care, and assistance for the establishment and activities of various support groups;
- *family care* – care of a person in a suitable family where he/she is not a member of the family. Local governments offer supporting services to help the carers and to pay compensation to cover the costs related to caring, which is not remuneration/salary;
- *home services* – services offered to persons at home, helping them to cope in their usual environment; notably, it excludes care that requires physical contact. The local government is responsible for assuring long-term aid to those living at home, making sure

they have access to general public services. Home services comprise, for example, help with household chores along with the procurement of food, pharmaceuticals, other necessities and firewood or other fuel, and information and assistance in administrative matters (see also section 3.4.2);

- *accommodation or housing services (including adaptation)* – the provision of facilities for 24-hour accommodation, including rented accommodation. Service providers are either a local government or private companies. Services include making necessary adaptations in the individual’s usual environment for more comfortable mobility. In the context of institutional welfare provision, security must also be offered. In 2006, 1,070 disabled persons used different types of accommodation provided by local government, 142 of which were adapted to special needs (MoSA, 2008);
- *personal assistance services* – help for persons with low coping ability to perform activities, for instance to move around, maintain personal hygiene and manage administrative matters at home and outside. Local government is the service provider. Help is also provided with tasks that require physical contact with the person. The main purpose of the service is to enable the person to remain active or maintain his/her capacity to cope. In 2006, 22,289 persons (61% women) with special needs received personal care (Karu and Leetmaa, 2009);
- *day care in a welfare facility* – support for individuals or their families to cope through facilities where individuals can spend the day. This service is also provided by the local government. Day care is provided by day centres where social services, developmental and hobby activities are offered during the day. An elderly or disabled person can visit the day centre as often as they wish (or have a need to). These facilities have specialists who are also trained to look after mentally ill persons. The purpose of day centres is to maintain the welfare and activities of their clients. The majority of visitors are disabled children (75.85%). In 2006 there were 20,614 visits made to 103 day centres on a weekly basis (Karu and Leetmaa, 2009);
- *long-term care in an institution* – service provision for persons who, owing to their special needs or social circumstances, are not able to cope independently because they require 24-hour care and assistance, and their independence cannot be secured through other welfare services or by providing other kinds of assistance in the usual social environment. Responsibility for quality and service provision lies with local government, MoSA and the EHIF (see also section 3.4.1);
- *strengthened-support care service* – assistance to improve the ability of a person to cope independently and/or to maintain the quality of life of a person with multiple disabilities by means of treatment, rehabilitation and assistance in everyday life. This service is also provided by the local government; and
- *strengthened-supervision care service* – assistance to maintain the quality of life of a person with an increased level of vulnerability by means of assistance in daily life tasks in a care unit with enhanced supervision and assistance. The local government provides this service.

In addition, rehabilitation is provided. Rehabilitation is a social service that aims at improving independent life, social inclusion and prospects for entering the labour market. The service includes assessing needs, drawing up a personal rehabilitation plan for six months to three years and providing the services described in the personal rehabilitation plan.

LTC services are mainly financed from two sources: local government budgets and persons themselves and/or their families. Cost sharing is maintained mainly for constant care services;

community care is provided with no or symbolic cost sharing. Half (50.3%) of the cost of 24-hour care is covered by the service customer or their families, and 47.6% by local governments (Koppel et al., 2008).

LTC is provided as an in-kind social service and is organised regionally. Vocational rehabilitation is provided by the Labour Market Board. Local authorities are responsible for the provision of social rehabilitation (e.g. special transportation for disabled persons, adaptation of the dwelling and personal assistants).

According to the Organisation of Health Services Act (*Tervishoiuteenuste korraldamise seadus*), nursing services include health care services and are provided as home-based, day-care and institutional services. Geriatric assessment is part of the nursing services provided by seven hospitals. Stationary nursing care, provided in nursing care hospitals, is limited (120 days, if a person wants to stay longer he/she has to pay for services). Medical personnel are included in the process. Nursing care services may prove necessary at all levels of the service system and are added as necessary to the service package of the welfare system, but care (welfare services) has to be distinguished from health (nursing) services. The goal of care is to maintain, regain or improve capabilities in day-to-day life, while either living independently at home, being at home with domestic care or in institutional care. The goal of health care services is to improve, maintain or regain health, or to adjust to the health condition that has developed.

According to the Social Welfare Act, all social (welfare) services have to be improved to common standard indicators by 2010.

Welfare and nursing care services are provided by institutions that hold an activity license pursuant to the current legislation. The criteria for applying for an activity license and minimum requirements are laid down by the state. In practice, welfare services are becoming competitive and therefore the planning of care homes and other institutions providing social services is a question of free enterprise.

The development of quality in the field of nursing care has been facilitated by the Network of Health-Promoting Hospitals. The quality of nursing care services can be assessed as one part of the quality system based on the document *Standards for Health Promotion Hospitals*. The quality of nursing care services relates to the tradition of quality assurance and quality improvement in core processes at hospitals – starting with the education of professionals, and continuing with developing the quality of nursing care services (including the quality of knowledge and professional activities), undertaking patient satisfaction surveys, and auditing the activities and documentation. Practice directives (e.g. in case of the death of a patient) and psychosocial support skills offered to the patient by the personnel help to raise the quality of nursing care.

1.4 Management and organisation

The person and his/her family are responsible for preventing the need for external help. Where help is needed, the family has the right and obligation to participate in organising help and financing. Local government, as the closest institution to the person in need, bears the primary responsibility for providing services – in terms of both organisation and resource usage (subsidiary principle). The state designates in its legislation the obligations of the first level, and lays down the list of minimum services, the requirements for providing services and the organisation of monitoring. Local governments are advised to determine guidelines for providing and developing welfare services: services provided on the spot and those provided outside the jurisdiction of the local government. The planning and supervision of the entire LTC system is carried out by MoSA and the local governments.

The amount of services needed vary and organising the availability of all services by one local government or even county council would not be a reasonable use of resources. It is recommended to provide a limited range of services or those related to special needs in cooperation with different institutions and regions (e.g. care for the demented and rehabilitation). It is the responsibility of the state structures to organise nursing care, which is planned and developed by the county governments (city councils). From the state and regional perspective, it is expedient to consider the nursing care and welfare services in the same context as the development plans, as the target group of the services is the same and the needs for the services are often in combination.

As mentioned above, the organisation of LTC in Estonia has been divided between the health and the welfare systems.

Benefits in cash are provided by the state or local municipalities, while benefits in kind are provided by the local municipalities. Social welfare services are organised by municipalities, because they are best acquainted with local life. A local government can provide services itself or purchase the services from private or public sector organisations. The care service provider can thus be an establishment or organisation of any ownership form, but the service it provides must meet established requirements. From the point of view of increasing service efficiency, it is advisable that local governments cooperate to supply certain services together. As there are over 200 municipalities in Estonia, many local governments are relatively small. Accordingly, it is not financially possible or even feasible for them to offer all the services in each municipality.

State welfare institutions provide the services offered in schools for special needs children, services in social rehabilitation centres, orphanages and special nursing homes. Local municipalities provide the services offered in general nursing centres, day centres with nursing care, home-based services, etc. Non-profit organisations and private companies may provide services in boarding houses or through home-based services, etc. Independent nursing care is offered by companies, foundations or sole proprietors working under the law of private companies.

As regards benefits arising from the specific status of a carer, either a member of the family or a volunteer carer, working under a contract entitles the carer to an old-age pension and health insurance. If the carer works in a welfare institution, there is a written employment contract between the employer and the employee. If the carer works at the dependent person's home, there is a written service contract between the local municipality and the carer.

The county administration is responsible for ensuring the quality of care services and monitoring the care system (care services, benefits, etc.). The county administration also processes the complaints of service users.

MoSA determines the national care policy and regulates the legislation on the access to and quality of care (as well as the quality standards for services). In addition, MoSA collects and analyses care statistics. MoSA also devises and implements development programmes for care.

1.5 Integration of LTC

1.5.1 Essence of integrated care

In 2008, Tallinn's city government decided to participate in the project "Future Care – Integrated Model of Care for the Aging Europe" as a regular partner to INTERREG IVC (ERDF). The project is expected to last until 2011. So far, the document *Integrated long-term care in Estonia: Providing health care, nursing care and social care services* (EGGA, 2008) has been prepared.

On an individual level, the objectives of the organisation of care services and the integrated care system described in the document are to

- achieve the best possible quality of life for people with care needs,
- base the assessments on everyone's individual needs, and
- enable individuals to cope in their habitual environment (home) for as long as possible.

Through the services provided to the elderly, the elderly with health and coping difficulties should also have a chance to continue a decent life and actively participate in public, social and cultural life.

Integrated care is one of the central terms in today's care conceptions. This term is well explained by the definition developed in the EU project "CARMEN" and on which the document is based: "Integrated care is a well organised set of services and care processes, which is aimed at solving the problems and meeting the needs of people with multiple problems or groups of people with similar needs/problems." Integrated care includes both health care and welfare services. Integrated care is a client-centred, rather than service-centred approach to care. Integration in care foremost means a process and is aimed on the one hand at the availability of different services and on the other hand at guaranteeing consistency of care. The target groups of integrated care are the elderly and the disabled. Integrated care can work in different models – either as integrated organisations or networks.

There is a model of a coordinating network in Estonia. This model implies that people and institutions in the network have focused their activities clearly on cooperation, but their ties are not necessarily very strong and the partners may change. In cases of such integration, the relationships are formed based on actions and (repeated) agreements.

Integrated cooperation based on agreements is also possible among institutions under separate administrations. The case manager is a member of the service providers' team that is in contact with the client (and each other) during the entire period the services are needed and has an overview of all the data concerning the care of the client.

In 2006, MoSA started developing a conception of integrated care, whereby care (nursing and welfare) services are considered part of one package.

Integration between the health care and welfare systems is currently low and arbitrary now. Consistent and needs-based provision of service is not ensured for everyone. These two systems are funded and organised differently, but the target group is the same and often uses diverse services in alternative systems at the same time.

The accessibility and quality of services is uneven across the counties. Cooperation among local governments is random.

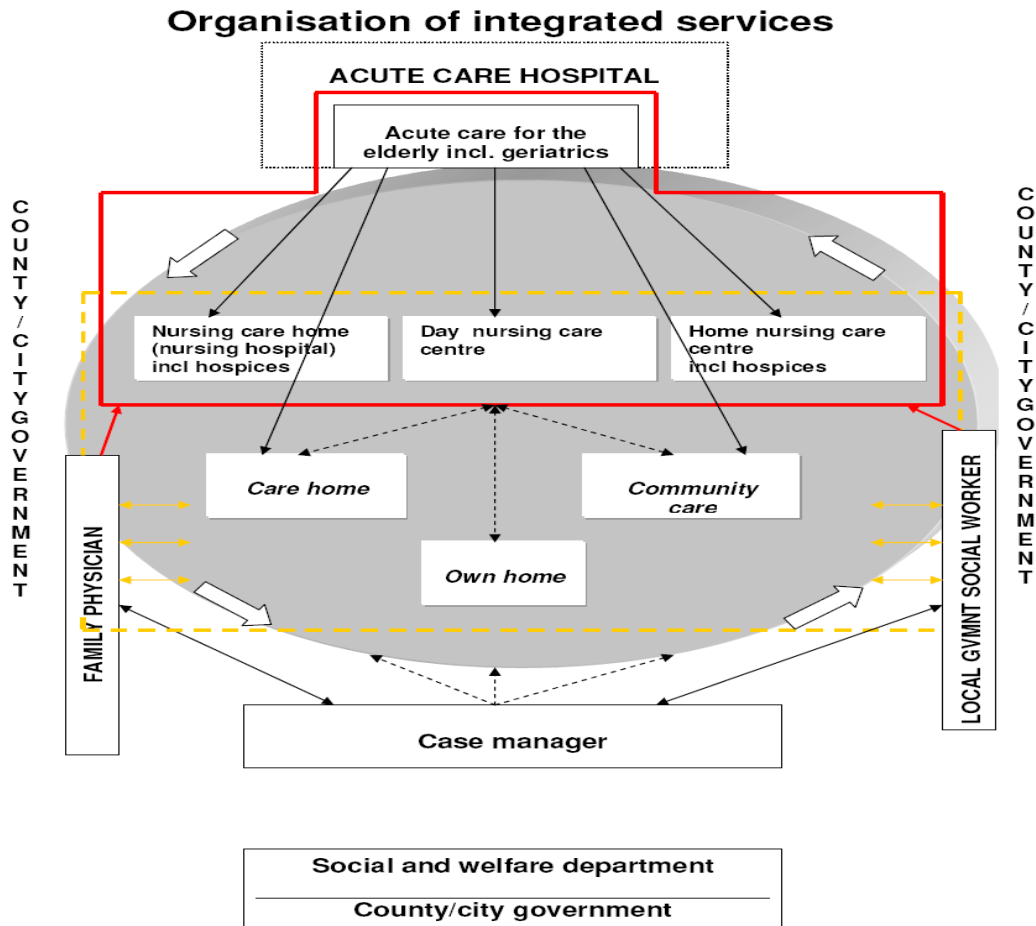
1.5.2 Implementing integrated care provision in Estonia

At the current development level the most appropriate model of integrated care for Estonia is the model of a coordinating network. As noted above, the coordinating model implies that the people and institutions in the network have focused their activities clearly on cooperation, but their ties are not necessarily very strong and the partners may change. In cases of such integration the relationships are formed based on actions and (repeated) agreements.

The family physician is the key person referring patients to nursing care services and in referrals to a local government social worker for welfare services (see Figure 1). Should a person's needs exceed just nursing care or welfare services, the organisation of services for the person is done through the case management principle. In this model, a case manager (i.e. care coordinator)

takes the central position, with the aim of guaranteeing that individuals needing a package of services receive those that are as suitable as possible as well as economical, and ensuring provision works smoothly. Surveys in several countries have proven the advantages of case management in guaranteeing continuity in providing services, and the need for institutional care has decreased by up to 50%.

Figure 1. Organisation of integrated services



The case manager has special training and is competent to assess the condition and the needs of a person, along with the welfare and nursing care services necessary. The case manager must have access to information concerning the services provided in the country, the list of service providers and be knowledgeable about the service-organising principles. The case manager is a member of the service providers' team that is in contact with the client during the entire period when the services are needed and has an overview of all the data about the client concerning the care.

For case management at a proper level there must be a database of client evaluations and information on the possibilities of the region's care institutions.

The principle activities of a case manager are the following:

- to receive information about a person in need and make contact with the client;
- to evaluate the client's needs with a recognised evaluation instrument (also to use prior evaluations if there are any);
- if need be, to use a primary assessment team (family physician, family nurse, regional social worker) or help from the geriatrics team; the family physician is the key person responsible for decisions regarding health;
- to plan the services (and support) package and organise the services to be provided to the client in the best possible way while following the principle of rational resource usage;
- to evaluate the compliance of the services provided with the plan and to organise the re-evaluation and changes in the care plan pursuant to the client's needs;
- to organise follow-up control and monitoring in their region;
- to provide social counselling services; and
- to make suggestions for planning and developing services.

The needs assessment and referral to services can be done by the primary evaluation team (in cooperation with the regional social worker, family physician and family nurse), but the case manager must receive all information concerning the evaluation and care plan.

In complicated cases when a person needs a more specific medical, functional and psycho-emotional assessment, an evaluation by a geriatrics team (in the geriatrics department) is carried out prior to drawing up the care plan.

In line with the practices already implemented in Estonia, it is best to start with case management on the county government level (also in larger towns), which has the responsibility of organising and monitoring primary health care. Central coordination is presumably neutral and guarantees subsequent control and monitoring of higher quality, including the use of finances. An alternative would be with the welfare institutions or local governments. The latter has welfare responsibility but lacks the competence for monitoring each type of service.

2. Funding

2.1 Costs of care

There are two major expense items that serve as a basis for the determining the cost of care and service provision:

- the costs of satisfying the basic needs of an individual (e.g. food, housing, safety and hygiene); and
- the costs of providing assistance (mainly the salary of nurses and carers, but also the costs of using instruments, transport, administration, safety supervision, etc.).

The first expense is quite steady – depending only on changes in economic conditions and it is usually the cheapest element of the costs of care. It is reasonable that if necessary and possible, users of care services may pay for satisfying their basic needs.

2.2 Nursing care services

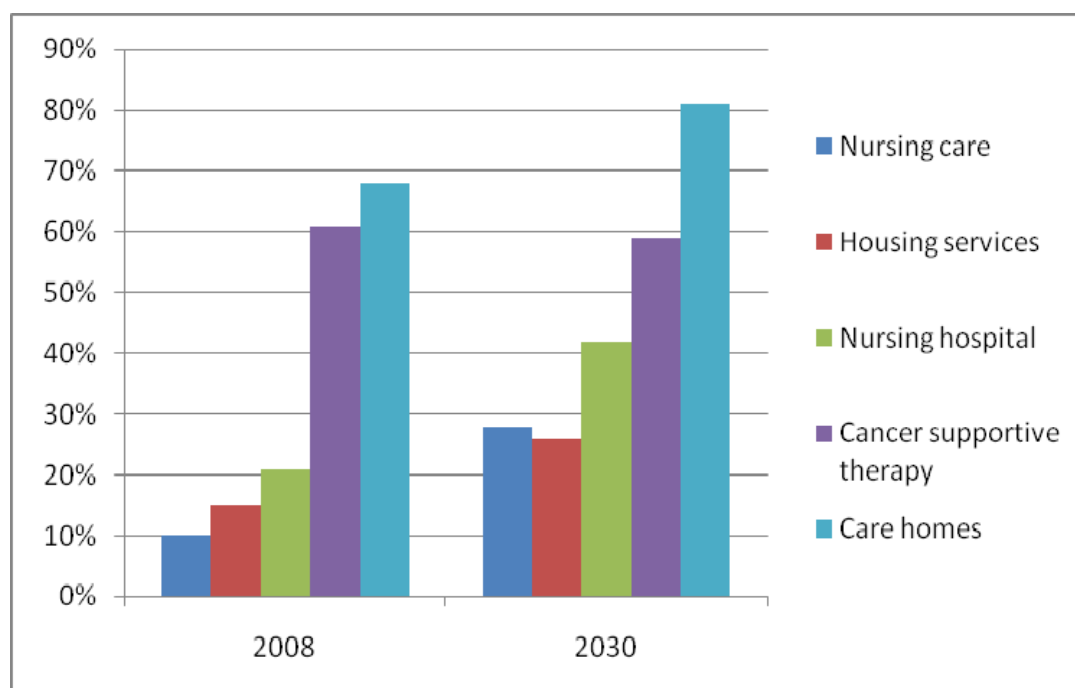
Public health insurance plays a significant role in funding nursing care (in institutions and at home), based on the principle of providing services tailored to the needs of insured persons,

regional accessibility to treatment and expedient utilisation of insurance funds. Health insurance is 13% of the earmarked social tax (33%) and is paid by employers for employees, while the self-employed pay the social tax from their income. Estonian health insurance functions on the solidarity principle: in case of illness, provision of the range of health care services does not depend on the amount of social tax paid for the person. The EHIF (*Eesti Haigekassa*) also pays for the services provided to non-working insured persons from the social tax paid by the working population. In Estonia, about 96% of the population is covered by health insurance.

Nursing care services are mainly funded by the EHIF. Nursing care in hospitals may be marginally paid by service users. Home nursing services may also be paid by the local government and/or service users. Geriatric assessment is fully paid by the EHIF.

Home nursing care (nurses and nursing services) has a large financing gap in Estonia. The development of such services is still at an embryonic stage. Figure 2 shows the coverage of care services by financial resources. For instance, the financing of home services is only 15% of the total need – the demand for such services is estimated at seven times higher than the volume currently provided. The projections for 2030 imply that the coverage should increase, as owing to welfare effects the need for such services is expected to decrease and the share of local government financing is expected to rise.

Figure 2. The estimated coverage of home care services in 2008 and 2030



Source: PwC (2009).

Based on the Nursing Care System Strategy of Estonia for 2004–15 (*Eesti hooldusravivõrgu arengukava 2004–15*), the goals for funding proportions of total expenses of nursing care for 2015 are shown in Tables 1 and 2. The aim is to deliver all services free of charge for service users, except those provided in care homes and home-based nursing care.

Table 1. Funding for nursing care services, goals for 2015 (%)

| Care service | Health insurance | Local government | Service user |
|-------------------------|------------------|------------------|--------------|
| Geriatric departments | 100 | – | – |
| Nursing care home | 35 | 49 | 16 |
| Care home | – | 71 | 29 |
| Nursing, day care | 100 | – | – |
| Home-based nursing care | 100 | – | – |
| Total | 56 | 31 | 13 |

Source: The Nursing Care System Strategy of Estonia for 2004–15.

Table 2. The distribution of total expenditures on nursing care, goals for 2015 (% of total expenditures)

| Care service | Percentage of total expenditures on nursing care |
|-------------------------|--|
| Geriatric department | 10 |
| Nursing care home | 36 |
| Care home | 32 |
| Nursing day care | 9 |
| Home-based nursing care | 13 |
| Total | 100 |

Source: The Nursing Care System Strategy of Estonia for 2004–15.

2.3 Welfare services

The majority of welfare services are financed by local government budgets. There are also other funding possibilities: the service user's out-of-pocket payments, donations, private sector investments, etc. Indirect financing occurs through the caregiver's allowance (from local government budgets) and allowances to individuals with disabilities (from the state budget). Care home services are the only services for which direct payments by service users are the main source of funding. About 58% of the costs of services were covered by service users in 2007 (see Table 3).

Table 3. Share of local government and service users' payments funding welfare services (% of total cost) in 2007

| Service/financing source | Local governments | Service users | Other |
|--------------------------|-------------------|---------------|-------|
| Care home | 41 | 58 | 1 |
| Home service | 98 | 1 | 1 |
| Day-care centre | 86 | 8 | 6 |

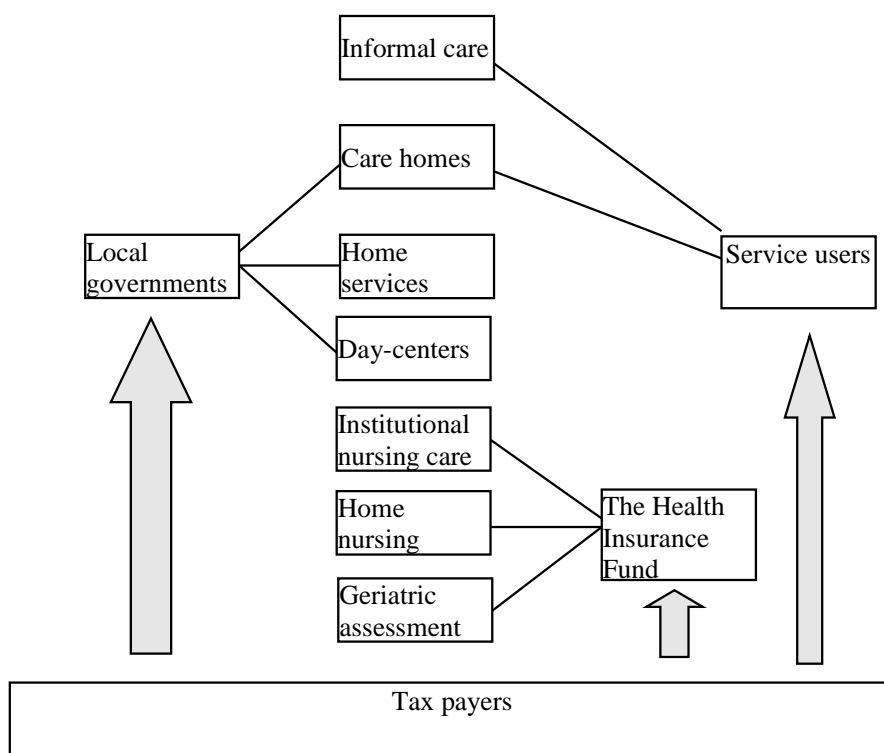
Source: Grünvald (2009).

2.4 Informal care

Informal care is mainly funded by local governments and is closely related to the economic possibilities of local governments. It is up to the local government whether to pay caregiver's benefits or not.

Local governments also fund supporting services offered to persons taking care of their relatives (see Figure 3).

Figure 3. Main funding of LTC services



Source: EGGA (2008).

3. Demand and supply of LTC

3.1 The need for LTC

Estonia has a population of 1,340,602 (as of 1 January 2008), approximately one-third of which lives in rural areas. Since 1990, the population has decreased by approximately 200,000, as a result of migration to the east and west, as well as natural negative growth. Although the crude birth rate has increased continuously since 1998 (from a low of 8.8 live births per 1,000) and despite the mortality rate falling steadily since 1994, the combined effect has not been sufficient to result in positive population growth. In terms of the population's age structure, less than 15% of the population is aged between 0 and 14, and the share aged 65 and older (17.1%) and aged 80 and older (3.5%) is rising (2007). These trends are not reflected yet by the age-dependency ratio, which has slightly decreased from 49% in 2000 to 47% in 2007, but the burden of an ageing population is expected to grow in coming years, as the working-age population declines.

Total expenditure on care services is relatively low in Estonia. According to the National Institute for Health Development (TAI, 2009), total expenditure on public-sector care services in 2008 was 0.28% of GDP. In 2009 PricewaterhouseCoopers (PwC) conducted an analysis of the LTC system in Estonia. The main aim of their study was to evaluate the sustainability of LTC. In order to assess the sustainability of LTC financing, the amounts of financing from current sources were projected until 2030 and compared with the estimated total costs. The demographic trends and changes in health status were also taken into account in their analysis. Two projections were prepared, for both demand and the actual need for such services. The demand projections assumed that the coverage and provision of formal care services remained at the current level, e.g. the share of formal care recipients among the total population aged 65+ remained constant. The projections of the need for formal services dismissed such assumptions.

The results revealed that with respect to the projected need, total expenditures on LTC services should be about five times higher (1.06% of GDP) compared with the current level.

According to estimations by the Institute of Estonian Demography, 37.8% of the population aged 65+ has a need for LTC. Only 5.6% of the population aged 65+ receives formal care services, but the need for formal care is estimated at 24.7% (see Table 4).

Table 4. The estimated need for total LTC, formal care and informal care

| | Actual 2007 | Proportion 65+ (%) | Needs 2008 | Proportion 65+ (%) |
|---------------|--------------------|---------------------------|-------------------|---------------------------|
| Formal care | 12,746 | 5.6 | 56,561 | 24.7 |
| Informal care | 73,810 | 32.2 | 29,996 | 13.1 |
| Total | 86,556 | 37.8 | 86,556 | 37.8 |

Source: PwC (2009).

In Estonia the planning of nursing care is based on the number and other indicators of persons aged 65 and older (elderly). According to the Nursing Care System Strategy of Estonia for 2004–15, the need for nursing care beds for 2015, based on calculations of 10 beds per 1,000 individuals aged 65 and older, is 1.4 per total population. For care homes (20 beds per 1,000 persons aged 65 and older), the figure is 2.9 per total population. At the end of 2007 there were 1,348 nursing care beds (according to calculations the need was for 2,305) and 5,128 (welfare) care beds (according to calculations the need was 4,610). Therefore, according to need, the number of care beds in welfare is optimal, but there must be more nursing care beds to meet the demand.

Determining the need for LTC in Estonia entails the following problems:

- insufficient analysis of the real need for care;
- difficulties in determining the number of clients able to pay their own share of financing;
- awareness of services (e.g. cancer supportive therapy and geriatric assessments);
- changing proportions of family care;
- a prospective increase in morbidity (e.g. cancer);
- acute-care quality improvements; and
- increased availability may bring growth in the demand for care.

Determining the need for welfare services also involves problems:

- insufficient analysis of the real need;

- prospective changes in the amount of family care and changes in its proportion compared with institutional care;
- changes in the expected healthy years of life owing to the increase in overall life expectancy;
- improvements in the image of care homes may increase the demand for such care; and
- improvements in the standard of living increase the capacity of clients to pay a share of financing the care.

3.2 The role of informal and formal care in the LTC system

While supplying older persons with LTC services, the emphasis is on helping individuals to remain in their homes as long as possible. In line with that goal, the amount of non-institutional services provided has increased, especially day care and other supporting services. The selection of different forms of care services, however, remains limited.

According to NOSOSCO, about 0.4% of persons under age 65 and 2% of those older than 65 are in care institutions. About 0.1% of those under 65 and 2.2% of those older than 65 receive home help.

3.3 Demand and supply of informal care

The Family Law Act provides a description of responsibilities children have for their elderly parents. Because informal care is not regulated by law in Estonia, there may be situations in which caregivers have too great a workload or they simply cannot handle it. In general, informal care is provided at home by the family (and hence free of charge).

There is no data about any kind of informal care in Estonia.

3.4 Demand and supply of formal care

The availability of home care and day-care services is inconsistent (see Tables 5 and 6). Access to nursing and health care services in care homes is low.

Table 5. Demand for LTC services in 2007

| | Service | Number of cases (% of total LTC) |
|--------------------------------|----------------------------|-------------------------------------|
| Nursing care | Institutional nursing care | 12,815 |
| | Home nursing | 13,627 |
| | Geriatric assessment | 1,149 |
| | Total | 27,591* (29%) |
| Care (welfare) | Care home | 7,016 |
| | Home services | 6,428 |
| | Day-care centres | 54,211** |
| | Total | 67,655 (71%) |
| LTC (nursing + welfare) | Total | 95,246 (100%) |

* Tallinn provides about 1,000 extra cases every year. According to that, the total number of cases in nursing care is about 28,591.

** The number of clients; the number of clients in day-care centres is approximate.

Source: Grünvald (2009).

Table 6. Supply of LTC services

| | Service | Number of providers (year) |
|--------------------------------|----------------------------|----------------------------|
| Nursing care | Institutional nursing care | 47 (2007) |
| | Nursing care | 44 (2007) |
| | Geriatric assessment | 7 (2007) |
| | Total | 98 |
| Care (welfare) | Care home | 118 (2007) |
| | Day-care centres | 82* (2005) |
| | Home services | 682 (2005) |
| | Total | 882 |
| LTC (nursing + welfare) | Total | 980 |

* For the elderly

Source: Grünvald (2009).

3.4.1 Institutional care

According to MoSA, in 2006 there were 4,737 persons in welfare institutions for adults (62% women and 40% over 80 years old) staying on average in the institution for 8.3 months. Compared with 2000, the number of persons in these institutions had increased by 45%. The fastest increase was among persons 80 years and older, making up 40% of persons in social care institutions in 2006 (compared with 34% in 2000). A total of 118 social welfare institutions offered care services to the elderly in 2007 (excluding those designed for persons with special psychiatric needs), providing 24-hour care to 4,970 persons, 80% of whom were above the age of 65. In 2008 there were already 2,008 institutions.

In 2007, 58% of expenses were paid by the service recipients or their families and 40% of costs were covered from the budget of the local government. The total cost was €23,015. The private share of expenses for institutions has increased over the years, as in 1998 only 23% of care in institutions had to be covered by the recipient, while 54% was covered by the local government and 17% by the state budget. Now, only 1% comes out of the state budget.

The demand for institutional care has increased by about 28% in the past five years, mainly because of the increase in the proportion of the elderly. The average waiting time for institutional care is 0.5-2 months. Waiting times differ by provider. The average waiting time for public institutional care is longer than private-for-profit institutional care. Waiting times have remained constant during the past five years.

The number of service providers and beds in institutional care (24-hour service every day) has increased. From 1998 to 2006, 25 new institutions and 1,500 service users were added. There are providers of round-the-clock care services in every county offering this main service, but not in every local government area.

In 2007, 9,580 persons (over 12,000 cases) used institutional nursing-care services (PwC, 2009). The average length of stay in institutional care was 27.6 months. The length of stay has increased in the past five years by about 4%.¹ The average cost per nursing care case was €842

¹ See the website of the National Institute for Health Development (TAI) (www.tai.ee).

(PwC, 2009). The average daily fee for institutional nursing care per recipient is about €41.² Fees vary among providers and according to the intensity of care needed. Care recipients can freely choose among providers.

According to the Development Plan of Nursing Care for 2004–15, there must be 4 helpers at night and 8 in the daytime per 30 clients in nursing care homes. There also has to be at least 1 social worker per 30 clients (PwC, 2009). At the end of 2005, the number of full-time employees in adult care institutions was 1,081. For 1 full-time worker, there were about 4 service users. In 2007 there were 1,173 workers in care homes, including 7 physicians and 174 nurses. That equalled 4.2 clients per care worker. In smaller areas, the number of clients per care worker was much larger (PwC, 2009). Institutional care providers cannot expand their capacity freely because of limitations in resources (workforce, number of beds, etc.). There is no remarkable competition between public and private sector institutional care providers.

3.4.2 Home care

Home-based services were provided to 6,428 persons, including 3,960 with special needs (i.e. disabled persons) in 2007. Among all service recipients, 76% were women (74% of persons with a disability). Out of all recipients of home services, 82% were older than 65 (44% over age 80). Among all recipients, 40% were women over 80 years old. When separately analysing recipients who are disabled, we can see that 75% were over 65. A high proportion of disabled individuals who received home services were older than age 65: 87% of women and 62% of men. The proportion of the disabled and elderly among home-service recipients has been increasing over the years. Although home services are the responsibility of local governments, not all of them are providing this kind of service (30% of them do not). In 2006, there were 667 social workers providing home services. On average, this service was provided to 45 persons per 10,000 (576 per 10,000 in the case of persons 80+) (PwC, 2009).

In recent years, the amount of home-care services has been stable – about 70% of local governments approve home-care services (PwC, 2009).

In 2007, 4,200 persons (over 13,000 cases) used nursing home care (including nursing care for individuals with cancer). The average cost per case was €143 (the cost of nursing care per patient with cancer was €85.80) (PwC, 2009). According to the Development Plan of Nursing Care for 2004–15, the optimal number of clients per nurse is 8-10. In 2007, the average number of visits per month per nurse was 132. At the same time, 17 doctors and 24 nurses were engaged in home care for individuals with cancer (PwC, 2009).

The number of clients per care worker in Tallinn in 2007 was 6.6 (PwC, 2009).

3.4.3 Semi-institutional care

In 2007, 1,100 persons (1,149 cases) used geriatric assessment services. The average cost per case was €1.10 (PwC, 2009).

In 2007, over 54,000 clients visited day-care centres. There were 1,001 workers, equalling about 54 clients per worker (PwC, 2009).

² See the website of the Estonian Health Insurance Fund (<http://www.haigekassa.ee/kindlustatule/tervishoid/taastus>).

4. LTC policy

4.1 Policy goals

Major LTC reforms are in progress and will take effect in 2013. Official LTC goals refer to the costs of formal care in general (€19,423,120), institutional care (€192,862) and home care (€16,613).³

The current LTC goals refer to different groups of recipients, e.g. persons with dementia or disabilities.

The overall goal is to ensure access to services for all and that the need for care does not cause poverty or financial dependency. In addition, the aim is to pay more attention to the inadequacy of access to services. The emphasis is on helping individuals in their homes as long as possible.

The Social Welfare Act sets out the following the main goals for welfare (care):

- less state and more individual and local government contributions;
- the development of case-management methodology; and
- the development of housing services.

The Nursing Care System Strategy of Estonia for 2004–15 lists the main goals in nursing care:

- to reach certain proportions of funding for total nursing care expenditures by 2015, i.e. 56% by health insurance, 31% by local government and 13% by service users. The aim is to provide all services free of charge for service users, except services in care homes and nursing homes;
- to increase the number of nursing care beds in nursing care up to 2010 to meet the need (based on calculations of 10 beds per 1,000 persons aged 65 and older);
- to ensure that all nursing care beds do not have time limitations on occupancy (now the maximum time of occupancy is 120 days), so that the nursing care time will be dependant on the need;
- to improve the quality and accessibility of nursing care services. Properly assessed needs should be considered when supplying services. More variety and needs-based services should be offered;
- to facilitate service users moving among different services according to care needs;
- for home nursing care to form the base and active nursing care the top level of nursing care, indicating a change in the focus of development planned for 2004–15;
- to create an effective network of nursing care by 2015 according to the objectives set in the national strategy. Also the aim is to uniformly cover the need for services everywhere in Estonia; and
- to decrease institutional services, to focus on the individual and provide flexible, integrated, community-based care services.

³ See the MoSA website, *Tervis, töö- ja sotsiaalelu 2007* (<http://www.sm.ee/fileadmin/meedia/Dokumentid/Sotsiaalvaldkond/kogumik/sotsiaalminist eetik trykki 1 .pdf>).

4.2 Integration policy

The development and sustainability of the nursing care and social welfare system is significantly influenced by the ageing of the population. It is evident that a decrease of the population of working age (15-64) from 2015 will result in the pressure to fund health care through taxation of the working age population or the increase of their own contributions. To facilitate the development of in-patient nursing care to the desired level there is a need to find new funding schemes, whereby health insurance would be assisted by the contributions of the local government and even individuals themselves, similar to the funding of care beds. Furthermore, along with growing revenues from the collection of health insurance, the private sector, central government and local municipalities should increase their expenditures on health care in pace with the growth of GDP in the future. The Local Governments' Act, however, does not set the requirement for the latter to finance health care.

The key values and principles now underpinning social service policy have a clear emphasis on the individual's needs rather than provision of the available services, supporting the maintenance of the greatest possible degree of independence and integration in local communities. In focusing on individual requirements, in recent years there has been more attention given to assessing needs and the instruments for doing so. Local government social workers have been educated on that theme. While developing the integrated system of care, regionally responsible centres will be established to improve matching services to individuals and movement among different services.

In practice, the level of integration among health, nursing and welfare services is very low and insufficient at present. As a result, for example, access to nursing and health care services is inadequate and limited for the elderly in care centres. To solve this problem, care and health specialists have united to develop the "Conception of Integrated Care Services for the Elderly". Nursing and welfare services will be provided in the same institutions. The practical outcome of an integrated system of providing care services will be regionally located, multifunctional institutions with stable and long-term (at least three-year) primary funding.

The integrated system is funded by three main sources. First, service users pay for housing, food and necessities. Second, medical personnel costs and nursing care given are funded by the EHIF (health insurance). Third, welfare services and equipment (as needed) are funded by the local government. More clear-cut funding will help the money to be used more effectively and make clear the share of payment by each participant.

4.3 Recent reforms and the current policy debate

Keeping health expenditures under public control has forced the health sector to increase internal efficiency (e.g. the reforms related to family physicians and hospitals). Since 2003, year-on-year the number of beds in institutional care has grown. In 2003, there were 976 and in 2007 there were 1,348 beds.⁴

The problem related to persons without health insurance must be solved to ensure the possibility of access to LTC services for everyone living in Estonia. The first steps have already been taken, e.g. giving health insurance to the unemployed who are actively seeking a job or attending refresher courses. Nevertheless, a lot of work remains to be done in the short run.

To improve nursing care quality, geriatric experts are formulating regulations for services. The EHIF supports this effort with funding and by monitoring the services provided according to the regulations of services in future. Digital solutions are being developed to aggregate all cases

⁴ See the website of the National Institute of Health Development (TAI) (<http://www.tai.ee/?id=5841>).

into one digital system. The so-called ‘e-Health project’ (*e-Tervise projekt*) makes it easier for different specialists to work with cases. It also improves the provision of person-centred care services.

In 2005, the state gave resources to local governments to pay a caregiver’s allowance. After that change, all care organisation instruments were in one place – in local governments. Assessing the needs of all clients was done with that change. As a result, local governments have a better overview of the needs of their residents and it is easier to develop services and plan resources. Moreover, as two-thirds of disabled persons are pensioners, the allowance is one way to support informal care.

The supply and volume of welfare services provided have grown from year to year. A future challenge is to encourage service providers to implement new, more economical and increasingly effective services.

One of the goals is to maintain the sustainability of the LTC system. Hence it is important to have enough qualified personnel. A large problem is the low salaries in the care sector. In recent years, however, the number of specialised personnel has increased. The salary of care workers (in the public service) is a topic that is currently being discussed at the state level in the government. To assess and develop the quality of labour, refresher courses and an employee registration system are being developed.

4.4 Critical appraisal of the LTC system

The main problems with LTC in Estonia are the lack of provision and high costs of services. For instance, the cost of care home services (i.e. long-term care in an institution) varies according to the institution, from around €319–447 per month to as much as €767–1,086 in some cases. Notably, average wages in Estonia in 2007 were €724–838 in the fourth quarter of 2008. The average old-age pension was €78 in 2008. Thus, in general care homes are really expensive and not widely available (MoSA, 2009).

The key difficulties faced by the LTC system are the following:

- The LTC system, based on the need for services, is not sustainable in the long term. More emphasis should be placed on developing home-based services and supporting more informal care services. As the demand for LTC services grows year by year, because of the ageing population, provision has to increase too.
- Less attention has been paid to informal care and financial support is insufficient.
- The availability and quality of services is uneven across the counties.
- Integration between the health care and welfare systems is low and random; consistency and needs-based services are not ensured.
- Salaries and the number of (qualified) personnel have to increase to improve the quality and provision of care services.

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About the PRAXIS Center for Policy Studies

The PRAXIS Center for Policy Studies (PRAXIS) is an independent, non-profit public policy think tank based in Tallinn, Estonia, founded in 2000. The mission of PRAXIS is to improve and contribute to the policy-making process in Estonia by conducting independent research, providing strategic counsel to policy-makers and fostering public debate. The main competence areas of PRAXIS are labour and social policy, health policy, innovation policy and education policy. The centre collaborates closely with experts from universities, NGOs and the public sector. PRAXIS has become a leading centre of empirical analysis of social and labour policy in Estonia. Its recent research includes evaluation of the impact of active and passive labour market policies, analysis of poverty and redistribution using micro-simulation methods, forecasting long-term sustainability of the pension and health care systems, analysis of the impact of family benefits on poverty and fertility behaviour, analysis of flexible forms of work and work-life balance. PRAXIS has also participated in a number of international projects (including FP6 projects).

ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

L launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).