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LOCAL ADMINISTRATION REFORM
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Comparative Assessment Report about EU Practices in Municipal Home Care Service Delivery to Elderly – EU Acquis and Five Countries Final Version

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Abbreviations

APA	Personal autonomy allowance
AGGIR	Autonomie Gérontologie Groupes Iso Ressources (Autonomy Gerontology Iso Groups Resources)
CA	Companion allowance
EC	European Commission
EU	European Union
ESPN	European Social Policy Network
EOHSP	European Observatory on Health System and Policies
GDP	Gross Domestic Product
LTC	Long-term care
LAR	Local Administration Reform
IPA	Instrument for Pre-Accession Assistance (EU)
MoEU	Ministry of Environment and Urbanisation
Mol	Ministry of Interior (Mol)
CSO	Civil Society Organisation
OECD	Organisation for Economic Cooperation and Development
SAAD	System for Autonomy and Care for Dependency
SP	Subsidiarity Principle
UN	United Nations
WHO	World Health Organization

1. Introduction

Within the scope of the project: 'Local Administration Reform III (LAR III)', it was decided to prepare service standards for Turkish municipalities for their delivery of home care to elderly. The standards shall be approximated to the standard in the European Union (EU) and therefore the present report presents a *Comparative Assessment Study on the Delivery of Home Care to Elderly in five EU countries*. The purpose is to compare and assess responsibilities at the subnational level in five selected EU countries within home care to elderly. The assessment should also provide information on the overall EU regulations on the 27 member countries' systems for home care to elderly and good practices. The five countries chosen for the assessment are Denmark, France, Italy, Slovenia, and Spain.

Textbox 1: Local Administration Reform, phase III

"LAR III is the third phase of the projects, which were financed by the EU in the framework of IPA funds¹ and implemented by the UNDP to support local administration reforms. The first phase of this project series (LAR I) was carried out in the period of 2005-2007 and the second phase (LAR II) was implemented in the period of 2009-2011.

The overall objective of the Project is to ensure effective, inclusive, accountable and participatory local governance in Turkey, in particular through support to further implementation of the LARs undertaken between 2003-2013, in line with international standards.

The specific objective of the project is to develop and strengthen the administrative capacity and cooperation of Ministry of Interior (Mol), co beneficiary Ministry of Environment and Urbanisation (MoEU) and Local Authorities themselves in the task of ensuring the effective implementation of the new local administration model in line with principles of democratic governance."

EU countries are obliged to follow the regulations agreed upon in the EU following the EU acquis. Turkey became an EU candidate country in 1999 and the EU-Turkish Accession Partnership was agreed upon 8 March 2001 including a Road Map towards membership. The real negotiations to become an EU member initiated with opening of accession negotiations 3 October 2005, which is conducted with the EU Commission. Since June 2006, 16 of the 35 chapters on EU Acquis have been opened, so Turkey can show its readiness for the requirements in the chapters. The chapters on Social Policy and Employment (19) and Consumer and Health Protection (28) have not been opened yet for discussion. Meanwhile, Turkey should therefore as part of its accession negotiating with the EU approximate its delivery of home care to elderly to the EU standards following the EU acquis¹.

Textbox 2: EU Acquis and the Instrument for Pre-Accession

Acquis communautaire refers to the cumulative body of European Community laws, comprising the EC's objectives, substantive rules, policies and in particular, the primary and secondary legislation and case law – all of which form part of the legal order of the EU.

Countries in negotiation with the EU for membership, including Turkey, negotiate on 35 specific Chapters dealing with the EU Acquis. Chapter 19 deals with social policies and employment and chapter 28 consumer and health protection.

The EU Instrument for Pre-Accession Assistance (IPA) is available to EU candidate countries: Turkey, Albania, Montenegro, Serbia, and the Republic of North Macedonia.

¹ www.ec.europa.eu/neighbourhood-enlargement/policy/conditions-membership/chapters-of-the-acquis_en

The aim of the present assessment is to present the best practices in the EU countries for delivery of home care to elderly with proper reference to EU Acquis. This should lead to the actual standard setting in Turkey including under emergency conditions and the current COVID-19 Pandemic.

The report starts with the methodology for the study and a discussion on what is meant by home care services for the elderly. The report continues with comparing the existing system in the five selected EU countries on the role of the public sector and the importance of the subnational level. The follows the assessment of the delivery of home care for elderly covering such issues as its content, need assessment systems, finance, the role of the informal system, coordination, digitisation, responses during COVID-19 and current challenges and current priorities in the five countries. All sub-sections begin with reference to the EU Acquis and the overall assessment of the situation in the five countries. Details for each country can be found in the table in Annex A.

In section four is discussed what a standard is and how it can be developed. Then it is suggested how the service can be described in an incremental manner from a basic standard to a more integrated approach, followed by considerations on eligibility, the informal system and co-payment.

2. Reviewing home care services for elderly in the EU

2.1 Approach

The comparative assessment was carried out based on current national and EU legislation, studies of home care for elderly from EU institutions and OECD, webpages from national authorities and other documentation (see references in section 6). An online roundtable was also organised with four EU municipalities: Palma (Spain), Trento (Italy), Zoersel (Belgium) and Gdansk (Poland) for a further understanding on their provision of the service. The assessment covers several aspects of the home care for elderly such as division of tasks between levels of government; service delivery model, and financing; coordination between public entities; legislation; involvement of the informal and the private sector; quality control and monitoring; digitisation, emergency responses during COVID-19; challenges and current priorities. The fact finding for all these aspects is presented in schematic form in annex A. That annex is the background for the synthesis assessment in the document and the discussion on standard development for home care for elderly in section 4.

The 27 EU countries all have their historical backgrounds, frameworks, governance practices and traditions for service delivery within social services. Also, the interest to involve the private sector and civil society organisations in service delivery varies from country to country according to certain traditions and the political economy. The five countries chosen for the assessment are Denmark, France, Italy, Spain and Slovenia. The countries have been selected to cover for different locations geographically in the EU, and different systems and traditions for the public sector's importance, and service delivery. The five countries have variations in the importance, structure, and size of the subnational (regional, municipal) level as follows below in table 1. Spain and Italy have delegated some statutory autonomy to regions, while the three other countries are unitary countries.

It is also important to understand that there are often significant discrepancies between *de jure* responsibilities and *de facto* service delivery in the public sector. This is often caused by ambiguous or contractionary subnational government frameworks, incomplete reforms or reversals of decentralization, budget cuts/unfunded mandates, capacity issues, bureaucratic inertia, or lack of implementation discipline. It is the intention to present the most interesting and relevant examples from the five countries and compare on different approaches.

2.2 The role of the subnational level

The opportunities for adequate service provision at subnational government level depend at a general level in its size in terms of population and relative share of public finance. Below is presented the average population size of the subnational level in the five countries and their share of overall public finance.

Table 1 Importance of the subnational level in the five selected countries.

	Municipal population on average	Average population, upper subnational level	Share of public spending (pct.)	Share of public revenues (pct.)	Expenditures to GDP (pct.)	Financing from local revenues (pct)
Denmark	58,459	1,158,440	66.2	65.0	34.0	43.6
Slovenia	9,739	NA	19.1	17.5	12.7	47.4
Italy	7,617	549,653	28.5	30.0	8.1	63.6
Spain	5,750	935,096	50.3	55.1	13.5	60.2
France	1,885	687,090	19.8	20.8	10.9	77.5
EU average	5,867	NA	33.5	34.5	10.4	57.1

Source: Key Data on Local and Regional Governments in the European Union, OECD/EU (2017 and 2016 (expenditures to GDP) data)).

Note: Subnational level includes regions and departments.

Danish municipalities are the largest in terms of population and are jointly with five regions responsible for 2/3 of all public expenditures and receive 2/3 of all public revenues. Municipalities in Slovenia are also large in terms of population, while their shares of public spending and revenues are the lowest (less than 20 pct.). The subnational level in Italy has a share of total public finance at around 30 pct., while the average population size is almost as large as in Slovenia. Among the five countries, France has the smallest municipalities in terms of population with less than 2,000 inhabitants, while the EU average is almost 6,000. For the 'upper' subnational level all population averages are relatively large with more than 500,000 inhabitants. The subnational level is dependent on transfers in all countries with a collection of resources locally between almost 45 pct. and 78 pct. of their expenditures.²

² Comparing cross country financial data may have certain limitations due to different statistic principle and demarcation of the subnational level. The real pct. of local financing in Denmark is e.g. more than 80 pct. if the municipal share of the income tax is considered a local tax.

3. Home care service for elderly

3.1 Care services for elderly in the EU

Because of the diversity among the EU countries, the EU Acquis does not define national care service policies for elderly in the member states. Instead, the EU actions serve to complement national policies and to support cooperation between member countries in the field of home care for elderly and their long-term care (LTC). As a minimum all EU countries shall fulfil the EU Charter of Fundamental Rights, which provides some basic guidance.

Textbox 3: EU Charter of Fundamental Rights (Art 25)

The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life.

According to a comprehensive EU study of perspective for long-term care (LTC) for elderly in the EU³, home and community-based services are most developed in the Nordic countries (Denmark, Finland, Island Norway, and Sweden) and some continental countries (Austria, Belgium, Germany, France, Luxemburg, and the Netherlands). While the coverage of formal LTC and home care services is low in the south such as Cyprus, Spain, Greece, Malta, and Portugal and most East EU countries.

The EU is in its politics and analysis treating home care to elderly as part of LTC to elderly. The definition of LTC is presented below:

Textbox 4: Definition of long-term care:

Long-term care “A range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care” (European Commission and Social Protection Committee, 2014: 11). The LTC system is understood as a mix of social and care services, as well as financial compensation – wholly or partially funded through the statutory social protection system – at local, regional and/or national level.

Source European Social Policy Network (ESPN), Thematic Report on Challenges in long-term care, Europe, EC 2018 p. 46

It follows from the table below, that the spending on LTC relative to GDP is highest in Denmark (2.5 pct.), while France is slightly above the EU average at 1 pct. The three other countries are below with 0.8-0.9 pct. of GDP.

Table 2 Coverage of LTC, coverage of home care and expenditure on LTC in the five countries.

Country	Use of LTC 65+ (pct.)	Use of home care 76+ (pct.) (questionnaire)	Exp. on LTC (pct. of GDP)	Total Social Protection (pct. of GDP)
Denmark	10	27	2.5	21.4
Spain	6	21	0.9	17.4
France	6	33	1.2	23.9
Italy	5	18	0.9	21.2
Slovenia	7	14	0.8	16.5
EU average	8	27	1.0	19.3

Source: ESPN, 2018 p. 21-23, Statistics Denmark and Eurostat.

³ Challenges in long-term care in Europe – A study of national policies’ European Social Policy Network, EC, 2018 p. 7.

The overall challenge in the EU is the increasing share of persons at 65+. The ratio is presented in table 3 and it follows that all five countries can expect the ratio to increase with 7 pct. points from 2020 to 2030. The situation is most critical for France and Italy, which can expect the ratio to increase to 40 pct. and almost 44 pct. respectively.

Table 3 Age Dependency (65+/15-64)

Country	Year	Year	Year
	2020	2030	2050
Denmark	30.6	37.3	43.4
Spain	29.8	37.2	59.5
France	33.2	40,0	49.3
Italy	36.2	43.9	61.5
Slovenia	31.3	39.2	54.9
EU Average	32,0	39,1	52.0

Source: Eurostat⁴.

3.2 What is home care for elderly?

Below in the textbox follows a definition from the European Observatory on home care for elderly:

Textbox 5: What is home care for elderly?

Home care can be conceived as any care provided behind someone's front door or, more generally, referring to services enabling people to stay living in their home environment. In some countries, 'someone's front door' can include a home for the elderly. As regards the type of services, home care may refer to care given only by professionals or in combination with care given by a spouse or relative (personal care or housekeeping). Many studies on home care lack precision in defining the activities, goals and even the target groups of home care.

Source: Home Care Across Europe, EC, European Observatory 2018 p. 9

The definition is broad, and it even suggests including residential homes in home care, which sounds somehow contra dictional. It is understood very differently across countries and sectors and the services included vary considerably among countries and even 'home' turns out to be an elastic term. In the present report home care service for elderly is care provided in the home of the beneficiary by a person from the formal or informal care system (family, friends, or other relatives). The care is limited to direct care according to the needs of the person.

It is important to note that informal home care and formal home care (professionally provided) are less distinct than they may seem. The availability of informal care may often make the difference between a patient or client staying at home or being institutionalized. The boundary between informal and formal care is even more blurred, when informal caregivers receive formal payments, for instance in the context of a personal allowance provided to the elderly. In Denmark, an elderly can select a person (informal) to be carer, but the carer will be hired directly by the municipality to formalise. In Italy, a carer can be paid directly from the allowance provided to elderly with need for home care.

⁴ ec.europa.eu/eurostat/databrowser/view/tps00200/default/table?lang=en

3.3 Home care for elderly in the EU and the five selected countries

In this section an assessment is presented on the delivery of home care to elderly in the five countries. The purpose is to provide an overview of EU Acquis and the practices with a focus on selected and relevant examples among the five countries.

3.3.1 Division of tasks

According to the EU Acquis, the division of public sector tasks should follow the subsidiarity principle (SP).⁵ The subsidiarity principle specifies that public services should be provided as closely to the citizens as possible with due consideration for economics of scale and the need for a suitable financial basis. This principle facilitates that services can be adjusted to local needs and demands. On the other hand, production costs and finances should also be considered as it may be more efficient to establish one larger (service) production facility instead of several small.

The legislation on social protection and home care for elderly is the responsibility of the central governments, although in Italy and Spain the provinces have some autonomy and can to a large degree decide on how home care to elderly is delivered including the role of municipalities.

All five countries are referencing to the subsidiarity principle by devolving the responsibility for home care for elderly to subnational level. Due to the costs and the size of municipalities in terms of population, only Denmark and Slovenia have devolved the service provision fully to municipalities. In France, Spain, and Italy the intermediate level, provinces (Italy and Spain) or department (France) have the overall responsibility. This is due to the existence of smaller municipalities, which do not have the financial and assessment capacity.⁶

Table 4 Responsibilities for home care to elderly

Country	Responsible subnational level	Secondary responsibility	Tasks regions/ departments	Task municipalities
Denmark	Municipalities			Assessment and provision
Spain	Regions	Municipalities	Assessment and allowance	Other social benefits
France	Departments	Municipalities	Assessment and allowance	Other social benefits
Italy	Regions	Municipalities	Assessment and allowance	Other social benefits
Slovenia	Municipalities			Assessment and provision

Source: ESPN, 2018 Denmark, Spain, France, Italy, and Slovenia supplemented with other sources.

In Denmark and Slovenia municipalities are financing the service directly with a substantial user fee in Slovenia and involvement of the private sector. In Spain, France, and Italy (the allowance countries) an allowance for home care service is provided to the elderly according to the degree of disability after

⁵ See Article 5 of the Treaty on European Union and Protocol (No 2) on the application of the principles of subsidiarity and proportionality.

⁶ 56 pct. of the municipalities in France have less 500 inhabitants and 84 pct. in Spain have less than 5.000 inhabitants.

an assessment. The allowance can be used for home care services from the public or private sector and even a specific person selected by the elderly. The quality and coverage of the services are to some extent up to the municipalities in Denmark and Slovenia, while municipalities in the three allowance countries can add additional social services for elderly such as access to a daycentre and other social activities. The private sector provides the home care service in all countries, but it can also be delivered by the municipality.

3.3.2 What does the home care for elderly consist of?

The text box below presents, what kind of services the home care service includes with a covering example from Slovenia.

Textbox 6: Home care service for elderly, Slovenia

Scope: Home care assistance and its scope shall be adapted to the needs of each beneficiary. The home care service may cover the following types of assistance:

1. assistance with basic daily tasks such as personal hygiene including, assistance with washing, feeding, performing basic living needs, maintenance and care of personal orthopaedic devices,
2. household assistance such as delivery of one prepared meal a day, basic shopping, dish washing, basic cleaning of living area, removal of waste including basic maintenance of the sleeping area,
3. assistance in maintaining social contacts such as establishing a social network, volunteers, and kinship, monitoring of the beneficiary and contact to institutions about their situation and any deterioration.

Source: www.gov.si/teme/pomoc-na-domu

The textbox presents the *de jura* situation as it follows on the government's home page on home care (pomac na domu), while the standard varies between the municipalities according to finance and priorities often with a higher coverage and better service of the elderly in the urban areas.

The scope of the home care for elderly is indeed similar in the other four countries, such as in Denmark, where the Service Law specifies that home care for elderly consists of: 1) personal help and care, 2) help or support for necessary practical tasks in the home and 3) food service (for a fee).

The quality of the service varies, however, substantially, as home care is delivered with substantial variations in quality between regions such as in Italy and Spain with autonomy provided to regions, and between municipalities in Slovenia and Denmark according to their financial situation and priorities. In Slovenia 58 municipalities of 212 provide only the service in the morning on weekdays; private providers do not exist in all locations, and the payment across municipalities and providers varies from free to EUR 8.43 per hour.

3.3.3 Legal basis

The provision of home care and the allowances are based on certain legal framework:

Textbox 7: Relevant legislation on home care service

Denmark	The Service Law. Chapter 16. The municipality provides assistance to 1) personal help and care, 2) help or support for necessary practical tasks in the home and 3) food service (for a fee).
France	The 2015 Act on adapting society to an ageing population. It includes more prevention.
Spain	Law on the Promotion of personal autonomy and care for dependent persons – LAPAD, (Act 39/2006)
Italy	Provincial legislation on social services and the CA legislation.
Slovenia	The Social Security Act 2007 with amendments. Several laws exist, including in relation to war veterans, so different routes to social care exists, which some overlaps. For example, the service

	provided and a social benefit. In late 2017 a Draft Act on long term care (LTC) was prepared, but it lacked criteria for placing recipients in different care categories according to health condition.
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3.3.4 Service delivery model

The service delivery mode varies substantially from the allowance countries to the municipal countries (Denmark and Slovenia). The eligibility for an elderly follows in all countries a need-based assessment, which in Denmark and Slovenia only exist in details at the municipal level. Below is presented the French personal autonomy allowance (APA) model.

Table 5 The French APA (personal autonomy allowance) model

Eligibility criteria	The beneficiary is at least 60 years old. Mid to high level of dependency according to the national assessment grid: the Autonomie Gérontologie Groupes Iso Ressources (AGGIR), which distinguishes between six levels of dependency into three cluster. The assessment is carried out by health specialist at the departmental level.
Information	Coordination centres (CLIC) with webpages at departmental level support elderly people and their families to identify existing support opportunities and locate the information they need for services.
Contribution from beneficiary	Proportional to the level of income: Below a monthly income of EUR 800: no contribute to the funding of the care plan. Above EUR 2945 of monthly income: contribution of 90% of the funding.
Amount of the allowance	Cat. 1: Up to EUR 1,713 monthly Cat. 2: Up to EUR 1,375 monthly. Cat. 3: Up to EUR 931 monthly. Cat. 4: Up to EUR 662 monthly.
Number of beneficiaries	1.25 million beneficiaries in 2015. Likely increasing to 2 million in 2040 with the same eligibility system. 60% of APA recipients live at home; 40% in residential homes. 45% have been assessed at mid-level. 50% are more than 85 years old. 3/4 are women.

Source: ESPN, 2018 France p. 6

The critical issue with home care service as opposed to many other municipal services is, that it shall be provided based on individual need for fairness and to control the level of the expenditures. In the French model, this is based on the so-called Autonomie Gérontologie Groupes Iso Ressources (AGGIR) groups, which are presented below.

Table 6 The French disability assessment grid (AGGIR)

GIR 1-2	Heavy level of dependency
GIR 1	People immobilized in bed or in the chair and whose physical and mental abilities are totally impaired.
GIR 2	Immobilized in bed or chair, mental abilities are partially impaired with need for help for most of the activities of daily living, as well as constant monitoring. Mental abilities are impaired but are still able to move and therefore need constant supervision.
GIR 3-4	Moderate level of dependency
GIR 3	Mentally relatively autonomous but suffer from physical impairments and need assistance in their bodily care at several times of the day.
GIR 4	Physical problems but able to move around in their home once out of bed. Need help or stimulation for washing and dressing but can usually eat autonomously. Without movement disorders but with need for assistance for bodily care and meals.
GIR 5-6	Weak level of dependency

GIR 5	Need for occasional aid for washing or homework.
GIR 6	Autonomous older people.

Source: Peer Review on “Germany’s latest reforms of the long-term care system” DG Employment, Social Affairs and Inclusion, EC January 2018.

The other countries are using similar models with categories:

In **Spain** eligibility to the System for Autonomy and Care for Dependency (SAAD) is determined by an assessment of the degree of dependency, evaluated by a qualified professional, and based on interviews and direct observation of the person in everyday environment. The degrees of dependency are determined according to the frequency and intensity of the assistance required:

- i) Moderate/Degree I: Intermittent support at least once a day.
- ii) Severe/Degree II: Extensive support two or three times per day; and
- iii) High Dependence/Degree III: Indispensable and continuous support several times a day. Once an individual has been assessed as being in need of care, an individualised Care Plan is prepared by the social services, including a list of appropriate services or cash benefits according to the degree of dependency.

If granted in Spain, the allowance for home care can be used for a specific person as carer, a private company, or non-profit providers for home care. The allowance ranged from EUR 300 to EUR 715 per month for personal assistance or for the purchase of the service. Another SAAD allowance covers informal care, from a relative, which is not always accounted for by the elderly. In 2018, it ranged from EUR 153 (degree I) to EUR 387.64 (degree III) per month. There is a certain waiting list (34 pct.) for the allowance due to the cut on public expenditures in Spain after 2010.

In **Slovenia**, the elderly (or the relatives) fills out a special request form for home care and submits it to the relevant municipal Centre for Social Work. Thereafter a social worker visits the person in need for an assessment of his/her situation and the service is defined.

In **Denmark**, a home visit is offered to everyone above 75 years of age by municipal staff. The visit is also offered to persons between 65 and 74 years in a special risk group e.g., without a spouse or close relatives. Persons above 80 years are offered a visit on a yearly basis. Municipalities can also organise public arrangements to attract elderly that decline visits to their home. The visit focuses on four elements: preventative measures, rehabilitation (after hospital treatment), home care help, and residential homes for the elderly. The amount of home care is initially decided by a municipal case worker after a home visit. On average 3.5 hours per week were allocated for home care in 2019.

The **Italian** ‘companion allowance’ (CA) amounted to only EUR 515 per month for all (2017) once health care authorities have approved the beneficiary for the allowance. The use of the monthly allowance is not accounted for by the elderly, so it may not always be used for care services. Clearly this allowance will not be able to finance home care services for beneficiaries with a higher degree of disability. This is probably the main reason why informal care is dominant in many parts of Italy.

3.3.5 The importance of the informal care system

As presented above in section 3.1 different traditions for home care exist in the EU countries with more institutionalisation and formal care provision in the north and central Europe and more informal and family-oriented care in the south and east. In Slovenia, it is estimated that about 13 pct. of 65+

are in informal home care, while only about two pct. are provided with formal home care. Elderly do often not receive home care service because of high user payment; non-availability of service providers and because a strong tradition exists for families to take care of their elderly.

The informal cares are generally mitigating strong pressure in the EU on expenditures for elderly services and some focus has emerged on how to maintain the informal element of the long-term care. In none of the five countries, the availability of family members or relatives is a formal criterion for the assessment of the need for home care to elderly. However, when a social worker assesses the need for the service in an interview with an applicant, the existence of help from relatives may reduce the actual number of hours for home care provision. This is the case according to municipalities in Belgium and Poland, while the allowance countries and Denmark are not affected by existence of informal help when the service is assessed.

Therefore, it would mitigate increasing care costs to support the informal carers without bringing them into the formal system. An instrument used to support the informal carers is to allow relatives to take a leave from their regular work to cater for care of their relatives during a specific time. This exists in all four countries (except from Slovenia) but only for relatively severe cases as exemplified by the Italian model.

Textbox 8: Care leave, Italy

In Italy care leave, which is fully compensated and receives pension coverage, is granted for public and private employees who have to care for severely disabled relatives or children; according to the principle of the 'sole carer', which means that no more than one worker in a household has the right to care leave as a carer for a severely disabled person. 3 working days of paid leave (at 100% of the last salary) per month; and up to 2 years of paid leave (at 100% of the last salary, but within an annual ceiling – EUR 47,446 in 2016).

Source: ESPN, 2018, Italy p. 8

The challenge with the informal care system is that it may result in some abuse of non-registered workers as presented in the textbox below.

Textbox 9: Migrants in informal care provision

In Switzerland, care migrants (mostly from Eastern Europe) are often not protected by labour law and do not have formal qualifications for dealing with diseases, and with the demanding context of fulltime care services. They are vulnerable to exploitation. Recently, the Swiss national parliament and cantonal administrations began to address these problems.

In Italy and Greece, most migrant care workers have irregular contracts, and the quality of their employment conditions is low. In Greece unskilled female migrant carers are often hired by the dependent's family on the basis of an oral agreement and not of a formal employment contract.

In Poland, migrant carers (typically from Ukraine or Belarus) are not monitored, are paid fully out-of-the pocket and typically not registered, contributing to creating a grey zone in the economy.

In Spain and Cyprus, migrant domestic helpers primarily engaged in domestic work provide informal care to dependents without having the required training for care. In Austria "24-hour care" at home is almost entirely provided by migrant workers, mainly from Slovakia and Romania. It has been legalised since but the rules in place still provide a framework for unfavourable and precarious working conditions, as well as for limited de facto access to social protection rights due to the wide take-up the self-employment status.

Source: ESPN, 2018 p. 33

In Denmark, a beneficiary can select a specific person to take care of them, but only if the person is hired formally by the municipality. This provides a better control on the expenditures and the service, but at the same time it might increase costs by bringing the informal carers into the formal care system.

3.3.6 Financing of home care for elderly

In the five countries home care for elderly is financed from the general public revenues of the public sector, social funds, and user payment as follow from the table below.

Table 7 Financing of home care to elderly

Country	Financing
Denmark	General municipal revenues (taxes, general state subsidy) and a fee for food service.
Spain	On average the SAAD is financed with 63% by the regions, 17% by central government and 20% by co-payments.
France	The departmental level (70%) and the national solidarity fund for autonomy – caisse nationale de solidarité pour l'autonomie, CNSA (30 pct.). And some user payment.
Italy	The CA is managed by the National Institute of Social Security (INPS) and financed through general taxation.
Slovenia	General municipal revenues with 30-50 pct. user payment.

Source: ESPN, 2018 Denmark, Spain, France, Italy, and Slovenia.

Except from in Denmark, the beneficiaries provide payment for the service including in the municipal model in Slovenia, where the user payment ranges from free to EUR 8.43 per hour. The user payment in **Slovenia** is income related, with 10 income brackets, thus the full or partial exemption is determined on the basis of the ability of users (or their families) to pay for the service. Even if a person owns real estate (apart from where she/he lives) a lien can be made by the municipality for the payment. In the three allowance countries, beneficiaries are paying for the service with the allowance, and normally some user payment, if the amount is not enough to cover the service. In Denmark, the service is free for all except for the meal service.

The finance model in all five countries depends on general public funding as opposed to financing models for curative health systems, that rely more on contributions to public or private insurance systems. Therefore, the increase in the costs in the coming years with the same service level, will mean a strong pressure on the public expenditures as user payment will only finance parts of the increase.

In **Spain** various levels of public funding for the SAAD exists, which permits some localisation: a) the minimum level, which is the same throughout the country (financed by central government); b) the supplementary agreed level, (co-financed central government and regions); and c) the additional level (financed by the regions). Thus, each regional government may establish a wider set of benefits for its residents.

3.3.7 Coordination and cooperation

Coordination and cooperation within and between relevant parts of the public and private sectors are key for good service delivery within home care for elderly. The clearer the division of functions

between different levels of government, the easier is the coordination. In the allowance model, it is not clear what can be expected from municipalities in terms of additional social services.

Public private partnerships (PPP) to develop home care jointly by the public and private sector can result in better standards and understanding of the peculiarities in the sector for the private providers. The experience from several Danish municipalities show that traditional tender processes may result in poor service delivery, complaints, and a troublesome service delivery.

In general, the coordination between the responsible public unit, the service providers and hospitals (regional level) is central in relation to coordination for rehabilitation of elderly in their home after hospitalisation, which will be related to the home carer in any case. In **Denmark** municipalities are establishing public health centres/units to coordinate this critical link, which are also focusing on general prevention measures to keep the elderly in shape in their own homes. The link to the providers for home care is critical as special attention is often needed after hospitalisation. Municipalities in Denmark also cooperate with the nationwide interest organisation for elderly, DaneAge Association on voluntary arrangement and the development of the sector.

The service provision standard is also coordinated between the Danish Municipal Association (KL) and the government (Ministry of Social Affairs) in regular meetings, which sometimes include a yearly agreement as part of the general agreement between the Government and the Municipal Association.

In **Spain**, the Interterritorial Council of the System for Autonomy and Care for Dependency has been established with the central government and regions to agree on the framework for intergovernmental cooperation and to avoid fragmentation. It deals with such issues as the intensity (frequency) of the care services, the terms and amounts of economic benefits, the criteria for co-payments by beneficiaries, and the scale for the recognition of dependency. The provinces also coordinate with the existing municipal daycentres and with formal and informal carers.

In **Slovenia**, where the primary health care system (health centres) is under municipal responsibility, a solid coordination on rehabilitation and prevention is ongoing in some locations with the home carers and in particular in urban areas.

3.3.8 Private sector involvement

EU treaties and regulations have a crosscutting impact on national legislative frameworks and the distribution of functions across levels of government. The distinction between 'Services of General Interest' and 'Services of General *Economic* Interest' has been a source of some controversy. According to the Amsterdam Treaty (1997) and the EU Services Directive (2006), EU single market barriers should be removed, and Services of General Economic Interest are prone to distort competition when subsidized or directly delivered by public authorities. The EU Services Directive implies that public authorities in general should leave the provision of public utilities and services to market forces and just focus on enabling the fulfilment of tasks related to the common good by the appropriate (private business) providers.

In the five countries the private sector is highly involved in the delivery of home care services and systems are set up, which give the beneficiaries some degree of free choice between private and public service delivery.

In **Denmark**, the beneficiary can decide for a provider from a municipal list with prequalified companies with at least two options. One of these may be the municipality itself. The private service is often developed in a private public partnership to ensure the quality and to monitor private operator closely⁷. A beneficiary can also propose a specific person as provider, who will be hired directly by the municipality.

In **France, Spain and Italy** prevail similar options for the application of the allowances for elderly care. In Spain, the SAAD allowance can either be given within the formal care system for: i) hiring personal assistance from a self-employed worker approved by the Social Security (regional level) with proper documentation for the payment to the caretaker or ii) through an accredited company (cooperative, private company etc.), which will be in charge of managing the service including providing an invoice to the user. Finally, iii) the benefit can be used for personal assistance provided privately, which could be a relative. In the Italian system it is relatively free how the allowance of EUR 515 per month is used once the companion allowance' (CA) is approved by the National Institute of Social Security.

3.3.9 Local priorities and challenges

Municipalities and subnational governments (departments, provinces) in countries selected for this assessment – and in the EU in general have responsibilities for home care for elderly, but due to the increasing number, and relative share of elderly, it is difficult to continue covering all assessed eligible for the service following the existent standard. The coverage has also declined in all five countries after 2010 and in **Spain**, a waiting list exists with about 34 pct. of the eligible for the SAAD.

In parallel, citizens are expecting high standard for public services, which complicates the service delivery even more. Finally, it is difficult to recruit social workers and the existing social staff is aging in several countries; the elderly sector is not a high priority for the younger jobseekers.

The EU Acquis and several EU countries including Denmark and France are therefore emphasising application of preventive measures to improve the general health of the elderly in coordination with public health policies for better nutrition and healthy living. This is done to improve the life of the elderly, so they need less home care and are able to live longer in their own home. In general EU countries prioritise home care to residential homes as home care is more economical and experiences show that the health of elderly deteriorates quicker in a residential home relative to in their own home.

After a large reform in the **Danish** municipal system from 2004 to 2007, the need assessment for home care service changed to a broader approach with inclusion of preventive measures, rehabilitation and more focus on home care as opposed to residential care. The main principle is to keep the elderly in his/her own home as long as possible with the application of assistive and personal orthopaedic devices and more digitisation. Municipalities are also increasingly involving voluntary organisations and others to support the elderly e.g., with activities and 'visitor friends'. The EU also recommends this broader approach. Involvement of NGOs and volunteers is also a priority in the other four countries and has during the COVID-19 pandemic demonstrated its relevance for emergency services like basic shopping and provision of basic meals.

⁷ As part of the *free municipality* experiment in Denmark, 10 municipalities have decided to provide the homecare service themselves as privatization according to the municipal council is too troublesome.

In **France**, 24 departments (of 96) are piloting a yearly conference focusing on prevention. It gathers institutional and professional actors involved in the elderly care sector to understand the needs of the 60+, to identify local initiatives, and to define a coordinated programme to finance individual and collective action.

3.3.10 Digitisation and innovations

Digitisation is important to improve the home care for elderly and simultaneously save costs. The public sector in the five countries provides webpages with information and in particular the Slovenian webpage www.gov.si/teme/pomoc-na-domu/ is designed in an interactive way with individual lock-in and information about all social services. In **Spain**, some municipalities offer tele-assistance on a daily basis for elderly with a lower degree of dependency. This can for instance be used to elderly that live alone as a daily check-up/in on any emerging needs. It can also be used to plan visits more effectively according to daily needs that shift quickly.

In the home care service sector several assistive and personal orthopaedic devices are emerging, which can support the provision of the services and the elderly in their home. Virtual communication including telemedicine⁸ and telecare are important tools with increasing application during the COVID-19 pandemic.

At the organisational level, some municipalities in Denmark have experienced better and more flexible service delivery by allowing self-managed team for planning instead of traditional management with detailed route planning. This allows that an elderly can postpone a visit to the next day, so better care can be provided to another elderly, which may have specific needs the same day. The private sector can also be more dynamic to implement new kinds of delivery models, but sometimes at the expense of the quality, which was seen in the Danish case mentioned in section 3.3.8.

In **France** home tele-assistance exists for elderly with a moderate degree of dependency (level 1). It covers advice via the internet, alert system, monitoring system, etc.

In **Italy**, an interactive portal is established <https://www.inps.it/> with social services and individual lock in for the beneficiaries. Other countries have similar webpages.

3.3.11 Quality control and monitoring

The quality control of the delivery of home care to elderly is done by specifics on what to deliver in each home, during which days and times and to what degree. This approach is sometimes rather rigid and inflexible in relation to the actual need of the elderly. In **Spain**, the Interterritorial Council of the System for Autonomy and Care for Dependency, CISAAD sets criteria with respect to staff qualifications, minimum care worker-to-recipient ratios and material resources, equipment and documentation to ensure a better quality.

Of high importance is the quality of the staff that are delivering the service and many home care workers are not trained formally. Countries are therefore setting up systems for short term or medium-term training. In **Denmark**, an education as social and health worker with a duration of two

⁸ Telemedicine is the provision of health care by using electronic information and telecommunication technology. It is done similarly for homecare by virtual platforms on smart phones or other devices.

years exits, but many of the trainees end up at hospitals or in other social services than home care. The Social Protection Institute of the Republic of **Slovenia** (SPIRS) organises courses for informal carers free of charge and training is arranged locally.

At the overall level countries should monitor the delivery and the satisfaction of the beneficiaries in surveys or by regular statistics. Surveys or collection of statistics are however not carried out on a regular basis except from in Denmark and Spain. The following indicators can be found in Statistic Denmark.

Table 8 Indicators from Statistic Denmark on home care for elderly

Data and details	Method	Timing
Quality of help: User satisfaction with practical help/personal help in own home/nursing home	Survey	Bi-annual
Stability of help: User satisfaction with the stability of help	Survey	Bi-annual
Number of helpers: User satisfaction with number of helpers	Survey	Annual
Number of referred and delivered home help	Register	Annual
Number of hours of, respectively, personal and practical help	Register	Annual
Number of recipients of practical help/personal care covered by free choice	Register	Annual
Number of hours of, respectively, personal and practical help under free choice	Register	Annual
Number of preventative home visits	Register	Annual
Number of visits and number of citizens receiving a visit	Register	Annual
Number of home help recipients who change provider	Register	Annual
Number of home help visits held as scheduled	Register	Annual

ESPN, 2018 Denmark. P.11

These data allow a solid monitoring of the home care for elderly and can also be broken down to municipal level. The information is used actively by the elderly organisation such as DanAge and the press.

In Spain www.imenso.se provides the following key indicators, which also provide some indication of the service delivery although in quantitative measures.

- SAAD beneficiaries as a proportion of the total number of persons entitled to benefits in SAAD (in %),
- Number and percentage of beneficiaries receiving LTC in-kind and/or cash benefits,
- SAAD beneficiaries as a proportion of the total national population (and the total population of each region) (in %).
- SAAD beneficiaries aged 65+ as a proportion of the total Spanish population aged 65+ (in %).

3.3.12 COVID-19 pandemic and emergency

With the outbreak of the COVID-19 pandemic a strong need for coordinated actions emerged between the health sector and the home care services, so beneficiaries and carers could be protected from the disease. Simultaneously, the elderly still needed home care and in particular the weakest and those without solid contact to relatives. The advantages in the countries, where municipalities are in charge of home care are that they can react swiftly and locally with alternative solutions and involvement of voluntarily organisations and relatives to the elderly. Meanwhile in the allowance countries responsible bodies are further away and not involved directly in the service delivery.

In general, with the COVID-19 pandemic outbreak, countries have initially centralised with the prime-minister offices taking the initial lead in coordinating the efforts, restrictions, and policies in the five countries. This mainly meant ensuring an effective collaboration among health actors and across other relevant sectors including education, sanitation, law enforcement, and between different levels of government, and non-government stakeholders. They followed the EU and the World Health Organization (WHO), which took a lead in guiding the national governments. Lower level of the governments including provinces, departments and municipalities have implemented the decisions.

The role of municipalities in an emergency situation with home care to elderly is to localise national plans and actions and during the COVID-19 pandemic to ensure that the service is delivered with due considerations for the security of the elderly and the staff. This means primarily provision of security equipment (masks and gloves and frequent testing) and shifting to more telecare and emphasis on social distancing.

Since the out bread of the COVID-19 pandemic in late 2019, actions to control and combat the spread of COVID-19 have been a high priority in municipalities in the EU countries. The pandemic initially affected the delivery to elderly in their own home due to priorities for containing the pandemic, but in general the municipalities have taken care of the most needed. This has been in cooperation with relatives and volunteers as in Slovenia and Italia, where the informal carers have overtaken some of the formal services. NGOs and volunteers have supported by e.g., doing basic shopping for elderly and some food services, which was also the case in Denmark. However, in general in the EU with increasing quantity of information on national and municipal webpages on protective equipment (gloves masks etc.) and more testing, the home care service has been re-stored including with more telecare.

This localisation of the emergency is illustrated by the political agreement about reopening of Denmark from April 2021, where municipal councils are provided with more authority to regulate activities as they are closer to the local situation and can act quickly:

“It is about being able to act quickly and safely in the event of local outbreaks. Sometimes it can be an advantage that we as a municipality can act without having to ask the central government for a permission. We can handle that responsibility as we are elected democratically and locally. And we are used to making big and small decisions for the city. But it must of course rest on a health professional basis, so we must of course be able to draw on agencies and authorities”. (Peter Rahbæk Juel, Mayor of Odense, 23 March 2021, translated from Danish).

4. Good practices for development of service provision standards for home care for elderly

4.1 Service standards

Clear service standards are significant for municipalities to manage, develop and enhance the quality of the services provided. The standards are critical for linking expectations of citizens and responsibilities of municipalities to service provision. As follow from the previous section, countries agree, in general, about what home care service to elderly should entail, but the quality and coverage of the service vary from country to country and within subnational units. The model is typically based on overall public finance from a small standard allowance (Italy) to free delivery of the good (Denmark and some municipalities in Slovenia). User payment also exists with substantial differences. Section three also provides information on different standards, which can be developed by going through the steps presented in the box below:

Textbox 10: What is a service standard and how can it be developed?

A local service standard should clearly define what a citizen can as a minimum anticipate for the delivery of a specific service. The delivered service might be better, but it cannot be worse. Local service standards should, as a minimum requirement, include quality (quantity), time (when) and cost (fee rates), when being provided to a client. In order to develop the service including the standard and later its implementation, the phases below could be followed:

1. Definition of the minimum service
2. Eligibility criteria (assessment of need for the service),
3. Preparation of legal framework for the provision of the service,
4. Establishment an organisational structure to provide the service,
5. Measures and options to involve the private sector,
6. Involvement of relatives, user groups and organisations,
7. Provision of uniformity and coherency in service delivery,
8. Estimation of service costs,
9. Development of principles to measure quality of service,
10. Development of methods for measurement, monitoring and assessment of the service performance,
11. Establishment of necessary mechanisms in solving challenges with the provision of the service, and
12. Systems for complaints, feed-back and evaluations.

Some of these steps are already partly defined by the existing national context and it might be more about accommodating standards within existing framework such as available finance and legislation than developing all 12 steps all over.

4.2. Best EU practices for home care for elderly standard

As follow above practices for home care for elderly vary in the five countries. The service delivery models depend on issues such as the political economy, national preferences, traditions for social in cash benefits, free choices, a decentralised or more centralised welfare state, and involvement of the private sector, relatives and CSO. The traditions with focus on the formal delivery system and the family/relative based informal system is also important.

The EU Charter of Account only specifies that: *The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life.*

According to EU Acquis services should be delivered with involvement of the private sector, but clearly individual countries in the EU have opposed to this model to allow for at least a combination of private, voluntary, public and individual providers. Furthermore, the market is failing as private providers are not available in all locations or cannot deliver the service properly.

Therefore, it is indeed cumbersome to define what best practices in the EU are. Rather the service should be delivered according to the best fitting into the national and local context and the social system that already exists. The present study provides examples of relevant and sensible practices that can be used for the delivery of home care to elderly in different contexts, which will not be repeated fully here.

In what follows is mainly presented some guidance of five incremental levels of how home care for elderly can be delivered; considerations on development of assessment systems for eligibility to the service; the importance of the informal care system and some considerations on co-payment and expenditures management.

4.2.1 Home care for elderly standards

At an overall level, the home care for elderly service practice presented in the report could be categorised into five incremental standards:

1. **The basic package** with the three elements: 1) personal help and care, 2) help or support for necessary practical tasks in the home and 3) food service. This is delivered in all five countries, although the quality and coverage vary, and delivery is intensive from the informal sector.

2. **Better quality and coverage of the service.** The intention is to provide the subnational level with tools to improve the service according to local priorities and resources, while still following the basic package.

The Spanish model for SAAD is in principle an example of a decentralized system, which ensure a basic level: a) the minimum level, which is the same throughout the country (financed by central government); b) the supplementary agreed level, (co-financed central government and regions); and c) the additional level (financed by the regions). Thus, each subnational government may establish a wider approach and set of benefits for its residents.

3. **Integration of prevention measures.** This is the third level with the addition to focus on keeping the elderly in better shape and sustain the ability to live in their home. It includes exercises, better nutrition, and may cover social events with other elderly such as in an elderly centre etc.

4. **Retraining and rehabilitation.** This includes more coordination with the curative health system for an integrated approach with rehabilitation after hospitalisation as part of the service.

5. **Fully integrated approach.** This is an integration of all four steps, similar to the long-term care concept by the EU. The integrated approach is explained by WHO (2016) as:

“Integrated care is a concept that focuses on more coordinated and integrated forms of care provision in response to the fragmented delivery of health and social services. It is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The

goal of these methods and models is to enhance quality of care, consumer satisfaction and system efficiency by cutting across multiple services, providers and settings”.

In Denmark municipalities describe in detail, what can be expected from home care to elderly. As part of the overall services within municipal health and care to elderly, Gladsaxe municipality (70,000 inhabitants) has developed a catalogue with the purpose “ to describe the politically decided level of service for health, prevention, rehabilitation, training, nursing and aids for all Gladsaxe Municipality's citizens, including adults with special needs and 65+.”⁹ For home for elderly 20 pages (of almost 300) provide details on *personal aid and care* and *practical help in the home* including cleaning, shopping and food service. Thus, the standards are described closely.

4.2.2 Assessment for eligibility

A good assessment system for eligibility is needed for fairness and to design and provide the specific service for each group of individuals according to their degree of disability - one size does not fit all. This is also important for transparency and to manage expenditures. The French model in section 3.3.4 is an example of an assessment with several degrees of disability and indication on how much home care to provide for each degree. It could be argued that more categories are needed for a more comprehensive, applicable, and fair model. The Belgium municipality of Zoersel operates e.g., with 18 categories.

4.2.3 The informal care system

The eligibility criteria for home care should not depend in the availability of informal carers (relatives). Rather, the informal carers should be supported by the public sector to continue the care. They should be acknowledged, and home care should be planned with them, so it will be some kind of partnership with relatives. Support from the formal system could be provided, so vacation and periodic relief periods are possible, when the relative is occupied or incapable. Formal care should also be provided for specific services that the relative cannot provide such as when the care gets more comprehensive. Relatives could also be offered short term training for free.

4.2.4 Co-payment and the increasing share of elderly in the EU

Following the EU charter above, all elderly in the EU should be able to afford the provision of home care services according to their degree of disability and income. In the five countries free service is only guaranteed in Denmark, while the other countries have some systems for user payment, at least in some parts of the countries or, if the allowance provided cannot finance the needed service as in Italy, for those with a higher degree of disability.

The challenge with free service for all is, however, that it might result in a high pressure on the expenditures for home care for elderly as the elderly's relative share of the population increases in all countries in the EU.

Basically, two options exist:

1. Adjust the user payment according to the income and wealth of the beneficiaries. This is fair, but also complex as it might provide an incentive to spend wealth, under-declare or hide income and wealth. It is also only possible if solid; reliable and transparent income and wealth statistics exist. The scale with ten income brackets in Slovenia for user payment is an example, which can be developed further.

⁹ Quality Standard – Health and rehabilitation, Gladsaxe 2021 (Kvalitetsstandarder sundhed og rehabilitering, Gladsaxe 2021). Quote p. 6. The catalogue has almost 300 pages.

2. Provide the service to all in need and adjust the revenue sources of the relevant subnational level accordingly. This will however imply more taxes and/or payment for other services.

The pressure on the public expenditure for home care for elderly will remain in the coming years, and countries need to control expenditures, which can also be done by reducing the service level.

Welfare technologies such as assistive and orthopaedic devices are increasingly available, which can save costs and improve the service to the elderly. Telecare can also be applied more, as during the COVID-19 pandemic, with application of electronic information system and telecommunication technology including smart phones and other devices. This tool can support a more flexible and user-oriented service. Below are presented the typical technologies applied in Danish municipalities from a study conducted by the Danish Association of Municipalities (KL).

Table 9 Welfare Technologies in Danish municipalities

Self-monitoring / motivational technology: Technologies for measuring or visualizing own progression such as apps that motivate for training, measures blood pressure or tracks physically activity.	Mobility technology: Lifting chairs, walkers catapult seats, ceiling lift.	Screen visit: Video solutions for virtual or online housing support apps, tablets.	Eating / meal technology: Dining robots, robot arms / armrests 3D-printed food.
Sensory technology: Lighting, circadian rhythm light. Sound and music therapy, robot pets. Stimulation games.	Telemedicine: Digital cross-sectoral solutions. Printing conferences, telemedicine for e.g. heart failure.	Security-Creating technology: GPS systems, sensor floors, locks / alarm systems. Smart home technologies, voice control.	Bed technology: Mechanical nursing beds, reversible layers, sensor mattresses.
Medication management: Automatic dosing machines. Reminder solutions.	Social technologies: Chat bots, online communities, virtual visitors, telepresence robots.	Cleaning and service technology: Robot vacuum cleaners, service robots (waste, laundry), disinfectants, floor cleaners.	Planning technology: Screens and information boards for planning citizens' daily lives and for optimization. Structure apps, watches, etc.

Source: Velfærdsteknologi i kommunerne, KL 2020 p. 10

5. Conclusion and Recommendations

Among the five countries assessed the national legislation provides more or less the same basic elements in home care for elderly but the delivery models are very differentiated. The EU Acquis is not providing details on the provision of home care for elderly except from the human right aspect to cater for the dignity and the participation of the elderly in the society.

The municipalities are playing an important role in the EU for providing home care to elderly, and the regional level is highly involved in three countries (France, Italy and Spain) that are providing an allowance for home care for elderly with some degree of user payment depending in the service standard wished for.

As opposed to other municipal services such as waste management, public schools and childcare defining a standard for home care to elderly is broader as the need of the beneficiary is essential for an efficient and effective service delivery. This is done legally in Spain and France by dividing the elderly into different standard categories based on an evaluation by regional social staff.

The EU is mainly dealing with long-term care as a broader and more holistic concept than home care for elderly. This is increasingly incorporated into the Danish municipal model, where the aspects of rehabilitation and preventive actions are covered. The WHO is also arguing for a more integrated approach to social services for elderly.

The COVID-19 pandemic has challenged the delivery of home care to elderly all over the EU. COVID-19 emergency has been managed at the national government levels following WHO and EU guidance. National health authorities, institutions and municipalities involved in the service have develop guidelines for protection of the vulnerable staff and elderly, who were not attended properly immediately after the outbreak. In some cases, relatives or friends have stepped in to take care of the elderly. Telecare has also been used more along with telemedicine for the elderly.

As good practices in home care services for elderly it is recommended to:

- Establish system that are following national and local context and social systems,
- Allow some overall national minimum standard and opportunities for localisation according to priorities, opportunities, finance and need,
- Include rehabilitation and prevention in the home care service for elderly,
- Establish coordination with primary health for a holistic approach to elderly care,
- Allow and incentivise relatives and friends of beneficiaries to be involved in the provision of the service,
- Apply welfare technologies for rationalisation and to improve services, and
- Involve interest organisations, voluntary organisations and CSOs as partners in relevant preventive activities for the elderly.

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Annex B: Assessment of home care to elderly according to the EU Acquis and five EU countries

Area	EU Acquis	Five EU countries: DK: Denmark, FR: France, ES: Spain, Italy: I and Slovenia: SI
<p>Division of tasks central\local roles and responsibilities</p>	<p>Subsidiarity Principle. The service should be provided as closely to the citizens as possible with due consideration for economics of scale and the need for a broad financial basis</p>	<p>Denmark, DK (hjemmehjælp). Municipalities (98) are responsible for providing services to elderly in their home or in a retirement home. Municipalities are also responsible for prevention and rehabilitation of elderly after hospitalisation, while regions are responsible for the curative health system. Overall legislation for social services is developed by the central government, while municipalities adjust the service level according to priorities and resources.</p> <p>France, FR (soins à domicile). Municipalities (35,358 communes) have responsibility for retirement homes and some social welfare. About 20,000 municipalities have less than 500 inhabitants, thus the capacity for service provision is limited and therefore the responsibility is in practice shared with the departments. The 95 departments, with elected councils, are responsible for the personal autonomy allowance (allocation personnalisée d'autonomie) APA, which is paid to person aged 60 or more (60+) with need for assistance to accomplish daily living activities. The departments are responsible for social policy and the elderly care sector. The departments have a statutory obligation to define local policy orientations within their territory; finance and implement the national APA programme. This includes regulation of care services within their territory. In addition, municipalities can develop specific voluntary measures to support elderly.</p> <p>Spain, ES (cuidado en el hogar). 17 self-governing regions are autonomous with own statutes, and organisation of local governments vary substantially. 50 provinces are responsible for overall coordination of social services, while municipalities with more than 20,000 inhabitants (about 5 pct.) are responsible for social services. Spain has 8,131 municipalities of which about 6,800 have less than 5,000 inhabitants. The comprehensive System for Autonomy and Care for Dependency (SAAD) is mainly managed and agreed upon by the federal and regional level for a nationwide benefit. Municipalities provide in some case extra benefits such as the provision of daycare centres.</p> <p>Italy, I (cura della casa). Municipalities (7,960 comuni) provide home and residential care services, while the 20 regions provide curative health care. With autonomy granted by the Constitution or statutes, functions and organisations vary from region to region including in the two self-governing provinces (Bolzano and Trento). 110 provinces, 15 metropolitan areas and 7,960 municipalities (comuni) exist. As a result, the provision of home care services varies substantially. For the elderly, the 'companion allowance' (CA), is a cash allowance for individuals with severe disability, which can be used for home care. It is managed by the National Institute of Social Security (INPS).</p> <p>Slovenia, SI (nega na domu. 212 local authorities are responsible for social welfare including the provision of home care for elderly. Primary health centres are also under the responsibility of the municipalities. The Institute of the Republic of Slovenia for Social Protection is implementing the legislation and monitoring the service provision.</p>
<p>Coordination and cooperation with</p>		<p>DK. Solid coordination is needed within the municipal administration in relation to rehabilitation and prevention and with the interest organisation for elderly, DaneAge Association (about 15 pct of the Danish population are members). Coordination between municipalities and regions after hospitalisation is also needed. The expectations and development of the service are</p>

CG and other institutions		<p>coordinated between the Municipal Association (KL) and the government (Ministry of Social Affair) in regular meetings, which sometimes includes a yearly agreement as part of the general agreement between the Government and the Municipal Association.</p> <p>FR. Coordination between municipalities and departments is needed to agree on the service provided to the elderly including the formal and informal home care service providers. Coordination centres (centres locaux d'information et de coordination – CLIC) have been created since 2000 to help elderly people and their families identify existing support opportunities and locate the information they need. The PTA (territorial support platforms for coordination – plateformes territoriales d'appui) is established to coordinate health and social care perspectives and delivery. 24 departments (of 96) are piloting a yearly conference focused on prevention. It gathers all institutional and professional actors involved in the elderly care sector to understand the needs of the 60+, identify local initiatives, and define a coordinated programme to finance individual and collective action.</p> <p>ES. Provinces are coordinating with municipalities. Municipal daycentres coordinate with formal and informal carers on the moderately disabled, which they care for in their homes. The Interterritorial Council of the System for Autonomy and Care for Dependency with central government and regions agrees on a framework for intergovernmental cooperation, the intensity of services, the terms and amounts of economic benefits, the criteria for co-payments by beneficiaries, and the scale for the recognition of dependency.</p> <p>I. As competences are shared between municipalities and provinces coordination is needed between the two for any extra service provided by municipalities. The care system is fragmented and a need for overall coordination and coherence exists.</p> <p>SI. Coordination is limited between the health and the social system such as with transfer from hospitals to home and for rehabilitation. The local health centres coordinate with the home care service in the municipality as both are under the municipal level.</p>
Service delivery model including financing	<p>Allow for free competition.</p> <p>EU recommends home care over residential homes. It keeps the elderly in better shape with more responsibility for their wellbeing.</p> <p>EU recognises different model and traditions.</p> <p>In general, the population in the EU is aging, so it recognises that involvement of</p>	<p>DK. According to the Service Law, Chapter 16, the municipality shall provide assistance to elderly in their own home for: 1) personal help and care, 2) help or support for necessary practical tasks in the home and 3) food service (for a fee). The standard provided follows a need based municipal assessment.</p> <p>The beneficiary can decide for providers from a list with prequalified companies with a least two options. One of these can be the municipality itself, while the other must from the private sector. The service is often developed in a private public partnership to ensure the quality, that providers are monitored closely and understand the dynamics in the sector.</p> <p>A beneficiary can also propose a specific person as provider, who will be hired directly by the municipality.</p> <p>The service is financed by the municipality from its general revenues and provided free of charge. The main exception is food services where a user charge cannot exceed EUR 7 per meal or EUR 467 per month. The home care is provided in coordination with rehabilitation after hospitalisation with emphasis on keeping the elderly active and selfsustained.</p> <p>An education as social and health worker with a duration of two years exists, but many home care workers are not trained formally.</p> <p>FR. The home care is based on a free choice model on a cash-for-care scheme: the personal autonomy allowance (allocation personnalisée d'autonomie – APA). It is financed by the departmental level (70 pct.) and the national solidarity fund for autonomy – caisse nationale de solidarité pour l'autonomie, CNSA (30 pct.). The APA can be used for home care service or a</p>

	<p>organisations and relatives is important and to avoid further institutionalising of the service for elderly.</p>	<p>residential care institution. Services are mainly delivered by non-profit organisations and public social care services from about 535,000 home care workers. Private companies are entering the market, but still only cover less than 5 pct. A quality certification is required, and prices are established freely in a contract drawn up with the cared-for person. The care user can hire the care worker directly or the service can be provided by an administrator (in the department).</p> <p>ES. The System for Autonomy and Care for Dependency (SAAD) established in 2007 defines a universal right for all those who (regardless of age), can demonstrate stable residence in the country for at least 5 years and one of the degrees of dependency established in the Act (Moderate (1), Severe (2) or High Dependence (3)). The SAAD covers 62% of the population at 65+. A benefit can either be given within the formal care system for: i) hiring a personal assistance from a self-employed worker approved by the Social Security (regional level) with proper documentation for the payment to the caretaker or ii) through an accredited company (cooperative, private company etc.), which will be in charge of managing the service including providing an invoice to the user.</p> <p>iii) Thirdly and outside of the SAAD, the personal assistance service can be bought privately, without the need to have any degree of dependency recognized.</p> <p>The SAAD is financed by taxes from the central government and regions, and co-payments by beneficiaries, according to income and wealth, and the type of service received. There are various levels of public funding: a) the minimum level, which is the same throughout the country (financed by central government); b) the supplementary agreed level, (co-financed central government and regions); and c) the additional level (financed by the regions). Thus, each regional government may establish a wider set of benefits for its residents. On average the SAAD is financed with 63% by the regions, 17% by central government and 20% by co-payments.</p> <p>I. The 'companion allowance' (CA), is a cash allowance for individuals with severe disability. It covered 1.83 million in 2016 of which 78 pct. were 65+, thus 13.5 pct. of individuals 65+ received the CA in 2016. It amounted to only EUR 515 per month for all (2017), with no variation in terms of the level of disability. The cash benefit is provided once health care authorities have certified the disability of the beneficiary. The use of the monthly allowance is not accounted for by the elderly. The CA absorbed around 55% of all long-term care (LTC) expenditure in 2016. The CA is managed by the National Institute of Social Security (INPS) financed through general taxation. Admission is based on needs but also on income levels and co-payment exists. The criteria for access to home care are differentiated within the country, depending on the region and the municipality of residence, as well as the criteria for co-payment. Municipalities provide two main types of home care provision: support for daily living tasks (cooking, cleaning, etc.) and nursing activities, which covered about 1.2 pct of the 65+.</p> <p>SI. Persons entitled to home care for elderly are 65+ that need occasional help from another person and are incapable of fully independent living. The person in need fills out a special request form for home help, which is submitted to the relevant municipal centre for Social Work. Thereafter a social worker visits the person in need for an assessment of his/her situation and the services is defined. Home help is financed from the user's own income and the municipal budget. The user fees are income related, with 10 income brackets. Full or partial exemption from payment is determined on the basis of the ability of users (or their families) to pay for the service. When the user payment cannot cover the cost of the care provided, the remaining amount is paid by the municipality or central government. Between 30 and 50 pct. of the service is paid by the users. If a person</p>
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		owns extra real estate (apart from where she/he lives) a lien can be made by the municipality. The informal care system is dominating with a coverage of more than 80 pct. of the elderly. The organisation of the service varies from one municipality to the other. Around 10% of the population receive some kind of long-term care (LTC). The Social Protection Institute of the Republic (SPIRS) organises courses for informal carers free of charge and training is arranged locally. Leave system for informal care persons does not exist. It is considered to implement a special LTC levy.
Challenges	The increasing proportion of elderly and 80+. To develop a more coherent and satisfactory home care system within the EU with all the existing disparities.	DK. More elderly and increasing expectations from them and relatives. It is difficult to recruit social workers and the social staff is aging. The new public management is focusing on results measuring and management, while the issue might be turning 'cold hands' (i.e., management) into 'warm hands' (i.e., client-oriented work). Municipalities are experimenting with self-managed team instead of traditional management with detailed route planning.
		FR. Prevention of illness have only been prioritised lately. Total share of elderly (+65) will likely reach 1/3 by 2060. Only 1 pct. of GDP is used on elderly services. A need exists for professionalisation of the home care of the elderly. The care is moving from a family-based system to a public care system with increasing costs and increasing interest from the private sector.
		ES. Large variation in coverage across autonomous regions. A need exists for sustaining the service of the informal carers. Costs are increasing. The traditional system with families is still strong. Need to train NGOs as providers.
		I. A large part of the funding for LTC is spent on the companion allowance (60 pct), which is not necessarily spent on home or residential care. Strengthening of the integration between social system and health care is needed. This can be done by developing a unified and coordinated professional services in LTC provision. It includes better joint planning of activities between health authorities and local authorities' social services, and stronger connection between hospital and home care, especially for hospital discharges. Better registration on elderly without relatives is needed to provide care for them. The coverage of the homecare is higher in municipalities in the North than the South.
		SL. Rural areas frequently do not provide sufficient institutional care or home care, while urban areas tend to offer a wider range of services. There is no care leave system for long-term care of the elderly. It is estimated that 103,666 or 13 pct. of 65+ are in informal care. While about 21,612 are in formal care (2015). People do not take the service because of user payment in some locations.
Municipal provisions and standards	The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life. (EU Charter of Fundamental Right ART 25).	DK. A home visit to everyone above 75 years of age is carried out by municipal staff and a visit to elderly between 65 and 74 years in a particular risk group. Persons above 80 years are offered a visit on a yearly basis. Municipalities can also organise public arrangements to attract groups that normally decline home visits. Home care is provided according to the need identified in the visit and cover personal care, practical help and support, and food services. Personal care consists of help in maintaining personal hygiene, to get dressed, to get out of bed, and to eat. Practical help covers cleaning, laundering and shopping. Local politicians define the service level within these services according to their budgets. The amount of home care is initially decided by a municipal case worker after a home visit. The idea is to focus on four elements at the visit: Preventative measures, rehabilitation (after hospital treatment), home care, and residential homes for the elderly. On average 3.5 hours were provided in 2019 to the beneficiaries.

		<p>FR. The APA is provided to any citizen above the age of 60, who need assistance to accomplish everyday activities or who need to be continuously watched over. It can be used for home care or retirement home. If provided a specific ‘care plan’ is elaborated with a multidisciplinary team of professionals from the departments, which cover the needs, which are not taken into account by the (curative) health insurance system. The APA can be used for relatives, who are playing an important role in the care of the elderly. Homebased care is characterised by a low level of care worker training, although a diploma exists. Municipalities may provide additional services for the elderly on top of the APA.</p> <p>ES. The SAAD recognises specifically the right of the elderly for a dignified life. Eligibility is determined through an assessment of the degree of dependency, evaluated by a qualified professional, and based on interviews and direct observation of the person in his/her everyday environment. The degrees of dependency are determined according to the frequency and intensity of the assistance required: i) Moderate/Degree I: intermittent support at least once a day; ii) Severe/Degree II: extensive support two or three times per day; and iii) High Dependence/Degree III: indispensable and continuous support several times a day. Once an individual has been assessed as being in need of care, an individualised care plan is prepared by the social services, including a list of appropriate services or cash benefits according to the degree of dependency. If granted the allowance for home care can be used for a specific person as carer, private companies or non-profit providers for home care. Home care covers personal hygiene, basic shopping, a walk and food service. The allowance ranged from EUR 300 to EUR 715 per month for personal assistance or for the purchase of the service. The other SAAD allowance covers informal care, from a relative, which is not always accounted for by the elderly. In 2018, it ranged from EUR 153 (degree I) to EUR 387.64 (degree III) per month. There is a certain waiting list (34 pct.) for the allowance due to the cut on public expenditures in Spain after 2010.</p> <p>I. Municipalities provide two main types of home care provision: support for daily living tasks (cooking, cleaning, etc.) and nursing activities. Admission is based on needs but also on income levels: co-payments can be a relevant part. The criteria for access to home care are differentiated within the country, depending on the region and the municipality of residence, as well as on the criteria for co-payment. In many regions carers are financed by the companion allowance (CA) and hired directly by the beneficiaries without any certification etc. The informal service is often provided by immigrants. Some southern regions tried to developed care services for dependent citizens as part of an EU project.</p> <p>SI. Home care service covers according to the Ministry of Labour, Family, Social Affairs and Equal Opportunities the following: i) assistance with basic daily tasks (dressing, washing and basic living needs, maintenance of orthopaedic devices); ii) household assistance (a daily meal and basic shopping, house cleaning); and iii) assistance in maintaining social contacts and coordination with other public institutions.</p> <p>The service standard varies, however, from one municipality to the other. Because of the high degree of informal support, the model is not very comprehensive. 58 municipalities (of 212) only provide the service in the morning on weekdays and private providers do not exist in all locations. The fee for home care varies across municipalities and providers – from free to EUR 8.43 per hour. Many are reluctant to pay and use the informal system instead.</p>
Priorities		<p>DK: Holistic approach with prevention, rehabilitation, home care, residential care. Municipalities are increasingly involving voluntary organisations and others in activities for the elderly.</p> <p>FR: Prevention. Better support to informal care such as relatives. The right to unpaid leave is not sufficient. Involvement of NGOs in service delivery.</p>

		<p>ES. Provide a more equal system all over the country.</p> <p>I. Keep cost down and free choice. Better coverage in the South and a more equal system. Trento: better networking and alternative living forms with large family. Keep the elderly in their own homes.</p> <p>SL. It is a priority to allow the informal care sector (relatives, friends) to prevail.</p>	
Quality, monitoring and complaint.		<p>DK: 27 indicators for elderly at Statistic Denmark with 11 related to home care. The municipal Elderly Council is monitoring and working on the Municipal Dignity Policies since 2016.</p> <p>FR. DREES, the Directorate for Research, Studies, and Statistics and the National Institute of Statistics and Economic Studies (INSEE) – carry out quantitative and sometimes qualitative studies. However, the data is outdated and not collected regularly. An exception is the APA, monitored by DREES since 2002 with data on the number and profile of beneficiaries and on the type of care plans.</p> <p>ES. The Interterritorial Council of the System for Autonomy and Care for Dependency, CISAAD sets criteria with respect to staff qualifications, minimum care worker-to-recipient ratios and material resources, equipment and documentation. The Information System of the System for Autonomy and Care for Dependency (SISAAD) includes information on the requests for assessment, the assessments carried out, the claimants entitled to benefits and those actually receiving benefits per region and by type of benefit, the number of benefits per beneficiary and the profile of the beneficiaries, broken down by degree of dependency, age and gender. This information has been disaggregated monthly from 2007 to the present. It is provided on the www.IMSERSO.se. Some key indicators are: • SAAD beneficiaries as a proportion of the total number of persons entitled to benefits in SAAD (in %) • Number and percentage of beneficiaries receiving LTC in-kind and/or cash benefits • SAAD beneficiaries as a proportion of the total national population (and the total population of each region) (in %)20 • SAAD beneficiaries aged 65+ as a proportion of the total Spanish population aged 65+ (in %).</p> <p>I. QA is an issue and not covered systematically in particular for home care, where the informal sector is dominant, and the service varies from province to province. Statistics on the allowance CA is prepared yearly at https://www.inps.it. A new database on health and social services is planned called SIAD.</p> <p>SI. QA is mainly done by inspections. A survey from 2014 with 4,917 users of home care in 154 municipalities showed a high degree of satisfaction as 80.4% were happy with the amount of help provided. No systematic collection of national data exists, only from particular surveys. There is no overall quality control, and the system is rather diversified according to each municipality.</p>	
	Legislation	No particular directive, only the human right perspective.	<p>DK. The Service Law. Chapter 16. The municipality provides assistance to 1) personal help and care, 2) help or support for necessary practical tasks in the home and 3) food service (for a fee).</p> <p>FR. The 2015 Act on adapting society to an ageing population. It includes more prevention.</p> <p>ES. Law on the Promotion of personal autonomy and care for dependent persons – LAPAD, (Act 39/2006)</p> <p>Italy. Provincial legislation under the provinces and the CA legislation.</p> <p>SL. The Social Security Act 2007 with amendments. There are however several laws, including in relation to war veterans, so different routes to social care exists, which some overlaps. For example, the service provided and a social benefit. In late 2017 a Draft Act on long term care (LTC) was prepared, but it lacks criteria for placing recipients in different care categories according to health condition.</p>

Crises management		DK. The crisis management for home care for elderly was managed by municipalities with instructions from the National Health Authority. CSOs and others organised citizens who voluntarily conducted basic shopping for elderly.
		FR.
		ES.
		I. www.inps.it provides information on COVID-19 initiatives.
		SI.
Digitisation		DK. Borger.dk description of the service. And municipal homepages. Application of welfare technologies
		FR. Tele-service.
		ES. Home tele-assistance exists for elderly with a moderate degree of dependency (level 1). It covers advice via the internet, alert system, monitoring system, etc.)
		I. https://www.inps.it/ Is an interactive portal with social services and lock-in for individuals.
		SI. www.gov.si/teme/pomoc-na-domu/ provides full description of the home care service and how to apply. Including precautions because of COVID-19.
Awareness and implementation of international regulations	NA	DK. Awareness rising about the service is provided by municipal homepages and interest organisation such as DanAge (Ældresagen).
		FR. Coordination centres (centres locaux d’information et de coordination – CLIC)
		ES. Provinces and governments are implementing national system
		I.
		SI. www.gov.si/teme/pomoc-na-domu
COVID 19 experiences with service delivery	EU perspective on how some human rights have been broken.	DK. The service provided has been upheld. Staff has been instructed to apply mask and improve cleaning.
		FR. France has announced a bonus for care workers during the COVID-19 crisis (OECD, 2020).
		ES. Tele consultations are available with moderate disables. In Palma, the service was reduced due to fear from the elderly. Volunteers, neighbours, relatives supported the elderly with shopping. The family network was stronger than expected.
		I. The existence of a large informal sector is mitigating the effect of COVID-19 as families take over. Trento: The service was partly suspended until preventive equipment was organised. The municipality kept delivering.
		SI. The informal care support system took more over. www.gov.si/teme/pomoc-na-domu/ includes precautions because of COVID-19.
Actions plans and programmes from International organisations		WHO is arguing for a more integrated approach to services for elderly: “Integrated care Integrated care is a concept that focuses on more coordinated and integrated forms of care provision in response to the fragmented delivery of health and social services. It is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care, consumer satisfaction and system efficiency by cutting across multiple services, providers and settings” (WHO 2016).

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