Social Investment and the Challenge of Long-Term Care in ageing European countries

Short Title: Social Investment and Long-Term Care

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Abstract

Demographic development and changing family structures make it necessary to rethink the provision of long-term care. Often, informal care by family members is no longer feasible and the state has the challenge to cope with this risk. Providing long-term care is very costly. Many Member States suffer from severe financial constraints and have to bring their budget in line with the demands of the European Financial Institutions. But these states are mostly the states with an inappropriate protection of persons in need for long-term care.

The European Commission has launched a social investment package to enhance social protection, especially in long-term care. Social investment could support new models of cohabitation, rehabilitation and prevention and improve the well-being of beneficiaries. The HORIZON 2020 SPRINT project reveals the Commission's explicit will to have a shift towards more social investment in long-term care. The project shall develop a model of social metrics to measure social impacts and economic returns of different LTC schemes. It should also propose reforms to social care policies that focus on social innovation and better allocation of resources. The project can develop assessment tools which show that investments in long-term care are a good value and create innovative ideas.

Keywords:

Ageing society, long-term care, social investment, informal care, Stability and Growth Act, financial constraints of EU-Member States, new forms of cohabitation in old age

I. Introduction

All EU-Member States undergo a rapid demographic change. In the last decades, life expectancy has risen constantly, mainly due to better nutrition and big progresses in medical treatment. Epidemic diseases that caused the death of ten-thousands, like the "Spanish influenza" in the first half of the 20th century (Billings 1995/2005) have disappeared and other potentially lethal ailments (e.g. heart problems) are operable or cured with better medicaments. In most Europeans countries life expectancy has achieved the mid-80s for women and also men can at least statistically expect to celebrate the 80th birthday. Moreover, the number of nonagenarians is increasing and even the accomplishment of a century is for many persons not out of reach. This positive development for the individuals has substantial consequences for societies, in particular for those which define themselves as welfare states or at least pretend having a social responsibility for the well-being of their citizens. It is not the increase in life expectancy as such that causes the problem but the rising longevity. Most people in the eighties are beginning to become fragile and need some support or help. With few exceptions, people in their nineties are rarely able to live on their own and need a form of personal long-term care for their activities of daily living.

But who is going to provide for this care? Who is responsible to allow elderly people a decent life? And last but not least, who should pay for the additional costs for these services? These questions on providing long-term care have become a severe challenge for all modern societies, in particular in Europe where social politics is still a key issue.

It is true that at all times some very old people had survived the perils of life but they were a negligible quantity whereas today it is a remarkable and permanently increasing percentage. In those days it was a given fact that the family was responsible to provide long-term care to the aged either for reasons of moral aspects or legal obligations. In agrarian societies the transfer of farm and land to the next generation was normally linked with the legal obligation to take care of the elderly. After World War II, an agrarian industry emerged to the detriment

of small family-run agrarian structures which almost disappeared together with the traditional form of providing long-term care for the fragile ancestors. In addition, beginning in the 1960s, the number of children decreased significantly due to the spreading and availability of contraceptives. The family is no longer the naturally given option to provide long-term care for the elderly. A result of the low birth rate is that many couples do not have children at all to take care of them in old age. But there are more factors that influence the situation. Family structures are changing. More couples get divorced and are no longer linked with the former parents-in-law. Labour markets expect flexibility and mobility and so less elderly persons live together with their families. More women have joined the labour market and are not available anymore as informal carers. And the increasing life expectancy itself has become an obstacle for providing long-term care. Most parents have their children between 20 and 30. Whereas in former times most carers were in their 40s or 50s when their parents became fragile at age 60 or 70, nowadays most family carers are themselves in their 60s or 70s. Having accessed retirement age, they themselves sometimes already face physical restrictions to look after their old parents. Therefore, the traditional model that younger family members take care of their needy relatives does not work anymore and is no longer feasible. As the long-term care family model is breaking away other solutions have to be found.

The development is very similar to the implementation of old-age benefits more than a hundred years ago. When families were no longer willing or able to maintain the elderly with financial resources it was up to social policy and the state to support or even replace the families by granting financial benefits. The new development of an ageing society in need for long-term care now urges Member States to implement systems for long-term care that support or replace the efforts and tasks of the families.

II. Models of Long-Term Care in Europe

However, it lasted up to the end of the 20th century that Member States realized that long-term care was a “new” social risk. The term “new” social risk is not quite correct. As we saw

above, there were always some people in need for long-term care. But long-term care was not comprised in the catalogue of traditional social risks as e.g. stipulated in 1952 by the International Labour Organisation in the Convention N° 102 concerning Minimum Standards of Social Security which came into force on 27 April 1955. Thus, it was not surprising that almost no member state followed a coherent strategy to cope with this risk. Because long-term care never got into the focus of international organisations like the ILO no international minimum standards were elaborated. This lack of international minimum standards is a severe disadvantage because it remains to the interpretation of each system to define the criteria for the need of long-term care. Thus, with respect to long-term care benefits there was neither a legal obligation for the states that was enforceable by international instruments nor a certain international guideline developed how to cope with the problem.

This is why up to now Member States rely on very divergent models (Greve 2017a, Becker U., Reinhard, H-J, ed. 2017). A good deal of Member States has linked long-term care with their health care system. This makes sense in so far as most persons in need for long term care are also in need for medical treatment. But of course, dependent persons need additional personal and individual services that medical treatment cannot provide. Most central and Eastern European countries provide long-term care in the frame of social assistance or have a mix of both approaches, i.e. health care and social assistance (Czepulis-Rutkowska 2017; Gal 2017; Koldinska, Štefko 2017). However, these services are often not well coordinated or provide only minimum services. In the Scandinavian countries, the municipalities are responsible to provide a comprehensive sample of long-term care benefits to their citizens (Greve 2017b; Weber 2017a; Weber 2017b). In the Netherlands, apart from state benefits (Dijkhoff 2017) begins to exist is a strong neighbourhood movement named “buurtzorg” which is supported by public authorities (Weißensteiner 2016). Spain (Reinhard 2017b), Italy (Hohnerlein 2017) and Portugal (Lopes 2017) have recently implemented rules but they are

fragmented and provide only an incomplete social protection. In Greece (Tinios 2017), benefits are linked to the payment of a certain type of invalidity pension. In the United Kingdom, England and Wales support is given only for the very needy (Glendinning 2017) whereas rules in Scotland seem to be slightly more generous (Bell, Bowes 2006). Up to now, only Germany has chosen a social security model financed by contributions (Matzke, Wiss 2017). However, in most cases, these social security benefits are by far not sufficient and have to be complemented either by co-payments or by tax-financed social assistance benefits (Reinhard 2017a).

In general, it can be said that there is no homogenous and overall protection for people in need for long-term care. This is true on the European level. Within a Member State, too, social protection in case of long-term care is not always uniform but regulations can differ extremely. This is the case in Italy (Pavolini et al 2017; Hohnerlein 2017) and Belgium, but partly also in Spain (Reinhard 2017b), where the responsibility lies on the respective regional entities. Moreover, almost all Member States face quality problems in providing long-term care. It is often difficult to find well-trained staff and sometimes the facilities (e.g. residential homes) are not maintained very well or are not yet adapted to modern standards. In many countries there is a visible downward slope in social protection for long-term care between bigger cities or agglomerations and the countryside. Whereas in the centres the infrastructure for long-term care might be fairly developed, people in rural areas are often left behind. It is hard for them to stay in their close surroundings because there are not enough social services that support their stay at home.

One main reason for this insufficient provision of long-term care is the fact that granting adequate long-term care is very cost-intensive. Long-term care needs a lot of manpower and the possibilities to save labour costs are very limited since it is a very personal and time-consuming service. Experiments with robot-provided long-term care cannot replace the

emphatic and emotional side of granting long-term care and raise severe ethical questions (von Stösser 2011). Manpower, however, means the payment of salaries and these unavoidable emoluments result in a need for sufficient financial resources. But many Member States, in particular in Southern Europe, suffer from severe financial constraints. The financial crisis has beaten them seriously and their available monies to extend social protection are restricted. The obligations under the European Stability and Growth Pact (SGP) and the requirements of the European Financial Authorities to bring household budget in line (Buti, Ongena 1998) do not allow a lot of leeway in decision-making on long-term care. On the other hand, these countries are mainly –but not exclusively- the Member States with insufficient provision of long-term care services. For these Member States it is a balancing act between better provision of long-term care for the needy citizens and the financial constraints that they have to respect in order to fulfil targets set by the European Union.

III. Solutions for the Member States

How can Member Sates solve this crucial question? Is there a way out of this trap at all? One solution is to focus again on the family. Informal long-term care by family members is still the cheapest way to satisfy the needs of dependant persons. But as it was already mentioned above, this solution is not really feasible in practice due to changed family patterns. Moreover, many family members are overextended with this task and work beyond their physical and mental capabilities. They are not professionally trained for this hard daily struggle and if they are in their seventies they sometimes face their own medical and mental disorders. Thus, within a short time, many caring family members themselves suffer from medical problems as back-ache, insomnia or even depression. Another aspect still handled discretely as a taboo is violence against dependent family members due to excessive demand against informal caregivers.

In view of the fact that many family members are not able to undergo this task accordingly the provision of long-term care has become a big market for a “care industry” given the dramatic

growth of the elderly and frail population. Profit-orientated enterprises may offer adequate care but they are only a way-out for the better-offs and not for the normal population which cannot afford high-level and expensive facilities. A way-out for less wealthy families is the "grey" labour market. Migrant workers, the majority of them women from Eastern Europe are working in precarious and underpaid contracts in Western Europe (Satola 2015). A good part of them come as tourists and thus a remunerated work including the provision of long-term care is per se not permitted. Others pretend to be self-employed but are in fact sent by enterprises with mafia-like behaviour. Only a few of them are covered by social security and –even worse- they have to leave their own children at home in order to make some money in Western Europe. Scientists have already created the term "work orphans" for this type of children (Lutz, Palenga-Möllenbeck 2012).

Since this problem does affect almost all Member States, on European level a debate was opened how to close this gap between growing needs for social protection for long-term care and the financial constraints.

IV. Debate on Social Investment in Long-Term Care

Thus, in recent years, on the European level a debate emerged on social investment. Meanwhile, this discussion has extended to social investment in long-term care. Social investment is not a legal term but a socio-political programme. According to a definition given by the European Commission, social investment is about investing in people (European Commission 2013a, Vandenbroek et. al, 2011). It means policies designed to strengthen people's skills and capacities and support them to participate fully in employment and social life. Key policy areas include education, quality childcare, healthcare, training, job-search assistance and rehabilitation.

The reason for this new socio-political idea is that the Commission has identified enormous challenges that Europe is facing:

- The *economic crisis* has led unemployment and poverty and social exclusion levels to record highs. This results in a huge drain on Europe's human resources at a time when public budgets are under pressure.
- Not surprisingly the Commission also found out that with the *demographic changes* the working-age population in Europe is shrinking, while the proportion of older people is growing. Solutions must be found to ensure sustainable and adequate social protection systems.

As a policy response the Commission (European Commission 2013b) has developed a Social Investment Package (SIP) which:

- *guides* EU countries in using their social budgets more efficiently and effectively to ensure adequate and sustainable social protection;
- *seeks* to strengthen people's current and future capacities, and improve their opportunities to participate in society and the labour market;
- *focuses* on integrated packages of benefits and services that help people throughout their lives and achieve lasting positive social outcomes;
- *stresses* prevention rather than cure, by reducing the need for benefits. That way, when people do need support, society can afford to help;
- *calls* for investing in children and young people to increase their opportunities in life.

According to the Commission the following groups should benefit from social investment:

- *Children and young people* should get early support to break the inter-generational transmission of disadvantage and address the severe youth unemployment problem.
- *Jobseekers* have to be integrated and to receive more accessible support for finding work, such as skills development.
- *Women* should have more equal opportunities, better access to the labour market and thus better social protection, notably in retirement.

- *Older people* should have more opportunities for active participation in society and the economy.
- *Disabled people* should get support for independent living and adapted workplaces.
- *Homeless people* should get help with reintegration into society and work.
- *Employers* could rely on a larger, healthier and more skilled workforce.

Although long-term care does not seem to have anything to do with all these aspects this is not the truth. Long-term care is a multi-facetted problem that does not only affect the life of the elderly but of all groups of population. Even children might be involved. The need for long-term care is not necessarily restricted to old age. Some children need long-term care themselves but there are also a number of cases in which children and young people are faced with dependent parents due to severe illness or an accident. Becoming a professional carer could be an option for jobseekers. For women who already work as carers it is essential to get a good protection in retirement. Since long-term care relates mostly to elderly people with disabilities the aspect of independent living is relevant, too. Some elderly people live under poor housing conditions and it can result as a main element to adapt housing to the necessities of the elderly. For employers new innovative products for long-term care could be a good deal and our societies could profit from all these aspects with higher productivity, higher employment, better health and social inclusion, more prosperity and a better life for all, in particular for the elderly which are going to become the majority of population.

The European Commission has called on Member States to prioritise social investment and to modernise their welfare states. This means better performing active inclusion strategies and a more efficient and more effective use of social budgets (European Commission 2013b, 2015).

The call features in a Communication on Social Investment for Growth and Cohesion adopted by the Commission (European Commission 2013), which also gives guidance to Member

States on how best to use EU financial support, notably from the European Social Fund, to implement the outlined objectives.

In spring 2017, the Commission has proclaimed the European Pillar of Social Rights (European Commission 2017), a strategy that intends to achieve more social cohesion among member States. The improvement of long-term care in the Member States is among the principle policy goals (European Commission 2016). The Commission will closely monitor the performance of individual Member States' social protection systems through the European Semester and formulate, where necessary, country specific recommendations.

The social investment package gives guidance to Member States on more efficient and effective social policies in response to the significant challenges they currently face. These include high levels of financial distress, increasing poverty and social exclusion, as well as record unemployment, especially among young people. These are combined with the challenge of ageing societies and smaller working age populations, which test the sustainability and adequacy of national social systems.

The social investment package shall ensure that social protection systems respond to people's needs at critical moments throughout their lives. More needs are to be done to reduce the risk of social breakdown and so avoid higher social spending in the future. In general, the social investment package aims at simplified and better targeted social policies, to provide adequate and sustainable social protection systems. Then the paper reveals that some countries have better social outcomes than others despite having similar or lower budgets, demonstrating that there is room for more efficient social policy spending. The paper asks also for upgrading active inclusion strategies in the Member States. Namely housing support and accessible health care are among the policy areas with a strong social investment dimension.

In the first step the Commission focussed predominantly on social investment in children, namely on a better education. Meanwhile the Commission has extended its approach and has

taken a deeper look at the situation of elderly persons within the European Union. Not surprisingly, the Commission has identified that the need for long-term care and the provision of adequate personal care and sufficient facilities is a major issue in most member states. The main problem is that it is not so easy to convince Member States that an investment in elderly people might be fruitful. Up to now, the provision of long-term care is seen as a big financial burden but not as an issue to invest money in it. To invest in children is comprehensible. A better education will hopefully give them better chance for their future life and make them good tax-payers. But for elderly and dependent persons the future is obviously limited in time. Thus, given narrow financial resources Member States will probably invest in children or disadvantaged persons in the labour market (e.g. women) and will not spend on the long-term care of elderly and frail people.

This is why the Commission within its programme HORIZON 2020 has launched a project named “Social Protection Innovative Investment in Long-Term Care (SPRINT)”. In this project, scientific institutions from 11 Member States and of different scientific disciplines work together. The aim of the project is to investigate the financial return of a social investment into better long term care. In the end, the Commission hopes that the findings will improve the situation of elderly people and convince Member States to invest more in this vulnerable group. The idea is to invest resources in order to improve the well-being of persons in need for long-term care.

Until now, long-term care is mostly regarded as a definite stage in life. For most elderly people, the need for long-term care seems to be inevitable. Almost no one wants to end up in a residential care home because once they entered into such a facility they stay until they die. However, it has proven that residential care is the most expensive form to provide long-term care. At the same time it is the less effective type. Most people feel uncomfortable because residential care restricts dramatically their personal autonomy.

Social investment has a different approach. The need for long-term care is, apart from severe accidents or very serious diseases, a long-standing and creeping process. Step-by step physical strength vanishes. In the beginning, most people need only some support to exercise their activities of daily life (e.g. shopping, preparing food, heating). In former times these things were done within the family which is no longer available. This results in a gap for people in need for some kind of care. It is true that in some countries social services exist but they are in most cases very limited in time and offering. Social investment means to focus more on such basic social services in order to allow people stay longer in their homes. Another form of support is prevention. In most Member States there are no legal provisions to support and finance preventive measures. The conception of social investment is to extend preventive measures and to avoid a stay in an expensive residential care home. If, for example, due to preventive measures the elderly person, does not have to go to a residential home or postpone the entry this would be the financial return of social investment. The same is true with rehabilitation measures. Although in some Member States rehabilitation measures for dependent persons are prescribed by law, in practice they are hardly applied. It is very rare that a dependant person will leave a residential care home because rehabilitation measures have improved his or her mobility. The same is true with housing. Sometimes it is quite easy to modify or adapt the housing of a dependent person. The idea of social investment is to grant some financial relief in order to improve the housing situation of the beneficiary. Moreover, in general new forms of living together are invented. Most elderly people fear loneliness in old age. A shared house or a shared apartment could prevent such a fate. Models of cohabitation with other persons in a similar situation are increasingly becoming an alternative to residential care homes the number of which is already reduced in in some countries (e.g. Germany). A social investment could support such models and thus improve the well-being of the beneficiaries.

These examples show how social investment as it is promoted by the Commission could contribute to the well-being of dependant persons. But it was already mentioned that many Member States suffer from financial constraints. The second idea of social investment is to find private investors that invest in these models. This already works in some countries with children. More and more people want to know what is going to happen with their money. They want to invest it in projects that have a social yield and contribute to sustainability. Such a social investment could relieve the financial burden of the member state. The difference to the already existing NGOs that work in charity is that a social investment is not just a donation but really a financial investment that might have in the end a financial gain. One vehicle could be the founding of a social enterprise. In several European Members States (e.g. Finland, Italy, United Kingdom) such social enterprises already exist. They collect money from investors that want to support a social investment. Up to now, these social investments go to vulnerable groups like children or homeless people but not to the sector of long-term care. The HORIZON 2020 SPRINT project shows that it is the explicit will of the Commission to change this and have a shift towards more social investment in long-term care. The goal of the project is to develop a model of social metrics that can be used to measure social impacts and economic returns of different LTC schemes in order to identify the most promising models to realize the ambition of the social investment paradigm (Muir 2017). It should also propose reforms to social care policies that focus on social innovation and better allocation of resources in order to be consistent with the achievement of broader European fiscal and social objectives. In the end, the project can develop innovative assessment tools which show that investments in long-term care are a good value and will develop innovative ideas.

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