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Socially investing in older people – Reablement as a social care policy response?

Tine Rostgaard
KORA – Danish Institute for Local and Regional Government Research

Introduction

According to the European Commission's recent policy initiative on social investment, Danish long-term care for older people offers new and innovative perspectives on ageing and the management of the risks associated therewith. Other EU member states are thus encouraged to "get to Denmark" and to develop their long-term care in accordance with the Danish approach. With the introduction of reablement policies (in Danish 'rehabilitering'), Denmark has, according to the European Commission, identified a viable way to address some of the problems associated with the presumed increase in the need for long-term care in ageing societies. The change from a so-called passive to a more "active" approach emphasises an overall strategy of "repairing," by offering short-term intensive physical training interventions instead of only compensatory care and assistance, as this should ideally enable the individual to postpone and reduce the need for care. This also ensures a more sustainable long-term care system in a time when otherwise the population of older people will grow, invariably increasing the cost of long-term care.

This paper will discuss the perspective of social investment and how the policy of reablement in long-term care falls within it, and then it will investigate whether the promises of reablement for creating a more sustainable long-term care system are realistic.

Why social investment?

The approach of social investment is not least an attempt to encompass new risks in post-industrial society, which traditional social policy has not been able to manager. As our societies change, our demographics, labour market structures, family systems and the social risks as we know them change. New social risks, such as lone parenthood or the need for care associated with ageing, were not considered in traditional social policy measures, such as unemployment benefits or pension benefits. As these social risks were increasingly acknowledged, the social policy approaches also needed to include measures that addressed such needs.

Tine Rostgaard is professor at KORA – Danish Institute for Local and Regional Government Research. Her main interest are studies of policies and practices of care for children and older people. Email: tiro@kora.dk.

The social investment approach gained particular momentum in the mid-1990s in Europe as it was realised that more money did not necessarily solve the problem. Inequalities in the population seemed only to grow, and intergenerational transmission of poverty and social exclusion was sustained, indicating lack of efficiency in social policy interventions. Despite an overall increase in social expenditure, we have witnessed visibly larger income inequalities in the 1980s and 1990s and a general increase in child poverty and in the 'working poor'. We have also witnessed increasing health inequalities. Additionally, the coming years are presenting even larger demographic challenges of fewer children being born and of ageing societies. Politically, in this period of time, the scene was set for fundamental reforms as the electorates in a number of European countries had supported left-wing/social-democratic governments who were now in charge of leading the (new) way. The overall conclusion was therefore that former neo-liberal and conventional social policy 'repair' policies had failed and that there was a need for new, sweeping changes.

From the perspective of social investment, the diagnosis is to view social policy not only as expenditure but also as a productive factor. Social policy is believed to be the foundation for globalised and knowledge-based societies, ensuring a continuous supply of highly educated workers, a flexible labour force and continued labour market participation. However, social policy also has a role of continuously enabling the individual to make use of his or her capabilities. There is a belief in that investing in the individual leads to higher productivity and economic growth. It requires focusing on the development of human capital, such as investing in high quality daycare for children and the right use of human capital, including ensuring that women and single parents can participate in the labour market. Likewise, there is a focus on the life cycle and on the future perspectives of the individual (Morel et al. 2012).

Active ageing

This tone is well reflected in the discourse of active ageing, which likewise emphasises the resources of the individual in old age. Despite obscurity in the definition and conceptualisation of active ageing, it has become a common policy discourse on ageing, and its promotion as a policy response to ageing societies is driven, in particular, by international organisations and states, especially the World Health Organisation (WHO), the Organisation for Economic Co-operation and Development (OECD), and the United States

(Moulart & Biggs 2012; Boudiny 2013). For example, the WHO saw active ageing as the continued participation in all aspects of life, "The word active refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force".

Within the EU, as well, the active ageing agenda has gained momentum as a discursive policymaking framework since 1999; and, over time, individual 'responsibilization' for managing and avoiding dependency has been increasingly emphasised, as expressed in the statement from the EC Newsletter Social Agenda from 2011 (quoted in Moulart & Biggs 2012, 9):

We need to enable older people to make their contribution to society, to rely more on themselves and to depend less on others and for this we need to create conditions that allow people to stay active as they grow older. "Active Ageing" promises to be such an approach because it seeks to help older people to: remain longer in the labour market; contribute to society as volunteers and carers; remain as autonomous as possible for longer.

While previous EU policy recommendations have especially focused on the productive aspects of active ageing, particularly in relation to labour market participation, the European Commission in 2013 addressed the social and economic returns of considering an active approach to long-term care as a social investment strategy in line with its recommendations for social investment in, for example, child care. The Danish reablement practice is recommended because it increases "the possibility of raising the overall quality of protection against long-term care risks" (European Commission 2013, 19). Thus, reablement is perceived as a risk-minimisation strategy, protecting the individual against the risk of old age and possible related dependencies, but it is also, and quite importantly, perceived as a policy tool offering a new capacity for the welfare state to more dynamically manage and address the societal risks associated with the ageing of populations.

Why we need a new long-term care system

The need for the EU Commission to accentuate a new approach to long-term care is, of course, not least reflected in the prospects of the looming ageing societies, and the fear of "the 'tsunami of geezers' that threatens to suck the life out of Western economies with their health and welfare needs" (Marshall & Katz 2012, 230). The expectation is that ageing societies will mean an almost doubling of expenditure for long-term care across EU member states, from the present average 1.8% of GDP to 3.6% in 2060 (AWG reference scenario). Some countries, such as Denmark, with already relatively high expenditure levels, are expected to spend as much as 8% of GDP on long-term care. (European Commission 2012.) If the expected costs for medicine and welfare technology are also included, expenditure levels are expected to increase even more (AWG risk scenario).

The variation in expenditure levels is not least because countries provide long-term care in quite different ways and with high variation in coverage rates. There is thus some difference in the proportion of older people receiving home care between countries in the North, such as Denmark, and countries in the South, such as Italy. (León, Pavolini & Rostgaard 2014.) However, what is also apparent where data are available for more than one year is that over time, an increasing number of people are receiving such services. This reflects the increasing recognition of ageing as a social risk and the political awareness and action to invest in this policy field.

Regardless of the changes in coverage rates, the challenge persists in that many EU countries have underdeveloped long-term care systems that are not prepared for the coming demographic changes. At present, many countries rely on informal caregivers, such as family members, for providing care. In fact, approximately 80% of all care that is provided to older people is informal care. With policies that at the same time promote women's labour force participation and longer working lives, it is difficult to see how such proportions of informal care are to be sustained. Lastly, formal care work is in most countries of low status and of low pay, which makes it difficult to recruit and retain care workers.

Setting the scene for reablement

Reablement thus comes at the right time as a policy solution, which is in line with dominant discourses on active ageing and prevailing policy agendas of social investment. It also offers a way out of welfare state inertia for member states facing ageing societies and that so far have done little, if anything about it, as the increasing longevity of populations due to better health is something that one should rightly celebrate, not bemoan. Reablement is therefore seen to increase "the possibility of raising the overall quality of protection against long-term care risks" (European Commission 2013, 19).

But what is reablement? According to one definition, it is "services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living" (Care Services Efficiency Delivery (CSED) Programme (2007), UK).

More specifically, it usually consists of a short-term intervention (3-12 weeks) in the home of the older person where the focus is on training in daily functions in order to re-gain or maintain their capacities. It is given as a supplement to or more often as a replacement for traditional home care. Common areas of focus are helping the older person re-gain the skills needed for dressing, using the stairs, washing and preparing meals. However, there are also examples of a more holistic approach that focuses on social and physical capacity, e.g., in Denmark. Reablement is a multi-disciplinary approach, involving close co-operation between social care workers and occupational therapists. It is goal-oriented, and all interventions should be based on outcome goals that matter to the older person, not to the care worker. At present,

reablement is obligatory in Denmark, widespread in England and Norway and is more infrequently used in New Zealand, Scotland, Australia and the US (under the name of restorative care) (**Aspinal et al. 2015**; Rostgaard et al. 2015).

The reason that is often argued for providing reablement is to increase the quality of life for the older person by focusing on re-storing self-reliance and independence of care, but it is also related to the cost-saving potential. For example, in Denmark, 80% of older people who apply for permanent home care services are given short-term reablement interventions instead. Municipalities here report an expected success rate of 60% with regard to self-sufficiency post-intervention.

What is the potential of reablement?

The question is whether reablement constitutes a fundamental change. Many care workers, including in Denmark, argue that this principle is not new and has been practised under the slogan of 'help-to-self-help' for a number of years. Regardless, looking closer at the organisational changes that have accompanied the introduction of reablement in Denmark, it is clear that a paradigm shift has taken place. Throughout the care system, and from initial needs assessment to the provision of home care, there is a focus on providing cross-disciplinary services based on the older person's own goals, and most importantly, with the focus of making the older person independent of care (Rostgaard & Graff 2016).

The way the service has been re-organised truly supports consistent cross-disciplinary understanding and cooperation. One advantage is that staff can apply specific competencies and perform an intervention with the focus on outcome and change. Reablement provides a platform for user involvement, as the intervention should be based on the older person's goals. It may also be the basis for societal changes in attitudes to ageing, as growing old is no longer only associated with frailty and decay, but actually with development and re-gaining capabilities.

More quality of life and lower costs?

However, the question remains as to whether reablement can deliver on two of the most prominent points. Does it increase quality of life for the user and ensure greater independence and control over daily life? Does it reduce the need for conventional care and thus reduce social cost?

So far the evidence is limited to a few studies. For example, a British study (Glendinning et al. 2010) using a control-group design finds that while there is a significant reduction in the need for social care (63% of participants in the intervention group ended with no need, while 26% ended with reduced needs), and thus decrease in costs, the total costs are the same. Even including start-up costs and health care costs, there are no significant differences in total costs (Glendinning et al. 2010).

A Norwegian study, also using RCT design, found some long-term effects (12 months) for the participants' quality of life in that they were more satisfied with functioning in daily activities (Tuntland et al. 2015). There were also some short-term (6 months) effects for users in that they experienced better functioning in daily activities and some improvement in physical functioning and health. However, the possible economic gain could not be confirmed. There were extra costs associated with providing the reablement intervention. In addition, while there was a post-intervention reduction in costs for home care, this levelled out, as did the cost for health care, with the overall end-result of no economic effect.

These findings certainly need to be tested in other studies. At present, a new RCT study on the effects of reablement is under way in Denmark, with results to be published in late 2017 (led by Rostgaard).

Reablement must, however, also be seen in relation to the development in other long-term care services, not only in relation to those changes that are taking place in home care. The Danish case provides such an example. Since the introduction of reablement, fewer older people now receive home care, and services have become focused on personal care, with less provision of help for cleaning services. This may reflect a number of factors. The more positive explanation is that reablement ensures less need for care as older people re-gain their functional capabilities in daily activities, such as dressing or vacuuming. It may, however, also reflect that fewer older people are applying for services as they know they will be met by the demand to (re-) learn skills, a phrasing that many older people dislike; they argue that they are applying for services not because they have forgotten to perform such daily activities but because they are no longer able to perform them (Rostgaard & Graff 2016). Lastly, the decreasing coverage rate may also be due to municipalities adjusting levels of services, hence making services less attractive and attainable.

One (unexpected) finding, however, is that reablement may also have an effect on care workers in boosting work morale. New data from Denmark confirm that care workers working intensively with reablement (daily or at least once daily) have a number of advantages. They are generally more likely to find care work rewarding; they find that they receive support from their managers; they find to a greater degree that older people's needs are met; and lastly, they are less likely to want to quit their job (Based on NORDCARE survey data) (Rostgaard & Mathiessen 2016).

Conclusions

The present dominating discourse on active ageing and the policy approach of social investment provides a strong case for introducing reablement in long-term care for older people. Reablement is claimed to have the potential to increase the quality of life for older people and to make long-term care systems more sustainable by reducing the need, and thus the costs, for care. So far, the evidence is limited and seems mainly to support the notion that older people gain new confidence in carrying out daily activities. The introduction of reablement has introduced a new element into the short-term provision of services as well as services that must produce

measurable outcomes. In Denmark, it has also triggered the targeting of home care services for the most frail and a refocusing on personal care at the expense of cleaning. However, there do seem to be positive effects for care workers, who find their work more meaningful when applying the reablement approach in their daily practices, with the result that they are less likely to want to resign.

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