European Network of Economic Policy Research Institutes

ANCIEN

Assessing Needs of Care in European Nations

THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN FINLAND

EDVARD JOHANSSON

ENEPRI RESEARCH REPORT NO. 76
CONTRIBUTION TO WP 1 OF THE ANCIEN PROJECT

JUNE 2010

ENEPRI Research Reports present the findings and conclusions of research undertaken in the context of research projects carried out by a consortium of ENEPRI member institutes. This report was produced by the ANCIEN project, which focuses on the future of long-term care for the elderly in Europe. Funding for the project is received from the European Commission under the 7th Framework Programme (FP7 Health-2007-3.2.2, Grant no. 223483). See back page for more information on ANCIEN. The views expressed are attributable only to the authors in a personal capacity and not to any institution with which they are associated.

ISBN 978-94-6138-018-0
Available for free downloading from the CEPS website (www.ceps.eu) and ANCIEN website (http://www.ancien-longtermcare.eu/node/27)

Contents

The Long-Term Care System for the Elderly in Finland

ENEPRI Research Report No. 76/June 2010

Edvard Johansson*

1. The Finnish LTC system

1.1 Overview of the system

The basic principle of the Finnish LTC system is that it is a publicly funded, universal system that is open to every citizen. The Finnish constitution (section 25) requires that the government ensure the implementation of fundamental and human rights. The rights of particular significance for LTC are equality and social security (sections 6 and 19 of the constitution). Thus, in Finland, it is considered to be the obligation of the public sector to provide a decent level of LTC services for the elderly.

In the most recent update of the National Framework for High-Quality Services for Older People, the Ministry of Social Affairs and Health outlined the main ethical principles guiding the delivery of LTC in Finland (Ministry of Social Affair and Health, 2008). They are:

- *The right to self-determination*, which means that older people must be allowed to make informed choices and obtain the information and help they need to make choices about LTC.
- *Equality*, which means that consistent principles in granting LTC services should be followed. Equality also means that discrimination should be prevented, and that differences between people should be accepted.
- *Participation*, which means that efforts should be made to enable older people to influence the development of the society and environment in which they live.
- *Individuality*, which stresses the importance of seeing people as unique individuals.
- *Security*, which means ensuring the safety of the home and care environment against fire and other hazards.

The Finnish public administration system consists of three levels: state, province and municipality. There are two main laws that govern LTC services provision in Finland. They are the Primary Health Care Act and the Social Welfare Act. They designate the municipalities as the bodies responsible for public sector production of health care and social services including LTC. However, Finland's municipalities enjoy a very broad degree of autonomy, and state level regulations and management in health care in general are not very detailed. Thus, legislation is not very specific on how municipalities' duties are to be performed in practice. Indeed, it has been argued that public responsibility for health care and social services are decentralised in Finland to a greater extent than in any other country (Häkkinen and Lehto, 2005).

* At the time of writing this paper, Edvard Johansson (maxedvard.johansson@me.com) was a researcher in the Labour Market and Education Economics research programme at the Research Institute of the Finnish Economy, Helsinki, Finland. He is now Rector at the Åland University of Applied Sciences.

For more information on the Research Institute of the Finnish Economy (ETLA), see the penultimate page of this study.

The Finnish LTC system covers the whole spectrum of LTC services. At one end, there is home care, where there are services that have a personal or social focus and to some extent also one of home nursing care. At the other end of the spectrum there is institutional care. Institutional care is provided both in nursing homes and in the inpatient departments of health care centres.

In Finland, entitlement to LTC services is based on residence, Thus, if an individual is in need of LTC services, he or she or some relative or friend should contact the local municipality. From that point onwards, the municipality together with the elderly person decide on which services should be provided.

1.2 Evaluation of needs

In view of scarce resources, eligibility decisions come down to an evaluation of needs in the Finnish LTC system. The evaluation of needs usually starts with the elderly person or his or her relative contacting the municipality, after which the social services department in the municipality starts the needs evaluation procedure. The result of this evaluation can then be that the elderly person receives home care services or perhaps will be admitted to an institution.

As mentioned above, the Finnish municipalities are responsible for providing LTC services in Finland. Furthermore, they have a vast degree of decision-making power over how this is implemented. There is no national definition of a ’need for care’. This is also the case for needs assessments, with the municipalities largely being able to decide how needs are to be assessed. However, the Ministry for Social Affairs and Health has issued guidelines on what is to be considered good practice in needs assessment.

According to these guidelines, a comprehensive assessment of service needs at the individual level is very important because it means that clients can be assured of effective, high-quality services. In urgent cases, the need for social services must be assessed without delay. In non-urgent cases, persons over the age of 80 and recipients of the social security institution’s highest care allowance are entitled to an assessment of their need for welfare services within seven days of contacting a local authority. The findings of such assessments can also be used when the service system of the whole municipality or region is being planned. Good practices for service needs assessment at the individual level are:

- comprehensive assessment of the various dimensions of functional capacity, i.e. physical, cognitive, mental, social and environmental factors.
- performance of this assessment in multi-professional collaboration and in cooperation with the client and his/her family.
- careful choice of the measures used in assessment (indicators of functional capacity), based on sufficient proof of their reliability.
- full understanding of the assessment process, the methods used, analysis of the data produced, and interpretation of the findings.

Because of this wide power of decision at the disposal of the municipalities, needs assessments and even thresholds of care eligibility will clearly vary between municipalities. The guidelines provided by the MSAH are useful for the municipalities, but they will not ensure that everybody gets the same services. There are and will be differences depending on the municipality.

1.3 Available services

When needs have been assessed, several forms of LTC are available. In Finland these can be classified according to the intensity and coverage of care (Stakes, 2006). The basic level of service is home-based care. This type of service consists both of services that have a personal or social focus and to some extent also of home nursing care, as many municipalities have merged

their health and social services departments. At the other end of the spectrum there is institutional care. Institutional care is provided both in nursing homes and in the inpatient departments of health care centres. The difference between medical care and long-term care may in this case be somewhat blurred. There may be individuals in the inpatient departments of health care centres that do not require medical care and individuals that live in nursing homes that from time to time require medical care. This medical care could either be in the form of an inpatient period at a hospital or medical care given at the nursing home.

During the last 10-15 years a new type of service that lies somewhere between nursing homes and the inpatient department at health care centres has been developed – sheltered housing (service homes). This type of service can in turn be divided into two categories, ordinary sheltered housing and sheltered housing with a 24-hour service. In 24-hour sheltered housing, care and medical facilities are available round the clock. Therefore, the distinction between this type of service home and a nursing home may be diffuse.

There are also other types of services that lie in between those mentioned above. For instance, social services may provide a kind of day-care centre for elderly people, which offers meals and some care and/or medical services.

There is no particular rule for deciding who is eligible for what service. It is up to the municipality to decide whether the elderly person is to receive home care services or a place in an institution.

Although the Finnish LTC system is mostly a system based on benefits in kind, there are also some benefits in cash. These benefits are not paid out by the municipalities, but by the Social Security Institution (KELA). The *Care Allowance for Pensioners* is intended to make it possible for pension recipients with an illness or disability to live at home, as well as to promote home care and to reimburse pension recipients for extra costs caused by illness or disability. The mean monthly allowance is around €100. There is also a special *housing allowance* for pensioners. However, it is not entirely clear whether this type of benefit should be accounted for as belonging to the LTC system.

As in the other Nordic countries, the Finnish LTC system is geared towards formal care. However, informal care exists of course. There is also a special home care allowance, which is available to carers. Thus, someone who stays at home to take care of a relative can be eligible for a home care allowance. This allowance is given to the carer by the municipality and constitutes taxable income. The amount of support is normally €336 per month, but can be up to €637 per month if the work is particularly demanding. The home care allowance is taxable income for the recipient. It is the local municipality that administers this type of support. The home care allowance can also be combined with various types of home care.

1.4 Management and organisation

Barring some minor exceptions all of the above-mentioned forms of service are provided by the public sector, the private sector and not-for-profit organisations. The role of the municipalities is strongest in the case of home-based care and institutional care. Of the home-based care, the private sector and the not-for-profit organisations provide some 25%. Regarding nursing homes in particular the role of the municipalities is large, as they produce more than 90% of output. Regarding service homes the public sector's share of production is less than half (Stakes, 2006). It should be noted, however, that private production mostly takes the form of outsourcing. Private companies operate a service home for instance, and the municipality then purchases services from this provider. Decisions on resource allocation, planning, and organisation of LTC are made by municipal health and/or social services boards, municipal councils and municipal

executive boards. Budgets are typically based on historical data and allocated without any specific targets or incentives (Vuorenkoski, 2008).

Legislation provides for the promotion of old-age health and welfare and the development of advisory services. The Primary Health Care Act (66/1972) requires municipalities to provide local people with advisory health services and health checks and to monitor their state of health, and the factors affecting it, by population group. Municipalities must also take health considerations into account in every aspect of their activities and work with other private and public bodies in their area to further public health. Under the Social Welfare Act (710/1982), municipalities must, for instance, arrange for public guidance and advice and for information on and access to various welfare and other social security benefits. They are also required to improve local social conditions and eliminate any defects (MSAH, 2008).

The regional evaluation of basic services is one of the essential statutory tasks of the State Provincial Office. In total, there are six of these provinces in Finland. The aim is to establish the accessibility and quality of basic services within the province. The evaluation conducted by the State Provincial Offices supports national development goals and complements municipal evaluations. It also serves the municipalities in the development of basic services. There is also a nationwide authority, the National Supervisory Authority for Welfare and health (Valvira), which starting in 2010 is responsible for quality control at the national level. In practice, this authority will deal only with particularly severe problems or cases with an implication for future practice in the field.

Municipalities can provide services for which they are responsible or jointly with other municipalities. They can also outsource services from private to public-sector providers or alternatively issue vouchers to service users to purchase necessary services from the private sector. Municipal federations provide services in much the same ways as independent municipalities (MSAH, 2008).

1.5 Integration

In Finland, municipalities are responsible both for health care and for implementation of social policy, including long-term care. However, in terms of specialised health care, municipalities are divided into 20 hospital districts.

In many municipalities the responsibility for social services and health care has been merged. Therefore, the distinction between long-term care, for instance home nursing care and health care services, is sometimes not very clear cut.

2. Funding

Finland switched to reporting its health care expenditure according to the OECD System of Health Accounts in 2008. Based on this, total expenditure on LTC amounted to €2,559 million, i.e. some 1.5% of GDP in 2006. Some 28% of this expenditure was spent on institutional care, some 18% on long-term care by primary health care, some 19% on home-help services, and some 32% on other services. It should be noted that the category ’other services’ includes sheltered housing with 24-hour assistance (Stakes, 2008b). Out of the total expenditure on LTC in Finland, some 28-29% was provided by the private sector. It should be noted that the Social Insurance Institution of Finland contributes very little if anything to LTC in Finland. Instead, funding is taken directly from taxes and user fees.

Legislation governs the user fees that municipalities are allowed to charge for LTC services). For institutional care, fees depend on the ability to pay. The maximum user fee can be 82% of the patient’s monthly earnings. However, a minimum of €90 per month must always be left for the patient. Monthly earnings comprise any pensions or capital income that the person may

have, such as dividends or rents. Also, the earnings of spouses will be taken into account. If a spouse is present, the maximum user fee is 41% of the combined earnings of the spouses.

Ability to pay is also the guiding principle for user fees in home care. User fees depend on income, the type of care to be provided, and size of household. Maximum user fees are always a percentage of income that exceeds a certain threshold. The following percentages apply (Table 1).

Table 1. User fees for home-based care in Finland

Household size	Income per month	Percentage
1	520	35
2	959	22
3	1,504	18
4	1,860	15
5	2,252	13
6	2,585	11

Source: Laki sosiaali (Act on user fees in social and health care)

Thus, if the household size is two, and the total household income per month is €1,200, 22% of the difference between €1,200 and €959 i.e. €52 should be paid. If it is a single-person household and the monthly income is €1,200, 35% of the difference between €1,200 and €520, i.e. the maximum user fee is €238 per month.

As stated, in Finland, public LTC services are provided by municipalities. The municipalities collect taxes themselves, but they also receive transfers from the central government. The municipal tax is proportional but the state tax is progressive. The sum of the funds from the municipal tax and the state transfers to the municipality forms the funding of the municipal budget. Government transfers are generally not specifically targeted towards specific purposes in municipalities, but municipalities have the power to decide how much is to be spent on, for instance, LTC. Thus, municipal taxes are not specifically targeted to LTC, but municipalities decide in what way their total budget is to be split between various types of expenditure.

3. Demand and Supply of LTC

3.1 The need for LTC (including demographic characteristics)

In 2008 the total population of Finland was 5,299,772 people. The population aged 65 or over was 875,356 people, or 16,5 % of the total population. In the EU-15, which is a reasonable reference group for Finland, the population aged 65 or over was 17,7 % of the total population. The population aged 80 or older in Finland consisted of 229,091 individuals in 2008. This amounted to 4,3% of the population. In the EU-15, the share was 4,7% of the population in 2008. In 2032, i.e. roughly one generation later, the share of the population in Finland aged 65 or over will have risen to 26,0%. The same number for the EU-15 is projected to be 24,7%. (The total population in Finland in 2031 is estimated to be some 5,568,256 inhabitants) This means that Finland faces a somewhat sharper increase in the population aged 65 or older than what is the case in the EU-15. Regarding those aged 80 or over, it is projected that this share will rise to 8,7% of the total population in 2032 in Finland whereas the corresponding figure for the EU-15 will be 7,5% (Eurostat, population projection, trend scenario). Thus, also in the case of the population aged 80 or over, the rise in Finland will be somewhat sharper than in the EU-15 countries as a whole.

The need for LTC is normally defined according to given needs criteria, such as being unable to perform a certain number of activities of daily living (ADL). Out of necessity such data have to be retrieved from population health surveys. There are no data on care needs in Finland according to for instance the Katz index of independence in activities of daily living or the Barthel index of activities of daily living etc. from representative surveys of population health. Data on how many clients there are in nursing homes etc. cannot be used as a measure of need in the Finnish case as they are really more representative of the intersection of supply and demand. However, there is one population survey, *the Health Behaviour and Health among the Finnish Elderly*, published by the National Public Health Institute, which contains some population-wide measures of health status for the elderly. If one uses the non-ability to perform heavy household chores without help as a measure of need, for instance, one comes to the conclusion that some 157,000 persons over the age of 65 would be in need of help. This amounts to some 18% of the population aged 65 or over.

The best comparative data on Finns' need for LTC probably comes from *The European Statistics of Income and Living Condition* (EU-SILC) survey. This data provides comparable, cross-sectional and longitudinal multidimensional information on income, poverty, social exclusion and living conditions in the European Union. In terms of self-perceived limitations in daily activities within the past six months, it seems that Finns report a somewhat higher prevalence of these problems. For 65-74 year olds, 20,3% of Finns report severe limitations in daily activities, versus 14,3% of individuals in the EU-25 in general. For 75-84 year olds, the corresponding figures are 29,7% for Finns and 23,5% for inhabitants in the EU-27 in general.

The European Commission's Ageing Report reports a substantially larger number of individuals in need of care (European Commission, 2009). In the "AWG reference scenario" of this report, some 274,000 people are assumed to be dependent. This number is projected to rise to 485,000 by 2035. This is a large number both compared to national sources and to projections in the other Nordic countries. The corresponding numbers for Sweden, for instance, are only marginally higher than those in Finland at 312,000 in 2007 and 485,000 in 2035. However, the total population in Sweden in 2035 is projected to be 10.4 million people, versus some 5.6 million in Finland. Furthermore, as health differences between the two countries are very small, it is surprising that the number of dependent people projected for Finland in 2035 is almost the same as that for Sweden.

3.2 Supply and demand for informal care

The LTC system in Finland is heavily tilted towards formal care and benefits in kind. Obviously there is also a lot of informal care but there are no reliable data about this. A rough estimation of 133,000 people as the number of individuals receiving informal care was provided in the Finnish report from the Euroframecare project.[1] This would be some 15% of the population aged 65 or more.

Another way of quantifying informal care is to look at the number of individuals or carers who receive support for informal care. In 2006, some 20,400 persons received this kind of support. The Finnish Eurofamcare report also provides information on the characteristics of the informal carers. Some 75% of carers are women; 39% of carers are themselves older than 65 years, and 43% of carers were spouses of the dependent person.

[1] See: http://www.uke.de/extern/eurofamcare-de/publikationen.php?abs=2.

3.3 Supply and demand for formal care

A public health system or LTC system with subsidised prices is by necessity a system of rationing. Therefore, observed volumes of LTC use cannot really be taken as indications of supply or demand. Nevertheless, they are of course interesting in themselves. In Finland, there is no reliable information on spare capacity in the LTC system, or information on capacity in general for that matter. However, because the LTC system in Finland for the most part is a tax-financed public sector system with waiting lists, it is likely that data in use at the same time can be taken as data on capacity, as demand exceeds supply in a system with rationing.

It goes without saying that waiting times exist in an LTC system of the Finnish type. However, there are no data on waiting times. The municipalities in charge of delivering LTC services are not obliged to collect such data. In practice, it is likely that there are huge differences between municipalities in this respect. There may also be large differences in waiting times depending on the form of LTC. For instance, it may be easier to get home-based care than a place in an institution.

In 2006, 18,538 persons (2.1% of the population 65 and over) lived in residential homes. 11,201 persons (1.3% of the population 65 and over) were treated as long-term inpatients in health centres. 8,692 persons (1.0 % of the population 65 and over) lived in service homes, and 18,064 persons (2.1% of the population aged 65 or over) lived in service homes with 24-hour assistance. In addition to this, some 55,000 persons aged 65 or more received regular home care, and some 20,000 persons aged 65 or over received support for informal care at home. Compared with earlier years, there has been a clear increase in service home living and home care, and a clear decrease in residential home and health centre care (Stakes, 2008).

In the Finnish LTC sector in total, some 67,000 people were employed on a full-time or equivalent basis. Of these, some 12,000 were employees/care givers in formal home-based care. The ratio of nurses to other personnel in formal home-based care was about two to one, i.e. there were some 8,000 nurses and 4,000 other helpers in formal home-based care.

4. LTC Policy

Long-term care in Finland is high on the policy agenda, at least on paper. Policy objectives regarding the form of services available, the financing of services, and the supply of carers are mentioned in the programme of Prime Minister Matti Vanhanen's second cabinet.

4.1 Policy goals

The overall policy strategy for the whole of Finnish social protection policy up to 2015 has been set out by the Ministry of Social Affairs and Health (MSAH, 2006). This major policy document has four themes, which are:

> promoting health and functional capacity", "making work more attractive", "reducing poverty and social exclusion", and "providing efficient services and income security.

For two of these, LTC is explicitly mentioned. Under the theme "promoting health and functional capacity" it is mentioned that "new models must be found for boosting the functional capacity of older people and under the theme "providing efficient services and income security" it is mentioned that "the availability and quality of services for older people must be improved."

4.2 Integration policy

Although policy in this relatively high-level document is portrayed in relatively broad terms, it is still interesting as it reveals the main direction of what is to be done. In terms of boosting the

functional capacity of older people the importance of preventive measures is emphasised (MSAH, 2006, p. 10). Clearly, it is of interest to policy-makers to expand the span of healthy life as much as possible in order to save on LTC costs. Some important directions for the future are set out regarding the availability and quality of services of older people. First, the importance of increasing home care and local production of LTC is emphasised. Second, the need to improve the assessment process is mentioned, with an explicit mention of the need to harmonise assessment between providers. Importantly, it is also mentioned that improved service quality would improve people's possibilities of living at home even if they suffer from dementia. Furthermore, the possibility of alternative funding models of LTC is also mentioned.

4.3 Recent reforms and the current policy debate

The Finnish LTC system has been criticised for not being particularly fair and equal regarding the amount and quality of LTC people receive in different municipalities. Partly in answer to this, the Ministry of Health and Social Affair and the Association of Finnish Local and Regional Authorities has issued the National Framework for High-Quality Services for Older People (MSAH, 2008). This framework defines the values and ethical principles guiding the provision of services for older people, and outlines strategies to boost quality and effectiveness. It also sets national quantitative targets for LTC that municipalities can use as a basis for fixing their own targets.

The municipal structure in Finland is undergoing a major overhaul at the moment. The process is called the 'Paras-project' (Ministy of Finance, 2009). This overhaul will have substantial implications for LTC service provision in Finland. As has been described earlier in this report, it is the municipalities in Finland that are responsible for the bulk of social services. The aim of this overhaul is to increase productivity in social services in Finland, including the productivity of LTC. One important policy tool here is to decrease the number of municipalities by municipal mergers. In short, the aim is to make better use of economies of scale. Further, as some remote areas are already hampered by lack of personnel, another aim is to make organisations bigger and thereby more attractive as employers.

4.4 Critical appraisal

However, simple guidelines issued by the MSAH or the PARAS-project may not be enough to sort out some of the problems in the Finnish LTC system or in the Finnish public sector in general. The demographic changes that are facing Finland in the short and medium term pose a challenge in two ways. First, the demand for LTC will increase. Second, the supply of LTC personnel will decrease. These two will put serious pressure on public finances in the years to come. Attempts to increase productivity in LTC by reorganisation and potentially more outsourcing may simply not be enough. The Finnish public sector may have to give up financing some services entirely. The debate about what the public sector can be expected to do in Finland in the coming decades will be a lively one.

References

European Commission (2009), 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060). *European Economy 2*.

Häkkinen, U., and Lehto, J. (2005), Reform, Change and Continuity in Finnish Health Care, *Journal of Health Politics, Policy & Law 30*, 79-96.

Ministry of Finance (2009), Valtioneuvoston selonteko kunta- ja palvelurakenneuudistuksesta (in Finnish) (http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/VNK-selonteko_suomi%2bkansi.pdf) (Author's translation: "Government Blue Paper on tranformation of municipalities and social service structures").

MSAH (2006), Assessment of older people's functional capacity as part of service needs assessment in social services; (in Finnish). Municipal Bulletin 5/2006.

MSAH (2008), National Framework for High-Quality Services for Older People (http://www.stm.fi/c/document_library/get_file?folderId=39503&name=DLFE-6710.pdf)

Stakes (2008a), Statistical Yearbook on Social Welfare and Health Care 2008.

Stakes (2008b), Health Care Expenditure and Financing in 2006. Statistical Summary 11/2008.

Stakes (2006), Hoivan ja hoidon taloudellinen kestävyys. Arvioita sosiaali- ja terveyspalveluiden kustannusten kehityksestä (in Finnish). Stakes, Helsinki 2006. (Author's translation: The economic sustainability of old-age and health care. Estimates of the future costs of social and health care costs.)

Vuorenkoski, L., (2008), Finland Health System Review. *Health Systems in Transition 4*.

About the Research Institute of the Finnish Economy (ETLA)

The Research Institute of the Finnish Economy (ETLA) is a non-profit private organisation, founded in 1946 to conduct research in the fields of economics, business and social policy designed to serve financial and economic-policy decision making. Today ETLA is the largest economic research institution in Finland with a staff of around 50. The core funding for ETLA's forecasting and research activities is provided by supporting organisations. This basic funding is supplemented with external funding for projects based on special research agreements. ETLA publishes monographs, reviews and forecasts in several different series. ETLA's research activities consist of four research programmes and the forecasting unit. With its long tradition in high-quality research on technology, R&D, and productivity the organisation has become one of the leading units in Finland in the fields of the knowledge society and innovation policies. Another high priority line of research relates to human resources, labour market institutions and labour market functioning more generally, aspects which have become increasingly important ingredients of the knowledge society and innovation policies. See **www.etla.fi** for further information.

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

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

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

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

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

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

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

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