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The Development of Long-Term Care in Post-Socialist Member States of the EU

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Contents

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Abstract

Long-term care (LTC) in the new EU member states, which used to belong to the former socialist countries, is not yet a legally separated sector of social security. However, the ageing dynamics are more intensive in these states than in the old EU member states. This paper analyses the process of creating an LTC sector in the context of institutional reforms of social protection systems during the transition period. The authors explain LTC's position straddling the health and social sectors, the underdevelopment of formal LTC, and the current policies regarding the risk of LTC dependency. The paper is based mainly on the analysis of information provided by country experts in the ANCIEN project.

Introduction

Many former socialist countries, including several new EU member states (NMS) such as the Czech Republic, Hungary, Slovakia, Slovenia, Poland, the Baltic countries, Romania and Bulgaria, have modified their social institutions quite radically over the last 20 years. This process occurred as they were emerging from a social policy model which had been relatively homogeneous in terms of institutional framework, but quite diverse from the standpoint of funding levels. Their pace of reform has varied and, moreover, their aims and directions remain very different.

The population in the Central and Eastern European (CEE) and Commonwealth of Independent States (CIS) regions is ageing rapidly, faster than in the countries of 'old Europe' (although until recently the opposite was true). This has altered the perspective on so-called "social issues" over the last few years. As early as in 2030 in several of the countries, namely in the Czech Republic, Bulgaria, Slovenia and Poland, the share of people aged 65+ will be close to the average observed in EU countries. And in 2050, the two EU countries which currently have relatively young populations, Poland and Slovakia, will be in the oldest category.

The impending social and economic challenges which European countries face due to the high rate of population aging are extremely serious. Efforts are focused on the future. As a first step, reforms of income security for the elderly were introduced in the form of changes to the pension system. Next, health care, and now long-term care (LTC), are being analyzed and reformed. In the NMS, LTC is not the most broadly discussed issue[1] and solutions in this area tend to be more traditional.

This paper aims to draw attention to the issue of LTC, the missing link in the social protection systems of the NMS. It has been prepared on the basis of work and discussions within the ANCIEN project (Assessing Needs of Care in European Nations), especially the first and last of its thematic packages (Workpackage I - Riedel, Kraus 2011, Workpackage VII – Mot, Birko 2012). In these packages, a classification of the solutions used in European countries was drawn up, and ways of identifying and evaluating the development of various forms of long-term care were studied. It turned out that the criteria used in the analyses and classification based on modest quantitative data did not always give clear results and required qualitative explanations concerning political, institutional, and sometimes cultural aspects.

[1] Other authors have also noticed this: "*During the entire period from 1990 to the present, long-term care did not play any prominent role in social policy reforms and was widely ignored as a social risk*" (Oesterle 2011).

For the paper, the authors used information drawn from the ANCIEN research provided by partners from CEE countries[2] published as ENEPRI Research Reports. Additionally, the authors studied national reports written under an earlier EU project on LTC issues: EUROFAMCARE (Services for Supporting Family Carers of Elderly People in Europe: Characteristics, Coverage and Usage) and studies by the European Commission, OECD and the World Bank. The first versions of this paper were reviewed by Monika Riedel and Erika Schulz, whom the authors would like to thank for their inspiration and suggestions.

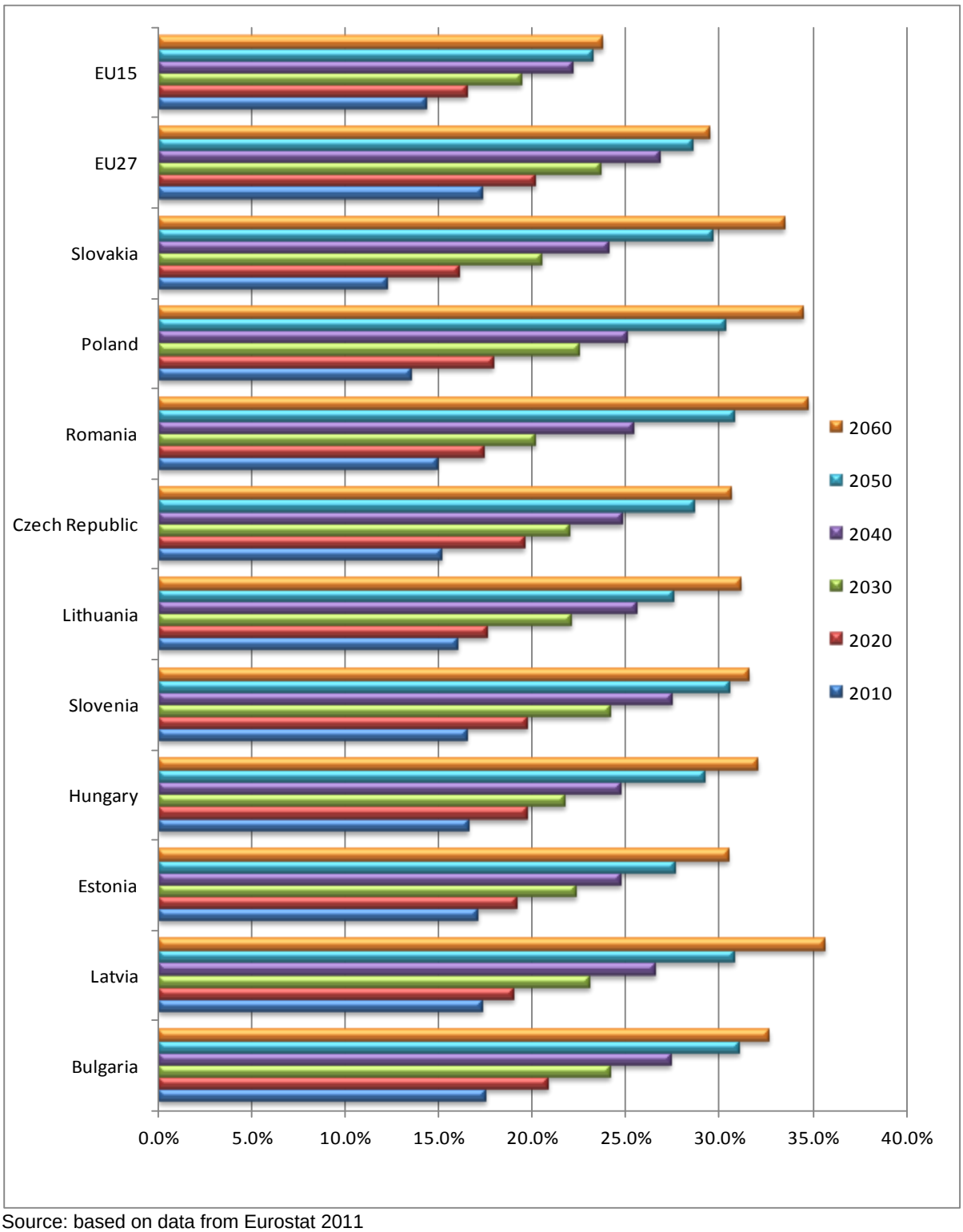
1. Future demographic changes in old and new member states of the European Union

New EU member states are countries which, at present, do not differ significantly from the old EU member states in terms of their demographic structure; some of them have an even younger structure, which is the case in countries such as Poland and Slovakia. It is worth noting that in Hungary, Bulgaria, Estonia, and Latvia, however, the share of the elderly is already high (see the graph below). Negative net migration represents a significant factor contributing to the high share of older people in the Baltic countries, Bulgaria and Romania. In turn, Hungary is the only country in the region where processes related to the so-called demographic transition and accompanying ageing of the population started earlier, similarly to the old EU member states. Hungary was obliged to take the implications of that fact into consideration when developing its social policy, especially as related to pension policy.

The demographic structure will undergo rapid changes. Each successive decade will bring growth in the share of the old and oldest people in the total population. The following graphs present these changes as compared to the average for the old EU member states.

[2] Czibere and Gal (Hungary), Ilves and Plakane (Latvia), Golinowska (Poland), Mincheva and Kanazireva (Bulgaria), Marcinkowska (Lithuania), Paat, Marilain (Estonia), Popa (Romania), Radvansky and Palenik (Slovakia), Rupel and Ogorevc (Slovenia), Sowa (the Czech Republic)

Figure 1. Persons aged 65 + in the population in 2010 and in the future: 2020, 2030, 2040, 2050 and 2060

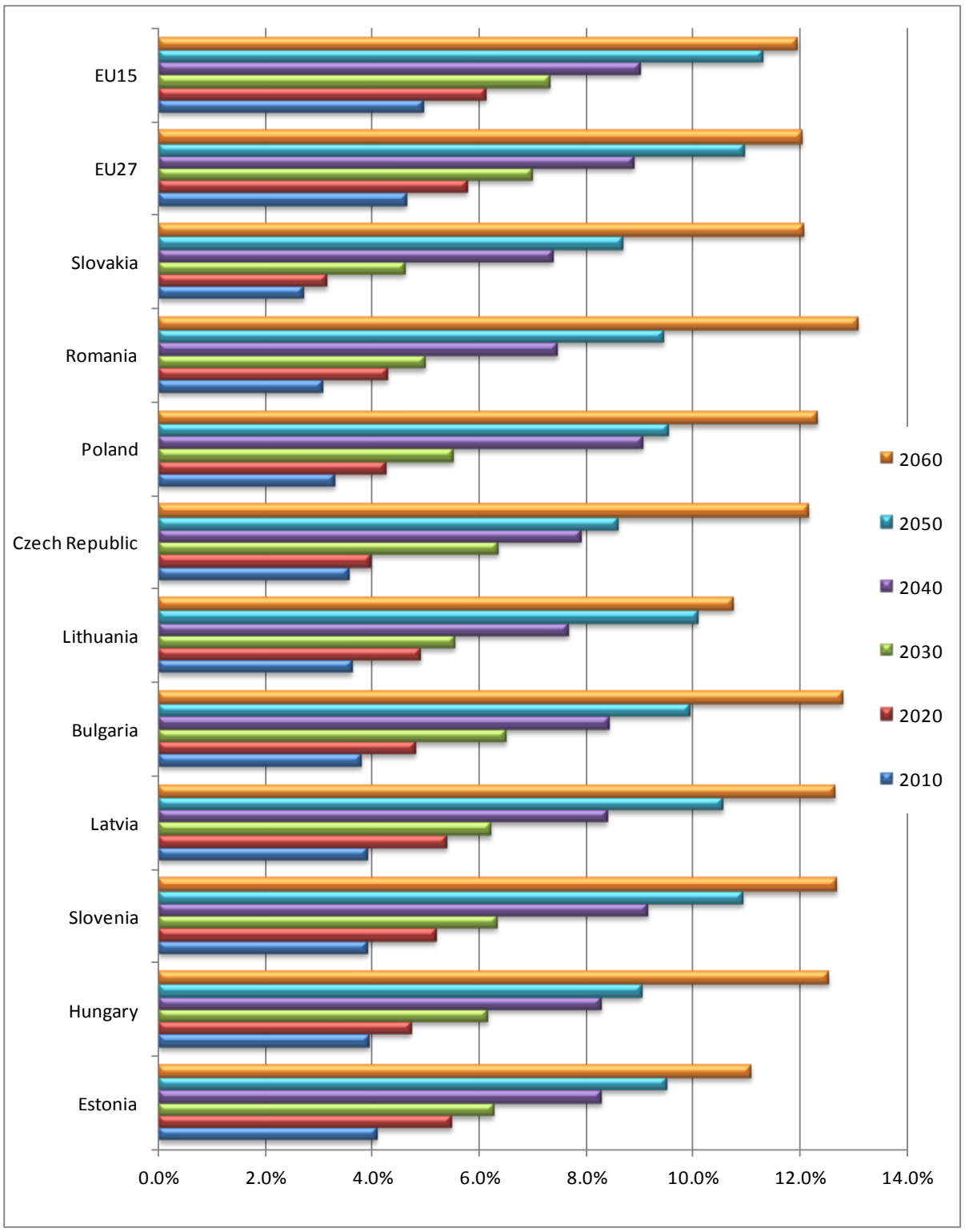


Source: based on data from Eurostat 2011

In 2050, as shown in the forecasts, the share of people over 65 years of age in countries such as Bulgaria, Slovenia, Slovakia, Latvia, and Poland will exceed 30%, while the average in the old member states will be less than 25%. The share of people in the oldest population group (80+ years old), characterized by a higher risk of dependence, will exceed 10% in a

number of the old member states and a few new ones: in the Baltic States (except Estonia), Bulgaria, and Slovenia. However, 10 years later, in 2060, the share of people over age 80 will exceed 12% in almost all European countries.

Figure 2. Persons aged 80+ in the population in 2010 and in the future: 2020, 2030, 2040, 2050 and 2060



Source: based on data from Eurostat 2011

As a result of future demographic changes, the old-age dependency ratio will increase dramatically. As a matter of fact, it will double. From a share of approximately 25% today, it will increase, reaching more than 50% in 2050; in Slovenia, it will even come close to 60%.

Table 1. Dependency ratio in 2009, 2030 and 2050

Countries	Demographic old age dependency ratio*		
	2009	2030**	2050**
Bulgaria	25.2	36.3	55.4
Czech Republic	20.5	35.7	54.8
Estonia	25.2	34.4	47.2
Hungary	23.8	34.1	50.8
Latvia	25.1	34.6	51.2
Lithuania	23.2	34.7	51.1
Poland	18.9	36.0	55.7
Romania	21.3	30.3	54.0
Slovakia	16.7	32.3	55.5
Slovenia	23.6	41.0	59.0
EU 27	**23.6**	**38.0**	**43.9**

* share of people aged 65+ in relation to those aged 15-64
** data for years 2030 and 2050 is derived from Eurostat 'Europop 2008' demographic projection
Source: Eurostat 2011

2. The notion of long-term care

In light of the fact that population ageing has now become the main theme of social debate on the future, following the example of Western Europe countries, CEE countries have also started using the concept of LTC. When explaining why LTC should be considered separately (from other forms of care), it is argued that LTC is a solution which is used to cover a new social risk, that is distinct from the types of social risk defined in international and domestic regulations pertaining to social protection (European Commission MISSOC 2009.) This risk **concerns being dependent in old age and requiring constant assistance from another person to be able to perform basic activities of daily living**. The risk of becoming dependent is regarded as a risk that is different from the risk of falling ill or becoming disabled, even though chronic disease/s (physical and/or mental) and progressive disability may be at the root of this risk.

LTC is defined in institutional terms as a cross-cutting policy issue that brings together a range of services for a person who is dependent on others for help with basic activities of daily living over an extended period of time (OECD 2005.) It should be perceived (and indeed sometimes is perceived) as a distinct part of social protection, integrating existing and

emerging institutions and solutions which address the care and nursing needs of the elderly. However, in many cases the precise definition of existing and emerging institutions to be included in this set is still lacking, and – consequently – there is no definition of financial and human resources that may be attributed to this category.

LTC services provided for senior citizens who are dependent on help may be nursing- and rehabilitation-oriented in nature, but they may also be focused on the provision of care and assistance in daily living. With regard to the provision of case, certain medical qualifications are required, so such services are typically rendered by nurses and rehabilitation specialists (or physiotherapists.) Daily living services tend to consist of social work and as such, are provided by social and socio-medical worker, who combine certain elements of medical and social care skills. In many countries, such combined qualifications are only just emerging as separate qualifications in the process of professional development and training.

Many countries classify LTC either under the “umbrella” of the health care sector or the social sector (most commonly, social assistance). However, in light of its two-fold nature (both medical and social) and the unique needs of the elderly dependent on help, it would seem justified to distinguish long-term care from other forms of care within the social protection system. The lack of such a distinction hinders the task of service identification. One especially important point is that it is hard to define long-term care needs. Moreover, it is not clear which sectors of the population of those in need of long-term care are included in the social protection system. There is a lack of relevant statistical data and the monitoring of the ageing process and the policies addressing the problems of the elderly has been inadequate.

3. Development of care for the elderly

The development of care for the elderly can be seen from two perspectives: on the one hand, one can focus on the development of formal care, the importance of which has grown with increasing human longevity and the development of medicine and rehabilitation techniques, which improve the lives of the elderly population; on the other hand, one can concentrate on the reduction in informal care, especially within the family due to social transformations and changes on the labor market and in the situation of women.

Development of formal care for the elderly

Formal care for dependent elderly people became a recognized medical activity at the beginning of the twentieth century. “Geriatrics” was considered a sub-specialty within internal medicine. It was formally introduced by Ignatz Leo Nasher, a Viennese doctor working in New York. He founded the world's first Geriatric Society, which began publishing a specialized journal called "Geriatrics". At that time, the first geriatric unit was created at the university hospital in Prague, along with Masaryk homes in Krc (Holmerova 2004), a health and social care institution.

In Poland, the first health care institution for elderly people with limited capacity for independent daily living was established in 1956 in Inowrocław: a geriatric sanatorium[3]. It soon became a training base in the field of geriatrics. In the other CEE countries, geriatric units at health institutions were created a little later: in the 1960s and 1970s.

Throughout the 20th century, care for dependent elderly people was seen as a predominantly medical activity. The medicalization of care was particularly evident in the period following the Second World War in the former socialist countries. Social issues within the framework of so-called “social and cultural activity” did not include issues of health, disability, and poverty. According to the prevailing ideology, difficult social situations could not have social determinants (because socialism had successfully eliminated these), but they were the result of one's individual fate and were related to health and/or disability (Zalewski 2004). Therefore, not only treatment, but also disability and dependence, were the domain of the Department of Health (the full title of which also included “Social Welfare”). For 40 years (between 1948 and 1989), with the increasing conformity to Communist ideology, human life under socialism became more and more institutionalized and care for dependent older people was provided mainly in hospitals and other health sector institutions[4].

A change in the approach to care for dependent elderly people took place in the 1990s along with the general systemic changes. In all of the former socialist countries, social welfare was separated out and, to a suitable extent, 'removed' from the health sector. The range of social welfare was determined and statutory regulations were introduced (first in Poland in 1990, then in Hungary in 1993, in the Czech Republic in 1997, and in Bulgaria in 1998). In this way, a separate sector of services was created, aimed mainly at people with special social and health problems, as well as the poor. Only care for chronically ill and dependent people requiring a range of medical interventions remained within the health sector, despite the fact that the prognoses for recovery and regaining independence were not favorable in such

[3] The first Polish geriatric clinic was established in 1960 in Opole. A year later the first two geriatric hospital units were created in Katowice and Lodz (Derejczyk et al. 2009).

[4] In Poland, church and religious centres, usually run by religious orders, have played a role in providing care for dependent persons and bedridden patients. They regained the right to conduct this kind of activity independently after 1956, a right of which they had been stripped during the Stalinist era (in the early 1950s).

cases. Initially, such persons remained in special wards in hospitals. Over time, a network of long-term care facilities was established for such patients. In this way, hospitals were relieved of the burden of expenditure on those who did not require expensive medical treatment, but rather needed long-term care. As a result, care for dependent elderly people is situated in two sectors: (1) the health care sector, which includes cases of dependency care, requiring a range of medical services; and (2) the social sector, which includes care for dependent elderly people who are also in a difficult situation: they are alone, come from dysfunctional families, or are poor.

With the introduction of market mechanisms (the deregulation of prices, economic freedom and privatization etc.), private entities offering nursing and care services for those in need (including the elderly) started to appear in the 1990s. Private institutions are becoming more and more numerous, especially in Poland, the Czech Republic, and Hungary. More and more senior citizens are taking advantage of the services they offer. Private institutions are not always commercial. Some of them are run by non-governmental organizations and are not profit-oriented. The participation of NGOs in providing long-term care also varies regionally. For example, in Poland there are regions with a traditionally higher share of NGOs operating in-patient care institutions, e.g. the Lesser Poland region (Mikos 2010).

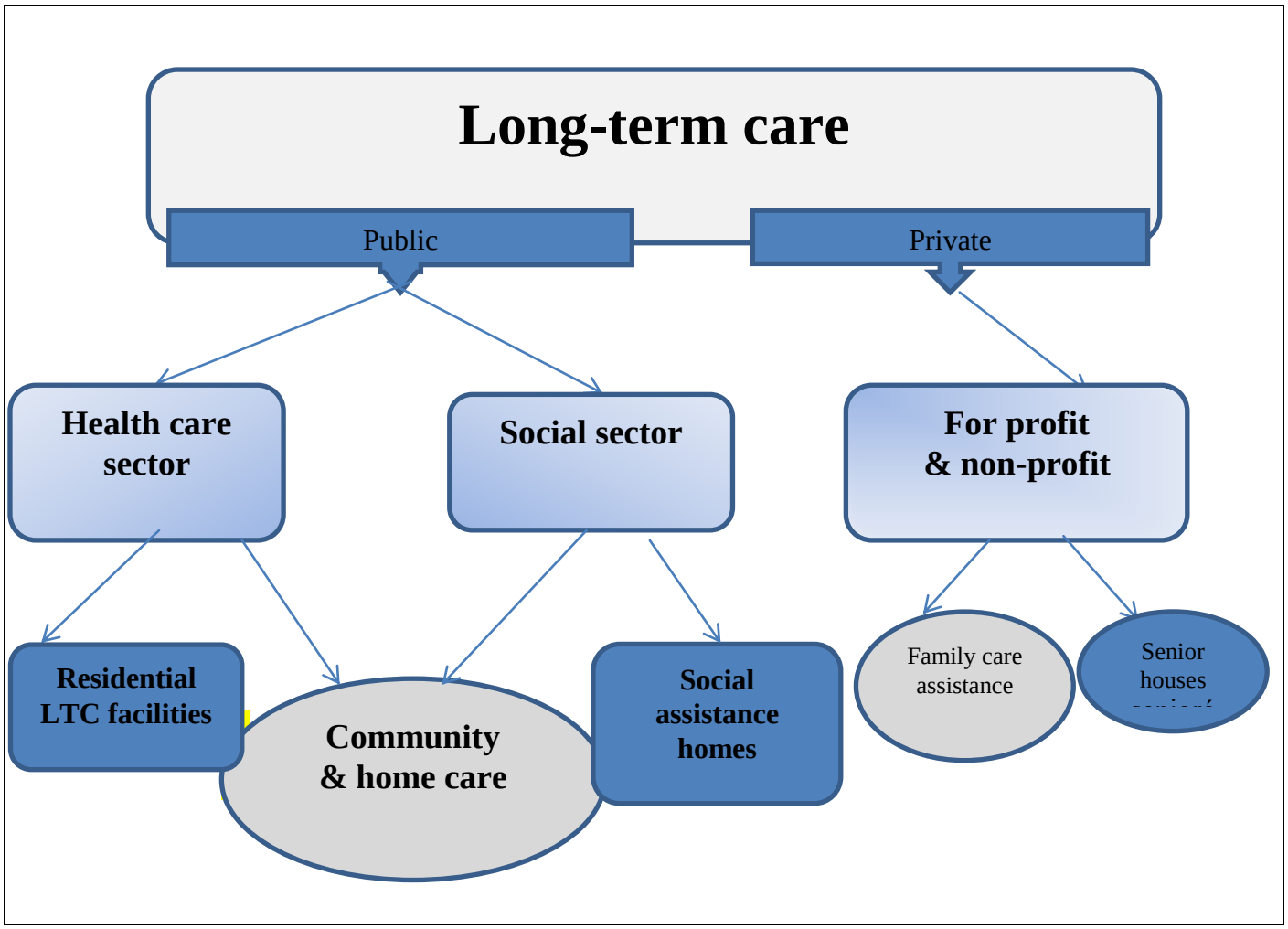
Private institutions do not always have a good reputation because their service standards vary and are not always disclosed in the offer. As the quality of care services is subject to either no supervision or inadequate supervision[5], the development of the private sector in this area would require a significant change in the quality control of services in the entire field of long-term care based on defined and implemented standards.

Another important factor affecting the development of long-term care in the post-communist countries is the decentralization of government and public administration. Decentralization reforms meant that the responsibility for the organization of long-term care became the task of local government. At the same time, however, the substantive responsibility for the form and content of care and its financing remained the responsibility of the health care sector. This caused difficulties in the coordination of actions, which - in some countries – have been 'offset' by special regulations on the operation of social services at the local level (parliamentary acts on social services: e.g., in the Czech Republic and Lithuania). In other countries, these problems still occur (e.g. in Poland).

The diagram below shows the complexities of formal care for dependent elderly people. Despite the impression of a multiplicity of solutions, suggesting a lot of options, access to

[5] In many countries, the media have been revealing the scandalous treatment of residents in private nursing homes, which has resulted in dwindling support for the development of this sort of facility from politicians and the local communities, even if the cases focused on by the media are only isolated and most institutions function properly.

long-term care is very limited. This includes *de facto* only severely dependent people who require a range of medical services[6], and people in extremely difficult economic situations with many social problems.



Development of informal care for the elderly

In the less industrialized countries of Central and Eastern Europe, care for children and the elderly remained within the family domain. After the Second World War, during in the period of accelerated industrialization taking place under the socialist system, the role of the family declined. However, in terms of the pace, the process proceeded differently in different countries of the region. The reduction in the caring functions of the family was more pronounced in the more industrialized countries which had a higher proportion of women in the labor market, such as the Czech Republic.

[6] In the post-communist countries, the practice of providing health services related to the human body is strongly medicalized. According to custom and to regulations in the health sector, only licensed medical professionals can provide such services.

The institutionalization of social life predominantly concerned children, young people, and workers and their families, rather than older people. This different approach to the elderly as compared to children was particularly characteristic of Poland7. It was commonly accepted that the responsibility for caring for a person in the final stages of their life was the task of his or her family. At the same time there was a push to increase the education and "professional activation" of women.

How was the conflict between family responsibility and increased female professional activity resolved in real life? The reconciliation of work and care tasks was facilitated predominantly by state regulations – mainly the possibility of early retirement. Women with a legally sufficient employment record could retire at the age of 55, which was taken advantage of on a massive scale. In the former redistributive pension system (still in existence for some cohorts born before 1949), the impact of one's employment record on his or her pension level was not significant to motivate against early retirement.

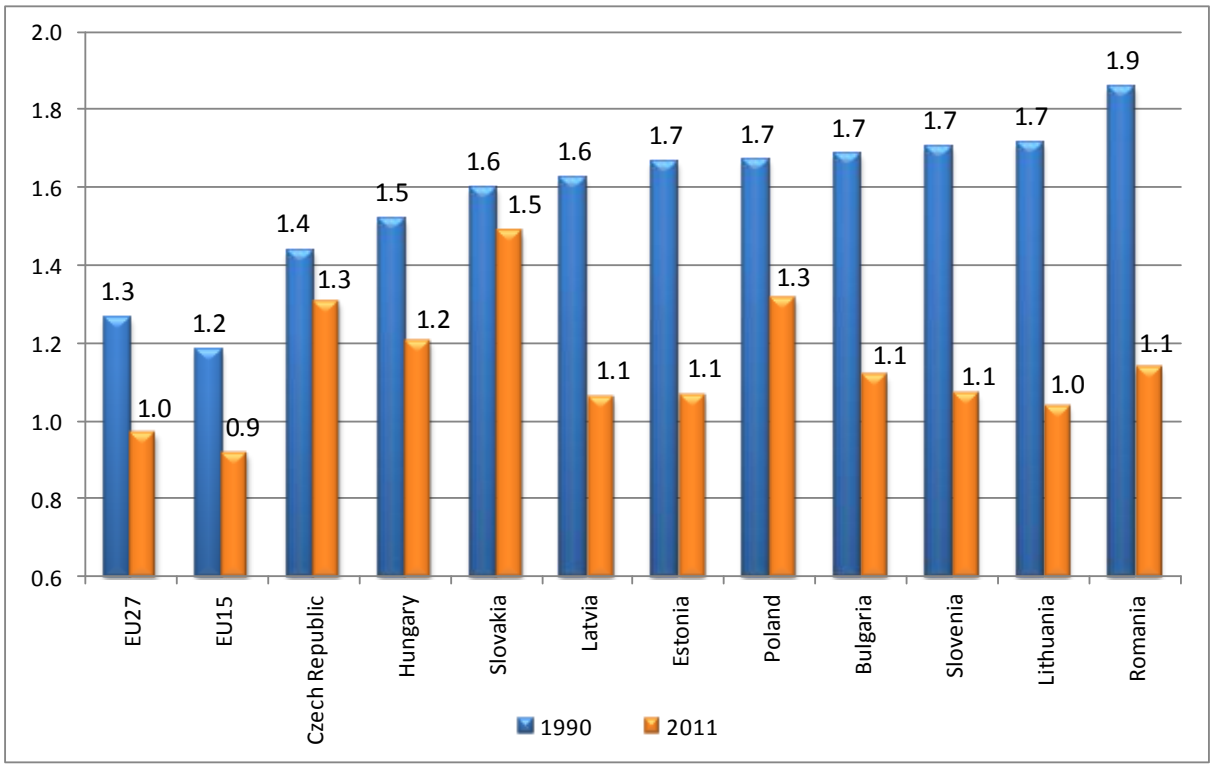
The tacit assumption that the family who should provide care for dependent elderly did not undergo a significant change in the years 1990 - 2010, despite the fact that the demographic trends, as well as labor market conditions were not favorable. The demographic potential for providing care services[8] decreased steadily (see chart), which was clearly visible in the Baltic States, Slovenia, Romania, and Bulgaria. At the same time, women sought to maintain their high level of professional activity (characteristic of the former socialist countries) in the so-called "immobile productive age" (45 - 59), with the exception of Poland.[9] A reduced employment rate remains the case in Hungary and Slovenia (Eurostat 2011).

[7] Hungarian experts claim that this obligation of the family concerning care for older people was reflected in legal provisions (Family Act, 1952, and 1986) which obliged the family (not just children) to assist the elderly in need (Szeman 2004).

[8] The indicator of care potential is defined as the ratio of the number of women aged 50-69 to the number of people aged 70 and more.

[9] In Poland, only highly-qualified women were professionally active for so long. Those with lower qualifications and those employed in industry benefited from many forms of early exit from the labour market, which, in the period of rapid transformation, were more numerous in connection with the social protection policies for the restructuring economy.

Figure 3. Indicator of women's potential for provision of care services in the years 1990-2010



Source: own calculations based on Eurostat data

The transition period, with its numerous market solutions (including solutions in the field of elderly care) resulted in the concept of financial support for the elderly in the form of an attendance allowance that would enable them to choose the sort of care they preferred: the purchase of private services or the option of partial compensation to a family for the care they provide. However, attendance allowances are usually amounts that are very small and do not, *de facto*, allow for the purchase of care services. In some countries, they are awarded on the basis of an income test. Consequently, informal care is still predominant and occurs within the family. As shown in the studies, in the last decade, the participation of immediate family members in the care of the elderly has not diminished, and in some countries it has even increased quite a bit (for example, in Poland - CBOS 2012). Older people have continued to benefit mainly from the care provided by spouses, children (mostly daughters or daughters-in-law), and grandchildren.[10] In cases where they used the services of persons outside the family, in most cases, these services were provided by persons employed in the shadow economy, usually immigrants.

[10] The structure of care-providing family members is not homogeneous; in Poland these include mainly children (63%), followed by spouses and grandchildren (38% - 29%) [CBOS 2012]. In the Czech Republic, the participation of spouses, siblings, and extended family is greater than in Poland.

Using the services of immigrants is still a characteristic of large cities in the new member states: Budapest, Prague, Warsaw, or Krakow. Such services are subject to a certain degree of social control. Usually, there is a limited network of contacts that allows persons seeking carers to reach a foreign carer and learn about her credentials (they are usually female). Research in this field in Poland (Domaradzka 2004) and in Hungary (Szeman 2012) indicates that the range of this type of care is not growing; it is, admittedly, small, but steady. Normally, it is provided by people from ethnic groups of the host country that exist in the country of origin, such as: in Hungary by Hungarian minorities from Romania (Transylvania) and Ukraine (Subcarpathia), and in Poland mainly by Polish minorities from western Ukraine and Belarus.

In parallel, formal home care services are developing, utilizing the pool of family nurses and carers (often it is a new profession) acting locally. In the World Bank report, this phenomenon is exaggeratedly referred to as "the strong growth in home and community-based services" (World Bank 2010). However, formal home care services usually do not replace family care, but help in the provision of the most difficult elements of care, or even some medical procedures: for instance, in the case of mechanically ventilated patients or patients on parenteral nutrition.

Family care is still the basic form of long-term care in the NMS of the EU. The slow but steady reduction in family participation in care can be attributed to the availability of formal home care services, which is facilitated by relevant regulations (Act on Social Services) and programs, such as those in the Czech Republic and Lithuania. The development of residential care as a result of moving away from hospital care to a new type of health care facility (nursing care facilities) also reduces the burden on families in the most difficult cases of dependency. However, this is a very expensive method and it is a burden on the limited resources of the public health sector. It also burdens the recipients of care (the elderly) and their families, whose co-participation in expenses is becoming larger and larger; covering the costs of accommodation and meals has been extended to encompass non-medical care services.

In all member states, we can observe the equalization of the retirement age for women and men (from 55 and then 60 to 65 years of age), and there are calls for its further extension to the age of 67. The decisions made have not, so far, gone hand in hand with significant changes in the development of LTC for the elderly, who will not be able to depend, to such a large extent as before, on care from women in their families. The above mentioned retirement age trend will - as a side effect - increase the pressure on the development of formal long-term care.

4. The family–based model of long-term care for the elderly

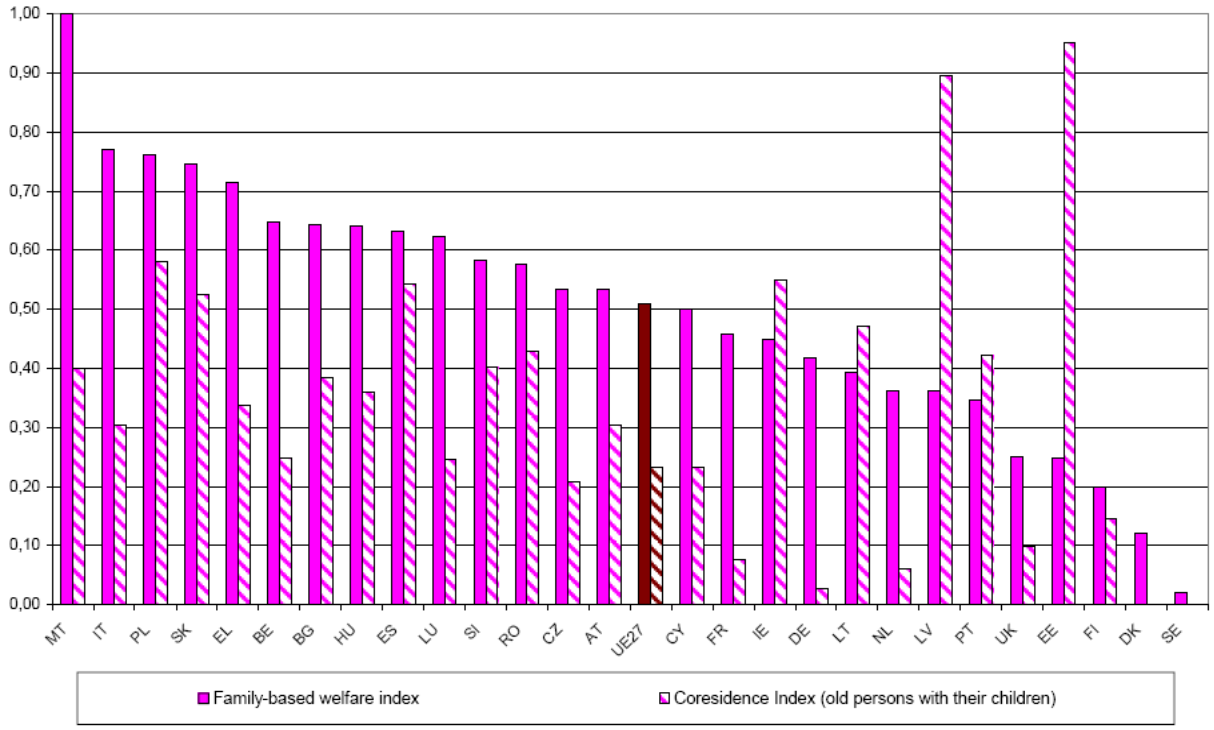
The development of long-term care in the new EU countries, where we are observing the exceptionally deep involvement of family members in the provision of care for the elderly, has been documented in European comparative studies. On this basis, a proposition was put forward, stipulating that the LTC social model in that part of Europe be a family-based welfare regime (Reimet 2009.)

The family-based welfare regime in post-socialist countries applies only to services for the elderly. As far as children are concerned, we can observe a high level of institutionalization in all countries except for Poland.[11] In a study conducted by Anne Reimet, she noted the high level of family involvement in the provision of care for the elderly due to two factors: co-residence of the elderly with an adult child (and that child's family) and the low level of professional activity of women at the pre-retirement age of 50-65. It should be noted, however, that the low level of professional activity of women at that age in the new member states is not a consequence of the low activity of women in general. Rather, it is a result of a mass movement of women towards all kinds of solutions involving an early exit from the labor market with income provisions: disability pensions, early retirement pensions, pre-retirement benefits and nursing benefits. Under the circumstances, family-based care is in fact co-financed by the state, albeit not directly, through some kind of income provided to any woman who is taking care of a family member.

Furthermore, senior citizens in post-socialist countries rely on a social insurance pension system, which on average provides them with a relatively decent replacement rate. They transfer it to the family, and in return they feel, in a way, entitled to some kind of care. Family transfers from senior to junior family members are quite substantial.

[11] Due to a different model of country development in Poland under the communist regime, with a high share of private agriculture and strong family values supported by the Catholic Church, institutional forms of care for small children were not developed to the same extent as in other socialist countries.

Figure 4. Family-based welfare index in elderly care according to Anne Reimet (2009)



As can be inferred from the figure above, not all of the new member states have higher indexes than the EU average. In the Baltic (post-soviet) States, the level of professional activity of women at pre-retirement age is high, despite a high rate of co-residence of old people with their children (see Table 2.) The reasons are both fewer opportunities for income provision after opting out of the labor market and substantial losses in the amount of income (present and future) after retiring from professional activity.

5. Long-term care – a female world

As demonstrated by Manfred Huber (2009) in his comparative report, one outstanding characteristic of long-term care services is the fact that those who provide care and those who receive it are mostly women.

By and large, women are the ones who provide family care. There are qualitative studies describing the forms and conditions of family care, but there is a lack of comparative quantitative studies which would provide relevant estimations. Provision of care for the elderly is reflected, with some approximation, in the indexes of the less intensive presence of women on the labor market at a more senior age of professional activity (55-64.) The role of

family care-givers in old European countries has been decreasing because women at pre-retirement age are more and more professionally active (European Commission 2009). The employment rate of women aged 55-64 is still significantly lower than that of men. The so-called 'gender gap' within this age group is still larger than the average: 16 percentage points against 12. The situation varies among the new EU member states. In the Baltic states, the employment rates of men and women at all ages, including the pre-retirement age group, are similar. In Estonia and Latvia, the employment rate of women is higher than that of men. On the other hand, in Poland, Slovakia, Hungary, and Romania, the employment rate of women aged 55-64 is only 24% - 33% and is significantly lower than the employment rate of men. It is also and lower than the average for both men and women.

In the Eurostat analyses concerning employment, using research on professional activity (LFS), the question of why women aged 55 were leaving the labor market was asked a number of times. Women in the new member states replied that it was due to the possibility of retiring or being granted disability benefits (80 - 90%). Only a small fraction of respondents said it was due to the lack of jobs (European Commission 2012).

Since women generally tend to live longer than men, they are at greater risk of disability in the final years of their lives. Women constitute two thirds of the approximately 4.7% of the population aged 80 or older. According to OECD analyses, the gender gap with regard to women who receive assistance and nursing care at that age is substantially higher, but not as high as it could be if it were proportional to the demographic gender gap. In the most affluent countries which have the longest life expectancy, the gender gap amounts to a dozen or so percentage points. In the slightly younger cohorts (65-79), the share of people who receive assistance and nursing care is much lower and distributed more evenly across genders (Fujisawa, Colombo 2009, p.19.)

Moreover, women constitute the vast majority of those who work as nurses and social assistants. Amongst the several major professions/occupations with a female predominance, health care and social care services are among the leaders, i.e. the most ‘feminine’ sectors of the economy, following sales, cleaning and personal services, and education (Eurostat 2007). The outcome of the quantitative assessment of the tendency, obtained through a pilot OECD study (2008), presents indicators with the share of women at the level of about 90% or more.

However, this traditional female world of LTC services has been somewhat disturbed. The female inclination towards training in nursing and medical care services has become less and less pronounced. It is a difficult and relatively low-paid profession, with a high rate of burn-out and a hardly motivating career path. For these reasons, nursing and care services

in more affluent countries are provided more and more frequently by female foreigners. For example, in Germany and the UK, about 30% of care-givers in formal care are foreign, and if informal care were taken into account, the ratio would be much higher. In the period of 1995 – 2006 in OECD countries, the tendency to hire foreign female workers in long-term care was on the rise. The qualifications of women who provide care are typically low, and they are much lower in the social sector than in the health care sector. They are also lower in informal care versus formal care (Fujisawa, Colombo 2009).

The CEE countries are still a source of migrant nursing workforce for the old EU countries, although this trend is weakening[12]. The number of educated nurses per 1000 population is in fact low, much lower than in Western Europe; this is especially the case in Poland, Romania, and Bulgaria (see table). At the same time, in the new EU member states, the demand has begun to increase for care services for dependent older people, which has further contributed to increased tensions on the nursing labor market (protests and strikes). As a result, decisions have been made concerning the education and training of carers for long-term care services, and concerning a gradual increase in nurses' wages - which are still relatively low, below the average wage in their countries (OECD 2010).

In new EU member states, the demand for assistance and nursing care for older people who are dependent on help has already started to grow, leading to an increase in domestic pay rates for those working in these professions and an inflow of foreign female workers to big cities in the CEE region, such as Prague, Budapest and Warsaw.

Table 2. Women's potential for care service provision and care service needs

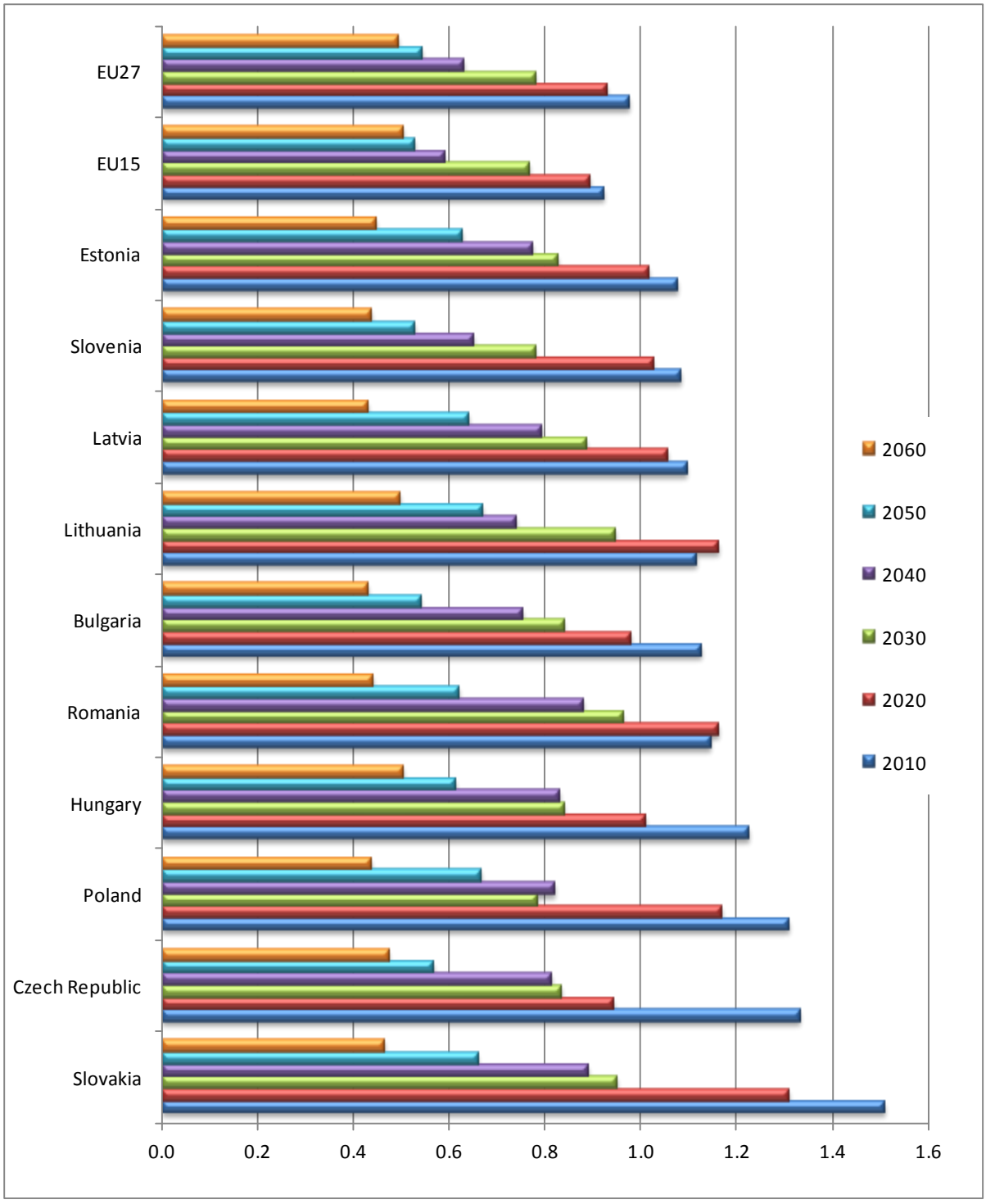
Countries	Rate of employed persons aged 55-64 (2010)		Share of persons aged 80+ by sex in the population 2010		Number of nurses per one thousand residents (2008)
	Female	Male	Female	Male	
Bulgaria	37.7	50.3	2.4	1.4	4.2
Czech Republic	35.5	59.6	2.4	1.1	9.7
Estonia	54.9	52.2	3.1	1.0	8.7
Hungary	30.1	39.6	2.8	1.2	8.7
Latvia	48.7	47.5	3.0	0.9	6.3
Lithuania	45.8	52.3	2.7	0.9	7.1
Poland	24.2	45.3	2.3	1.0	5.2
Romania	33.0	50.3	2.0	1.1	5.5
Slovakia	28.7	54.0	1.9	0.8	6.3
Slovenia	24.5	45.5	2.8	1.1	6.3
EU 27	**38.6**	**54.6**	**3.1**	**1.6**	**9.8 (EU total)**

Source: Eurostat 2010 and 2011, OECD 2010

[12] In Western European countries, the number of Asian workers in this sector is increasing.

As a result of the demographic changes, the nursing potential of family care is expected to become severely limited (see chart below). All the more so when we take into account the fact that, in light of high ageing dynamics and pension system stability concerns, politicians tend to promote a policy of longer employment, thus shifting the retirement age upwards. Clearly, we can observe a conflict in social policy directions concerning the elderly population in the context of the longer presence of women on the labor market. As a consequence of the fact that the retirement age for women and men is both equal and higher, the nursing potential of women in family care is becoming less available. A strong need for the institutionalization of LTC services is becoming apparent, both in terms of care provided at home and in specialized facilities. It is a huge challenge that can probably be successfully addressed, but only assuming a much deeper involvement of social policy in this segment of social protection than there has been to date.

Figure 5. Indicator of women's potential for care service provision – forecast for the next decades 2020 – 2060.



Source: own calculations based on Eurostat 2011 data

6. Introducing long-term care into social protection legal regulations

In the post-socialist countries, long-term care is not a separate division within social security. However, in most of these countries, we are seeing a slow evolution of social legislation towards identifying selected institutions to provide long-term care. We can see a tendency that consists in separating out long-term care services from existing health services and the social welfare institutions that are being created. However, this process is still occurring separately in the health and social sectors.

On the basis of an analysis of the information contained in the national reports drawn up for the ANCIEN project, one can attempt to formulate a classification based on differences in the degree of development of long-term care regulations. There are three basic degrees (stages):

(1) The establishment of more general regulations clearly defining the policy towards the elderly and dependent persons, defining the responsibility of the state and other entities for support of nursing and care functions, and suggesting relevant institutions to perform these functions.

(2) The determination of long-term care as one of the tasks of, on the one hand, the social welfare system (in development), and on the other hand, of the local authority, within the framework of the de-centralised power structures. The new regulations indicate these functions and determine the conditions for entitlement to long-term care.

(3) The legal regulations rarely indicate, and do not specify in detail, the function of long-term care in the existing branches of social security and health care. Traditional names are used: 'social welfare' and 'support of people with disabilities'. The category of 'long-term care' is used mainly by experts. However, in the regulations concerning the functioning and requirements formulated in relation to various entities and their activities, some guidelines are introduced.

The Czech Republic is in the **first group of countries**. A general regulation equivalent to an act of parliament was adopted there with regard to social services, which include care services aimed at the elderly and persons with disabilities. However, these services are not referred to explicitly as long-term care services for older people, but more generally as social

services. This act allows the creation of public and private entities to provide various social services. The Czech Republic is also distinguished by the fact that at the government level, a programme was developed in order to prepare activities connected to the ageing of the population: the 'National Programme of Preparation for Ageing 2008-2012'. This program fosters a greater awareness of demographic changes and their effects and the acceptance of taking tough steps such as extending the retirement age.

Despite the law on social services, part of these services, both in in-patient and home care, are still provided within the health care system. In-patient services are provided in long-term care homes, often created from hospital wards, for long-term patients requiring skilled nursing and specialist medical care. All in all, the long-term care system is not yet fully integrated and is managed under the Czech Ministry of Health and the Ministry of Labour and Social Affairs (Sowa 2010).

Innovative integration solutions can also be observed in Slovakia and in Hungary, where a local project has been developed aimed at the integration of social and health care systems – the ISZER (Integrated Social and Health System). Integrated care programmes are oriented towards home care, within the framework of which various services operate, depending on needs. The use of an integrated approach is also planned in Estonia.

The second group of countries includes Lithuania, Latvia, Bulgaria, and Romania. In these countries, there are no separate regulations on long-term care for the elderly. There are, however, regulations concerning care in general (for those suffering from diseases, people with disabilities, and the elderly) and the operation of centres providing support, as well as nursing and care services. These regulations define the tasks and social activities of local authorities. At the same time, regulations concerning social welfare and the decentralization of the state's system of power and administration have also been formulated. One might say that in this group of countries, long-term care is defined more in social than in medical terms. The level of co-payment by the care recipients is significant. Facilities providing long-term care services at the local level may receive a budget grant from local authorities if they meet certain standards (in Bulgaria, these were defined in 2008 as 'financial support standards per one place').

Older people requiring long-term care services of a more medical character are still patients in the healthcare system (e.g. they usually use the services of special hospital or para-hospital wards). Receiving long-term care services in the case of chronic diseases and dependence requires a medical certificate. The term 'long-term care system' is not used in the legislation and operates only as a term adopted by expert groups.

The third group of countries includes Poland and, partially, Hungary. These countries do not have any general regulations on long-term care for the elderly either. At the same time, various public and private institutions that provide long-term care services are functioning or are being set up. These institutions operate under a number of laws: the law on health care centres (healthcare), the law on social assistance (nursing homes), the law on public benefit organizations (NGOs), and the act on the freedom of economic activity (commercial facilities). With regard to home care activities, the law on health care services and on the nursing profession applies. It allows nurses to provide nursing care as community nurses/health visitors. This type of development of long-term care has been referred to as supply-oriented, because the state encourages the creation of facilities and services, and is less concerned about the ability of the recipients of care services to pay for the services offered. In Poland, a project was discussed concerning a method of insurance-based funding of such facilities (draft by Senator Augustyn), but for now it remains in the parliamentary "deep-freeze".

7. LTC organization and management

Institutional development in Central and Eastern Europe countries is still undergoing transitional changes, which means that governance and coordination in many areas of economic and social life remain *in statu nascendi*. From the standpoint of social services (including long-term care), a lot of attention should be devoted to the process of decentralization. A key role in social policy implementation is assigned to the emerging (and re-emerging) local and regional self-government authorities. Having said that, self-government authorities do not have adequate resources as of yet; they lack the funds, manpower and competence to effectively execute the tasks they have been assigned. As a result, numerous social policy solutions lack an effective coordination platform and they are not adequately monitored or regulated under relevant provisions. Long-term care is one such area. The specification (table) below specifies key institutional actors and their LTC accountability.

Specification 1. Accountability for the organization and delivery of LTC

Actor	Accountability	Area of accountability	Country
Central government	General	Regulations, strategies, standards, professional education, financing principles, resources for regional and local government units	All analyzed countries
Health care sector	Institutional care, home-based nursing care	Rules governing access and service financing	All analyzed countries
Social sector	Socio-medical institutional care, home care	Rules governing access and co-funding	All analyzed countries
Regions	Regional LTC policy	Institutional network development, cohesion policy	Hungary and Slovakia
Local government	Residential, day, community and home care	Needs identification, co-funding, co-management, development of infrastructure, service delivery	Most of the analyzed countries
NGOs	Fundraising and sponsoring LTC services, LTC delivery	Service delivery in cooperation with local government	Czech Republic, Poland, Slovakia, Hungary and Romania

Source: Author's compilation

As far as the development of social services is concerned, there were high hopes in the post-socialist countries related to the development of civil society and non-governmental organizations. In the initial phase of the transition, NGOs mushroomed in the prevailing spirit of democratization in political and social life, together with the introduction of regulations on the freedom of business activity, assembly, speech and state support for NGOs. Today, after two decades of transition, the lessons learned from the development of NGOs are not all optimistic. One cannot overlook the significant difficulties in their development path. Stable organizations are more common in countries which have had some previous experience in non-governmental forms of social assistance: those connected with the church (e.g., in Poland), hobbies and pastimes (e.g. in the Czech Republic), or established in response to political oppression (for example in Poland and Hungary). As far as long-term care is concerned, the Catholic Church, monastic orders, and religious organizations (e.g. CARITAS) still play a significant role. 'Lay' organizations have focused on the needs of disabled children and adolescents. It should be noted, however, that the main focus is centered on the generosity of the general public in terms of fundraising and sponsoring some

residential institutions that deliver LTC services rather than on 'grass-roots' initiatives aimed at building organizations which could provide such services themselves.

8. LTC funding

In light of the fact that long-term care functions in CEE countries are performed within several different segments of the social and health protection system and by various institutions, in order to be able to get a good overall picture of the financing of LTC functions, one needs to aggregate various streams of funding utilized for LTC purposes in different places. Aggregation by itself is a simple procedure, but its components are not easy to identify. The amounts consumed by long-term care are not separated from the overall budgets of institutions involved in other types of activities as well. The specification (table) below indicates the institutions involved in long-term care and their sources of funding.

Specification 2. Institutions involved in long-term care delivery according to sources of funding

Institutions	Source of funding	Co-payments	Country
Wards in general hospitals: specific and non-specific	Health insurance fund or directly from the state budget	Informal Formal	Poland, Lithuania, Hungary Czech Republic (since 2008), Bulgaria
Nursing and care facilities in health care sector	As above	- Provided free of charge - Covering the costs of accommodation - Broader scope of cost sharing	Slovenia Poland, Czech Republic Bulgaria, Estonia, Slovakia (means testing)
Hospices	Health insurance and sponsoring	Cost sharing, formal or voluntary	Poland, Czech Republic
Institutional care facilities for older people in the social sector: - residential - day care	Central budget and territorial government budgets (from general taxation)	Formal cost sharing Income-dependent	Czech Republic and Slovakia Poland, Slovakia, Slovenia, Hungary
Community nurse services	Health insurance and local budgets	- Informal - Formal cost sharing	Poland, Czech Republic, Slovakia, Slovenia, Hungary, Bulgaria, Estonia,
Non-public organizations: - non-profit - commercial	Contracts with regional and local self-government units	Cost sharing, voluntary payment or full payment	Poland, Czech Republic, Slovakia, Hungary, Romania

Institutions	Source of funding	Co-payments	Country
Family	Family income and income of care receivers (old-age and disability pensions)	State financial support in the form of care allowances for the caregiver and/or care user	All analyzed countries

Source: Author's compilation

Taking into account LTC financing in many places and from many sources, the full cost of spending (public as well as non-public) on LTC services would appear to be as follows:

$$\textbf{Total LTC} = [Shc + Hhc] + [Ss+Hs] + N + Ic + Ip$$

where:

Shc – spending on in-patient care in the health care sector (in hospitals and other facilities)

Hhc – spending on home nursing care, delivered and financed in the health care sector

Ss – spending on in-patient care in the social sector

Hs – spending on home care, delivered and financed in the social sector

N – spending on in-patient and home care delivered by NGOs (including services subsidized from public funds)

Ic – co-payment from recipients of care services and their families

Ip – personal income spending on LTC services delivered informally (care-givers hired to work at home) and provided by commercial facilities.

Moreover, a comprehensive evaluation of LTC funding should also include earmarked benefits supporting the income of the population, including a general indication as to the purpose of a cash benefit as well as income conditional upon meeting a specified requirement.

A comprehensive evaluation of expenditures on LTC services requires many estimations, because the amount of resources allocated to care services for the elderly are not distinguished (listed separately) either in health care or in the social sector, which presents a serious barrier to the disaggregation of financial data according to age. Furthermore, it would be almost impossible to disaggregate the data according to the type of service delivered to patients, both in terms of health care and social care. Separation of LTC services from hospital services represents a particularly difficult challenge, and it is a well-known fact that

in the countries of the CEE region, hospitals are still heavily involved in the provision of nursing and care services.

The structure of spending on LTC services in CEE countries is varied and volatile[13], which demonstrates that the sector is still in a state of flux (*in statu nascendi)* and each country is at a different stage of the process of separation and stabilization of the sector.

In the Czech Republic, expenditures incurred in the medical sector are dominant, both in terms of institutional care and home nursing care. Expenditures on social services and institutional care (in senior citizen homes) are smaller by almost half. Institutional care involves a significant co-payment component, which represents, on average, about 20% of total spending on social services directed mainly towards older people according to data from the Czech Ministry of Labor and Social Affairs. In recent years, there has been a tendency towards developing home care services in an effort to support the family in the delivery of care. Such benefits were defined in detail in the 2006 Social Services Law. One should note, however, that the share of family care in the delivery of care for the elderly with limited capacity for independent daily living is lower in the Czech Republic than in other CEE countries. Likewise, the co-residence index for older persons living with their children is lower as well.

In **Slovakia,** the health sector resources allocated to long-term care services are crucial to the total formal expenditure. In the social sector, an important element of financing is the co-participation of the recipients of care services in the expenses, the scale of which depends on their income. Approximately one-third of the costs are covered by such co-participation. An unusual solution in subsidizing long-term care institutions from health and social insurance (regardless of the facility's public or private ownership status) is co-participation in costs according to an amount dependent on the level of fitness and dependency of the recipients of care services, as assessed by appropriate tests (Radvansky, Palenik 2010). Within the framework of family care, it is possible to support a guardian of a dependent elderly person (when a relevant medical certificate has been obtained) with a suitable allowance, as defined by the support system for people with disabilities. Since 2009, Slovakia has created centers for fully-integrated care, providing both health and social services, which are funded in a way that integrates multiple sources. This solution is new and its success has yet to be fully evaluated.

Hungary does not differ from other post-socialist countries in terms of the organization and funding of long-term care services. In-patient services for most dependent persons are financed from health insurance funds. In the social sector, an important role is played by the

[13] Which is known from in-depth country reports published as ENEPRI Research Reports 2010 and 2011

local government, which is already funding 46% of total spending on long-term care, including in-patient, out-patient and home-care (Czibere, Gal 2010). Recipients of care services co-participate in expenses for services, depending on their income and the type of services needed. The role of the family in the care of elderly dependents is significant. However, in Budapest, paid external assistance is also widely sought. Family caregivers can receive benefits, the conditions for which are defined within the framework of the support for people with disabilities. Being able to obtain a certificate from a family doctor plays a significant part in being granted such an allowance.

Slovenia is one of the new EU member states where spending on long-term care services is the highest; it is similar to the relative level of expenditure in the old EU member states (about 1% of GDP). These services, like in other countries, are provided separately in the health and social sectors (both within the framework of social welfare and as part of local social activities for the benefit of residents who are in need). The largest part of the funding comes from health insurance, which fully finances in-patient care, being part of the system of primary health care (family doctor). Other costs of long-term care services are covered by local budgets. Home care services are a significant part of that spending. Family caregivers receive allowances as part of benefits for people with disabilities.

In Poland, the biggest share of resources continues to be allocated to cash benefits subsidizing the incomes of the older population, with a special emphasis on care-related needs. This is consistent with the tendency towards an overriding share of family efforts in the provision of care and of family spending on informal and commercial services. On the other hand, due to insufficiently developed specialized facilities and LTC services, a significant proportion of care is still delivered in hospitals. The emphasis on hospital services is additionally reinforced by the fact that they are free-of-charge. Facilities established on the basis of hospitals and operating within the health care sector have introduced payments, but at a rate considerably lower than the rate for facilities administered outside the health care sector. Expenditures by the social sector and self-government units come third. This area is not transparent; there are different regulations and various practices. It seems, however, that in the future, the above mentioned first two types of LTC services development will be reduced, and the third type, i.e. services at a local level, arranged on the basis of a public-private mix and support from regional and local budgets, will expand and grow. However, a "civilized" development of this sector requires enormous attention and focus from the state in terms of design and a consistent implementation of high quality standards, development of a level network of accessible facilities, and investments in nursing and care-giving personnel.

In Lithuania, long-term care services are delivered mostly without payment in a family setting, except for in cases where the person is heavily dependent on other people's

assistance (including nursing and medical supervision), in which case services are delivered in hospitals. This is reflected in the level of spending on various types of care in particular sectors. According to fragmentary data provided by the Lithuanian Statistical Office, expenditures in the social sector dedicated to cash benefits supporting families who take care of an elderly person are the highest and have gone up by almost 100% since 2000. Health care sector spending on institutional and home nursing care is equally high. Just as in the previous case, the expenditure level has gone up substantially over recent years. The lowest spending is allocated to assistance with daily duties within the framework of social assistance, although even in this area, the level of expenditures has increased quite considerably (by more than 120% in 2000-2007). In recent years, the Ministry of Social Policy and Labor has decided to focus on the development of non-institutionalized forms of long-term care, i.e. different types of care services delivered at home. Nevertheless, the share of such assistance in services for the elderly is so low that a significant proportion of formal care is provided in hospitals. The private sector plays a marginal role as far as long-term care provision is concerned. Detailed information on development and spending in that sector is not available.

Latvia's LTC situation is similar to Lithuania's, although the responsibility for providing LTC in Latvia is more clearly defined. The state only supports people with appropriate certificates of disability and dependency and those with serious mental disorders. In recent years, care services supported by local authorities have been developed and have already overtaken those provided by the state (Ilves and Plakane 2010). Long-term care (both in-patient and home-based) can be provided following a very thorough evaluation of the care needs, circumstances, and material standing of the family in question. The recipients of care services cover the costs, committing 90% of their income (such as pension or disability benefits). As the demand for formal long-term care services is high, the government is supporting the expansion of local institutions providing care services.

In **Estonia,** there are several solutions that are unusual in comparison to other new EU member states. Those in need of long-term care services are subject to a comprehensive geriatric assessment. LTC services are still provided separately in public health and social welfare sectors, but the introduction of a fully integrated system of long-term care at the local level is planned, with major responsibility on the part of primary health care (the family doctor) for the medical component of the integrated service. Family care is to be included in the integrated system. Family caregivers can already receive assistance (transportation, housing adaptation enabling the provision of home care, etc.). Long-term care costs are currently mainly covered by local governments, but plans for the creation of an integrated system anticipate that the health sector will cover 50% of costs. The share of costs borne by

recipients of care services is high (estimated at 58% of home care) and is expected to continue to be significant (Paat, Merilain 2010). In the future, it is foreseen that the share of total expenditure on long-term care will exceed 1% of GDP, whereas the current share is below 0.3% (op. cit.).

In **Bulgaria,** long-term care is an element of social assistance and the policy towards people with disabilities. There are no specific regulations or programmed for long-term care. However, with reference to social welfare and people with disabilities, there are new regulations defining the conditions for access and financing and the responsibilities of relevant bodies for organizing such services (Mincheva, Kanzireva 2010). The role of cost sharing by care recipients is significant, both in the health sector[14] and in the social sector. As a result, access to formal long-term care for elderly people is limited. Dependent older people have only themselves and their families to turn to.

Romania is another example of a country where most services are provided informally and without payment in a family setting. Institutional services (in-patient or day care facilities) and formal home care services are financed from local budgets and social insurance and when these resources are inadequate, spending is co-financed from the central budget. Private resources are derived mostly from non-governmental organizations and co-payments for institutional care made by nursing home clients. It seems, however, that the key problems are the inadequate development of long-term care institutions and the extremely low level of funding for LTC services.

In spite of underlying difficulties in identifying and estimating the cost of long-term care, there have been attempts to evaluate it in the new EU member states. The table below presents comparative data derived from various reports: Eurostat, European Commission research programs, and the OECD. Data varies due to different ranges of activity included in long-term care for the elderly and due to varied access to data. In some cases, lack of data is treated as lack of spending.

According to Eurostat, LTC includes care allowances for the elderly in cash as well as accommodation and assistance in carrying out daily tasks, both in institutional facilities and at home. Most probably, Eurostat data does not fully encompass the strongly decentralized social sector, which can only be monitored to a much lesser extent. In turn, in the data prepared by the Ageing Working Group (AWG), benefits which typically are not taken into account in other classifications, such as care allowances received together with retirement and disability pensions in Poland, have been included in the category of long-term care benefits.

[14] In Bulgaria, cost sharing of medical services by users was made official with the introduction of the health insurance reform.

OECD estimations take into account expenditures spent on private services, but they do not fully include all other expenditures on care and nursing benefits for the elderly from public funds. Consequently, the estimations presented in the table below are not mutually comparable. Indicators for particular countries within each attempt at estimation, however, are more comparable. Such comparisons point to significant discrepancies, both among individual CEE countries and between CEE countries as a group and average indicators for the EU - 27, not to mention the EU - 15. Expenditures are relatively higher in Poland and in the Czech Republic. In Poland, universal cash allowances which subsidize the income of senior citizens play an important role, and in the Czech Republic spending on in-patient and home care services has a considerable impact.

Table 3. Estimated public spending on long-term care, health care and social assistance

Country	Spending on long-term care for the elderly as a % GDP				Spending on health care as % GDP 2006	Spending on social assistance** as % GDP
	Eurostat 2008	AWG 2007	OECD 2005*	Ancien WP I 2008 estimation		
Bulgaria	0.02 (2007)	0.2			4.5	0.4
Czech Republic	0.26 (2007)	0.2	0.4	0.25 (2006)	6.5	0.5
Estonia	0.20 (2007)	0.1	-		3.9	0.1
Hungary	0.22 (2007)	0.3	0.3		6.4	0.1
Latvia	0.22 (2006)	0.4	-		3.1	0.1
Lithuania	0.47	0.5			3.9	0.2
Poland	0.37	0.4	0.5	0.23 + 0.5***	4.5	0.4
Romania	0.65	0.0	-		5.0	0.3
Slovakia	0.90 (2006)	0.2	0.3		4.8	0.5
Slovenia	0.68	1.1	-	1,0		
EU 27	**0.48**	**1.2**	**1.3 (EU 15)**		**7.5**	**0.3**

*data estimated for OECD projection, including public and private expenditures
** social benefits for social inclusion not classified elsewhere (i.e. in social and health insurance, housing policy and family policy)
*** allowances supporting income of the elderly (universal) and earmarked allowances (nursing)
Source: Eurostat 2009 and 2010, OECD 2006, WHO 2009, Eurostat 2008 – Esspross

In view of the fact that no additional sources of funding (a new/increased contribution or increased taxation) have been defined in new member states to cover the cost of long-term care, these costs absorb health insurance as well as social assistance resources. In CEE countries, the levels of health care sector and social sector spending are relatively low and, as a result, long-term care funding from the modest resources of both sectors is low as well. The Czech Republic is, in a way, an exception; it has the highest share of expenditures on health care and long-term care among all new EU member states, but it is still far below average EU indicators.

The level of LTC spending over the next several decades has been analyzed in projections prepared by the Ageing Working Group (AWG.) The projections are based on estimates pertaining to older people who, due to certain handicaps, will need care. The projections were made on the basis of information obtained from SHARE[15] and EU – SILC survey studies. The range of LTC services covered in the AWG projections include: institutional care, home care and cash benefits for handicapped persons and/or their care-givers. Analogically to other segments of Ageing Working Group projections (expenditures on old-age pensions, expenditures on health care, etc.), LTC projections have been made for several alternative scenarios, contingent upon expected changes in population health status, share and type of formal care, and unit cost of care in future decades. The most important scenarios were defined as follows:

- "pure" demographic scenario, based on estimations of older people in need of care,
- scenario assuming fewer handicaps and improved health condition of elderly population,
- scenario assuming decreased share of informal care and increased share of formal care considered for three alternatives: greater share of institutional care (option 1 in Table 4), greater share of home care (option 2), and equal distribution between institutional and home care (option 3). The higher unit cost of institutional care than home care was an additional assumption.
- scenario assuming an increase in unit cost of care together with an increase in GDP per capita.

The Table below presents the outcome of projections for the four scenarios.

[15] The Survey of Health Ageing and Retirement in Europe (SHARE) was conducted in selected EU countries in 2004 and 2006, aimed at describing the socio-economic status of the elderly, their health, disabilities and a need for care.

Table 4. Projected spending on long-term care as a share of GDP in 2009-2060 (AWG)

Country	Base year (2007)	„Pure" demographic scenario (2060)	Constant disability scenario (2060)	Switch from informal to formal care scenario (2060)			Increased unit cost with GDP per capita scenario (2060)
				Institutional care	Home care	Instit. & home care	
Bulgaria	0.2	0.4	0.4	0.5	0.5	0.5	0.3
Czech Republic	0.2	0.7	0.6	0.9	0.7	0.8	0.6
Estonia	0.1	0.1	0.1	0.3	0.2	0.2	0.1
Hungary	0.3	0.6	0.6	1.0	0.9	1.0	0.6
Latvia	0.4	0.9	0.9	1.9	1	1.5	0.7
Lithuania	0.5	1.1	1.0	1.4	1.2	1.3	0.9
Poland	0.4	1.1	1.1	1.2	1.4	1.3	0.9
Romania	0.0	0.1	0.0	0.1	0.1	0.1	0
Slovakia	0.2	0.6	0.6	0.6	0.8	0.7	0.5
Slovenia	1.1	2.9	2.8	3.5	3.2	3.4	2.3
EU-12	**0.3**	**0.8**	**0.8**	**1.0**	**0.9**	**1.0**	**0.7**
EU-15	**1.3**	**2.6**	**2.4**	**3.3**	**2.8**	**3.0**	**2.4**
EU- 27	**1.2**	**2.5**	**2.3**	**3.2**	**2.7**	**2.9**	**2.3**

Source: European Commission 2009

No matter which scenario of long-term care development is adopted, one should expect an increase in spending levels due to population ageing. The situation where the health status of the elderly improves and the demand for care does not increase dramatically seems to be the most favorable. Interestingly, in light of the AWG analyses, the projected increase in the cost of care is much greater in new European Union member states than in EU-15 countries, where LTC spending is already much higher.

9. Development of separate and institutionalized long-term care

The development of separate and institutionalized long-term care can be evaluated on the basis of two processes: a shift from a family setting to external service provision and the appearance of external institutions catering specifically to the elderly population within the social and health protection system. These processes can be described by means of three indicators: the share of family care for the elderly, the proportion of public care vs. private care solutions (within the framework of external care) and, last but not least, the proportion of residential care vs. home care.

The share of family care in the NMS, defined on the basis of outcomes of national and comparative studies (Reimet 2009), is higher than the EU average, with the exception of the Baltic States. This is most likely because the Baltic countries, which used to be incorporated within the USSR, are more institutionalized in the field of social services, which include care for the elderly, which is reflected in low family and home care indicators. Interestingly enough, it is in the Baltic countries that adult children frequently tend to live with their parents, which usually contributes to the delivery of family care. In this case, however, it does not seem to have such an impact.

Specification 3. Model of elderly care

Country	Share of family care – compared to average EU index, equal to 50%	Informal non-family care	Ratio of paid institutional care to paid home care
Bulgaria	Quite high – more than 60%	Limited scope	Greater share of using residential care than home care
Czech Republic	Quite high – about 60%	In some regions of the country, the share of private informal care is considerable	As above
Estonia	Much lower – 25%	Occurs	Tendency towards equalizing the share of home care and residential care
Hungary	Quite high – more than 70%	Occurs but its scope is limited	Use of residential care is greater than home care
Latvia	Lower – about 40%	Occurs	As above
Lithuania	Lower – about 40%	No data available	As above
Poland	High – more than 80%		Greater share of institutional care versus home care
Romania	Quite high - almost 60%	As above	As above
Slovakia	Quite high – more than 70%	As above	Equal share of home care and residential care
Slovenia	Lower - about 30%; high employment rate of women	As above	Almost equal share of home care and residential care, with strong promotion of home care

Source: Author's compilation based on ANCIEN country reports and additional internal country information

A shift from family long-term care to external forms of care is occurring in many different ways at a varied pace.

To begin with, a shift towards external forms of care may take place without government intervention or with a very small involvement of the state – by virtue of private solutions. This may take the form of both residential care (private facilities: commercial and non-profit) and home-based care, i.e. hiring care-givers and nurses in the household. Poland is one of the CEE countries with a significant range of private solutions. In Poland, care-givers are hired

by households for LTC services on a conspicuous scale. Also, there are private residential facilities for dependent clients in old age. It is important to note that such facilities are established not only in the commercial sector, but are also set up by NGOs and church organizations.

Secondly, the development of non-family forms of LTC services may be achieved with a significant involvement of the state, in a regulatory, logistic and financial dimension.

Generally speaking, this process involves the regulation and standardization of care for elderly dependents, creating special solutions for them, or integrating long-term care into existing solutions. An example of a country with more advanced solutions of this kind is the Czech Republic.

At the present stage of welfare state development in European countries, the process of institutionalizing long-term care consists in the establishment of a separate LTC segment within the social protection and the health care systems. In the new member states, the process of the emergence of long-term care as a distinct, separate item is not always equally advanced among different countries. One can distinguish the following stages of the process:

- LTC services are identified as integrated socio-medical services, but are still divided between the social sector and the health sector. In the social sector, care services are defined in special regulations, covering the entire range of social services (e.g. in the Czech Republic) or only in the field of social assistance. In the health sector, this entails transferring LTC services to new units in the system of out-of-hospital health care.

- Responsibility for the identification of needs and the organization of services is shifted to the level of local and regional self-government, which itself is at an initial stage of development. Decentralization reforms were initiated in the 1990s; they identified social policy tasks entrusted to local and regional self-government authorities, but very often they did not equip them with adequate resources needed for the execution of these tasks.

- Introduction of regulations supporting NGO involvement and sponsorship in delivering care services for the elderly.

- Actions which formalize and support the provision of care services in the recipient's home; standardization and individual plans of care.

- Promoting and exploiting the potential of nurses (primary health care nurses and community nurses) and training candidates for a new profession – medical care-giver working with the elderly.
- Introducing quality standards in long-term care provision for quality assurance and advancement.
- Monitoring and controlling the delivery of LTC services, including the operation of the non-public sector as well.
- Defining and identifying new sources of funding for separate care services (e.g. through the introduction of nursing insurance, following the German model.) Given that expenditures on nursing care services represent a significant part of health insurance proceeds, the generally low outlays on health care in CEE countries are even lower.
- Defining and implementing comprehensible and socially acceptable rules governing co-payments from recipients and their families for LTC services.

Conclusions

At the time of transition from a centrally planned to a market economy, the formerly socialist countries experienced numerous market-based solutions, including those in the area of social services, and focused on the de-institutionalization of social service delivery, with service provision within the framework of home-based and family care.

The tendency towards the de-institutionalization of lifestyles was more pronounced in relation to child care than care for the disabled elderly. This was due to the fact that elderly people in communist countries were not subject to the same extent of institutionalization as the young. Therefore, family care was the typical solution in cases where the need arose for long-term care.

Another pattern in the development of long-term care in the former communist countries is its medicalization. In cases of serious disability that require care services, the elderly would use hospital care. With time, long-term care services started to be 'moved' out of hospitals and into nursing homes created specifically for that purpose; however, such services remained within the scope of the health sector.

The inclusion of long-term care into the social sector took place in the 1990s with the creation of the social assistance system, including the development of its facilities and the training of qualified staff.

The decentralization of government and public administration, another process of systemic change in post-socialist countries, brought about increased responsibility for social issues at the local level.

At the same time, the idea that family and home care are better than residential care was widely proclaimed. Family care has always existed and its promotion in a situation where there is pressure on female occupational activity to grow has caused some irritation. In some cases, undesirable phenomena also occur within the family such as lack of care, inadequate care, or even violence[16]. Furthermore, in conditions of poverty and unemployment, families have sometimes exploited the elderly financially, not taking their special needs into consideration; in some cases, a senior citizens' pension or disability benefit has, de facto, been the family's only source of income.

In reality, the predominance of a certain type of solution is neither easier nor always desirable (Phillips 2007). Caregivers willing to provide it were required: nurses, physiotherapists, and social workers. Their training process did not begin until a few years ago. It should be mentioned that primary health care doctors complain of a chronic shortage of nurses, as the nurse employment rate in the new member states is very low (see Table 3). In this situation, primary health care doctors have never been too happy with positions for independent community nurses.

Home care requires assistance in adapting elderly peoples' homes so that care services can be provided there. This fact is taken into account only in a small number of countries (Slovenia and Estonia). The transportation and communication requirements of such people should also be taken into consideration. Electronic supervision should also be provided.

Investing public and private money in the supply of new infrastructure and new care centers is proceeding slowly, but steadily. However, a single solution to funding long-term care services has not been found. In some countries, the recipients of care services and their families are supported universally, regardless of their income; other countries provide assistance only in the cases of poverty and an overwhelming need for medical and nursing care.

[16] Many international and national studies have been carried out in recent years on abuse of the elderly, undermining the stereotypical views on the advantages of some specific forms of care over others (Tobiasz Adamczyk 2009).

The new member states face a great demographic challenge, while still having to deal with many other problems arising from the transformation processes and, in many regions, from economic underdevelopment. In this situation, long-term care is an issue that is not sufficiently taken into account in the countries' social policy and development plans and strategies. The simplest solutions, both financially and politically, are often chosen. Those include the promotion of family care and, sometimes, home care, and the development of private services (home and residential) with decent allowances for seniors.

It appears that the development of residential care and day care in the new EU member states is inevitable in the near future; also, public funds will be created (e.g. in the form of special social security for attendance) to supplement care users' income and fund the provision of care services.

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Annex

Identification of long-term care in social protection systems of new member states

Country	Legal regulation	Content of the regulation	Governmental accountability?	Role of local and regional self-government
Bulgaria				
Health care sector	Health Act	National health system, Health protection, health services, health promotion	Ministry of Health	General organization of health care protection and control of public health
	Health Insurance Act (2004)	Health insurance regulations	National Health Insurance Fund	--
	Act on Medical Establishments	Types of medical establishments, their functions, management and financing; in-patient and out-patient care	Ministry of Health	Creation and management of medical and social facilities
Social sector	Social Assistance Act (and the Regulations for its implementation, 1998)	Organization and provision of social assistance and social services, eligibility criteria for social assistance benefits and services	Ministry of Labor and Social Policy	Provision or outsourcing of social services. Development and implementation of social welfare programs. Monitoring.
	Ordinance No. 4 on the Terms and Conditions for Social Service Provision (1999)	Eligibility criteria for social services	Ministry of Labor and Social Policy	Provision or outsourcing of social services.
	Ordinance on the Criteria and Standards for Social Services (2003)			
Czech Republic				
Health care sector	Act on Private Health Care Units (1992)	Operation of hospitals, long-term care facilities and nursing care services	Ministry of Health	-
	Act on Health Protection (1991-1992, last amended in 1997)	Financing medical services and procedures	Insurance funds	--
Social sector	Act on Social Services (1988, changed in 2006)	Regulations for in-patient and home-based social services, including cash benefits for the disabled	Ministry of Labor and Social Affairs	Provision or outsourcing of social services. Monitoring.

Country	Legal regulation	Content of the regulation	Governmental accountability?	Role of local and regional self-government
Estonia				
Health sector	Health Services Organization Act (2007)	Organization of medical services, including organization of LTC by family doctors, specification of nursing services	Ministry of Health	Organization of nursing (by counties)
Social sector	Social Welfare Act (1995)	Regulates issues of social care, including provision of LTC to the elderly and people with activity limitations	Ministry of Social Affairs	Planning, funding as well as provision or purchasing of LTC services.
Hungary				
Health care sector			Ministry of Health, National Public Health and Medical Officer service	
Social sector	Act on Social Welfare (1993)	Determines the types of care provided, eligibility and the rules of financing	Public Administration Offices, Ministry of Local Governments, Ministry of Social Affairs and Labor	Provision of services, contracting out, identifying population eligible for benefits.
Latvia				
Health care sector	Regulation No.1046 "Order of health care organizing and financing"	Organization and funding of medical services	Ministry of Health	
Social sector	Law on Social Services and Social Assistance (2002)	Regulates issues of social care, including provision of LTC (home care, day care, institutional care)	Ministry of Welfare	Planning capacity, development, provision and monitoring of LTC.
Lithuania				
Health care sector	Act on Health Insurance Act on Health Care system Act on Health Care Undertakings	Regulations on the functioning of LTC facilities and nursing services in the health care system.	Ministry of Health	Primary health care monitoring.
Social sector	Act on Social Assistance Benefits Act on Social Services	Regulations on the delivery of social assistance for those who need long-term care.	Ministry of Social Policy and Labor	Development and implementation of social welfare programs.
Poland				
Health care sector	Act on Health Care Undertakings (1997, last	Provisions allowing operation of two types of	Ministry of Health	Ownership and administration of hospitals, secondary

Country	Legal regulation	Content of the regulation	Governmental accountability?	Role of local and regional self-government
	amended in 2006)	long-term in-patient care facilities: *ZOL*s (medical care facilities) and *ZPO*s (nursing care facilities). Regulations allowing LTC service delivery at home.		and primary care
	Act on Health Care Services Financed from Public Resources (2004, last amended in 2009)	Home LTC service delivery allowed	Ministry of Health	Provision and coordination of care
	Act on the Profession of a Nurse and a Midwife	Provisions give nurses independence and allow them to sign individual contracts with the payer	Ministry of Health	--
Social sector	Act on Social Assistance (1990, amended in 2004)	Delivery and financing of services for the poor and socially excluded	Ministry of Social Policy and Labor	Coordination and co-financing of home care. Maintenance of social welfare homes.
	Act on Family Benefits (2003)	Regulations on family and nursing benefits for the disabled and persons dependent on help	Ministry of Social Policy and Labor	Payment of benefits, coordination, monitoring
Romania				
Health care sector	Act on Health Care Reform (2006)	Principles governing delivery and financing of medical services for the entire population.	Ministry of Public Health	Organization and provision of medical services.
Social sector	Act on Social Welfare Services for the Elderly (2000, last amended in 2008) Act on Social Welfare (2006)	Principles governing provision of social services and care for the elderly	Ministry of Labor, Family and Social Protection	Organization and provision of social services.
Slovakia				
Health care sector	Regulation No. 910 on State health policy (2000)	General health policy regulations	Ministry of Health	
	Act No. 576 on health care and services related to	Defines medical services available, eligibility criteria	Ministry of Health	

Country	Legal regulation	Content of the regulation	Governmental accountability?	Role of local and regional self-government
	providing healthcare (2004)			
	Act No. 578 on providers of healthcare, medical workers and medical professional associations (2004)	Regulations on medical professions	Ministry of Health	
	Regulation No. 770 of Ministry of Health (2004)	Determines characteristic sign of class of the individual medical facilities	Ministry of Health	
	Regulation No. 364 of Ministry of Health (2005)	Determines scale of nursing practice executed by nurse independently and in cooperation with physician and extent of birth assistance practice executed by birth assistant independently and in cooperation with physician	Ministry of Health	
	Government ordinance No. 640 (2006)	Setting minimal public network of healthcare providers	Ministry of Health	
Social sector	Act No. 447 (2008)	Eligibility criteria for benefits in-cash	Ministry of Labor, Social Affairs and Family	Provision of benefits
	Act No. 448 on Social Services (2008)	Eligibility criteria for social care, social nursing care and social palliative care	Ministry of Labor, Social Affairs and Family	Community plans for social services, provision, contracting and funding of social services
Slovenia				
Health Care sector	Act on Health Care and Health Care Insurance (1992, last amended in 2010)	Regulations on defining insured groups, their rights to health care, financing of health care services for entire population.	Ministry of Health	Organization and provision of all medical services at primary health care level
Social sector	Act on Social Care (1992, last amended 2007), Act on Pension and Disability Insurance (1999, last amended 2010), Act on Veterans (1995, last	Principles governing provision of social services and care, regulation of social transfers to defined categories of population	Ministry of Labor, Family and Social Affairs	Coordination and determining social transfers, provision of social care, monitoring

Country	Legal regulation	Content of the regulation	Governmental accountability?	Role of local and regional self-government
	amended 2006) and War Disabled (1995, last amended 2006)			