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## Who Cares in Europe? A Comparison of Long-Term Care for the Over-50s in Sixteen European Countries\*

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### Long-term care undergoing change

Long-term care (LTC) in the Netherlands has been changing for several years. Many people make use of this care, and the costs of the care sector amounted to 5 per cent of the Dutch gross domestic product (GDP) in 2010. In this work, LTC means the help provided to people who, due to a chronic physical, cognitive or psychological impairment, need long-term support in their daily functioning. Population ageing means the number of older persons needing care is rising, leading to a concomitant rise in the costs of care. Through a series of economy measures and reforms, the Dutch government is seeking to create a stable and efficient care system. Comparison with other countries is a useful means of gaining an insight into how the Dutch care system could work better. In this report we compare the Netherlands with a group of countries which represent a wide array of care systems.

Specifically, this report describes the degree to which LTC for people aged over 50 years living independently in the Netherlands differs from that in other European countries in the following five areas: (1) the LTC system; (2) the care need; (3) the risk of a LTC need and care utilisation; (4) the family care network; and (5) utilisation of paid and unpaid care.

To answer the research questions we draw on data from the Survey of Health, Ageing and Retirement in Europe (SHARE), a survey of persons aged 50 years and older living independently in a number of European countries.

### Comparable problems, different approaches

As in the Scandinavian countries, the government in the Netherlands assumes a high degree of responsibility for providing LTC. Additionally, at least in the Netherlands, providing help for people with relatively slight health impairments is also regarded as a task of the government. In the Southern European countries, by contrast, as well as in Switzerland and Eastern Europe, the family takes primary responsibility for caring for people with a health impairment. In Belgium, Germany, France and Austria, responsibility for providing LTC is shared between family and government. Non-residential care in the Netherlands is regulated at the central level, though implementation is increasingly being devolved to the regional and local levels. The organisation of care in a number of Southern and Eastern European countries is highly decentralised.

Broadly speaking, two policy trends can be observed in the countries covered in this study. The first trend is that countries with a large amount of publicly funded care are increasingly shifting the focus towards family or social responsibility, and towards promoting informal care. At the same time, in countries where informal care already dominates, that care remains important, but efforts are also being made to improve the quality and accessibility of publicly funded care. The second trend is that the organisation and regulation of care is increasingly being devolved to local and regional authorities, based on the assumption that, if the provision of care is organised close to the recipient, this will lead to more appropriate care solutions. These two trends can also be observed in the Netherlands.

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Countries where care is seen as the responsibility of the government are characterised by relatively high public spending on LTC. However, this is not a one-to-one relationship. Public spending on care is also high in some countries where care is seen as a responsibility of the recipient's family. Public spending on LTC does not appear to be related to whether the care is organised centrally or locally/regionally. Compared with the other countries in this study, the Netherlands spends an average percentage of GDP on non-residential LTC.

Based on the expenditure on non-residential LTC and the entity that bears responsibility for providing care, the European countries in this study are clustered into groups when discussing the results. There is a Northern cluster (comprising the Netherlands, Sweden and Denmark), a Central European cluster (Austria, France, Belgium and Germany) and a Southern and Eastern European cluster (Italy, Spain, Portugal, Estonia, Hungary, Czech Republic, Poland, Slovenia and Switzerland). As a general rule, countries in the Northern cluster are characterised by high public spending and low family responsibility for care, the Central European cluster by average expenditure and average family responsibility and the Southern and Eastern European cluster by low public expenditure and high family responsibility.

### **Diversity in health impairments of the over-50s in Europe**

The prevalence of health impairments in the population is very important for the volume of care utilisation. Based on data from the share dataset, we operationalise care need using three measures of health impairment: physical, psychological and cognitive, plus an overall measure summarising the care need. Roughly one in three over-50s living independently in Europe have no health impairment at all; just under one in three have a slight impairment, while the remainder (one in six) have moderate or severe impairment. Just under half the younger members of the over-50 age category have no health impairment, compared with only 6 per cent of those aged over 85 years. A not inconsiderable proportion of the "younger" over-50s thus have some form of impairment. The percentage of people with health impairments rises with age in an almost linear trend.

There are considerable differences between the countries in the study. The proportion of Dutch over-50s without health impairments is high (45 per cent), as it is in the Scandinavian countries and Switzerland. This proportion is much lower in the Southern and Eastern European countries (around 30 per cent). The same conclusions in terms of country differences apply for the age categories 50-64 years, 65-79 years and over-80 as for the entire population aged over 50. Physical impairments occur commonly in all countries studied; psychological and cognitive disorders are less common. All forms of health impairment are more prevalent in the Southern countries.

Although a sizeable proportion of the population aged 50 years and older have some form of health impairment, not everyone experiences it as such. It may be that, with mobility aids, care and/or home adaptations, over-50s are perfectly capable of functioning well in their daily lives and therefore claim that they have no difficulties. Just under half those with a severe impairment report that their health is poor, while just over half say they experience limitations in their daily functioning. It is striking that there are relatively few over-50s in the Northern countries with health impairments, but a relatively high number who experience limitations to their functioning, whereas in the Southern countries, people often state that they experience no limitations in their daily functioning despite having health impairments.

### **Wide differences in risk factors for care utilisation**

Other characteristics in addition to health impairments, such as sex, age, marital status, education level and income, can play a role in explaining differences between countries in utilisation of LTC. These are *predisposing* and *enabling* factors for care utilisation. The proportion of single persons among the over-50s living independently is higher in almost all European countries studied than in the Netherlands. The Netherlands falls into the middle range in Europe in terms of the percentage of over-50s with a low education level; Spain, Italy and Portugal, in particular, have a high proportion of low-educated over-50s. The Netherlands has more highly educated over-50s than most other countries in Europe. Total annual household income in the Netherlands also differs markedly from the other countries studied. The share of higher incomes is greater in the Netherlands than in most of the other countries.

In addition to demographic and socio-economic factors, life events can also create a care need (predisposition). We therefore investigate the degree to which the following life events occur in the various countries: serious illness as a child; going through one or more separations/divorces; death of a partner or child; and change of lifestyle. We find a number of differences between countries in the degree to which people aged over 50 have experienced such events. Over-50s in the Netherlands have experienced a serious childhood illness considerably more often than their peers in the Northern and Southern countries. There is also a striking difference between the European regions as regards behavioural adjustments that can promote health. A higher proportion of over-50s in the Netherlands and Scandinavia have, for example, given up smoking, reduced their alcohol intake and began taking more exercise than in the other European countries. People in Southern Europe have least often changed their life habits.

### Many people have a family network

Andersen and Newman<sup>1</sup> argue that the social network of people aged over 50 is an important enabling factor for care utilisation on which those in need can draw. People who do not have access to a social network but who need help are more likely to have to seek recourse to publicly funded care. This report looks only at the presence of a family care network from which the person needing help might be able to receive unpaid care. That network consists mainly of partners and children. The share dataset contains insufficient information on the availability of others, such as neighbours, friends and acquaintances. The family care network covers much of the entire network that is able to provide unpaid care. In practice, however, parents and children will not always be able to actually provide care if needed. They may face impediments that prevent them from providing care, because they are themselves sick or unfit for work, or, in the case of children, because they work full-time, have young children of their own or live a long way from their parents. In the light of this, the proportion of the potential family care network that experiences such impediments is considered in more detail.

Three-quarters of Dutch over-50s have a partner, a higher proportion than in most other countries. This percentage declines with advancing age. One in ten Dutch over-50s has one or more children living at home and two out of three (also) have children living away from home. In total, 90 per cent of Dutch over-50s have access to a network that could potentially offer unpaid help. This is in line with the average in the countries studied. In the Netherlands and most Southern European countries, the network consists mainly of people within the recipient's own household; elsewhere in Europe, it often comprises children living outside the home. Around 10 per cent of all Dutch over-50s do not have access to a family network, and the same percentage applies in almost all other countries studied.

This is potentially a very vulnerable group. Just under 70 per cent of over-50s living independently in the Netherlands have someone in their family care network who could provide care without encountering impediments. The average across the countries studied is 66 per cent. Portugal is the only country where this figure is higher than in the Netherlands. It should be noted that in most countries those aged over 80 less often have a family care network that could provide care without impediments than those aged 65–79 years and those aged under 65.

### Greater government responsibility for LTC equates to more paid care

Finally, we describe the use of paid and unpaid care. We only have information about *paid network care*, i.e. paid private or public care that is provided by people in the social networks of people aged over 50. These may be people from home care organisations, but may also be private individuals or family members who are paid for the services they provide, for example, from a personal budget held by the care recipient. This approach ignores care that is provided in other ways, for example by regularly changing caregivers who do not form part of the recipient's network. As regards unpaid care, we include all care provided by family members, neighbours, friends and acquaintances, but also care provided by voluntary organisations. Unpaid care is also referred to as informal care. In

<sup>1</sup> Andersen, R. and J. F. Newman (1973) Societal and individual determinants of medical care utilization in the United States", in: *Millbank memorial fund quarterly*, 51(1): 95–124.

order to be able to construct a picture of total care utilisation, we use share data from 2007 to estimate the total utilisation of paid care.

A small proportion (2 per cent) of Europeans aged 50 years and older receive paid care provided by caregivers from within their networks. This percentage is slightly higher in the Netherlands (3 per cent). The differences in utilisation of paid network care across countries reflect differences between the LTC systems. Responsibility for LTC in the Southern and Eastern European countries lies mainly with citizens themselves, and the use of paid network care is accordingly low in these countries. In the Northern and Central European countries, as well as in the Netherlands, the government has much more responsibility and the use of paid network care is accordingly higher. Roughly six out of ten Dutch over-50s receive unpaid care, often from members of their own household (around a third), but also regularly from children living outside the home (about a fifth). Southern and Eastern European countries, in particular, score highly on receipt of unpaid help (approximately 70 per cent). Given the earlier descriptions, there are broadly two explanations for this. It is often the norm for different generations to live together in these countries, so that the availability of unpaid care is relatively high. Moreover, there are few opportunities to use publicly funded care because of its limited availability. In countries where the availability of publicly funded care is much greater, such as the Netherlands and Scandinavia, the use and intensity of unpaid care is much lower.

On average, just under 70 per cent of over-50s in Europe receive unpaid care or paid network care. The Netherlands scores below average, at 61 per cent. Care utilisation in Southern and Eastern Europe is substantially higher than in most other countries, principally because people receive more unpaid care in those countries. Paid network care accounts for only part of the paid care utilisation. According to the share dataset, 7 per cent of the European population received paid care in 2007. Although the level of paid network care use is considerably lower in the 2011 dataset, the country differences remain comparable. The use of paid care is higher in the Netherlands and the other Northern and Central European countries than in the other European countries. If we assume that the ratio of paid to unpaid care remained unchanged between 2007 and 2011, it can be deduced that 64 per cent of over-50s living independently in the Netherlands receive paid or unpaid care. That is lower than in the countries of Southern and Eastern Europe, but higher than in countries such as Sweden and Austria. The percentage of people utilising care rises with age; people aged over 80, in particular, often receive care, but more than half of those aged between 65 and 79 and those aged under 65 also receive paid or unpaid care.

## Conclusion

Briefly summarised, the Netherlands spends an average proportion of GDP on non-residential LTC compared with other countries, whilst population ageing in the Netherlands is among the lowest in Europe. As in Denmark and Sweden, responsibility for LTC in the Netherlands lies mainly with the government and much less with the family. Compared with their peers in other countries, relatively few independently living Dutch over-50s have physical, psychological or cognitive impairments. However, a relatively high proportion of this age group report that they experience their health problems as limiting. Most of the risk factors for care utilisation occur to roughly the same degree in the Netherlands as elsewhere. The Netherlands has few independent over-50s living alone and a lot of highly educated and affluent over-50s compared with the other countries studied. This age group do however report more often than the average in other countries that they had poor health as a child, but are more often inclined to modify their unhealthy lifestyle. Dutch over-50s have access to a family care network that could potentially offer unpaid help just as often as their peers in other countries. In contrast to elsewhere in Europe, the network mainly comprises partners rather than children. Family care networks in the Netherlands experience impediments in providing care slightly less than average. The percentage of over-50s living independently in the Netherlands who were receiving care in 2011 is estimated to be slightly lower than in most other countries. According to our estimates, only Sweden, Austria and Switzerland have fewer over-50s living independently who are in receipt of care; the use of unpaid care in those countries is the same as in the Netherlands, but the use of paid care is lower. The percentage of over-50s living independently in Southern and Eastern Europe who are in receipt of care is much higher than in the Netherlands, mainly because of the much greater use of unpaid care.