CHAPTER 8

LONG-TERM CARE IN EUROPE

An introduction

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Abstract: A European overview of the situation of long-term care faces the problem that this type of care is mostly organized at local level. It is therefore rather difficult to make a comparison between countries and to give a European overview. Overall figures hardly exist due to this difficulty. On the other hand, the present challenges and future trends are rather similar in the various countries.

Keywords: long-term health care

INTRODUCTION

There is a strong relationship between long-term care and Farming for Health (FH). Most of the persons who benefit from FH are elderly people, persons with mental and physical handicaps and persons with psychiatric handicaps. Most of the clients belong to the target group of long-term care. It is not surprising that long-term care is one of the major sources of income of FH.

Long-term care is understood as a well-planned and well-organized set of services and care processes, targeted at the multi-dimensional needs/problems of an individual client or a category of persons with similar needs/problems. Elements are home nursing and long-term health care, social care, housing, and services such as transport, meals, occupational activities, empowerment activities, etc.

The exact meaning of ‘long’ differs from country to country. It is not so much defined by the length of the period as by the functions and services. If in The Netherlands you receive one week home help, it is still called long-term care.

What do we really mean when we talk about long-term care? Persons with physical or mental handicaps and frail elderly need support and help in their daily life activities; 80% of their demands regard assistance with shopping, small repairs in the house, help in getting in or out of bed, help with dressing, help with all kind of forms, cleaning the house, help with putting on supporting stockings, social activities, support with finding and carrying out work, contacts with other people,
help in spending the day: activities that ask little technical but a lot of social expertise; activities that do not belong to the medical domain but the social one; activities that belong to the daily life domain.

DIFFICULT COMPARISON

It is very complicated to give a European overview, and hardly any facts have been aggregated at European level. Much is known for individual countries. The reasons for the lack of national and European aggregation are:

- Services are often divided between different public structures and budgets (national, provincial, regional, local), between health budget and services, and between social budget and services.
- Long-term care is highly influenced by different structures of informal and family care (Mediterranean countries have family care far above average and the number of long-term care beds is therefore far below the European average).
- Systems of long-term care are being reformed: reorganized and innovated (mostly with budget consequences) in northern and central countries and expanded in southern countries.
- Dealing with personal social services in the local context is far more important than in the national or European context.
- Nordic countries started to develop social care services already during the 1950s (undergoing marked differentiation between different types of services and institutions, professional concepts and approaches). Southern-European countries are still in a pioneering phase (difficulties regarding funding and staffing).
- There is a sharp contrast with general health care with its well-defined medical professions, differentiated competences, monitoring, registration, etc. Social services are often lacking even national regulations.

FINANCING SYSTEMS

There are two main systems of financing health care, working with public funding mechanisms, in Western Europe:

1. The Beveridge model, which is tax-funded with infrastructure of ownership and control of authorities (Denmark, Greece, Spain, Ireland, Iceland, Italy, Norway, Portugal, Finland, Sweden, UK).
2. The Bismarck system, which is social-insurance-funded and controlled by legal private organizations (Belgium, Germany, France, Liechtenstein, Luxemburg, Netherlands, Austria, Switzerland).

Some countries have a tendency towards a mixed system. Table 1 gives some examples.