European Network of Economic
Policy Research Institutes

ANCIEN

Assessing Needs of Care in European Nations

QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EUROPEAN UNION

COUNTRY REPORT: ESTONIA

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Abstract

The Ministry of Social Affairs (MOSA) is responsible for the quality of long-term care in Estonia, particularly in matters of development and control at national level. The Health Board is responsible for staff quality, standards and supervision of LTC. The Estonian Health Insurance Fund is responsible for LTC care and service quality. At the second level, county governors represent the government in 15 counties, but local municipalities are the main providers of social services to citizens in Estonia. Guidelines and manuals to improve service quality have been developed by MOSA, including two sets of guidelines for nursing care provision. Despite the numerous frameworks and developments in quality assurance, including internationally recognised LTC indicators, they are yet to be adopted, however. At present, no national or local-level quality indicators are measured in Estonia.

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Contents

Introduction 1

1. LTC quality policies 1
   - 1.1 Organisation of quality assurance in LTC 1
     - 1.1.1 Responsibilities in developing policies and standards 1
     - 1.1.2 Policies and regulations in LTC 2
     - 1.1.3 Monitoring results 3
   - 1.2 Quality policies for LTC 4
     - 1.2.1 Minimum standards of quality 4
     - 1.2.2 Publicity of quality measures and monitoring frequency 6
     - 1.2.3 EBM (evidence based medicine) guidelines 6
     - 1.2.4 LTC professional curricula 7
     - 1.2.5 Policies for informal care 8
   - 1.3 Results of quality policies: effects and evaluation of the policies and possible plans for changes in the policy in the near future 8
2. LTC quality indicators 8
   - 2.1 Types of quality indicators at the national and local levels 8
   - 2.2 Selected data about quality indicators 9

Quality Assurance Policies and Indicators for Long-Term Care in the European Union

Country Report: Estonia

ENEPRI Research Report No. 106/March 2012

Agris Koppel and Gerli Paat-Ahi*

Introduction

An assessment of quality assurance policies in LTC in Estonia finds in general that much progress has been achieved in creating and monitoring the quality of inputs of services (infrastructure, personnel, planning and funding). Some attempts have been made to evaluate the processes of LTC services, but almost nothing is found about the evaluation of the results.

Another problem is that quality monitoring is not yet developed, but some steps towards routine monitoring and publishing the results have been included in future plans of social and health care in Estonia. Also, quality-related databases are expected to be improved and published, which allows patients and clients to find the best practices according to their needs.

1. LTC quality policies

1.1 Organisation of quality assurance in LTC

Quality assurance (QA) in LTC has been developed together with increasing attention to the quality of health and social services in Estonia. The first steps in QA were taken during the 1990s as quality issues were added to the education curricula for medical professions and for social workers. During the last 15 years, several health care quality policy documents have been drawn up in collaboration with international experts and bodies (such as the World Bank), but only in 2002 was the new Health Services Organisation Act embedded in legislation, formalising the requirements of quality assurance for health services providers. According to these regulations, all health service providers should have a Quality Handbook, which is the basis for their internal quality assurance system. However, QA in social care services is not specifically regulated by any legal act.

1.1.1 Responsibilities in developing policies and standards

The organisation and supervision of LTC services is one of the main responsibilities of the Ministry of Social Affairs (MOSA) in Estonia. In the Ministry, there are separate Health and Social Care Divisions, which started to cooperate closely during the last five years. MOSA is the leading body in developing policies and standards for LTC, as called for by the Social Welfare Act[1] (SWA) and Health Services Organisation Act[2] (HSOA).

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[1] MoJ (2010), *Social Welfare Act (consolidated January 2010)* (http://www.legaltext.ee/et/andmebaas/tekst.asp?loc=text&dok=X1043K10&keel=en&pg=1&ptyyp=RT&tyyp=X&query=sotsiaalhool).

[2] MoJ (2010), *Health Services Organisation Act* (http://www.legaltext.ee/et/andmebaas/tekst.asp?loc=text&dok=X40058K7&keel=en&pg=1&ptyyp=RT&tyyp=X&query=Health+Services+Organisation+Act).

The Health Board (HB) is a government agency under MOSA, which registers health professionals (doctors, nurses and midwives) and renews licenses every three to five years for health service providers (including hospitals nurses and home nurses). The HB also includes the Department of Health Protection, which ensures that activities to protect public health are implemented in Estonia.

The Estonian Health Insurance Fund (EHIF) is an agency that organises compulsory health insurance and finances health services in Estonia. According to the EHIF Act[3] and the Health Insurance Act,[4] the EHIF should pay only for quality health services. Therefore, EHIF has set up systems to regularly monitor waiting times and to carry out audits of service provision and clinical practice.

At the second level, there are **county governors**, who represent the government in 15 counties of Estonia. Under the SWA and HSOA, the county governors organise and monitor the primary health care and supervise social services.

At the third level, there are **local municipalities**, which do not have any role in organising health services, but one of whose main tasks is to organise social services and financial support for people in need. According to the law, each local municipality should develop its own social services development plans, programmes and proposals for the introduction of new services.

Non-governmental organisations

There are many parties involved in developing policy and standards in LTC in Estonia. One of the most relevant organisations in the field is the Estonian Gerontology and Geriatrics Association (EGGA), which has been involved in extensive development of nursing care in Estonia, but has also played an important role in integrating the health and social sectors through discussions about LTC. The Estonian Nurses Association is a highly recognised partner for government organisations in developing nursing policy and standards in Estonia. Other LTC professionals also have their own organisations and associations in which they are involved as partners to develop policies and standards in the sector.

1.1.2 Policies and regulations in LTC

All activities in the area of LTC are generally set up in the Development Plan of MOSA, which is renewed yearly. To date (Development Plan of MOSA 2010-2013),[5] there have been very general aims regarding QA in LTC and most activities are related to QA development in the health sector. Since 2011, however, there are specific aims in developing quality in the social services sector as well (Development Plan of MOSA 2011-2014). According to this plan, there are the following activities:

1. Implementation of standards, normative criteria and EBM (evidence based medicine) guidelines in social services,
2. Enhancing QA and supervision of social services
3. Ensuring the continuous education and qualification of social care staff.

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[3] MoJ (2009), *Estonian Health Insurance Fund Act* (http://www.legaltext.ee/et/andmebaas/tekst.asp?loc=text&dok=X50003K4&keel=en&pg=1&ptyyp=RT&tyyp=X&query=haigekassa).

[4] MoJ (2008), *Health Insurance Act* (http://www.legaltext.ee/et/andmebaas/tekst.asp?loc=text&dok=X60043K3&keel=en&pg=1&ptyyp=RT&tyyp=X&query=Health+Insurance+Act).

[5] MoSA (2009), *Development Plan of MoSA 2010-2013* (http://www.sm.ee/fileadmin/meedia/Dokumendid/APO/Arengukavad/Sotsiaalministeeriumi_arengukava_2010-2013.pdf).

All county governors should present supervision reports to MOSA (currently only 20% of reports are presented), and guidelines are under development for at least of half of social care service types.

In the health area, development plans include very few and only very general aims concerning QA in long-term nursing care services, as they are mainly connected to the increased efficiency and sustainable financing of LTC services.

All social care institutions for adults should follow the health protection requirements set up by the Regulation of the Health Protection Requirements for Adult Social Care Institutions (MOSA, 2002). Also, the general safety requirements both for social and nursing care are set up in acts of Public health, Occupational health and safety, Electrical safety, Occupational health and safety requirements for manual handling of loads and other regulations.

At the same time, in the health sector, the policy developments in QA are realised through different legal acts and policy documents. As stated above, the quality requirements have been set up in the HSOA since 2002 and implemented through different regulations of MOSA, which also apply to LTC services (nursing hospitals, home nursing care and geriatric assessment) in Estonia:

1. Regulation of criteria for QA in health services. Requires implementation of the QA system in every health service provider organisation: ensures service quality, evaluation of patient satisfaction, professional competences and management quality of the organisation.

2. Regulation of hospital standards. Includes requirements for nursing hospitals, which should fulfil certain professional and technical requirements.

3. Regulation of hospital accommodation standards. Sets up standard patient and other rooms' parameters.

4. Regulation of the list of independent nursing care services. Regulates the home nursing services and limits the activities a home nurse can provide at the home of patients.

5. Regulation of the health service documentation, Regulates all duties around patient and health data management to ensure that all relevant health information is gathered and managed on behalf of the patient's health and safety.

6. Regulation of the health services accessibility and managing patient waiting lists. Regulates most aspects of health service accessibility and sets up criteria for managing patient waiting lists.

As a result of these regulations in the health system, the nursing care providers have also adopted the needs of registering and ensuring continuous education of health personnel: all providers have licenses for service provision and they should all ensure high-quality patient management and safety in their institutions.

1.1.3 Monitoring results

Monitoring and supervision of QA in Estonia have been performed on the basis of controlling the 'hard criteria' or inputs or resources of service provision. Some levels of assessment of the quality of processes have been implemented, while outcomes are not evaluated at all.

The HB's responsibility is to supervise the health service provision according to the legal regulations. The agency monitors health services providers regularly in 3- or 5-year periods when the licenses are first given or renewed. There is also the Expert Commission of Health Service Quality, whose duty is to assess the quality of health care services provided to patients and to consult the HB, EHIF and other health service providers in patient care quality issues.

The Commission is one body to whom a patient can complain, if (s)he is not satisfied with health services quality.

The EHIF has set up systems to regularly monitor waiting times and to carry out audits of service provision and clinical practice. It is decided yearly what specialities and areas of service provision will be evaluated. In 2006-07, an audit of nursing hospitals was performed by an expert team of EGGA. Unfortunately, that audit has not been published, but it outlined the main issues around QA in nursing hospitals. The assessment instruments used were CareKeys – MAssT and Institutionalised Care key indicators, which allowed the evaluation of most aspects of quality of patient care. The results showed that there are serious issues around documentation of assessment of care needs, care activities provided and results of care. The suggestions of the audit were as follows:

1. Documents related to nursing care activities should be standardised (including referrals from family doctors, etc.);
2. Nursing personnel need special trainings in documentation care and care management;
3. More attention should be given to social, psychological and environmental aspects of nursing care;
4. Monitoring of nursing care quality should include medical and functional issues, but also aspects of patient satisfaction and quality of life; and
5. There is a need to apply a standardised classification system for assessing care needs and resource allocation (e.g. interRAI).

In the social sector, the main responsibility of supervision of quality in social care services is given to county governors. They should prepare the three-year plan and yearly report results to the MOSA. Guidelines for supervision have been developed, but in 2009, only three reports (out of 15) were received by MOSA. This shows that monitoring in the social sector is not well implemented and the quality of social care services is uneven.

Local municipalities (LMs) in Estonia are the main providers of social services to their citizens, but there are no special monitoring activities in QA. LMs are often owners of social care institutions and therefore are directly interested in the quality of care. Also, LMs should compile social welfare development plans, which as in the case of national plans, more often include the quality measures as well. One example here is Tallinn City Government, which approved the implementation of social care standards during 2006-08 in their Social Care Development Plan 2006-2010.

1.2 Quality policies for LTC

1.2.1 Minimum standards of quality

In nursing care, the minimum standards of quality are set up by the Regulation of hospital standards, which outlines the following minimum criteria of infrastructure and technology for nursing hospitals:

I. Compulsory devices

    1) ECG device
    2) Blood pressure measuring device
    3) Glycometer
    4) Thermometer
    5) Syringes and i/v infusion systems
    6) Feeding tubes and instruments

7) Catheters
8) Stoma care instruments;
9) Gas tubes
10) Enema tools
11) Aspirator with tools
12) Wound care instruments and tools
13) Peritoneal dialysis tools
14) One lifter-washing chair per 20 beds
15) One washing bed per 20 beds
16) Minimum five wheelchairs
17) Minimum 10 different walking frames
18) Patient bed cabinets with eating plate
19) Minimum elevated toilet seats
20) Two sets of patient lift systems
21) Hydraulic transport stretcher
22) Tools for occupational therapy
23) Patient lift bag per 40 beds
24) Functional and ordinary beds in patient rooms

II. There should be doctors, nurses and carers. Nurses and carers should work around 24-hour shifts.

III. Compulsory rooms in nursing hospitals:

1) Patient admission room
2) Waiting room for patients
3) Doctor and nurse consultancy room (at least 12 m^2)
4) Procedures room (at least 10 m^2)
5) Patient rooms (at least 7 m^2) per bed if patient lift is available or at least 10 m^2 per bed if patient lift is absent
6) At least one WC per 8 beds
7) At least one shower per 8 beds and bath or washing room for recumbent patients
8) Physiotherapy room

IV. Nursing hospitals should have contracts with providers of laboratory and radiology services.

Similar requirements for all rooms and technology needed in formal social care institutions are listed in the Regulation of the Health Protection Requirements for Adult Social Care Institutions.

The education and qualifications of criteria are set in the curricula of social and health care providers. However, only doctors and nurses are required to register in HB to be able to work in Estonia. Also, some specialities organise non-obligatory recertification or accreditation courses.

In Estonia, the Estonian Qualifications Authority maintains and develops the professional standards for many occupations. Currently there are developed standards for Social Care Workers (levels I-III), Nurse Assistants (levels I-III) and Nurse Practitioners (levels III-V). These standards can be acquired after fulfilling the requirements of competences, working experience and theoretical studies.

1.2.2 Publicity of quality measures and monitoring frequency

Currently, the only annual published national quality measure is the patient satisfaction survey (organised by MOSA and EHIF), which gives the overview of patients' opinions of health services, but not on LTC services in particular.

In the health and social sectors, a large body of data is gathered yearly in national databases, but aside from the analysis of service provision and financing, there is no overview about quality measures. As described above, the audit of nursing services was conducted in 2006-07, but these data are not published either. Also, the yearly supervisory reports from county governors are not conducted as requested by law and therefore, no data are available to the public either.

But according to the national and local development plans in the health and social sectors, the monitoring frequency and publicity of quality measures should start to improve in future years.

1.2.3 EBM (evidence based medicine) guidelines

In addition to several aspects of quality assurance incorporated into the legal framework for the provision of health and social services, quality projects are also carried out in Estonia. In the health sector, the development of clinical guidelines has been supported by EHIF and in 2003 the EHIF set up the Clinical Guidelines Advisory Board. The Board's main responsibility is to promote the development and approval of clinical guidelines. Currently there are 37 officially approved clinical guidelines, and over 50 more have been prepared by medical specialties (but not approved by the EHIF). An important difference between officially approved and non-approved guidelines includes the agreed costs of medical treatment and diagnostics, which EHIF covers. As EHIF is a member of the Guidelines International Network, Estonian health professionals have access to most internationally developed clinical guidelines.

Two main sets of guidelines have been produced for nursing care provision in Estonia.

I) Practical Guideline for Nursing Care Services, 2007. This guideline provides a comprehensive overview of modern concepts in nursing care and integrated LTC care. It is intended to be used by nursing hospitals, but is also suitable for other formal institutional care facilities. Suggestions are provided for standards of care management, care processes and care assessments. The core principles include the following items, which are further described through measurable indicators:

1. Quality assurance system implementation
2. Documentation and data management
3. Nursing care management
4. Patient responsiveness and safety
5. Ensuring professional quality
6. Multi-level assessment of patient needs
7. Environmental quality of nursing care
8. Risk management

It is not possible to give an overview of all dimensions and indicators suggested, but it is strongly assumed that if this guideline is used by facilities, then quality of care should be maintained and enhanced.

II) Practical Guideline for Home Nursing Care Services, 2004. Because home nursing service was introduced in Estonia some years before 2004 and EHIF started to finance it in 2003, this guideline was prepared to distinguish between social home care and nursing care at home. The guideline targets all relevant issues around home nursing service provision, but the QA suggestions are based on regulations, which were introduced for

health services in Estonia during 2001-04. Therefore, no specific quality indicators are suggested today in Estonia.

There are other guidelines and handbooks developed for the health and social sectors (e.g. interRAI-based assessment tools for institutional and home care), but they are not relevant to the activities described in the current report.

1.2.4 LTC professional curricula

1. General practitioner\ Family Physician\ Primary Care Physician

There is only one Medical Faculty in Estonia to prepare doctors: Tartu University. The basic six years of study gives a general medical degree and everyone should pass through a 4-year residency programme to become a family doctor. All continuous training programmes and postgraduate studies are also performed by Tartu University.

2. Hospital physician

Hospital physicians are also trained at Tartu University through 3-5 years residency programmes. However, currently there is no such sub-specialty like geriatrics approved by MOSA in Estonia.

3. Social worker

Social workers are prepared in the following universities and colleges:

- Tartu University (including Pärnu and Narva Colleges), both bachelor and master degrees in social work
- Tallinn University (including Rakvere College), from bachelor to PhD level curricula in social work
- Lääne-Virumaa College, diploma studies
- Tallinn Pedagogical College, diploma studies

Continuous education and special training are also provided by smaller training institutions.

4. District nurse

By definition, a district nurse is actually a home nurse in Estonia, whose education is based on general nursing training. However, there are health care colleges and smaller educational institutions that offer special training programmes for home nurses.

5. Care managers and nurses

There are continuous training programmes for health and social professionals who want to become care managers. For example, the health and nursing management training is offered as Master degree programmes by the Department of Public Health and Department of Nursing Science in Tartu University.

6. Health Educators

There are no educational programmes for health educators in Estonia, excluding the additional programme of health education for school teachers.

7. Nurse Practitioners

A general nursing and specialised nursing qualification can be obtained at two institutions in Estonia – Tallinn Health Care College and Tartu Health Care College. The continuous education and scientific degrees can be obtained from the Department of Nursing Science in Tartu University.

8. Nursing Staff

Nursing staff in Estonia can be structured as follows according to education qualification:

1. Diploma equal to Bachelor (graduation from 2000) – 3655 nurses
2. Bachelor degree (graduation from 1998, equal to Masters in 3+2 system) – 61 nurses
3. Masters' degree (graduation from 2004) – 36 nurses
4. Doctoral (PhD degree) in nursing - no programme available in Estonia – 0 nurses

9. In addition there is a 2-year bridging programme available to those belonging to the categories 1-2. Categories 1-2 make up the majority of Estonian nurses (7509). The latter categories (3-5) make up ca 1/3 (3655) of Estonian registered nurses with higher education. Care workers or care assistants

Care workers and assistants are prepared mostly in colleges (see above) or during onsite training at nursing facilities. Continuous education and special training are also provided by smaller training institutions (e.g. NGOs, etc).

1.2.5 Policies for informal care

In general, there are no policies developed for informal care. However, the national policy on Economic Growth and Labour Market Development 2008-2011 outlines the need to support the development of more flexible labour policies and employment contracts. There are around 20% of informal carers of working age who need support because of long-term unemployment or to lower the risk of becoming unemployed (Analysis of care burden of people with disabilities and their families, 2009). According to these policy options, EU Structural Funds are used to develop activities in social and nursing care, which improve the efficiency and quality of home-based services in Estonia (Operational Programme for Human Resource Development 2007-2013, INNOVE).

1.3 Results of quality policies: effects and evaluation of the policies and possible plans for changes in the policy in the near future

As described above, there are quite a lot of general and detailed quality measures in legal acts and regulations, but there is less information about quality assurance systems implemented by organisations and the efficiency of these systems. However, it is already evident that in the near future the LTC policies in national and local social and health development plans will include the development of quality measures.

2. LTC quality indicators

2.1 Types of quality indicators at the national and local levels

At present, no national or local level quality indicators are measured in Estonia. However, there are considerable frameworks and developments around QA, including internationally recognised LTC indicators, which should be adopted in Estonia.

In the social sector, some national level indicators have been proposed to measure quality of services starting from 2011 (Development Plan of MOSA 2011-2014). These indicators are as follows:

i) Share of supervisory reports provided in social care. This indicator measures yearly how many county reports are presented out of 15 by the county governors.

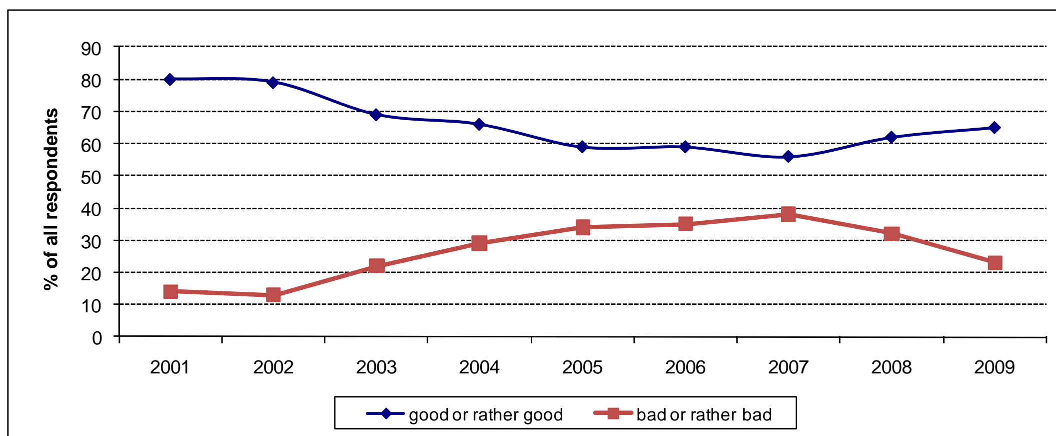
ii) Share of social services, which are covered by service guidelines. This indicator measures how many social services have been covered by service guidelines yearly.

In Estonia, general patient satisfaction has been measured annually since 1999, but the quality of nursing care is hidden in the data on primary and specialist care, as specific LTC questions are not asked. The results of patient satisfaction obtained from surveys administered between 1999-2009 are given in the final section below.

2.2 Selected data about quality indicators

1. Share of supervisory reports provided in social care – 20% (3 reports out of 15 were presented) in 2009, target is 100% in 2014.
2. Share of social services, which are covered with service guidelines – current number is 0; target is 50% in 2014.
3. Opinion on health care quality (% of all respondents) – see table and figure below.

	Good	Rather good	Rather bad	Bad	Don't know
2009	22	58	11	3	6
2008	24	55	10	3	7
2007	23	46	18	4	9
2006	17	49	23	6	5
2005	13	46	27	7	7
2004	13	46	26	9	6
2003	16	40	26	12	6
2002	19	43	21	11	6
2001	18	47	20	3	11



EUROPEAN COMMISSION
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SEVENTH FRAMEWORK PROGRAMME

Funded under Socio-economic Sciences & Humanities

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

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

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

2) How do different systems of LTC perform?

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

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

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

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance.

Principal and Partner Institutes

CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination. Other partners include: German Institute for Economic Research (DIW); Netherlands Interdisciplinary Demographic Institute (NIDI); Fundación de Estudios de Economía Aplicada (FEDEA); Consiglio Nazionale delle Ricerche (CNR); Universitá Luiss Guido Carli-Luiss Business School (LUISS-LBS); Institute for Advanced Studies (IHS); London School of Economics and Political Science- Personal Social Services Research Unit (PSSRU); Istituto di Studi e Analisi Economica (ISAE); Center for Social and Economic Research (CASE); Institute for Economic Research (IER); Social Research Institute (TARKI); The Research Institute of the Finnish Economy (ETLA); Université de Paris-Dauphine-Laboratoire d`Economie et de Gestion des organisations de Santé (DAUPHINE- LEGOS); University of Stockholm, Department of Economics; Karolinska Institute-Department of Medecine, Clinical Epidemiology Unit ; Institute of Economic Research, Slovak Academy of Sciences (SAS-BIER); Center for Policy studies (PRAXIS). Most of the ANCIEN partners are members of the European Network of Economic Policy Research Institutes (ENEPRI).

For more information, please visit the ANCIEN website (www.ancien-longtermcare.eu) or the CEPS website (www.ceps.eu).