

TRENDS IN AGEING & CHALLENGES FOR THE PROVISION OF CARE FOR OLDER PEOPLE

NORDIC CONGRESS OF GERONTOLOGY
COPENHAGEN
13TH OF JUNE 2012

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Focus of presentation

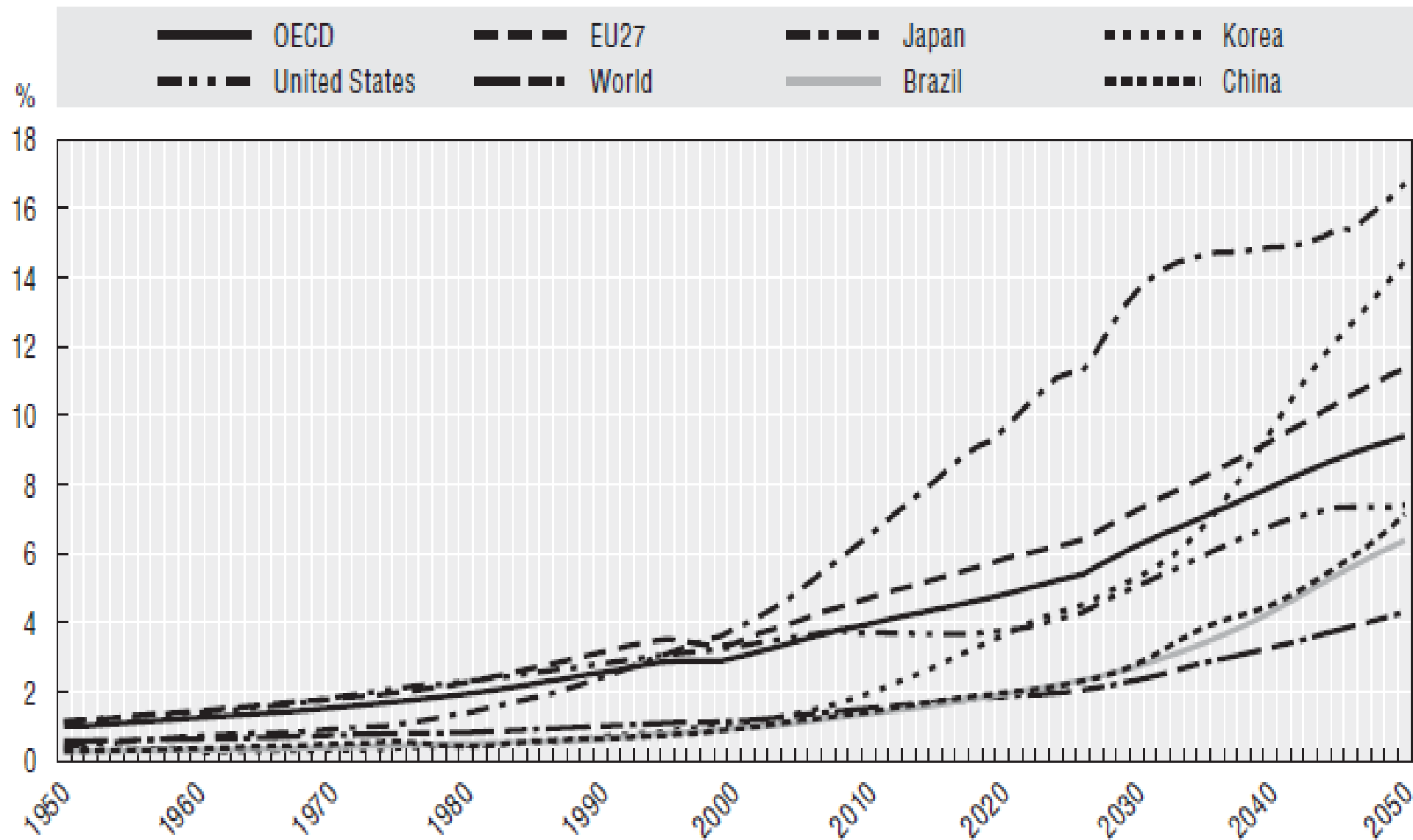
Trends in ageing,
with the view to shedding light on challenges &
opportunities for the provision of care *for* older people
and
by older people

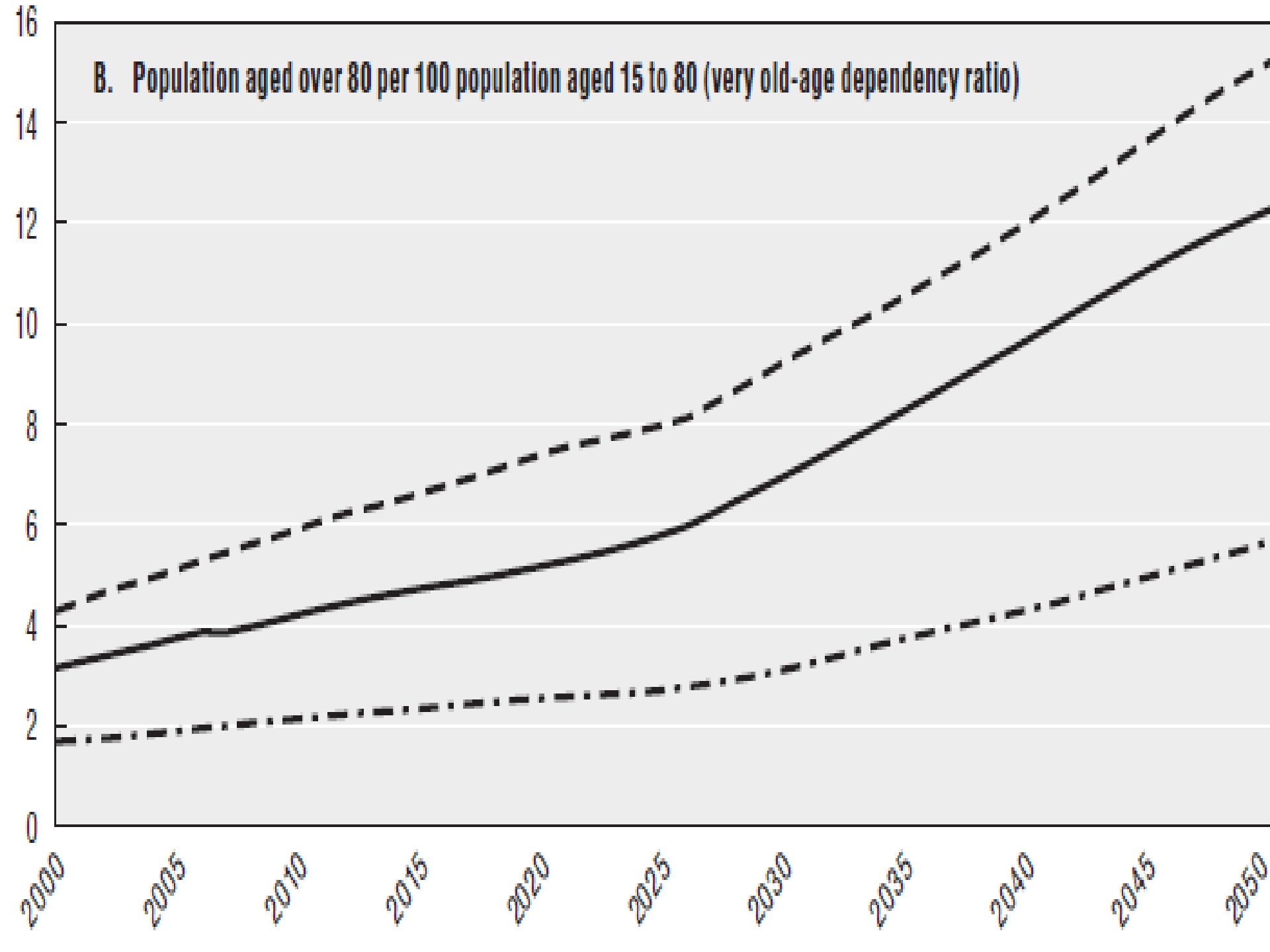
- **For others**
- **For themselves**

... having regard to socio-economic inequalities and
considerations of fairness and justice

Share of global 80+ population

Source: OECD (2011)





Disability trends

- No consistent trends on disability at older ages: some studies show increases, others decreases (Lafortune et al. 2007)
- Complex and shifting picture e.g. lower rates of smoking vs. increasing prevalence of obesity; greater likelihood of diagnosing dementia
- Increasing longevity of people with care needs
- Even allowing for some decline in disability, population ageing and longevity will have the effect of driving up the sum total of care needed

Pressure on LTC systems will grow because...

1. Demand for LTC will increase (notwithstanding possible and variable decreases in disability/compression of morbidity)
2. Demographic, societal and labour market changes will (in aggregate) suppress the supply of informal care
3. People will increasingly demand good-quality, responsive care
4. Care provision may have to be re-organised due to technological innovation

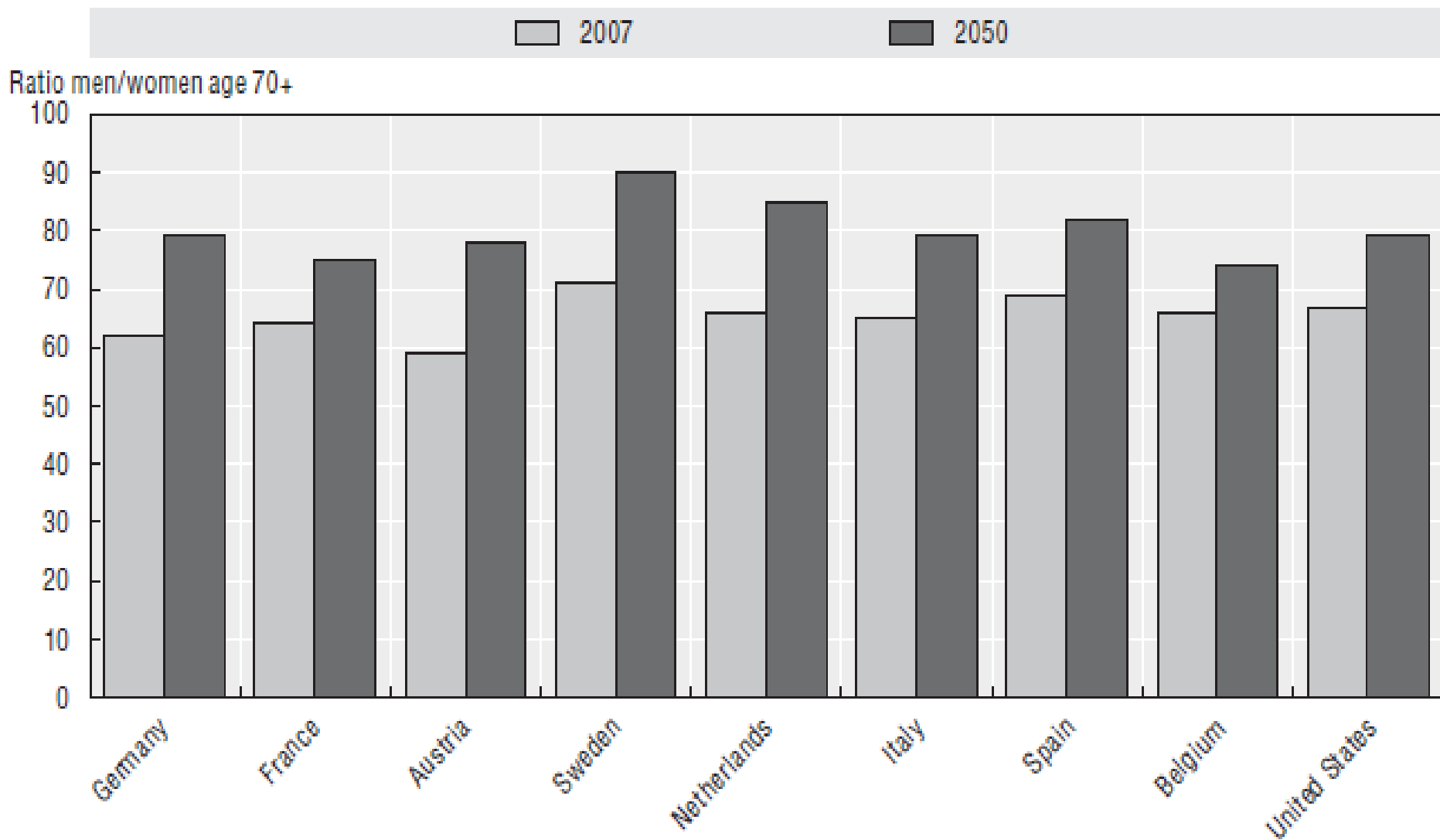
There will be demand for

- More care
 - More formal care
 - Of a better quality
 - Care that is attuned to individuals' needs and preferences
 - In a way that makes better use of ICT
 - Better integrated care
 - That does not impose unreasonable direct or indirect costs on individuals or their families
 - Is deliverable at a cost that is politically acceptable
- = complex set of quantitative and qualitative changes, most of which will point to increases in the costs of care

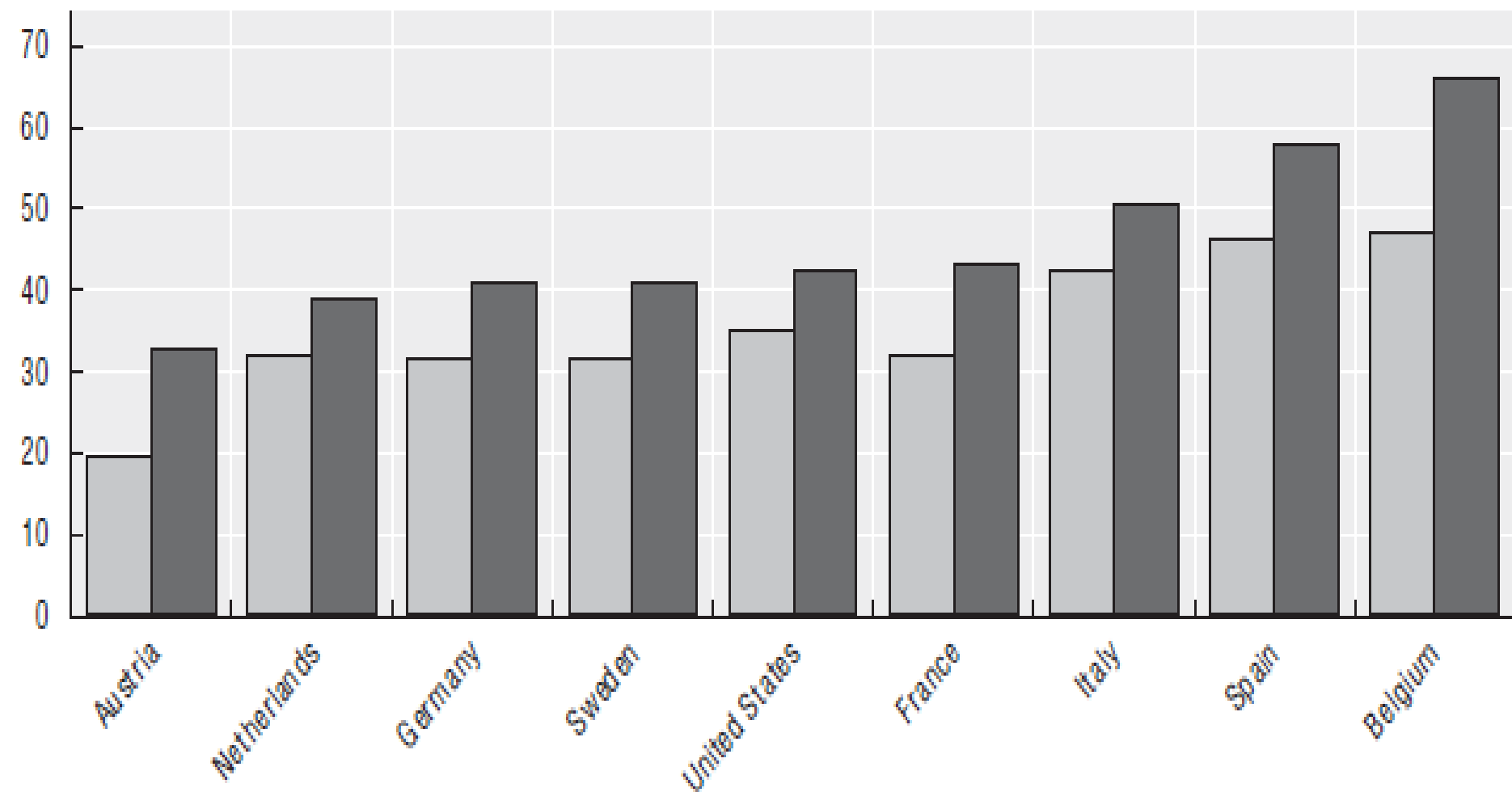
The 'good news'...

- In some countries, changes in marital status distribution among older cohorts and past fertility patterns will result in an INCREASE in availability of spousal and/or adult child carers
- Longer co-survival of spouses/partners —women more likely to have the benefit of a co-resident (caring?) spouse

Ratio of men : women age 70+

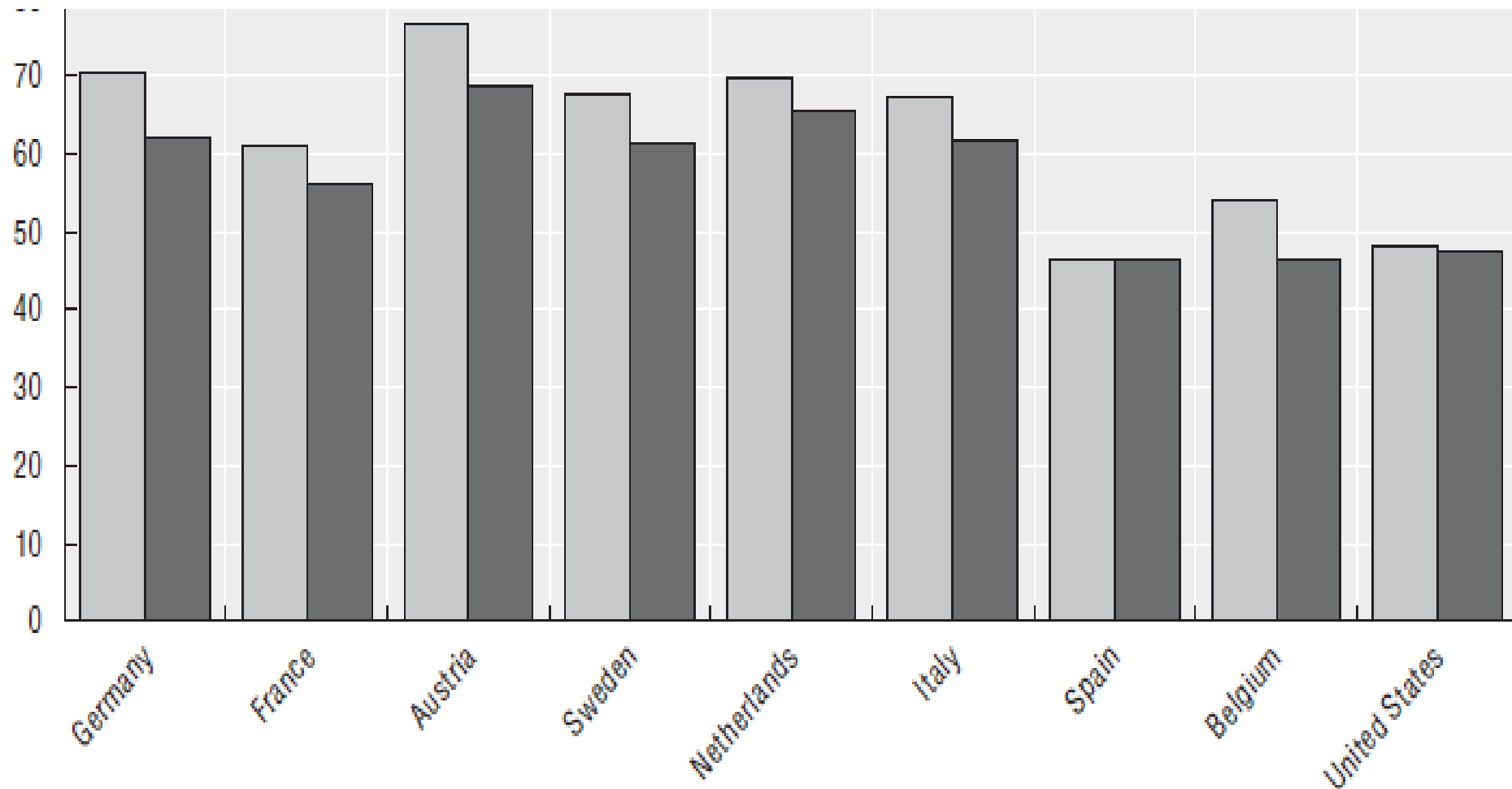


Proportion of married women 70+ in 2007 and 2050



% of 70+ with disability, living alone or with a frail partner

2007 and 2050



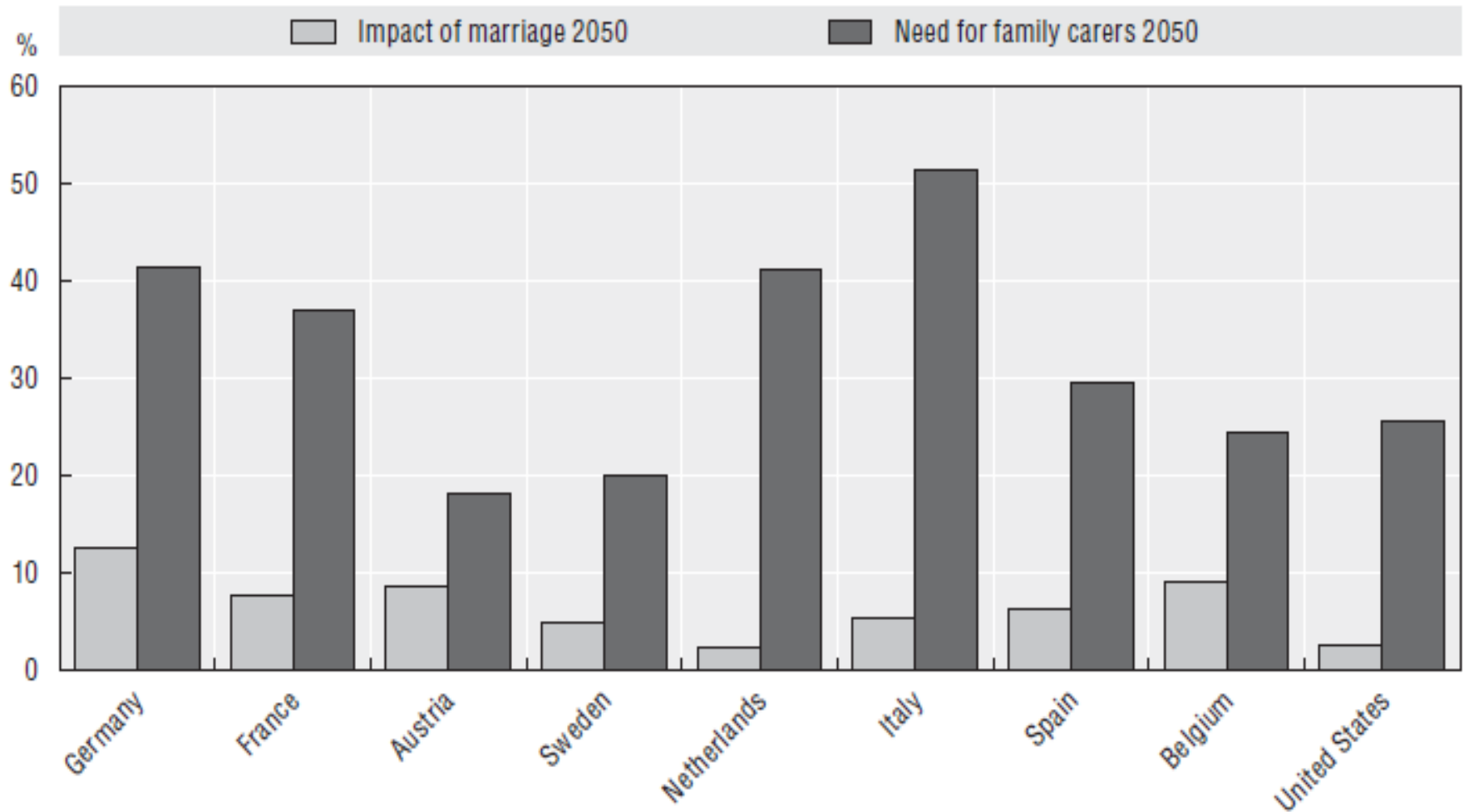
The not-so-good news on 'the potential pool of family carers'

These increases in care capacity will not keep up with
pace of growth in 80+ population

And will be compounded by patterns since 1940s...90s

- Declining family size (= fewer adult children)
- Rising childlessness
- Changing living arrangements (less co-residence)
- Divorce / separation (if not followed by re-partnering)
- Some countries: lower marriage rates
- Rising / high paid employment among (older) women
- Postponed retirement
- Decline in willingness to care ????

The 'care gap'



Filling 'the gap'

... Perhaps we should not discount the possibility of significant improvements in healthy/disability-free life expectancy relative to life expectancy

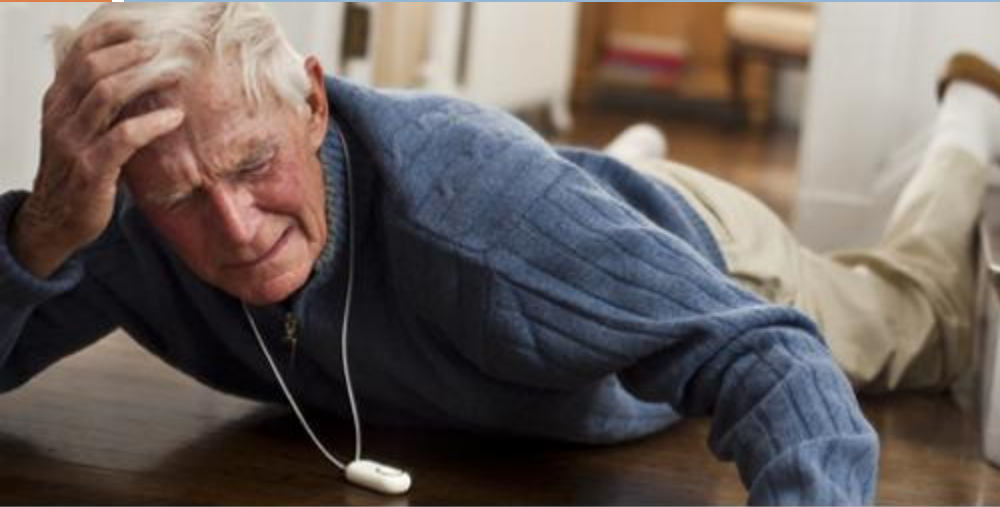
But in the meantime:

- Higher proportion on 'non-dependent' population becomes active in care-giving
- Those already involved redouble their efforts
- Inputs from the formal sector increase
- Technology replaces some human labour

Brave new world?

- Remote/electronic care delivery and monitoring systems, yet little empirical evidence and theorising exists on the extent to which can they replace care provided by people (various professionals and family members), and how this varies by level of care needs.

Call Lifeline now: 1-800-380-3111
Get a price on independence



Lifeline Medical Alert Service

- \$0 – No equipment to buy
- \$0 – No long term contract
- \$0 – No hidden fees



One of 8 'family resources' on Philips website

How to get up from a fall

1. Prepare



Getting up quickly or the wrong way could make an injury worse. If you are hurt, call for help using a medical alert service or a telephone.



Look around for a sturdy piece of furniture, or the bottom of a staircase. Don't try and stand up on your own.



Roll over onto your side by turning your head in the direction you are trying to roll, then move your shoulders, arm, hips, and finally your leg over.

2. Rise



Push your upper body up. Lift your head and pause for a few moments to steady yourself.



Slowly get up on your hands and knees and crawl to a sturdy chair.



Place your hands on the seat of the chair and slide one foot forward so it is flat on the floor.

3. Sit



Keep the other leg bent with the knee on the floor.



From this kneeling position, slowly rise and turn your body to sit in the chair.



Sit for a few minutes before you try to do anything else.

Talk to your primary care provider about having a fall-risk evaluation. The fact that you have fallen once means you have a high risk of falling again.

Care of older people is - and will be - largely informal care

- Across developed countries, informal care provision constitutes the bulk of caring, ranging from 70 to 90% of all care-givers

(Alber and Kohler, 2005; Fujisawa and Colombo, 2009)

Informal care is often intensive

Ireland:

Among older people
who get help with personal
care and household tasks,
assistance from family
members and friends
amounts to **30 hours
per week on average**



2012

Profile of
community-dwelling
older people with
disability and their
caregivers in Ireland

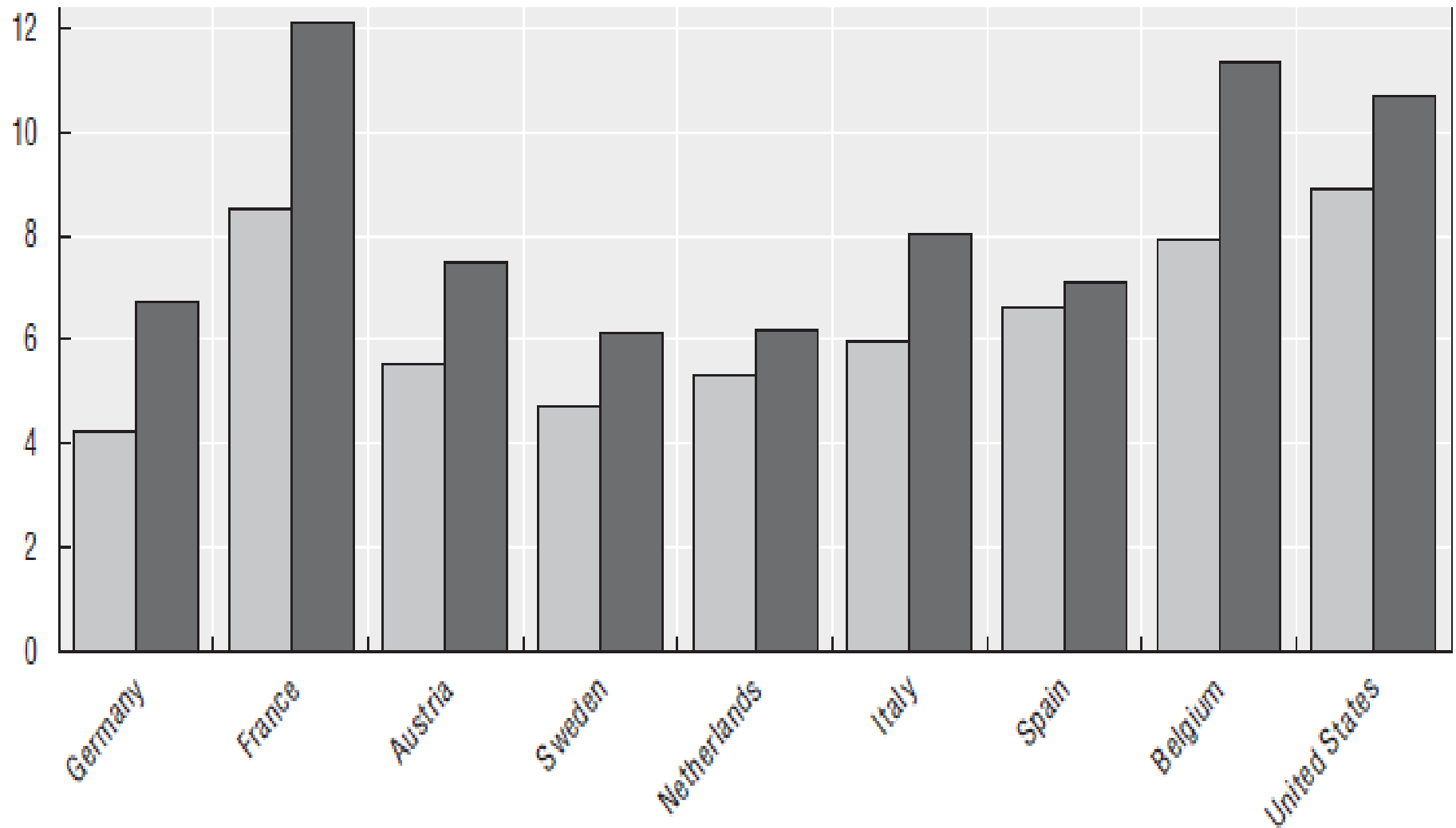
Care-giving is highly gendered

- ❑ Seven out of 10 main caregivers are **women** (TILDA, 2012)
- ❑ Nine out of 10 paid caregivers are **women** (TILDA, 2012)
- ❖ Proportions strikingly similar across very different social policy and cultural contexts

The spousal caregiver is often unsupported, and in need of care

- Spouses are most (and increasingly) frequently identified as the main caregiver
- Spousal carers are increasingly older and hence more likely to have care needs themselves

Couples where both have ADL difficulties, as share of 70+ population with disabilities, in 2007 and 2050



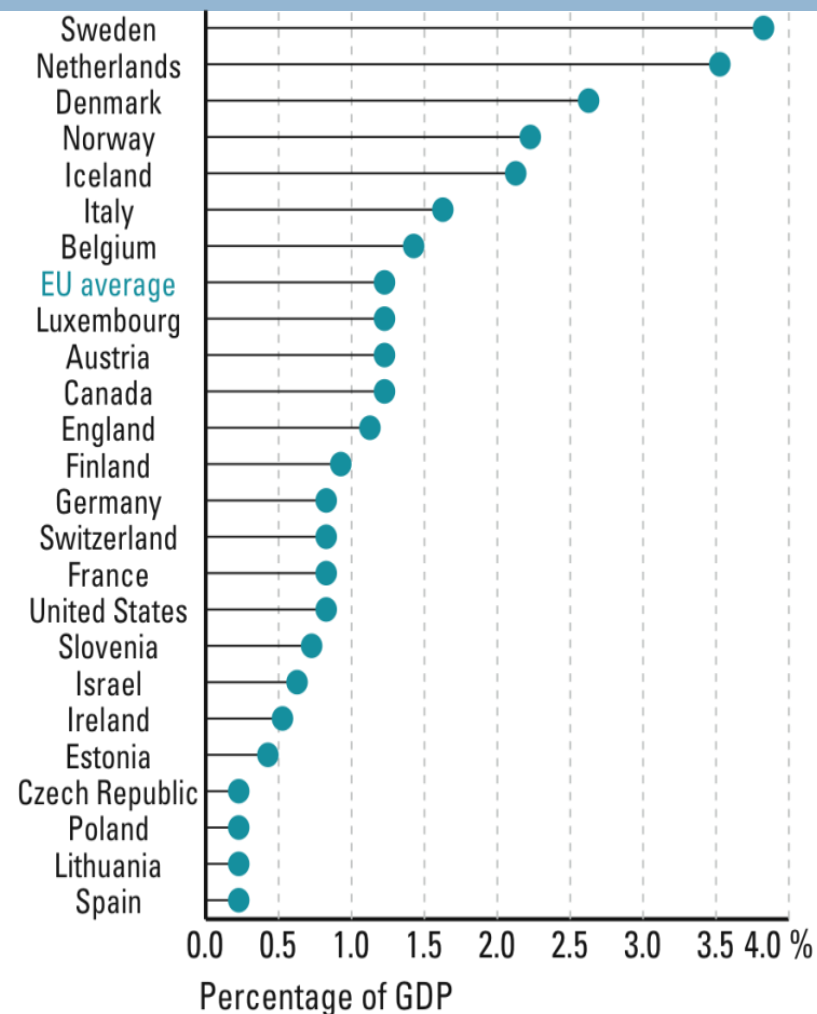
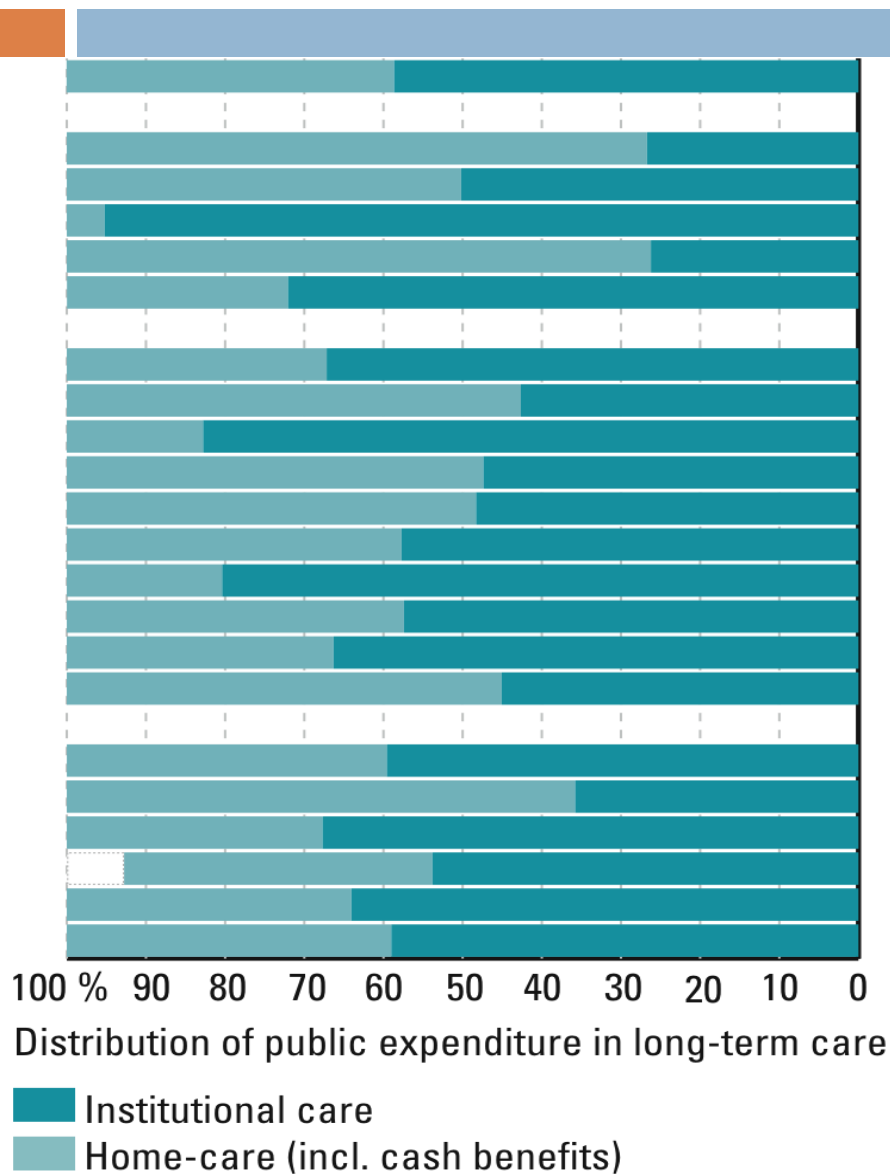
How to support ageing spouse carers?

- Respite care (at home)
- Good day centres (for men as well as women)
- Training – for family **and** formal carers who are often perceived as lacking skills, capacity and sensitivity

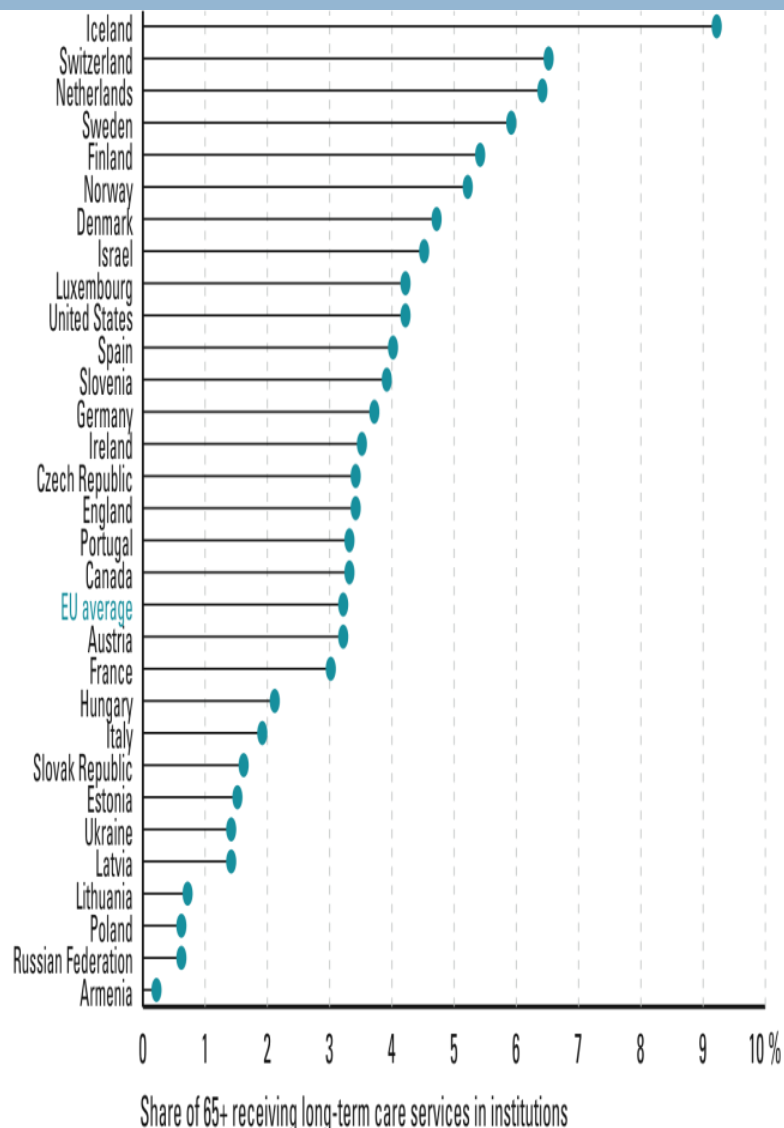
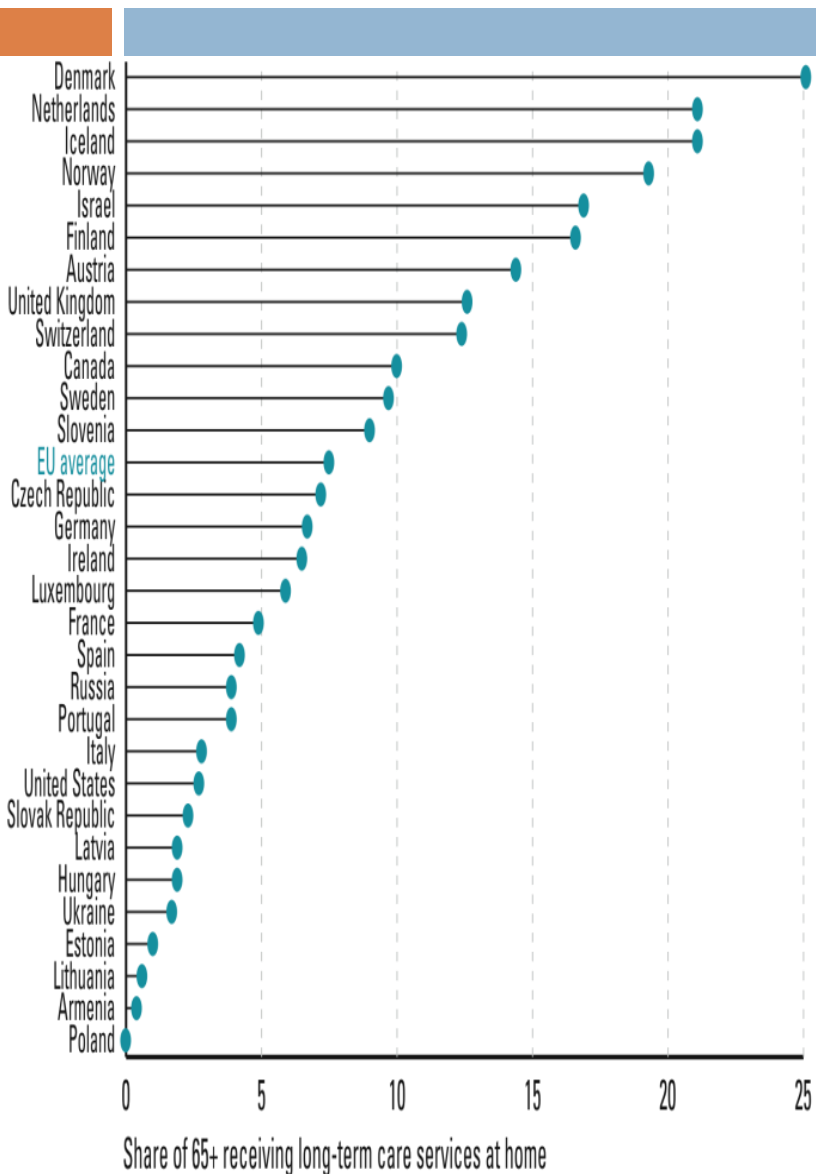
Over and above reliance on 'free' family care - Among OECD countries:

- One-third have universal coverage, either through tax-funded LTC services (Nordic countries), or through social insurance schemes (Germany, Japan, Korea, Netherlands)
- No LTC system as such, but universal personal-care benefits in cash (France, Italy, Austria) or in kind (Australia, NZ)
- Safety-net (means-tested) schemes (UK & US)

Social expenditure on long-term care (% of GDP) and distribution of expenditure between institutional and home care (Source: Huber et al. 2009)



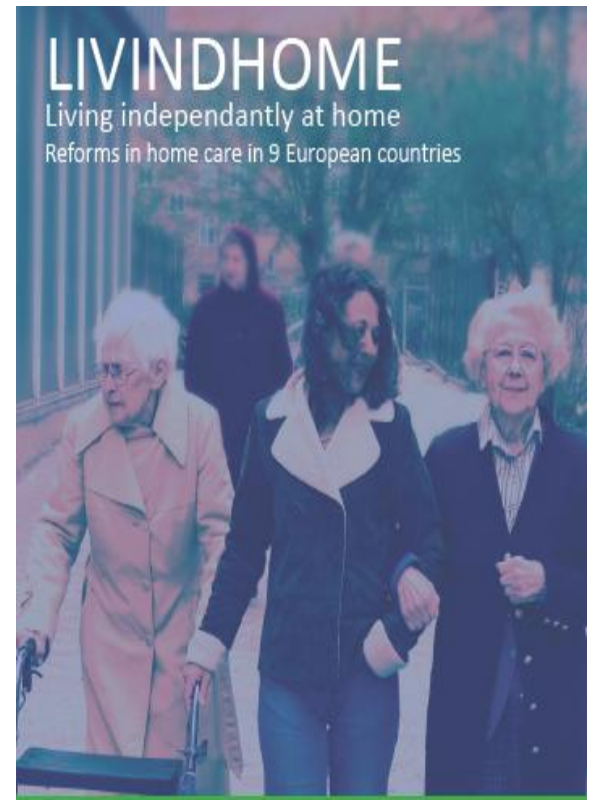
% of population aged 65+ receiving home care services and institutional care (Source: Huber et al. 2009)



Diversity overshadows commonalities

- Policymakers and societies have made very different choices in response to a common task, providing care to growing numbers of older people with support needs.

Special Issue on
*Reforming
Home Care in Ageing
Societies*



Some widely shared responses

- Perception that **home care** services can provide care and support of independence for older people and people with disabilities in a financially sustainable manner
- The number of recipients of institutional care has declined and home care arrangements is now prioritised in OECD countries, reflecting preferences for home help and care but also an attempt to reduce reliance on **expensive** institutional care, particularly for recipients with lower levels of disability

The challenge of de-institutionalisation



- With falling rates of institutional living, more people rely on home care services, and this means that the home care systems have had to adapt to coping with higher levels of disability (Jacobzone et al., 1999).

Widely shared responses

- Narrowing eligibility through increased targeting
- Containing costs through the introduction of cash allowances
- Embedding family and 'grey' care labour into the architecture of home care provision
- Introducing new technological and efficiency measures
- Seeking to preserve capacities and place responsibility on home care client to (re-)acquire independent living skills

Family care & choice

- Older people often prefer to receive home care provided by professionals and to maintain residential independence by not having to move in with relatives (Daatland and Herlofson, 2003; European Foundation for the Improvement of Living and Working Conditions, 2004)
- This is highly welfare state specific
- Those who are not (or not exclusively) cared for by their family members have varying patterns of formal service use, differentiated by purchasing power and preferences, and by the extent to which the state is involved in financing care

Substitution effects?

- Care systems which provide generous and high quality formal care may in fact ensure the continuous involvement of informal carers, as there is evidence that increased public services leads to increased informal care (ter Meulen, Arts and Muffels, 2001, Künemund and Rein, 1999) – but this is dependent on type and level of care needs
- Trends towards informalisation and marketisation, as older people turn to the market or the family when levels of public home care services are reduced (Szebehely, 2007; Szebehely & Trydegård, 2012).

Choice...and routinisation

- Stronger 'user orientation' through the introduction of various choice options, e.g. cash support for informal care or opportunities to choose between providers of formal care (Burau, Theobald and Blank, 2007)
- The introduction of cash-for-care allowances has in many countries been accompanied by a general trend towards market-inspired reforms sometimes termed 'New Public Management' (NPM), as a way to make services more cost-efficient and effective (Vabø, 2003; Knijn, 2000; Ungerson, 2000; Szebehely 2007)
- Specification and routinisation of care tasks may affect quality of care & the job satisfaction of workers

LTC policy is often

- Piecemeal
- Crisis-driven (fiscal, political)
- Short-medium-termist
- Ageist
- Sexist
- Racist / ethno-centric
- Reflective of political / power structures

... But is it *unsustainable*?

Actions required

- Any single 'solution' untenable
- Prevention and delay of disability onset the single best means – but calls for a foresighted approach, and investment upfront for expected future spending reductions – *not attractive for policy-makers who operate with short time-frames*
- Fairness considerations in light of social gradients in health and disability
- Formal and informal sector inputs needed
- This calls for more co-ordination between the two:
Do we understand how this works ?

Recommendations (OECD, 2011)

- Better supports for family members who can and want to care – without entrapment and exclusion from labour market – through cash payments, support services & flexibility at work
- Increasing supply of care workers in formal sector – through increased recruitment, higher retention rates & improvements in productivity – which in turn calls for better working conditions & possibilities for advancement

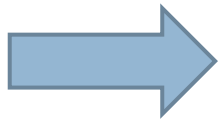
= cost, although reduction in staff turnover, more careful allocation of work tasks according to qualifications & good use of ICT will help to dampen cost pressures

- How likely / feasible are these? – Challenge of proving 'cost-effectiveness'

What is the alternative?

- Those who can, purchase the care
- Those who cannot, turn to family
- The rest turn to (diminishing availability of) state-financed care

(this is *de facto* already the case in many countries)



Over-reliance on family care

Possible problems with quality/quantity of care

Growing inequalities in care

Concluding thoughts - agenda

- Reasonable expectation: increasing heterogeneity in 'care constellations' and likelihood of growing inequality in access to and variability in quality of care
- We need to gain a better understanding of 'what works'
 - ❖ In remote/tele-care/other ICT applications
 - ❖ In combinations of formal and informal care
 - ❖ In prevention and 're-enablement'
 - ❖ Who can do what and when (to optimise use of human and IT resources)
- We need to raise awareness of inequalities and unfairness in how care is organised and (directly or indirectly) paid for

Some Key References

- OECD (2011) Help wanted? Providing and paying for long-term care. Paris: OECD.
- Special issue on home care, in the journal *Health and Social Care in the Community*, 2012, edited by Glendinning, Rostgaard and Timonen
- The LIVINDHOME report available at <http://www.sfi.dk/livindhome-7284.aspx>