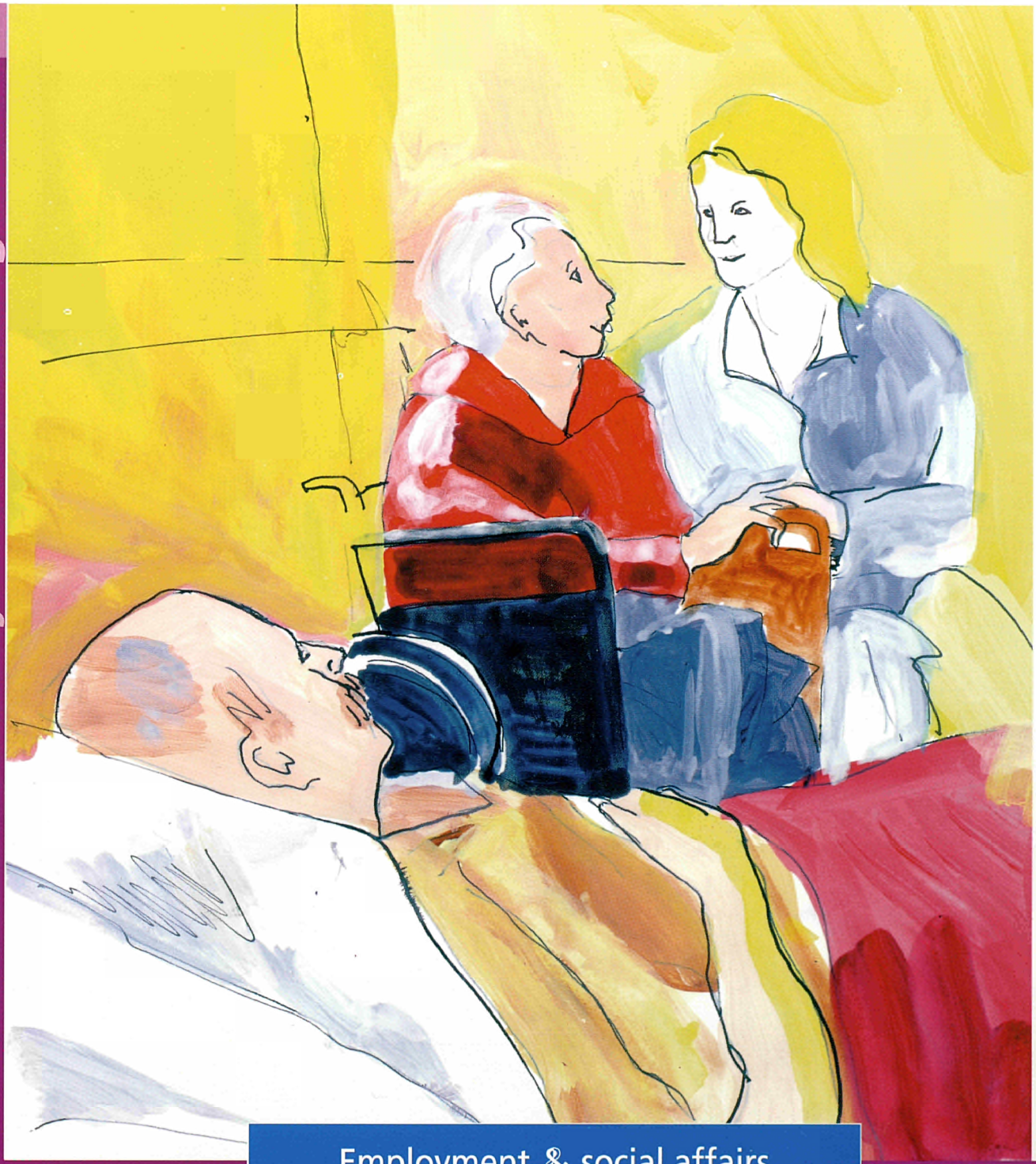
# Social protection for **dependency in old age** in the 15 EU Member States and Norway

Social security & social integration



Employment & social affairs

European Commission

# Social protection for dependency in old age in the 15 EU Member States and Norway

*Synthesis report commissioned by the European Commission and the Belgian Minister of Social Affairs*

Jozef Pacolet – Ria Bouten – Hilde Lanoye – Katia Versieck
Higher Institute of Labour Studies – Catholic University of Leuven

Employment & social affairs

Social security and social integration

**European Commission**
Directorate-General for Employment, Industrial Relations and Social Affairs
Unit V/E.2

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The information used in this comparative report is to a large extent based on national reports for which the national contributors have the complete responsibility.
The comparisons, the analysis and the conclusions presented in this report remain the responsibility of the authors of the Comparative Study. The research has been conducted by independent researchers and does not engage the authorities that commissioned the project.

A great deal of additional information on the European Union is available on the Internet.
It can be accessed through the Europa server (http://europa.eu.int).

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# *Foreword*

The publication of this report, which summarises a large comparative study on social protection for dependent elderly persons in the European Union and Norway, forms part of the European Commission's efforts to raise awareness and stimulate the debate about the challenges that an ageing population will pose for social protection systems in the field of long-term care.

The European Commission's Communication on *Modernising and Improving Social Protection in the European Union* (COM(97)102) identified the need for Member States to consider adapting their health and social care systems to meet the needs of an ageing population. The fourth pillar of the *Employment Guidelines* emphasises the need for adequate provision of good quality care for older people in order to support the entry and continued participation of women and men in the labour force.

All Member States will have to face the challenge of providing an adequate, efficient and cost- effective response to the rising demand for care services in the context of demographic changes. Although responses will need to reflect differences in existing provisions and the specific intensity and timing of rising demands, policy makers will have many problems in common. Closer collaboration and the sharing of experiences at Community level can therefore help Member States in their search for adequate ways of addressing the long-term care challenge.

This report provides us with the first analytical overview of the layout of existing dependency provisions and of recent policy debates about how to secure ample protection for the frail among the elderly and I hope it will stimulate a policy debate at European level on long-term care for the elderly during this, the 1999 United Nations Year for Older Persons, and coming years.

Allan Larsson
Director General DG V

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# *Introduction and acknowledgements*

This synopsis report is based on a comparative study on the social protection of the dependent elderly, commissioned by the Directorate-General V: Employment, Industrial Relations and Social Affairs, Commission of the European Communities and the Belgian Minister of Social Affairs.

The report updated a previous report on six Member States and enlarged it to the other Member States. Also one country of the EEA, Norway, was included in the comparison.

The aim of the project is to provide an overview of the social protection arrangements which are available in the EU Member States and Norway for dependent elderly people above normal retirement age and in need of long-term care. The comparative study is concentrated on the needs of dependent elderly persons, without ignoring the fact that ageing is not synonymous with dependency.

Nevertheless, the ageing of the population in the EU means that there are and will continue to be an increasing number of dependent elderly people with long-term care needs and these needs will have to be catered for. There are several ways in which the risks can be covered, and all new proposals within this context have to be compared with the present levels of social protection and the various forms that it assumes. We have opted for a holistic approach to the dependency risk in the present social protection system.

The aim of the study is not only to provide an overview of the present social protection arrangements for dependency in old age, but also to give some insight into present and future policies.

The present report contains:

1. a macro-economic and budgetary overview of social protection in the different countries;
2. an overview of the existing institutional provisions;
3. an assessment of the way in which countries differ in their treatment of similar categories of dependent elderly people and of the way methods change within individual countries from one type of case to another;

4. an overview of present policy discussions in the countries regarding steps which are to be taken in this field of social protection for dependency in old age, as it is culminating in a debate on long term care insurance.

This multiple study approach naturally produces different - and even conflicting - points of view. It has the advantage, however, of cross-checking information and of providing a more in-depth understanding of each national situation.

By confining the discussion to social protection, the picture will be incomplete for countries (or case studies) where private protection is preferred. However, we acknowledge that the 'privatisation' is of a gradual nature. Examples of the private-oriented movement include the increasing number of personal charges, private insurance plans and private care consumption and organisation.

In the same context, social expenditures for housing, fiscal expenditures, and tax and social contribution exemptions, can influence substantially the level of protection, the level of public spending and the situation of the elderly themselves. It was also not possible to cover these elements completely in the comparative report.

It is often very difficult to distinguish social protection from total protection for elderly persons. Various components of private protection will inevitably crop up during the discussion, but they are too numerous to mention them all.

The impact of the ageing of the population on social protection will be felt in the level and scope of health and social services, as well as in the expenditures for and financing of the pension schemes. These are objective needs. However, the expenditures for them are also determined by the stage of economic development (the possibilities) and the political discourse about them (the choices). These choices are partly influenced by economic arguments. Most European countries expect the ageing of the population and especially the increase of the very old to occur in the next two decades, though certain elements of increasing elderly population pressure are already being observed at the present time.

* *
*

The project was co-ordinated by the following members of the central study team of the Higher Institute of Labour Studies at the Catholic University of Leuven: Jozef Pacolet/Ria Bouten/Hilde Lanoye/Katia Versieck.

The report was written by this central study team on the basis of country reports prepared by national experts:

| | |
|---|---|
| Austria | Kai Leichsenring |
| Belgium | Jozef Pacolet/Hilde Lanoye/Ria Bouten |
| Denmark | Eigil Boll Hansen |
| Germany | Bernd Schulte |
| Greece | John Yfantopoulos/Theodore A. Georgakopoulos |

| | |
|---|---|
| Spain | Gregorio Rodriguez Cabrero |
| Finland | Marja Vaarama/Mikko Kautto |
| France | Marie-Eve Joël |
| Ireland | Eamon O'Shea |
| Italy | Francesco Belletti/Harmke Keen |
| Luxembourg | Nicole Kerschen |
| The Netherlands | Norma Schuijt-Lucassen/Kees Knipscheer |
| Portugal | Manuel de Almeida/J. Manuel Nazareth |
| Sweden | Lennarth Johansson |
| United Kingdom | John Bond/Debbie Buck |
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We want to thank our colleagues from those nations for their careful and far-reaching contribution to this project. The information used in the comparative report and this synthesis is, to a large extent, based on their work (see list of prepared reports on last pages). The analysis and conclusions presented in this report, along with any possible misinterpretation or errors, remain the responsibility of the authors of the comparative study. At the closing of this project we were informed that our colleague from Portugal Manuel de Almeida died in May 1998. We commemorate him as a gentle person, dedicated to this research and social-economic policy field.

The national and the comparative reports have been commented on by a second group of national experts (see list in annex) without, however, attributing to them any responsibility for the results.

All reports have been prepared by independent experts and should not be taken to represent the views of the European Commission or the Belgian Minister of Social Affairs. Here we want to take the opportunity to alert the reader to this comparative report, and comparative, synoptic tables. Each figure has in its country a specific definition, an institutional setting, a changing policy strategy, and probably also statistical problems behind it. Each figure can tell a complete story and this is sometimes illustrated in our comments. This report should be read in combination with the basic report, its volume of annexes and also, most importantly, the national reports, which is the basis of most of this information.

Finally, we want to thank Ria Bouten, Hilde Lanoye and Katia Versieck for their contribution to the project at various stages and the huge amount of work that has

been done. We owe also special thanks to the secretaries for their help in preparing this report.

Prof. dr. Jozef Pacolet
Head of sector Social and Economic Policy
Higher Institute of Labour Studies, Catholic University of Leuven

# *Summary*

## 1. A completed debate or an emerging one?

The European year of the older people in 1993 created a momentum of increased interest in the role of older citizens in the EU, and an awareness of the challenge that the ageing of the population creates for the existing systems of social protection. At the same time it created great expectations in the Member States that high standard systems of social protection for older people would be maintained or completed. Although it is inappropriate to assume older people to be dependent persons, and there is substantial progress in changing that relationship older people continue to face growing concern about their present and future income and expenditure on health care. This personal feeling of insecurity is reflected at macro-level in the overall concern of governments about pension schemes and health expenditure in the next decade. It has been very well documented in previous research (A. Walker, J. Alber, A.M. Guillemard a.o. (1993)) that older people feel comfortable about their personal surroundings, but uneasy about the political concern about their cause, and perhaps also about the ability of governments to cope with those problems. In particular, the increasing proportion of very dependent older persons concerned many groups. It is in this context that the European Commission and the Belgian Government supported comparative research into the social protection of dependent older persons. While at first sight the European Union demonstrates a diversified and highly developed care mix and public support for dependency, a second look reveals aspects of under insurance or no insurance for the new risk of long-term care. This explains why the issue of long-term care is on the agenda in some countries. In several countries electorates were promised, as a response to this insecurity, that the cost of most long-term care would be covered by insurance in one way or another. Following the long debate on long-term care insurance in Germany the question has been whether other countries will follow the German example and establish a new pillar of social insurance. In some countries this route has been followed (Austria, Germany) and even very recently (decision of May 1998) in Luxembourg; in other countries the debate continues but is sometimes undecided (France, Belgium). In other countries it is not so explicitly on the agenda. This can be for different rea-

sons: in the Nordic countries because it exists already and policy makers are sometimes still considering reduction rather than expansion; in the Mediterranean countries because of other care models or because the budgetary constraints are too heavy. The comparative report gives an inventory of social protection in macro-economic, institutional and micro-terms, and a description of the ongoing political debate for change.

## 2. Aim of the comparative report

The aim of this comparative study is to give a detailed overview of the social protection arrangements for dependent older people above retirement age and in need of long-term care in the EU. The study examines the coverage of the needs and dependency risks of older people in the welfare states of the European Union. A description of the current arrangements and an assessment of policy trends and perspectives is given. The focus is on the availability of, and the eligibility conditions for, access to the systems of social protection, taking into account the living conditions of dependent older people. The report concentrates on the social protection elements whilst also situating these within the complete set of provisions, including those which are private or informal in character.

Dependency can be caused by several factors and may imply a need for help or support in a number of ways. Dependency needs are broadly defined and refer both to aspects of income, housing, health and social care, and to integration and empowerment.

The adequacy of care for dependent older people is determined by the interaction of a comprehensive set of formal and informal provisions (in kind aid, income support, savings, informal support by main carer, etc.). To ask how many people have access to a given care system and to what extent the total amount of their needs is covered by these systems, is just one part of the picture. Adequacy will also depend on the amount of resources at their own disposal or available through their network of family or friends.

Provision and funding of protection may be the responsibility of different institutional levels and may account for a larger or smaller percentage of total spending. Formal social protection includes three main systems:
- income support - pension systems;
- health care - health insurance;
- (social) services for the elderly.

In addition to these formal systems, informal care and support facilities continue to be provided quite extensively and are becoming progressively integrated into the formal sphere. Within this formal and informal care framework, new risks or needs in other areas of care are calling for various kinds of protection. What are or

will be the relative roles of the public, private and voluntary sectors in new provisions?

In this report basic emphasis has been placed on data-collection and cross checking of information by means of a multiple research strategy. Institutional aspects (facts and figures on the arrangements available), macro-information (macro-economic spending, policy debate) and micro-aspects have been considered.

There is a considerable amount of evidence on the level and structure of pension provision for older people and on health care expenditure. This research attempts to draw a more comprehensive overall picture of the elements of social protection of relevance for the needs of dependent older persons, ranging from income, health, social care to support for the informal care and integration and empowerment.

Information is given on the care systems followed by additional information on the average profile of each service. The advantage of this approach is that it gives a complete institutional picture and a quantitative, macro-economic overview of the social protection systems. The amount of detail available depends on the existing administrative information system, which is sometimes limited. This report summarises the available information and looks at it from a second approach starting from dependent older people themselves. This methodology assesses on a theoretical institutional basis what options are open for certain categories of the elderly population. It reveals how older people with a certain degree of dependency and a certain level of income experience significant differences in coverage of their care needs. The advantage is that it gives a clear view of the situation of similar groups of older people in different countries. This allows missing information on the cumulative effects of certain care systems, or the remaining blank spots, to be detected. At the same time it helps to characterise further the social protection systems in each country.

Information on the socio-economic and political debate on the need for changes in the way social protection for older people is financed and organised provides a further insight into how provisions function and are perceived by older people and policy makers in the Member States.

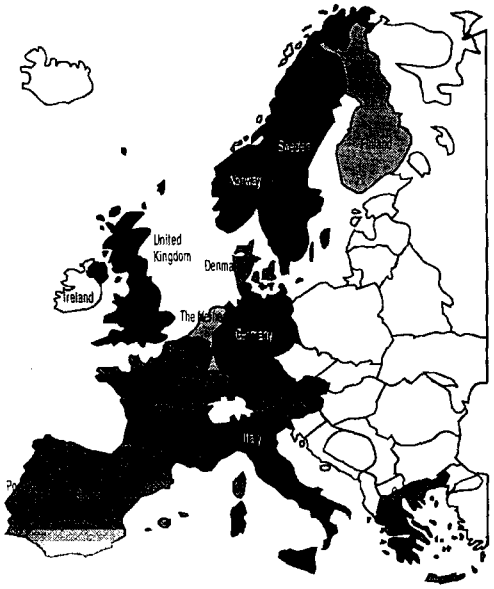
## 3. Dependency

There is no homogeneous and operational definition of dependency. Mostly it is reduced to physical or mental aspects, but a social and economic dimension can be added to it and has for the purpose of this study been used to define the scope of the inventory of systems of social protection.

After retirement individuals usually become dependent on social protection for part or all of their income. In the more narrow definition of dependency referring to physical and mental aspects, it is inappropriate to identify older people as such with dependent persons. Many older persons are completely self-reliant and inde-

pendent for several years after retirement. Furthermore, there are indications that the relation between age and dependency is changing for the better. The onset of dependency appears to be happening later in life than before.

Yet the ageing of the population will result in a significant increase in the number and proportion of the very old and hence by implication in the amount and share of dependent persons. In the 65+ group, currently between 3% and 5% of people are severely dependent, whereas the partly dependent constitute up to 15% of this part of the population. For persons 75+ the pronostics of highly dependent persons increases to 10 percent, while the partially dependent make up 25%. This amounts to a population of very dependent persons of, on average 3% of the total population, or about 9 million persons in Europe. On the basis of the national reports there are at least 7.6 million older persons who in some way or another are counted as dependent or receive some form of social protection, in cash or in kind because of dependency.




high
low

| % population over 65 (1995) | |
|---|---|
| Austria | 15.1 |
| Belgium | 15.8 |
| Denmark | 15.1 |
| Germany | 15.4 |
| Greece | 14.8 |
| Spain | 14.8 |
| Finland | 14.3 |
| France | 14.7 |
| Ireland | 11.5 |
| Italy | 16.4 |
| Luxembourg | 14.3 |
| The Netherlands | 13.1 |
| Portugal | 14.8 |
| Sweden | 17.4 |
| United Kingdom | 15.7 |
| Norway | 15.9 |

**Figure 1.** The ageing of the European population

The pressure from growth in life expectancy and the number of dependent older persons, places a higher burden on the existing care systems than they were originally designed for. This has been the case in many countries, stimulating the debate on long-term care insurance. But the major impact of the greying of the population is to be found in the existing systems of social protection and concerns primarily pensions and health care expenditure. There is, however, no clear-cut relationship between the share of the population above 65 and the share of pension expenditure in relation to GDP (varying from 5 to 15% of GDP). For the pension schemes for instance we concluded that there is no substantial shift away from pay-as-you-go systems. This is confirmed by the European Commissions

1997 report on Social Protection, which adds the observation that there is a new reinforcement of the relationship with previous income, so reinforcing the insurance character of the social insurance(European Commission, 1998).

The level of expenditure on health care is the second major category of social expenditure: it varies from 4 to 8% of GDP, increasing with the level of national income. After years of cost containment and declining expenditure shares the cost of health care has been increasing in almost all Member States since the beginning of the Nineties. However, the most recent evidence in the above mentioned EU report on social protection, which includes an extra year of information (1995) and distinguishes two subperiods 1990-1993 and 1994-1995, shows a decline in the latest period, after an initial increase.

30 to 50% of this expenditure is directed towards the population of above 65 years of age. On top of this, in many countries, social expenditure on personal social services for the elderly amount to a budget between 0.19 and 2% of GDP.

The picture from this overview is not entirely clear due to lack of information on many aspects, but there remains a picture of substantial differences in levels of expenditure and levels of social protection.

## 4. The welfare mix

The study makes an inventory of additional dependency-related income support such as support for housing costs and a growing list of support systems for housing accommodation and adaptation, residential and semi-residential services for older people and community care services. Many of these have been studied in greatest detail elsewhere (eg. payment for care systems, social housing, etc.) but this is the first time that such a broad set of elements has been brought together. The comparative study concentrates on further describing these health and personal social services for the older people. A picture emerges of a growing and maturing mix of differently organised but mostly publicly financed care provision within a mainstream public discourse of budgetary austerity.

### 4.1 Variety

The study identifies 8 systems of permanent residential and semi-residential services for the elderly, 17 temporary residential and semi-residential services and 22 community services. This variety illustrates the diversification that has taken place in this sector over the last two decades, and it was only possible within a context of a further expanding welfare state. After a period of quantitative expansion of the traditional systems of social protection, from the second half of the Eighties the sector entered a period of innovation and qualitative differentiation into new institutional arrangements within a framework of cost-containment. Since then (and this is also reflected in health expenditure) a quantitative expansion has occurred again. This expansion path need not necessarily be the same in

all countries, and different countries certainly are not the same stage, but the impression remains that there exists a common European way, combined with national characteristics.

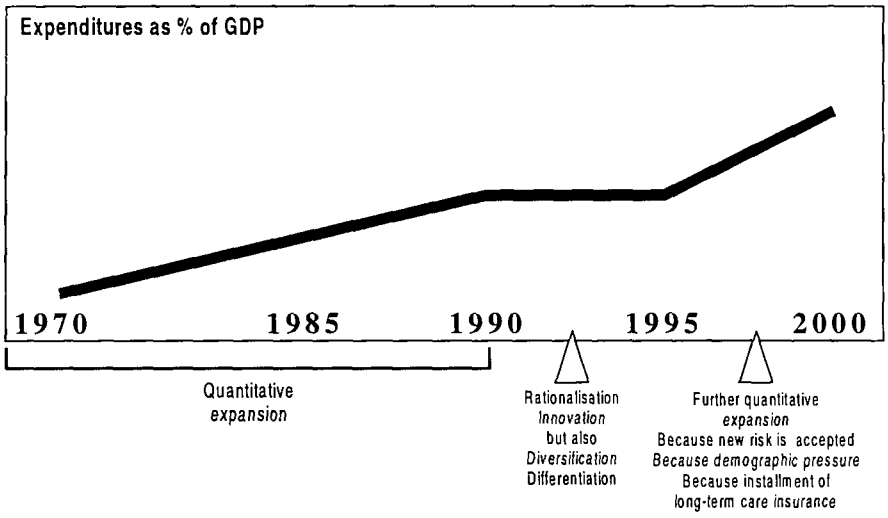



**Figure 2.** Stylised expansion path of the development of social protection for older people: a common European way?

## 4.2 Availability

Although almost all countries refer to similar existing or emerging services, the absolute level and the relative importance of the mix of services vary significantly. Most of the countries remain oriented towards an institutional care system, with a high number of places available in several types of institutions per 100 older persons. In some countries these institutions remain traditional old age homes. In others a transformation of those homes into care intensive nursing homes or other types of sheltered housing has already taken place. The borderline between housing and services is fading. Several countries mention the unbundling of housing and care, but in reality more and more integrated and variable services emerge. The level of development of this form of institutional care is remarkably low in the Mediterranean countries.

Although much more diversified, the level of development of community care seems to be even lower. Many countries with a relatively high degree of institutional care show lower levels of availability of community care (measured as number of personnel in the main community care services per 100 aged 65+). This is for instance the case in Austria, Belgium and the Netherlands. On many countries, however, clear information is missing. The general picture is one of a topping-up of residential and community care instead of a clear substitution. Those already with good residential services, also have better community services.

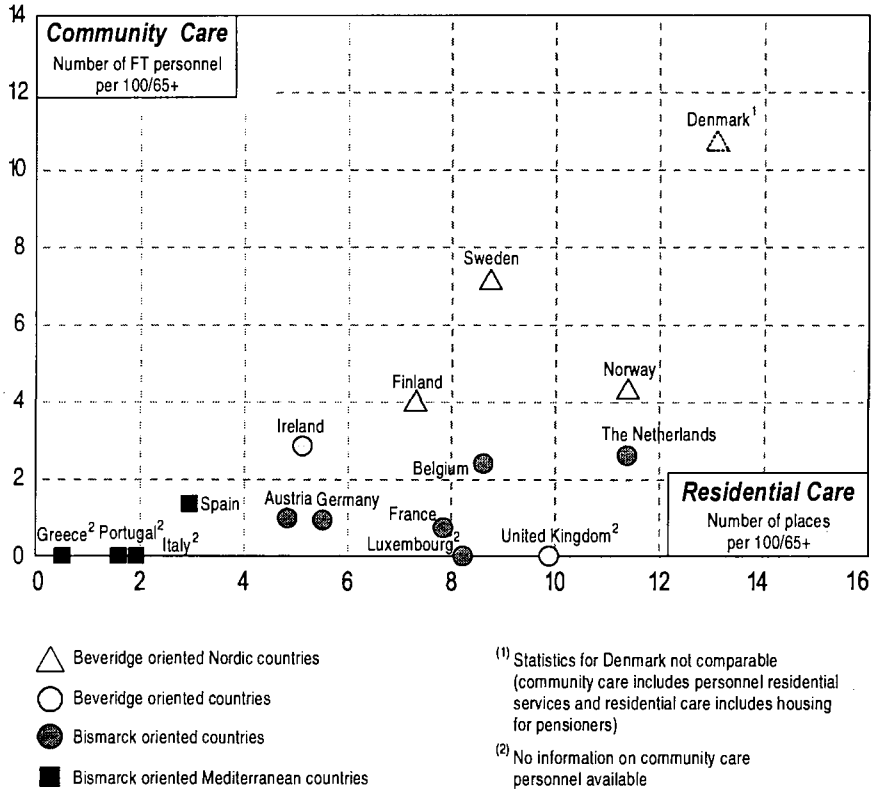



**Figure 3.** Development of residential and community services for older people in Europe

Also to be noted, emerging both from this European comparison and from previous research on the State of the Welfare State (Pacolet, Versieck, 1998) is that the choice between formal and informal care has led in the Nordic countries to a substantial level of job creation in those activities, jobs which add value and therefore contribute to economic growth. For the Mediterranean countries, this option still remains open.

This huge difference in services available could imply in some countries some form of underinsurance for certain categories of services or in general. Considering this, it becomes understandable that the debate started about the creation of long-term care insurance in some countries. It is however even more driven by the aspect of affordability.

## 4.3 Affordability

Besides availability, affordability is also an important element in describing the degree of social protection. The more cure-intensive services remain to a large extent publicly financed, as they are situated close to the health care system. Examples are nursing homes and especially district nursing that is completely publicly financed almost everywhere. The more care-intensive systems, or those services concentrated on housing and household aspects, tend to have a lower degree of public financing. But care and cure are also difficult to distinguish,

which is probably why there remains a reasonable overall degree of public financing. There is some indication that the financing of services for older people is reasonably protected - where it is available, which is not always the case (quantitative rationing) - but in some cases the level of co-payment is already very high. Elements of underinsurance are emerging, calling perhaps for the creation of long-term care insurance.

## 5. Present characteristics of the European care system

It is more instructive to distinguish common characteristics in the social protection of older people in Europe than to highlight and typologise the differences between the Member States. There is convergence in a number of areas despite the fact that social protection is determined in the context of subsidiarity and has national historic roots. Sometimes the direction of new solutions springs from the existing national system, at others inspiration is down from solutions in other Member States, leading to convergence. For example, systems based on State provision may seek to involve the private sector, flat-rate systems may introduce elements of earnings-related pensions, etc. But convergence or similarity of systems does not mean equalisation of levels of protection. The case studies reveal how people with similar degrees of dependency and income enjoy different levels of social protection.

There is a trend to shift from service provision to cash support. In fact, apart from pensions, the provision of services is the major part of social protection for older people. Levels and types of formal services differ, but for almost all countries a long list of services is mentioned. Almost all Member States also mention payment for care or allowances in some way. Rent subsidies are also common.

The trend is towards substituting formal care with informal care, but in many countries there are limits to this substitution. Some reports mention that in hours terms, informal care is 5 times more important than formal care. Many countries have introduced some payment for care, sometimes as a benefit paid to the person being cared for, sometimes paid directly to the informal carer.

The quantitative expansion of basic provisions came to an end because of budgetary austerity. This is at odds with new demographic needs. A possible solution is diversification and differentiation within mature systems. For example care in a nursing home is less expensive than care in a hospital; provision of sheltered housing is less expensive than provision of care in nursing homes; community care may be less expensive than residential care, depending on how on views the issue of dependency; paid informal care is less expensive than paid formal care. There are however limits to the contribution of diversification to cost containment: sheltered houses need more services; there is a growing upward convergence between service flats, old age homes and nursing homes which eventually end up meeting the same needs for the same groups of older people. Quan-

titative expansion in certain areas arises: the need for long-term care insurance has become a common characteristic in many Member States.

Differences remain on the organisational aspects of social protection (Bismarck or Beveridge-oriented welfare states, lower or higher degree of state provision) but the fundamental point is the total amount of formal services available. Although the focus of this comparative study is to provide a comprehensive overview of this availability, figures need to be handled carefully. Given that caveat, reported levels in residential care differ on a scale of between 1 and 5 for the higher and lower group and between 1 and 3 in the case of community care. The range for financial differences is even larger. The Nordic countries and the Mediterranean countries are situated at the upper and lower extremes of this range.

## 6. Debate for change towards long-term care insurance

Despite the fact that the level of public financing of care for older people remains high and approaches figures for financing in health care (80 to 85% of total cost in some services), there continues to be growing concern in many countries about public financing of those services, now and in the future. Despite the high level of social protection, there are in many countries indications of underinsurance. In France and Germany, there are lower levels of provision than could be expected according to the general standards of social protection. In several countries there is recourse to social assistance when older people cannot bear the total costs. In some Nordic countries, older people lose their pension when entering residential care and are left with only pocket money. In other countries contributions by older people themselves represent such a high proportion of average income that the net effect is to leave older people with only pocket money. In other countries recourse to the family is legally enforceable, or older people tend to live with their childrens families.

The high level of co-payments are another sign of underinsurance.

In some countries (Germany, perhaps also France and Austria) a low level of services is observed, while the opposite would be expected based on income, age structure and average level of social protection. This has been the subject of political debate in those countries. The issue of underinsurance has been under debate in Germany: too many people had to have recourse to assistance; there is a lack of services; a substantial increase of supply has occurred since the creation of the new insurance arrangements, confirming that there was underdevelopment before the changes; a substantial amount of 'new money' had to be raised (1.7% of wages net on savings). In France the same issues have been raised: problems of underprovision and underfinancing, but also concern about the lack of 'new money' in the existing proposals. In Belgium, when the new needs have been identified and quantified, the need for 'new money' is more limited, illustrating that the existing systems already provided better insurance cover.

Where there is debate for change, it suggests deficiences in the existing system of social protection, in that long-term care at home or in residential accommodations seems not to be covered completely. In Germany it was an explicit concern for policy makers that so many people had to have recourse to assistance when confronted with the cost of long-term care because of dependency. Dependency was considered as a normal risk of life, in the same way as deteriorating health. In several countries of the central region, there is sometimes a high level of payments by older people themselves for these long-term care services, sometimes with recourse to family resources (for instance Luxembourg, France, Belgium, Germany). Sometimes the older persons financial resources must be completely depleted before they can have recourse to social assistance. In the Southern countries there are in general fewer residential at community services.

**Box 1.** Long-term care: uninsured risk?

- The problems
  - new risk: growing number of older persons (not necessarily growing dependency)
  - higher costs: less informal care and upgrading of services, including demand for payment for care
- Signs of uninsured risk:
  - in some countries recourse to family remain
  - in some countries recourse to assistance
  - in some countries services remain underdeveloped
  - formal care withdrawn when there is informal care
  - in some countries high levels of payments from older persons themselves

So, there is a clear problem of underinsurance (be it public or private) for the cost of long-term care. Too large proportions of these costs have to be covered by the current income or even by previous savings. An alternative form of financing these services via a long-term care insurance system has been discussed. This debate is summarised in the last part of the research. Among the questions addressed is whether long-term care for dependent older persons, at home or in institutions, is financed implicitly within the existing systems of health insurance and social insurance, or whether new and more explicit schemes of long-term care insurance are being planned and established. There is also an attempt to delineate how the debate is evolving in each country. The Member States with Beveridge-oriented systems of social protection seem to have long-term care integrated in existing health and personal social services, be it at a high or a more moderate level. The Member States with more Bismarck-oriented welfare states are expereincing, or have concluded, an often lengthy debate on the creation of an explicit social insurance scheme for long-term care. In the Netherlands an explicit insurance scheme for exceptional medical expenses has been in existence for several years. In Austria, Germany and Luxembourg the systems are more recent. In Belgium and France there is a long list of proposals and new initiatives, but a final

system has yet to emerge. In 1998 a Royal Commission on Long-term Care was set up in the United Kingdom. Long-term care has characteristics of both health insurance (triggered to a large extent by medical reasons, organised by the same or similar providers) and old age (pensions) insurance. In the UK those systems have been organised differently within the social protection system: health insurance in the pay-as-you-go, state financed, universal National Health Services, and pensions increasingly through privately-organised, funded schemes. With both experiences and traditions in this country, the outcome of the Royal Commission's work could help lead to a better understanding of the nature of long-term care insurance.

In the Mediterranean countries there has been less debate on the need for long-term care insurance, perhaps because there is an attachment to the family-based informal care model (care in the family, by the family) or because those countries were concentrating more on budgetary discipline. In the Nordic countries it is not on the agenda because the welfare states are highly developed, sometimes even subject to debate on downsizing.

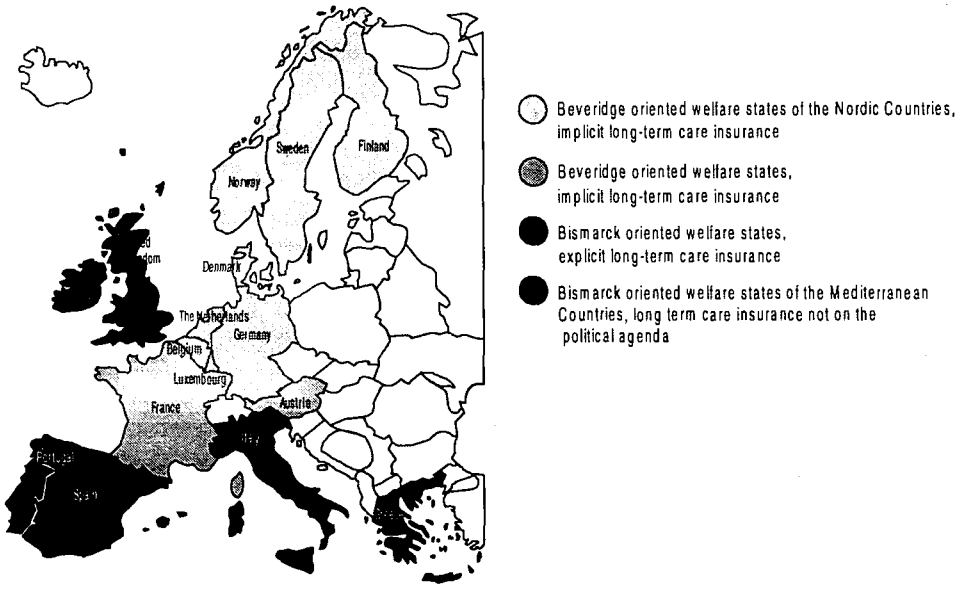



**Figure 4.** Relation between type of social protection and type of long-term care insurance: some common features

Where they already exist, long-term care insurance systems are not limited only to older people; they cover all long-term care situations. They are oriented towards services as well as cash support for the recipient or the main carer, implying some form of support or payment for informal care. This broadening of the scope is in line with the observation that, in general, in many countries fairly wide definitions of costs to be covered are used (including cure, care, housing, hotel costs). This illustrates the difficulty of determining what should be publicly financed, and

what privately, and the fading borderline between health care, social care, institutional care and community care, housing and living costs. The borderline between health and social services, between and within residential and community services, and between all kind of professional work tends to have disappeared. Perhaps in future the distinction between formal and informal care will also begin to lose its relevance, since informal carers will receive training and become more professional in their work and to some degree even be paid for their work. There is also no clear choice in favour of cash or in-kind support. Cash support (apparently allowing perhaps more consumer choice and empowerment) is in practice to a large extent oriented towards the financing of services. The mature welfare states seem to want to support both formal and informal care.

Only limited evidence has so far been found relating to widespread private involvement in long-term care insurance, at least as regards the insurance and financing aspect.

**Box 2.** How is the risk of long term care is covered

- sometimes implicit in the existing health and social care financing schemes
- sometimes financed by retaining pension income
- in the Bismarck-oriented systems with explicit insurance schemes
- most of the time of a pay-as-you-go (unfunded) nature
- situated in health insurance or close to it
- with wide definitions of costs
- most through public provision
- enlarging its coverage to payment for care

## 7. Conclusions

Concern about the social protection of dependent older persons and growing interest in the organisation of long-term care insurance are probably based on the observation that this risk is underinsured. The report puts forward several indicators on this. The report also describes the diversity, availability and affordability for large groups of the population of the benefits and services for the older people developed in the welfare state. Where the risk is insured, the political debate on the new risks of care for dependent older persons is still evolving along classical lines relating to social protection systems that have historically proved their viability. New systems of long-term care insurance seem to cover, currently, more than seven million European citizens. The principles according to which those systems continue to be developed are:

- in many countries long-term care is included in social expenditure or, more precisely, health insurance, organised in the same way as the rest of social protection in those countries;
- especially in the Bismarck-oriented system, there is some willingness, but not an absolute commitment, to define a new pillar for long-term care;

- wide definitions of the risk to be covered are maintained, since there is an increasingly unclear borderline between social services and health care;
- prioritising in-kind provision, or at least not rendering it unaffordable (for example, Germany has double the amount of resources available for in-kind help compared with cash help);
- including housing costs in the covered risk very often, but to a varying degree;
- enlarging the welfare state by (supplementary) systems of payment for care or support for the main carer, representing a shift to more support for informal care and to cash support;
- resistance to including it in social assistance systems, or to placing too much emphasis on income testing; retaining a preference for social security schemes. There is less willingness to require recourse to the family for help with financial costs, depletion of personal resources, and recovery of costs from inheritance;
- almost no presence of funded systems. Most of the solutions are pay-as-you-go, publicly-financed (or social security) systems. Some countries have chosen funded pension systems, but the 'funded' solution is almost absent from the practical European debate on long-term care;
- after a period of rationalisation in health care expenditure there is a renewed expansionary trend in expenditure, while services for older people continue to grow in variety and availability. This appears not to be at odds with the requirements of budgetary discipline;
- although the cost of long-term care is huge for older people who have to pay for it themselves, long-term care insurance, when existing, seems to be affordable at macro-level.

Whilst this conclusion is generally positive, it should not be forgotten that there are problems of under-protection, deteriorating quality, uncovered needs, or social protection falling behind the rest of the economy. Long-term care insurance can help prevent this. Although based on current facts and figures at this moment in time, this conclusion could change as illustrated above, and close monitoring of these phenomena is needed.

## 8. Need for basic data-collection

This comparative European report has been drawn up on the basis of reports by national experts on policy towards older people or on social protection. On several occasions no information could be obtained on certain aspects, leaving many comparative overviews with blank spots. This problem applies not only to expenditure data, but also to information on aspects of the care systems. Continued efforts to complete the facts and figures and to harmonise definitions, would greatly improve this situation. It would therefore be helpful for the authorities concerned to commit themselves to collecting uni-dimensional data on output, financing and clients of social and health services (for older people among others).

# *CHAPTER 1*
# *Methodology of international comparison of social protection of dependent older persons*

## 1. Research methodology

### 1.1 International overview

The research will focus on the availability of and the eligibility conditions for access to the systems of social protection, taking into account the living conditions of the dependent elderly. No attention will be paid to the organisational aspects. We will concentrate on the social protection elements, though within the framework of the complete set of provisions of which some are of private character.[1]

Several approaches are possible for obtaining an overview of the overall system of social protection provided for the dependent elderly. Dependency can result from various factors and it implies a need for help or support in a number of ways.

Care for the elderly is determined by a comprehensive set of formal and informal aspects, (in kind aid, income support, wealth, informal support by main carer, etc.). Care provision and funding may be the responsibility of different institutional levels and it may account for a larger or smaller percentage of total spending. Formal social protection includes three main systems:

- income support - pension systems;
- health care - health insurance;
- (social) services for the elderly.

In addition to these formal systems, informal care and support facilities continue to be provided quite extensively and are becoming progressively integrated into the formal sphere. Within this formal and informal care framework, new risks or needs in other areas of care are calling for various kinds of protection.

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1 For the moment in a lot of countries, the long-term care of the elderly is not completely covered by the national systems of social security, partly because much of the in kind support was regarded to be a regional or local responsibility. We have partial evidence that regional disparity is increasing, so that the regional factor is becoming an important discriminating factor.

This is illustrated in the matrix in Figure 1.3 (see section 2.3) regarding the financing structure of care for the elderly. This matrix needs to be extended with information on eligibility for the several systems and with the actual results of the available choices: how many people have access to a given care system, and to what extent is the total amount of their needs covered by these systems?[2]

Normally, studies start from the coverage of certain care systems and then additional information is given on the average profile of each service. Missing information is how certain care systems cumulate in level of protection but also in costs, or otherwise left possible blank spots. The advantage of this approach is that it gives a complete institutional picture and a quantitative, even macro-economic, overview of the social protection systems. The amount of detail available depends on the existent administrative information system. The results can be presented in the matrix below, completed by a list of provisions available for the dependent elderly. This report summarises the available information.

## 1.2 Typology of the elderly population

An alternative methodology starts from a sample of the older population, sketching their socio-economic situation, and especially their dependency situation and the care systems available to them. The problem is that these surveys are not always available, so they need to be specially organised and may not be representative enough, particularly for health and dependency questions. When the information is available, then average situations can be described according to certain criteria, such as age, family situation, income, etc., and even statistical instruments can be used (e.g. factor analysis) to identify certain representative profiles.

Since these typologies based on identical surveys imply an extensive gathering of data and institutional analysis, this research method will not be used.

## 1.3 Case studies

A third methodology assesses on a theoretical institutional basis what options are open for certain categories of the elderly population. The advantage is that it gives a clear view of the situation of similar groups of elderly persons in different countries. The problem, however, is how representative the categories are, as well as the different solutions that are open to them. For the theoretical availability of certain systems, this methodology is probably reliable, but there remains a problem of quantifiable representativeness.

This methodology is sometimes used in the case of relatively simple situations as, for example, a specific group of handicapped persons and a limited number of (often also specific) elements of social protection. What is typical for the circum-

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2 See, for instance, data used in health care relating to how many persons are protected by health insurance, and what share this is of the total cost (see OECD health data).

stances of the elderly people, however, is the great variety of health, social, economic and care situations. The number of case studies can therefore be multiplied to an almost unlimited extent, raising questions about the representativeness of these cases.

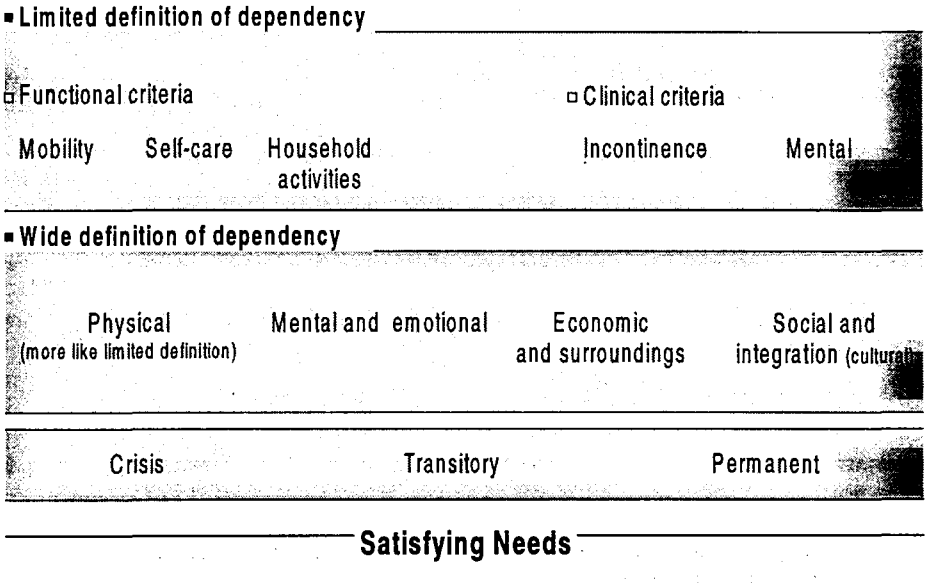
This methodology is very convenient, however, for comparing how people in similar objective situations are treated in the social protection systems of the different countries. Therefore in Chapter 5 of the report we use the methodology based on examples.

## 2. Definition of dependency and the need for social protection

### 2.1 Definition of dependency

Dependency can be defined in terms of four dimensions. Dependency can be expressed in *physical* terms and, as such, can be measured by means of scales (e.g. Katz). Such a scale can be expanded to contain *mental* aspects. In addition to these two dimensions, there is the *social* dimension and, finally, the *economic* dimension.

In the case of physical dependency, care services - supplied by professionals or non-professionals - will have to be focused upon. In the case of social dependency, a support network will have to be established, and in the case of economic dependency, income support will be necessary.




Source: Based on Wilkin and Thompson.

**Figure 1.1** Definition of dependency

Because the focus of the study is on dependent people in need of long-term care, special reference should be made to the physical and mental dimension of this

dependency. These, as well as other dimensions of dependency come back in the case studies. The social dimensions (living alone or having the support of a network) and the economic dimensions seem to have substantial operational meaning in these case studies: eligibility criteria are sometimes related to aspects of living condition and income.
For a clear description of who is 'to a large extent disabled or physically dependent', the Katz Index of ADL containing six personal activities is used. It is supplemented with four instrumental activities because attention should also be given to activities experienced by older persons living in the community, such as housekeeping, transportation and shopping. Definitions of the four instrumental activities (I-ADL) and six personal activities (P-ADL) can be found in Table 1.1. In executing one of the ten activities, an older person can be either 'independent' (meaning that no third person is involved in the activity) or 'dependent'. A cumulative scale has been constructed on the basis of these ten activities. Research on the basis of this scale (Sonn & Åsberg, 1991) showed that people were either independent or dependent on I-ADL or dependent on both I-ADL and P-ADL; nobody was dependent on P-ADL and independent of I-ADL. In defining our case studies, only elderly persons dependent on I-ADL and P-ADL are retained. This means that of the grades I+P-ADL as described in Table 1.2, all elderly persons of grade five and above are included in the study. Comparisons have also been made with one of the six dimensions in the WHO handicap classification scale, the dimension of physical independence, which is based on the actual performance of the persons and not on their capability. The physical independence/dependence continuum is broken down into eight different levels:
0 = fully independent;
1 = aided independence;
2 = adapted independence;
3 = situational dependence;
4 = long-interval (>24 h.) dependence;
5 = short-interval (every 10 h.) dependence;
6 = critical-interval dependence;
7 = special care dependence;
8 = intensive-care dependence.

Categories 4 to 8 are considered as being equivalent to the categories of elderly people retained for our research.

In the case studies of couples living in the community, only one of the two older persons is considered to be fully disabled.

**Table 1.1** Definitions of I-ADL and P-ADL

| Definitions of four instrumental activities and six personal activities included in the Katz Index of ADL and of independent, partly dependent and dependent | |
|---|---|
| *Shopping* | Gets to the store, manages stairs or other obstacles, takes out groceries, pays for them and carries them home |
| Independent | Performs the activity when necessary |
| Partly dependent | Performs the activity but together with another person |
| Dependent | Does not perform the activity or needs assistance with some part of the activity |
| *Cleaning* | Performs housing-cleaning, vacuum-cleaning, washing floors |
| Independent | Performs the activity when necessary |
| Partly dependent | Gets assistance in taking the carpets outdoors or assistance very seldom |
| Dependent | Does not perform the activity or gets assistance with some part of the activity regularly |
| *Transportation* | Gets to the stop for public transportation, gets on and goes by bus, tram or train |
| Independent | Performs the activity when needed |
| Partly dependent | Performs the activity but together with another person |
| Dependent | Does not perform the activity |
| *Cooking* | Gets to the kitchen, prepares the food, manages the stove |
| Independent | Performs the activity when needed |
| Partly dependent | Does not prepare dinner food, or only heats up prepared food |
| Dependent | Does not perform the activity |
| *Bathing* | Means sponge bath, tub bath, or shower |
| Independent | Receives no assistance (gets in and out of tub by self if tub is usual means of bathing) |
| Partly dependent | Receives assistance in bathing only one part of the body (such as back or a leg) |
| Dependent | Receives assistance in bathing more than one part of the body (or does not bathe self) |
| *Dressing* | Means getting all needed clothing from closets and drawers and getting dresses, includes using fasteners, and putting on a brace, if worn |
| Independent | Gets clothes and gets completely dressed without assistance |
| Partly dependent | Gets clothes and gets dressed without assistance except for help with tying shoes |
| Dependent | Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed |
| *Toileting* | Means going to the 'toilet room' for bowel and urine elimination, cleaning self after elimination and arranging clothes |
| Independent | Goes to the 'toilet room', cleans self and arranges clothes without assistance |
| Partly dependent | Receives assistance in going to the 'toilet room' or in cleaning self or in arranging clothes after elimination, or in using the night bedpan or commode |
| Dependent | Does not go to the 'toilet room' for elimination |

**Table 1.1** Definitions of I-ADL and P-ADL. Continued

| Definitions of four instrumental activities and six personal activities included in the Katz Index of ADL and of independent, partly dependent and dependent | |
|---|---|
| *Transfer* | Means moving in and out of bed and in and out of chair |
| Independent | Moves in and out of bed and in and out of chair without assistance (may use support object such as a cane or walker) |
| Partly dependent | Moves in and out of bed or chair with assistance |
| Dependent | Does not get out of bed |
| *Continence* | Means the function of controlling elimination from the bladder and bowel |
| Independent | Controls urination and bowel movement completely by self |
| Partly dependent | Has occasional 'accidents' |
| Dependent | Supervision helps keep urine or bowel control, or catheter is used, or is incontinent |
| *Feeding* | Means the basic process of getting food from plate or equivalent into the mouth |
| Independent | Feeds self without assistance |
| Partly dependent | Feeds self except for getting assistance in cutting meat or buttering bread |
| Dependent | Receives assistance in feeding or is fed partly or completely trough tubes or with intravenous fluids |

Remarks: Partly dependent is assessed as dependent in cooking, shopping and transportation and as independent in cleaning. Partly dependent is assessed as dependent in toileting, transfer, and continence and as independent in bathing, dressing, and feeding.
Source: Sonn U., Åsberg K.H. (1991), p. 193-202

**Table 1.2** Cumulative scale on the basis of I-ADL and P-ADL

| Katz ADL Grade | Grades I + P-ADL | Definitions |
|---|---|---|
| B | 5 | Dependent in all I-ADL and one more activity |
| C | 6 | Dependent in I-ADL, bathing and one more activity |
| D | 7 | Dependent in I-ADL, bathing, dressing and one more activity |
| E | 8 | Dependent in I-ADL, bathing, dressing, going to the toilet and one more activity |
| F/G | 9 | Dependent in all activities |
| Others | Others | Dependent in two or more activities but not classifiable as above |
| If the item of continence is included, the definitions of the last two steps will be as follows; | | |
| F | 9 | Dependent in I-ADL, bathing, dressing, going to the toilet, transfer and one more activity |
| G | 10 | Dependent in all activities |

Source: Sonn U., Åsberg K.H. (1991), p. 193-202

## 2.2 Risks

There are various risks dependent people can be confronted with, and the ways in which they can insure themselves against these risks are equally various. They need income support and various forms of professional and non-professional care. The following scheme summarises this well. The means to cover these needs for care are as diverse as the needs themselves. Normally, the social security system covers the income and health care risks and different levels are responsible for other forms of care. Sometimes the costs have to be borne individually or by private insurance. Finally, a lot of care is still provided by the family.

The systems that have been developed in the past, however, are no longer able - or prepared - to bear certain risks. Surely this opinion has grown out of the realisation that the greying of the society will multiply the needs for resources in the future. Proposals have thus been made to let the elderly bear more of the burden, and ideas concerning new care systems which will assure this care, publicly or privately, have been developed.

To inform ourselves on how care for the elderly is insured nowadays, the next matrix should be filled in. The matrix is constructed in ascending order (private to public), illustrating the idea of subsidiarity that inevitably accompanies the organisation of care.

We have clearly opted for a broad definition of dependency. We can be sure of some of these aspects that they are guaranteed and will be guaranteed in the future. Income support in the form of pensions will be provided on an index-linked level. The health care system as it now exists will not be called into question. The degree to which the risks are covered, however, differs greatly from country to country.

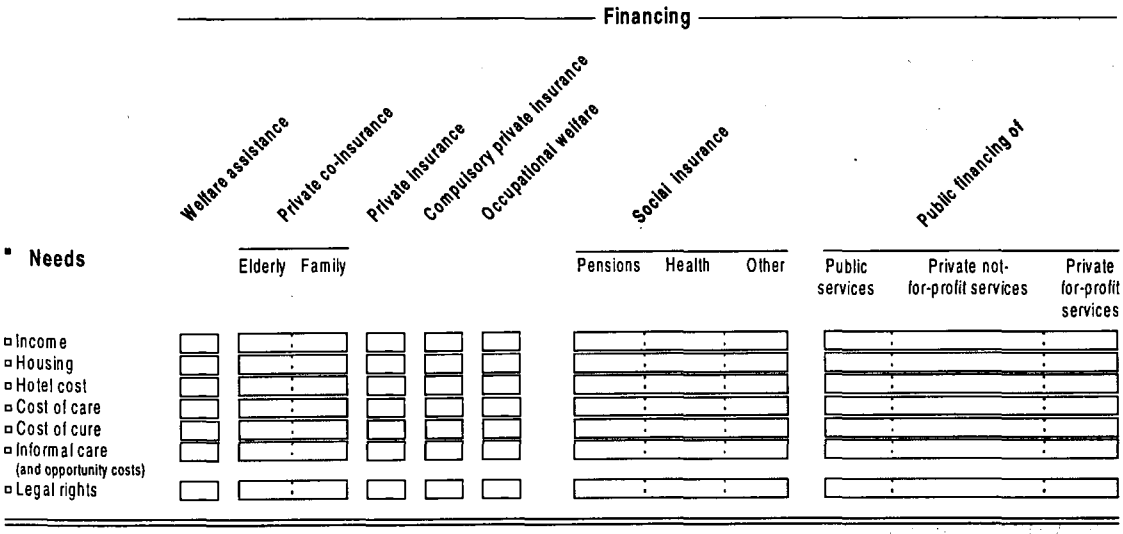



**Figure 1.2** Financing several components of care for the elderly

## 2.3 Some theoretical concepts relating to the organisation of the care

Care of the elderly concerns to a great extent the acquisition of personal help. These needs of the elderly are usually considered to be vital - as a kind of 'merit want'. Nobody should be excluded from it. The provision can be made either by assistance in kind (services provided) or in cash. The latter means income support and redistribution policies so that the elderly can buy the services on the market. Advocates of assistance in kind argue that the state or service providers can better assess the needs of the client, while advocates of assistance in cash stress consumer sovereignty. (Further, we will show that there need not be an opposition between these two). An extreme position, finally, could be that of no intervention by the state. There is a substitution between aid in cash and in kind. When there are more services available at a low price, then there is less need for income support, and vice versa. So when looking at services for the elderly, we must in any case not forget the income policy with regard to the elderly (when comparing countries and looking into the future).

Aid in kind includes a complete set of organisational models of what can more or less be called intervention by the government in the financing or organisation of services. This picture should be further completed by the distinction between the formal and the informal sector, since income support and services in kind could be provided both by the formal sector (the state or the market) and by the informal sector (individual responsibility, self help, family help and social networks).

Figure 1.3 gives a summary of these different organisational forms, together with the financing methods.[3]

Services can be financed by personal resources, charity,[4] private insurance,[5] or by public subsidy. The public subsidy can be complete or partial. It mostly goes to the formal professional services. These can be provided by private for-profit or non-profit organisations, or by public firms. In rare cases, the informal sector is financed (for instance a fee for the main carer or paid volunteers).

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3 A comparable structural arrangement of the welfare organisation can be found in Grindheim J.E., Selle P., 1990, p. 64.

4 This type of private solution is not always a guarantee of cost-efficiency: some commercially organised charity actions show extremely high costs and, considering the usual tax subsidy, they do not raise much extra money.

5 Here, too, inefficiency is possible. Most current Medicare supplemental insurers in the USA spend 40% of the premiums on marketing, administrative expenses and profits (Rivlin A.M., Wiener J.M., 1988, p. 213). The organised health care system in the USA, which is to a large extent private, takes a higher proportion of GNP for a lower degree of protection of the population.

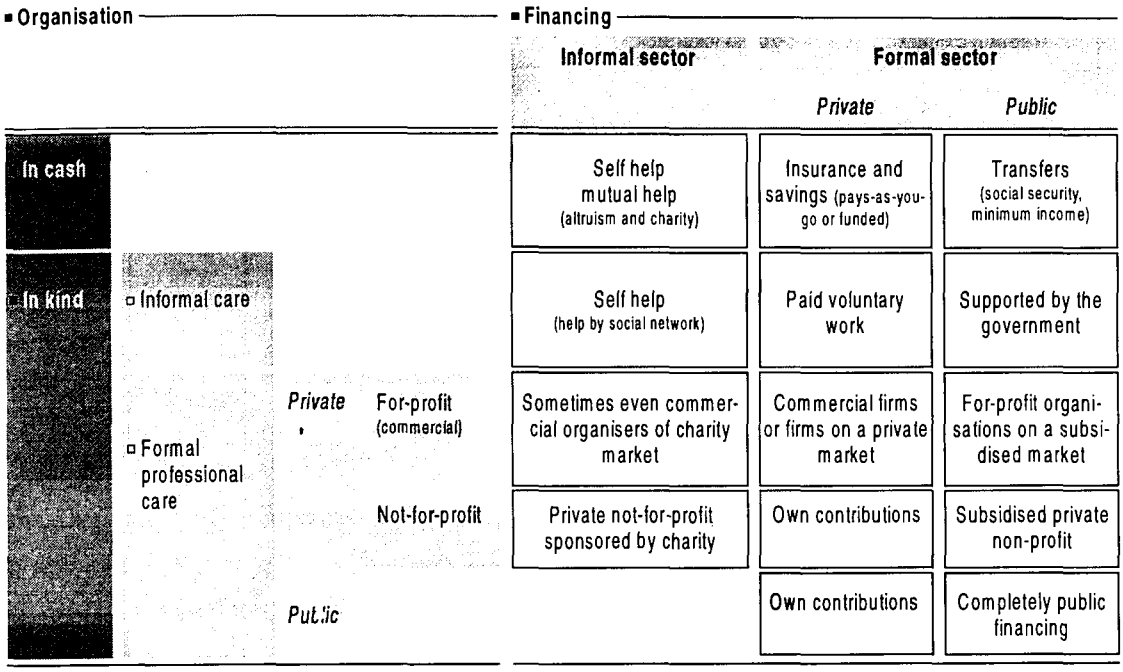



**Figure 1.3** Matrix of financing and organising care of the elderly

## 3. Some macro-assessment of the risk

There is limited information available on the risk of old age dependency; it relates basically to four factors:

- the increasing number of older persons;
- the increasing life expectancy;
- the increasing degree of dependency;
- the increasing need for several types of care.

This is summarised in the following scheme:

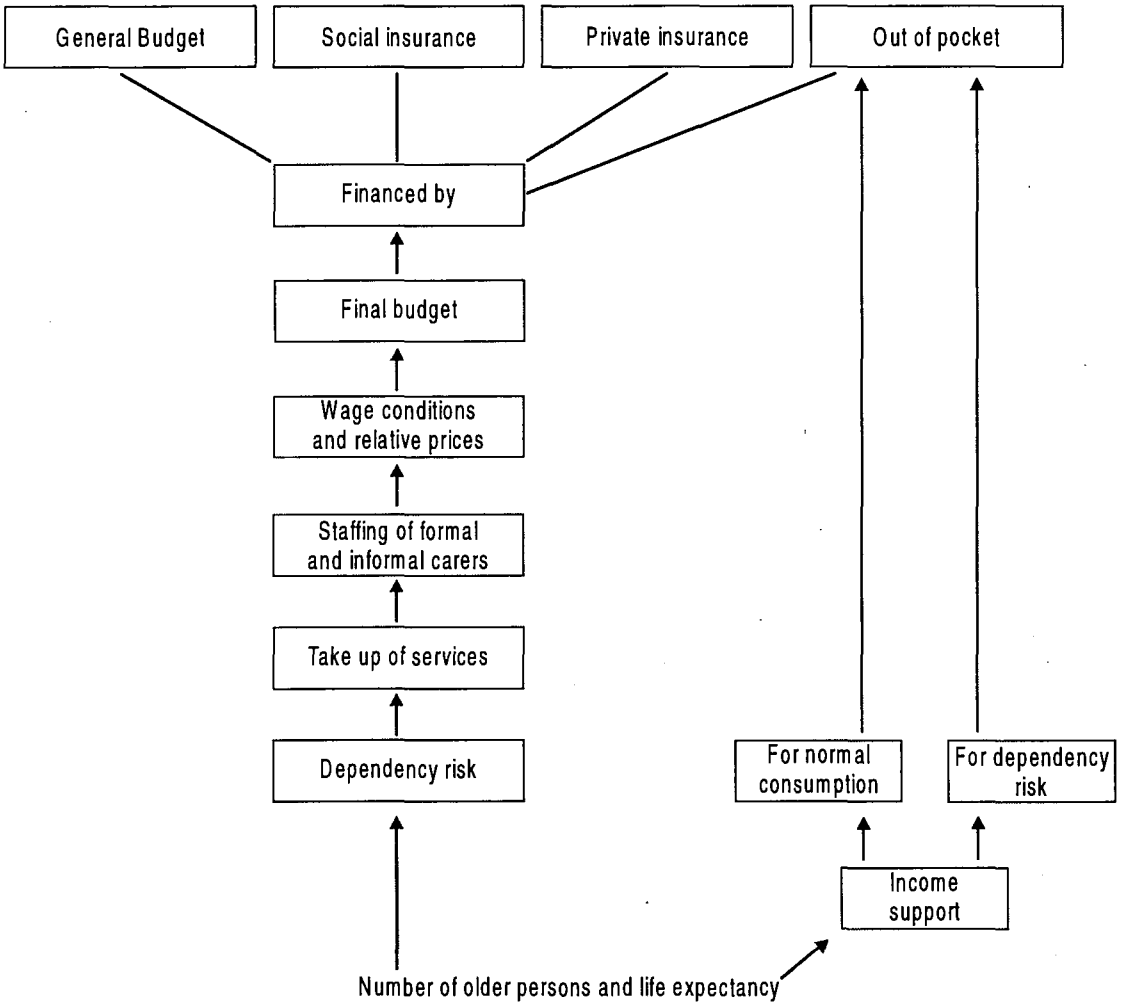



**Figure 1.4** Macro-assessment of the risk of old age dependency

# *CHAPTER 2*
# *Number of dependent older persons*

Based on a certain combination of macro-figures and micro-information of dependency, we give some indication of this overall risk, defined as the share of the population whose long-term care needs have to be covered.

The macro-risk related to the cost of old age and dependency of an economy is determined by the age structure of the population and the degree of illness and disability or dependency among older persons. 'Dependency' is multi-dimensional and can be defined in physical, mental (or emotional), economic and social terms.

Figure 2.1 starts with the obligatory age structure of the population.

The number of older persons overwhelmingly determines the overall macro-risk. The proportion of people above 65 will increase in the EU between now and 2020 from 15% to 20% of the total population (see figure 2.1).

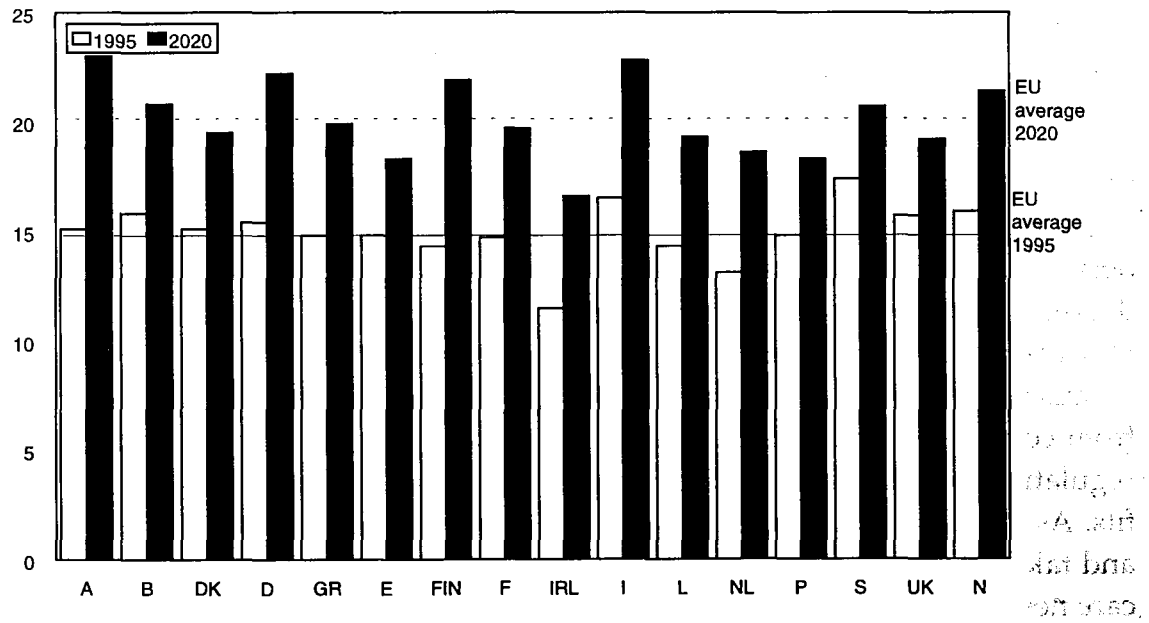



**Figure 2.1** Percentage elderly persons (65+) in total population, present situation and forecast for 2020

On a micro-level, dependency can be defined by using various scaling techniques or assessment procedures, (for instance those used to define dementia). Each country and service provider, and even each researcher investigating services for the elderly, defines dependency in a different way. Generalising and aggregating to a macro-level the findings of Figure 2.1 and Table 2.1, we can conclude that the old-age risk is now linked with ±15% of the population, ±20% of whom will be dependent on PADL (Personal activities of daily living) and IADL (Instrumental activities of daily living) after the age of 65. Approximately 5% of the 65-plusers are expected to be severely dependent on PADL ('median' figure).

Most of the EU Member States currently have a population above 65 of between 11% (Ireland) and 17% (Sweden) of the total population. Generally the average proportion is around 15%. In the year 2020 it will be between 18 and 23%. This ageing of the population will be the result of the increasing life expectancy of the population, (which between 1980 and 1993, for example, was 1 to 4 years).

At the same time, the ageing and the double ageing of the population will imply a significant increase in dependent persons. Of the 65-plusers, between 3% and 5% are severely dependent, and up to 15% are partially dependent. If we consider persons 75 and older, the number of highly dependent persons increases to 10%, and the partially dependent goes up to 25%. This leaves us with a population of highly dependent persons of on average 3% of the total population, or about 9 million persons in Europe. On the basis of the national reports, we identified in the member states at least 7.6 million persons who in some way or another are receiving an allowance because of dependency (see also Tables 2.1 and 2.2).

The pressure of this increasing dependency and increasing life expectancy places a higher fiscal burden on the existing systems than they were originally designed to bear. This has been discovered in many countries and has led to the debate on long-term care insurance. The European year of the Elderly in 1993 brought this phenomenon to public attention in many countries. This growing public awareness could transform a 'fact of life' into a source of political pressure.

Up to the age of 70, there are only a small percentage of fully dependent elderly persons, but above this age the percentage rises to more than 10%. The largest degrees of dependency are noticed particularly in the age groups 75+ and 80+. However, we must be very careful when drawing conclusions from these figures, because they are only estimates. Moreover, the definition of 'dependency' differs from country to country. The table below presents definitions applied in existing regulations, or definitions illustrating the real take-up of certain services or benefits. As yet, there are no universally applied standards for measuring dependency and take-up of care. These definitions are very important, however, for estimating care needs.

Therefore it is inappropriate to identify the elderly with dependent persons. The elderly are, to an increasing extent, healthy and even wealthy citizens, who are seeking empowerment and high-standard living conditions. However, this is not

the total picture. Older persons are often confronted with an early exit from the labour market, which implies at least one form of exclusion. The elderly are especially confronted by increased concern about their present and future income and health expenditure. This personal feeling of insecurity is present on a macro-level, in the overall concern of governments about the future of the pension schemes and health expenditure in the next decade, exacerbated by the pressure of the ageing population. Previous research by A. Walker (Walker A., Alber J., Guillemard A.-M., 1993) has documented that the elderly feel comfortable about their personal surroundings, but uneasy about the political concern for their cause, illustrating that individual morale and collective morale do not necessarily co-exist. For some, this concern about economic insecurity has already become a reality, and for others it has never been anything else. In many countries, older persons are in a deprived situation and are confronted with high care expenditure. However, most of the time their needs are covered and protected by well developed welfare state systems. A description of the present situation regarding the social protection of dependent older persons provides us with an opportunity (because the starting point is dependency, and therefore people in need of care) to show the map of the welfare state for this target group. Even more, the way we take care of the frailest elderly best illustrates the level of social quality and dignity of the care systems and the welfare state in general. Dependency can be enlarged from narrow to broader definitions so that we can illustrate how the complete welfare state responds to these dependency risks and needs.

**Table 2.1** Degree of dependency of elderly

| Country | Definition of dependency | Number of dependent elderly | % dependent elderly |
|---|---|---|---|
| A | The assessment of dependency is based on the number of hours a person needs care. All people with disabilities and/or chronic illness, who are in need of at least 50 hours of attendance and care per month, are entitled to an attendance allowance. | ±250,000 pensioners received an attendance allowance in 1996: | ±21% of 65+ |
| B | A person is considered to be physically dependent if he is at least dependent in bathing, dressing, transfer and/or toileting. | 57,150 persons in homes (1996): | 3.5% of 65+ |
| | | 30,793 elderly persons in the community (1992): | 2% of 65+ |
| DK | Elderly persons are considered to be dependent if they are dependent as regards performance of the 4 instrumental activities: cooking, shopping, cleaning and transportation. Furthermore they are dependent on assistance as regards carrying out at least one of the following six personal activities: eating, dressing, bathing, toileting, continence and walking. | | 10% of 70+ is dependent on help to PADL (1989) |
| D | Persons in need of long-term care are persons who in the field of personal hygiene, alimentation or mobility need help at least once a day for at least 2 activities, and who require help with household affairs several times a week. | Persons in need of long-term care aged 60-80: 650,000; >80 years: 600,000 (1995) | 5.6% of age group 60-80; 18% of 80+ |
| GR | | | |
| E | Fully disabled means having very serious difficulties in performing personal care, domestic activities and external relations (shopping, visits to relatives, ...) and needing permanent care of relatives or social services for at least 8 hours per day. | | |
| FIN | There is no universal definition of dependency, but various need indicators are implemented. Often they are based on the ADL and IADL indexes. | ± 35,650 elderly over 65 years are severely incapacitated. | 5% of 65+ |
| F | Fully disabled means that the persons are either bound to bed or chair [1], or else not bound to bed or chair but in need of help for toileting and dressing [2]. | 290,000 [1] (1990): 370,000 [2] (1990): | 3.6% [1] of 65+ 4.6% [2] of 65+ |
| IRL | Functionally disabled means requiring assistance with mobility and personal care, as well as having medical and psychological problems. | 66,000 old people living at home are functionally disabled (1988): | 17% of 65+ |

**Table 2.1** Degree of dependency of elderly. Continued

| Country | Definition of dependency | Number of dependent elderly | % dependent elderly |
|---|---|---|---|
| I | Persons not self-sufficient to perform the Activities of Daily Living in part or completely. | 2,024,770 older persons: not self-sufficient in at least 1 activity (1994): | 22% of 65+ |
| | | 901,943 are not self-sufficient in at least 3 activities (1994): | 9.8% of 65+ |
| | | total disability: 184,070 older persons (1994): | 2% of 65+ |
| L | Fully disabled means according to the Luxembourg legislation 'dependent in one or more physical or mental functions to that extent that the help or constant care of a third person is needed'<br>3 levels of dependency can be distinguished:<br><br>level 1: needing help different times a week<br>level 2: needing help once a day<br>level 3: needing help on a permanent basis. | Older persons living at home:<br>level 1: 1,200:<br>level 2: 1,242:<br>level 3: 389 (1995):<br>Older persons living in an institution:<br>level 1: 932:<br>level 2: 1,553:<br>level 3: 1,123: | <br>2.1% of 65+<br>2.2% of 65+<br>0.7% of 65+<br><br><br>1.6% of 65+<br>2.7% of 65+<br>2% of 65+ |
| NL | The definition of dependency is based on a combined index of impairment of ADL and IADL activities, reduced to a division into four categories:<br>1. little or no impairment: no ADL problems and IADL activities can be performed almost completely alone (help for at most one activity is needed);<br>2. moderate impairment: independent in conformity with the ADL-index and help needed for at most two housekeeping activities;<br>3. severe impairment: dependency on one or two ADL activities and simultaneously difficulty with many housekeeping activities;<br>4. very severe impairment: difficulties with many ADL activities and any of the housekeeping activities can no longer be performed. | 697,450 older persons report problems in performing at least 1 ADL-activity:<br>1,754,180 older persons report problems in performing IADL-activities: | 34.3% of 65+<br><br>86.2% of 65+ |
| P | Fully disabled means 'being in need of permanent help' | | |

**Table 2.1** Degree of dependency of elderly. Continued

| Country | Definition of dependency | Number of dependent elderly | % dependent elderly |
|---|---|---|---|
| S | B-category = dependent in all I-ADL and one more activity<br>C-category = dependent in all I-ADL, bathing and one more activity<br>D-category = dependent in all I-ADL, bathing, dressing and one more activity<br>E-category = dependent in all I-ADL, bathing, dressing, going to the toilet and one more activity<br>F-category = dependent in all I-ADL, bathing, dressing, going to the toilet, transfer and one more activity;<br>G-category = dependent in all activities<br>Others = dependent in two or more activities but not classifiable as above | | 65+ in nursing homes: A: 5%; B, C, D: 9%; E, F: 58%; G: 25%; Others: 3%<br>65+ in the community: B: 11.3%; E: 2.4% |
| UK | People defined as short-interval dependent may have needs such as bathing and washing which need to be met at specific times of the day and at least once a day<br>People who are critical-interval dependent have needs which are unpredictable such as assistance with toileting and they usually require 24 hour supervision | 1,320,000 elderly are short- or critical-interval 'dependent': | 15% of 65+ |
| N | Fully disabled persons = persons with long-term and rather severe dependency in instrumental and/or personal activities of daily living | All residents in institutional care are severely dependent: | 6-7% of 67+<br>20-25% of the 65+ living at home: dependent upon help for shopping and cleaning; 2-4%: help for dressing and to move around indoors (1995) (1) |

(1) Only the latter criteria (dressing and moving indoors) imply a dependency level fairly close to a 'need for institutional care'.
Source: Definitions and figures mentioned in the national reports.

**Table 2.2** Summary table on ageing and dependency

| | Austria | Belgium | Denmark | Germany | Greece | Spain | Finland | France |
|---|---|---|---|---|---|---|---|---|
| **Ageing** | | | | | | | | |
| Total population (x 1,000) (1995) | 8,053 | 10,131 | 5,251 (1996) | 81,539 | 10,368 (1993) | 38,662 (1994) | 5,117 | 58,038 (1994) |
| % population over 65 (1995) | 15.1 | 15.8 | 15.1 (1996) | 15.4 | 14.8 (1993) | 14.8 (1994) | 14.3 | 14.7 (1994) |
| Total population (x 1,000) (2020) | 8,369 | 10,382 | 5,113 | 77,936 | 10,080 | 38,348 | 5,393 | 60,021 |
| % population over 65 (2020) | 23 | 20.8 | 19.5 | 22.2 | 19.9 | 18.3 | 21.9 | 19.7 |
| **Dependency** | | | | | | | | |
| 65+, fully dependent | | | | | | | | |
| Number | | 87,943 | | 650,000 (60-80) | | | 35,650 | 660,000 |
| % | | 5.5 | | 5.6 (60-80) | | | 5 | 8.2 |
| 65+, partly dependent | | | | | | | | |
| Number | | | | | | | | |
| % | | | | | | | | |
| 70+, fully dependent | | | | | | | | |
| Number | | | 36,000 | 600,000 (80+) | | | | |
| % | | | 10 | 18 (80+) | | | | |
| 70+, partly dependent | | | | | | | | |
| Number | | | | | | | | |
| % | | | | | | | | |

**Table 2.2** Summary table on ageing and dependency. Continued

| | Ireland | Italy | Luxembourg | The Netherlands | Portugal | Sweden | United Kingdom | Norway |
|---|---|---|---|---|---|---|---|---|
| **Ageing** | | | | | | | | |
| Total population (x 1,000) (1995) | 3,571 (1994) | 57,269 | 385 (1991) | 15,382 (1994) | 9,927 | 8,816 (1994) | 57,808 (1994) | 4,370 (1996) |
| % population over 65 (1995) | 11.5 (1994) | 16.4 | 14.3 (1991) | 13.1 (1994) | 14.8 | 17.4 (1994) | 15.7 (1994) | 15.9 (1996) |
| Total population (x 1,000) (2020) | 3,876 | 53,649 | 439 | 16,286 | 9,955 | 9,466 | 61,130 | 4,670 |
| % population over 65 (2020) | 16.6 | 22.8 | 19.3 | 18.6 | 18.3 | 20.7 | 19.2 | 21.4 (2030) |
| **Dependency** | | | | | | | | |
| 65+, fully dependent | | | | | | | | |
| Number | | 184,070 | 1,512 | | | | | 41,690 |
| % | | 2 | 2.7 | | | | | 6 |
| 65+, partly dependent | | | | | | | | |
| Number | | 2,926,713 | 4,927 | | | | 1,320,000 | |
| % | | 31.8 | 7.2 | | | | 15 | |
| 70+, fully dependent | | | | | | | | |
| Number | | | | | | | | |
| % | | | | | | | | |
| 70+, partly dependent | | | | | | | | |
| Number | | | | | | | | |
| % | | | | | | | | |

# *CHAPTER 3*
# *Some macro-observations regarding social protection of dependent older persons*

How are the needs of the (dependent) elderly met? A broad definition of needs has been used in this study. Income, housing, health, social services, rights of participation and legal rights to maintain privacy, autonomy and empowerment are included.

Dependency refers not only to functional or clinical criteria, but also includes physical, mental, economic and socio-cultural aspects relating to the elderly, ill or handicapped persons. The needs derived from this complete set have to be met by social protection systems. These systems have until now exhibited a high level and largely differentiated mix of care for the elderly.

Actual utilisation, the supply of services, the quality of care and the cost of supplying this care determine the financial risk related to the actual care expenditures. This risk depends on the likelihood of care being required, the length of care and the intensity with which it is used. Detailed (actuarial) studies are not readily available. The actual level of services being supplied reflects only the needs which are now being recognised and satisfied. It does not inform us as to the unmet needs.

The level of social protection in the countries under consideration is reflected in the volume of public expenditure on this sector as a percentage of GDP. The bulk of this expenditure is earmarked for pensions and health care. In some countries, this expenditure is as high as 20% of GDP.

The distinction between in-kind and in-cash aid may provide us with another angle from which to examine the welfare state. The Netherlands and - to a lesser degree - Belgium, Germany and France have more cash-oriented welfare systems. The UK and Ireland are more services oriented. This distinction in systems, which is illustrated in the detailed analysis of the social protection systems, can influence the direction taken by new proposals.

There is a huge number of studies on pension and health care systems. Here only certain macro-information is given on pensions, which are meant to maintain the complete scope of the social protection system for the (dependent) elderly. Since the focus of the study was on the protection of the dependent elderly, this

macro-overview of the income support system is completed with certain micro-information on additional cash benefits and allowances related to dependency. The major social expenditures related to dependency are situated in the health insurance. Again as context variables we describe the general evolution of social expenditures and the share of expenditures for older persons.

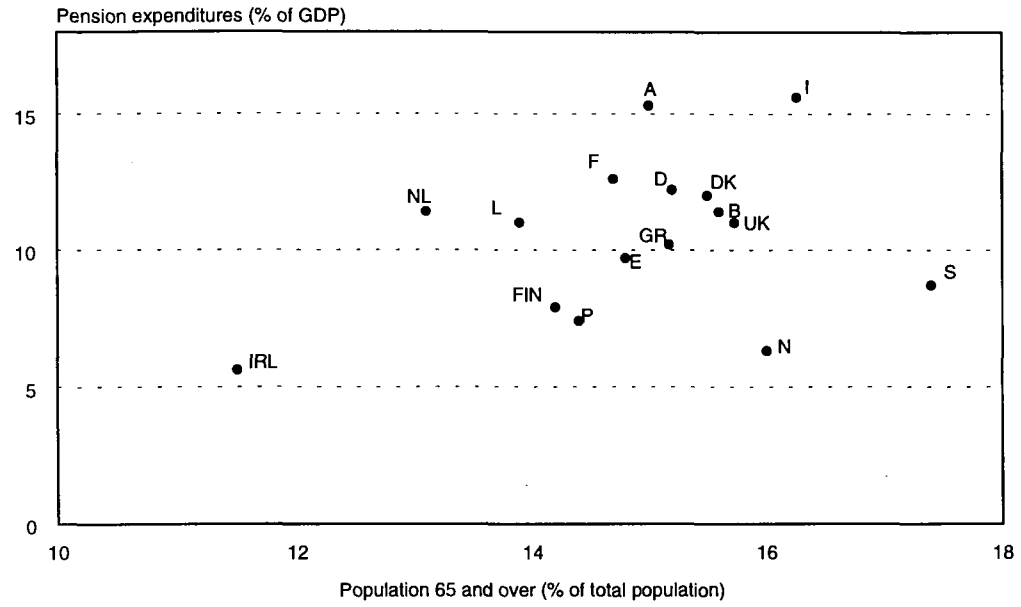
The main macro-characteristics are summarised in Table 3.2.

## 1. Income protection

The pension schemes range from the legal pension scheme, occupational welfare and guaranteed income, to private life insurance, individual pension savings accounts and other allowances (such as in-cash benefits).

In 1995 the share of persons above 65 varied from 11.5% (Ireland) to 17.4% (Sweden). For pensions, the total public spending in the basic system varies from less than 3% of GDP in Ireland to 15% in Austria and Italy. Some countries are definitively more cash oriented in their social protection systems, with very high replacement ratios for the pensions. Figures on pension expenditures and replacement ratios in Table 3.2 normally relate to the first pillar. Countries with a compulsory national second pillar are the exceptions to this rule.

In the next figure, the EU countries and Norway are compared on the basis of their position regarding ageing (proportion of those over 65) and the scope of pension expenditure (as a percentage of GDP).




Source: Eurostat

**Figure 3.1.** Pension expenditures (basic + compulsory occupational + voluntary occupational) as a percentage of GDP and percentage of population aged 65 and over, 1994

Figure 3.1 demonstrates the positive link between the degree of ageing of the population and the proportion of pension expenditure as a percentage of GDP. In other words, countries with a relatively older population also spend more, generally speaking, on pensions. Ireland, for example (relatively younger population and relatively lower pension expenditure), can be compared with Denmark (relatively older population and relatively higher pension expenditure). Nonetheless, it is equally clear that such a link has to be placed within a broad margin of institutional choices concerning the level and structure of protection. Replacement ratios, the overall level of social protection and the existence of funded alternatives can all influence the picture. In addition, problems of definition are always present. For instance, in 1994 the number of those over 65 in Greece and Austria was identical, while the difference in relative expenditure is considerable. On the other hand, the Netherlands and Belgium have very similar pension expenditures, although they differ in terms of relative ageing.

The following figure gives the percentage of supplementary pensions in total pension expenditures.

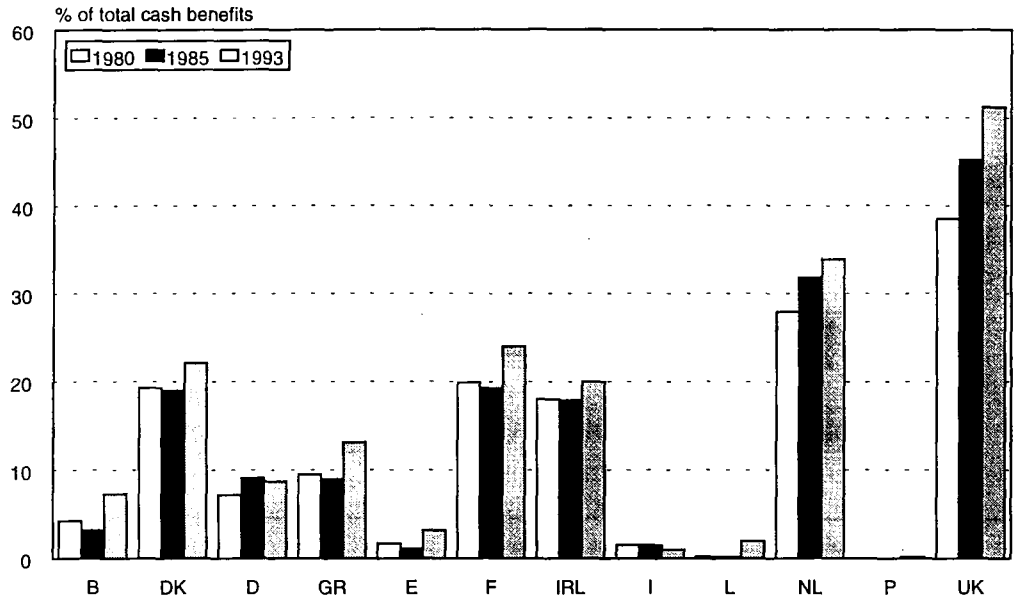



**Figure 3.2** Supplementary pensions as a percentage of total pension benefits

In recent years, supplementary pension systems have been developed, partly as a way of alleviating the difficulties of financing state pensions. In the Netherlands, the United Kingdom and France, supplementary pensions already account for a substantial proportion of total pension benefits (see figure above). Different countries have opted for different systems: some concentrate on the legal pension (Belgium, Germany, Italy, Luxembourg, Spain and Portugal), others on the substantially funded pension (the United Kingdom and the Netherlands), and still others on a system in between the two (Denmark, Ireland and, remarkably, also France). It can also be observed from this picture that those choices have not changed substantially over the last fifteen years. The relative importance of 'second pillars' remains stable, at least in the payout of the pension system. In future this can/will change because there is some change in the number of persons contributing to 'second-pillar' pension schemes (see the basic report). The legal pension system remains the major part of social protection, although second and 'third pillar' solutions occur and are growing.

## 2. Other elements of income support: cash benefits and allowances

As illustrated also by the detailed analysis of individual case studies (see Chapter 5), income support for the elderly is not limited to the pension system.

There is a clear difference between the pension systems of, for instance, Germany, Belgium and France, where substantial statutory pensions are available (systems more typical of countries on the European mainland), and the universal but sometimes rather low flat-rate, basic pension system with important occupa-

tional and private, contractual systems of a funded nature such as in the Netherlands, the UK and Denmark.

Additional characteristics that ought to be taken into account when defining the level of social protection is the pensionable age and the extent to which people of a pensionable age are allowed to continue to be gainfully employed, sometimes in combination with receiving a pension.

In addition to the public pension system of income support for the elderly, all the countries under consideration offer tax expenditures related to occupational welfare and nearly all the countries have tax benefits related to individual pension fund schemes or private pension savings.

In many countries, income support is accompanied by a rent subsidy system for lower income groups. Rent control could be an alternative: in Portugal a remarkable example is given of how this can benefit older persons. Rent subsidies are highly developed in Denmark, the Netherlands and the UK. In some countries there is a highly developed system of social housing, whereas in others home-ownership is encouraged. This also has a positive effect on welfare in old age: home ownership is pension savings (even in a real asset) 'avant la lettre'.

In certain countries, additional benefits are provided to older people (and others) with a high degree of dependency. This extra income support is based on the need to offset the additional costs people incur because of their dependency. In some cases, it is specifically intended to be a payment for the main carer. Among other initiatives in this field that are already in operation in some Member States, new initiatives are being taken in some countries in the context of long-term care insurance (see below). This increases the theoretical discussion as to whether the further use of (in-cash) benefits should be preferred to the further financing of services. Sometimes mixed forms appear, such as the voucher systems (a cheque for certain services). Related to these forms of additional allowances is the idea of providing substantial support for the informal carer (payment for care, social insurance rights for the main carer) or only in a symbolic way. Another debate concerns the relative advantages of social protection in the form of cash, for instance by means of giving a budget to the dependent person or to a budget-holder.

For some countries we have indications of the relative importance of these categories of income support.

**Table 3.1** Overview of in cash benefits (payments for care)

| | Name | Recipients | Number of beneficiaries | Amount | Conditionalities |
|---|---|---|---|---|---|
| Austria | Pflegegeld | - The dependent person<br>- If staying in old age/nursing home: provider receives 80% of amount<br>- Attendance allowance is frozen if staying in a general hospitals since more than 4 weeks | ± 250,000 60+ | Paid in 7 levels: range between 160-1,600 ECU/month | - Non-means-tested<br>- In need of care for more than 50 hours/month |
| Belgium | Hulp van derden (Allowance for help from at third person within the framework of an occupational disease or industrial accident) | - The dependent person | | 13,216 ECU per year (1994) | - Active or has been active as an employee<br>- Needing help from a third person<br>- Having an occupational disease /being disabled |
| Denmark | Tegemoetkoming voor hulp aan bejaarden (Allowance for help for older persons)<br>Integratietegemoetkoming | - The dependent person<br>- Older persons who have become disabled before the age of retirement | 3% of the elderly in 1992 | Max. 2,800 to 4,008 ECU per year (1996) | - Non-means-tested<br>- Above age of 65+<br>- Dependency-related<br>- Means-tested |

**Table 3.1** Overview of in cash benefits (payments for care). Continued

| | Name | Recipients | Number of beneficiaries | Amount | Conditionalities |
|---|---|---|---|---|---|
| Germany | Pflegeleistung in Geld (Aid for persons in need of assistance) | | | | - Income-related and means-tested |
| | Leistung bei schwerer Pflegebedürftigkeit der Gesetzlichen Kranken-versicherung | | | | - Income-related and means-tested |
| | Pflegeld (Pflegeversicherung) | | | Between 200 and 600 ECU/month | - Dependency-related |
| Greece | | | | | |
| Spain | Ayuda tercera persona (Allowance for help for older or handicapped people) | | | | |
| Finland | Omaishoidon tuki (home care allowance) | - Payable for carers caring at home | | 445 ECU/month | - Dependency-related<br>- Dependent person lives at home |
| | Eläkkeensaajan hoitotuki (pensioner's care allowance) | - Payable to recipients of disability or old age pension, whose functional capacity has diminished due to an illness or injury | | Paid in 3 categories | - Dependency-related<br>- Not paid if staying in institutions |
| France | Allocation compensatrice | | 124,400 60+ (=60% of beneficiaries) (1992) | Between 311 and 622 ECU/month | - Income-related<br>- Dependency-related |
| | Allocation pour majoration de tierce personne | | | | |
| Ireland | Carer's allowance | - Designated for carers who live in the same household as the dependent older person | | 82.5 ECU/week | - Means-tested |
| Italy | Payment for care | | | | - Local standards |

**Table 3.1** Overview of in cash benefits (payments for care). Continued

| | Name | Recipients | Number of beneficiaries | Amount | Conditionalities |
|---|---|---|---|---|---|
| Luxembourg | Allocation de soins (AS) | In theory only for persons who keep an elderly dependent person at home, paid to the carer | | 381 ECU/month (1999: 508 ECU/month) | - Means-tested (income <2,780 ECU/month)<br>- Dependency-related |
| | Allocation pour personnes gravement handicapées (APGH) | Is accorded to the handicapped person, indifferent of the place where the old person is staying | | 381 ECU/month (1999: 508 ECU/ month) | - Dependency related |
| | Prestation en espèces (assurance-dépendance) (from 1.1.1999; for people only receiving AS or APGH they have the choice) | Paid to the dependent person but 'ear-marked' to pay for informal or formal help | | Maximum 800 ECU/month | - Dependency-related |
| The Nether-lands | | | | | |
| Portugal | Payment for care | Subsidises the help of a third person | | 51 ECU (1995) | |
| | Payment for care | Pension supplement for a cohabiting informal carer | | 23 ECU (1995) | |
| Sweden | Care salary<br>- cash<br>- Attendance allowance<br>- Carers allowance<br>- employment | An attendance allowance (not taxed) is paid to the dependent in order to be used as reimbursement for care given by the spouse, the daughter or whatever person actually responsible for the caring<br><br>A carers allowance is the term used for those situations where a family member is employed by the municipality to care for a next of kin. In these cases the payment goes to the carer and is seen as any other remuneration for salaried work (tax-wise, social protection, ...) | | Attendance allow-ance: 141-588 ECU/month | - Dependency-related |

**Table 3.1** Overview of in cash benefits (payments for care). Continued

| | Name | Recipients | Number of beneficiaries | Amount | Conditionalities |
|---|---|---|---|---|---|
| United Kingdom | Attendance allowance | - Dependent person | | Payable at two rates: 39.7 or 59.4 ECU/week | - Non-means-tested<br>- Dependency-related<br>- Not paid if staying for more than 4 weeks in institution |
| | Severe disability premium | - Dependent person eligible for the attendance allowance | | 44.6 ECU per week | - Dependency-related<br>- Being eligible for the attendance allowance |
| | Invalid care allowance | - Payable to people who care for someone who is in receipt of attendance allowance | | | - Means-tested (carer is not gainfully employed)<br>- Carer is under pensionable age at the time of the first claim |
| | Carer's premium | - For those receiving invalid care allowance, although the person receiving the care will lose any entitlement to a severe disability premium | | 15.9 ECU per week | - Dependency-related |
| | Regulated Social Fund | - One-off payments for those in receipt of income support | | | - Income support (means-tested)<br>- Additional criteria |
| | Community Care Grants | | | | - Income support (means-tested) |
| Norway | Omsorgslön | - Care salary for relatives | Not earmarked for the elderly, but quite a few of the 'users' are older persons | | |
| | Assistance allowances (to compensate for high expenditures for sickness) | | Few apply (±1%) | | - Means-tested<br>- Dependency-related |

## 3. Health Care

Figure 3.3 presents the national income for 1985, 1990 and 1994. The middle income countries among EU-member states (Greece, Portugal, Spain and Ireland) are now catching up with the rest of Europe. To make the figure more readable, the origin does not start at 0. This influences the picture. The graphic representation using two sub-periods illustrates possible changes of regime.

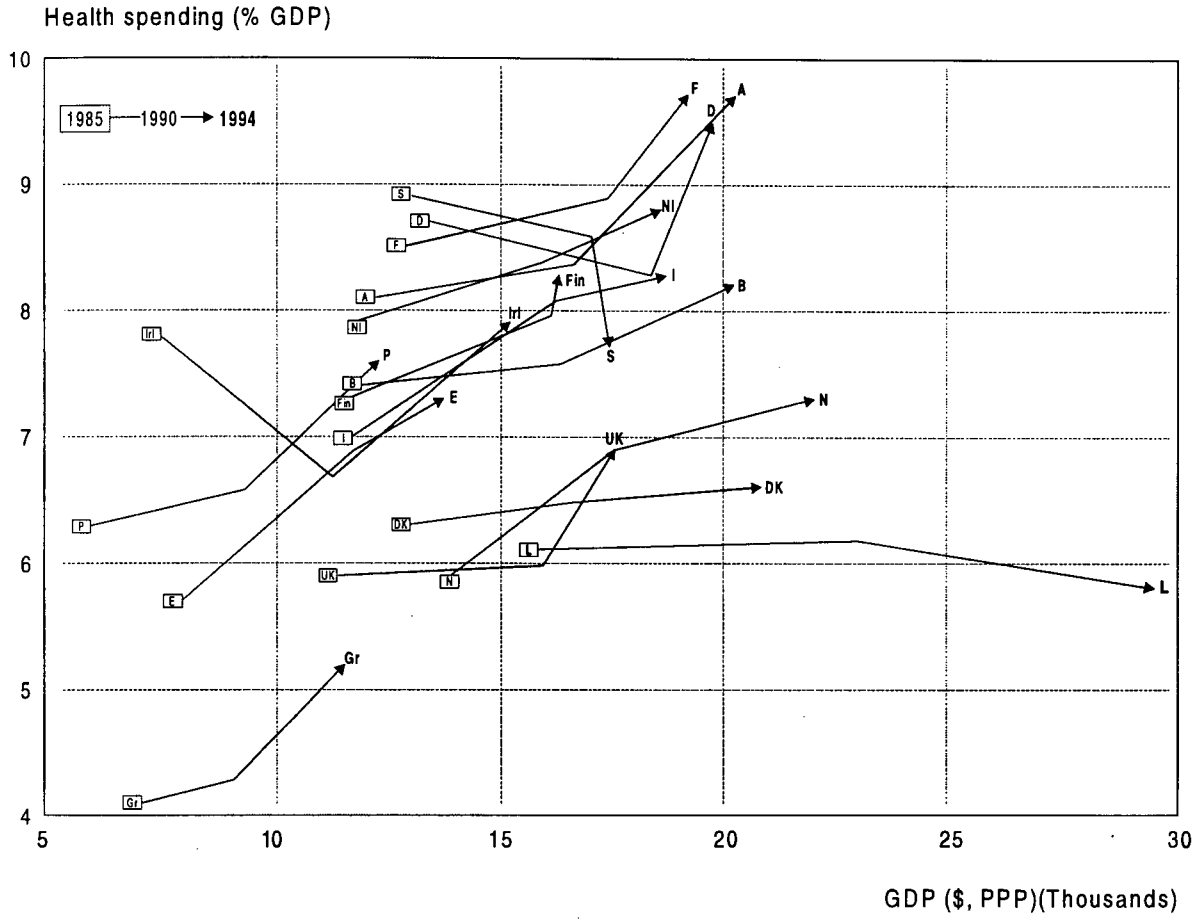
Studies by the OECD have shown that the higher the (per capita) GDP, the higher the expenditure on health care.[1] For the 27 OECD countries, it has been found that each 10% difference in per capita GDP is associated with a 14% difference in per capita health spending (Schieber & Poullier, 1989). In Figure 3.3, the share of GDP spent on health care is also shown. Most EU Member States spend similar proportions of their national income on health, but the Scandinavian countries and Bismarck-oriented welfare states such as Germany, France and Belgium also have a higher expenditure.

Ireland has an unexpectedly high level of expenditure (it is poorer and younger). In the other Member States, the younger or poorer countries (Greece for instance) have a lower expenditure. Over the years, all countries have experienced growing percentages of total health care spending per capita. Luxembourg, Ireland and Sweden did have a lower percentage in 1994 compared to 1985. However, we must bear in mind that definitions of 'health care spending' may have changed between 1985 and 1994.

Relating to the question of 'Has there been a change in regime in the health expenditures?', Figure 3.3 is very illustrative. The arrows show the evolution of income per capita and total health care expenditures in 1985. The breaking point is 1990 and the end point is 1994. Ireland and Sweden are the only countries that cut their public health care spending between 1985 and 1990. Since 1990, Ireland has again expanded its expenditure on health care. Although the cost containment ideology is present in most of the health insurance schemes, expenditure on health care continued to increase in most countries, although with some convergence trend (the richer countries grew more slowly than the poorer, which were attempting to catch up with the more wealthy countries). One point of reference for those health care expenditures at the highest extreme of the spectrum is the high level of expenditures in the USA. This system can be characterised by a decade already of debate on cost containment, the introduction of HMO's, managed care and similar strategies to realise such cost containment. This was unable to prevent the expenditures in the USA from being the highest of the OECD countries, having increased the most in recent decade (increase from 10.7% to 14.2% of GDP from

[1] This does not mean that income (per capita GDP) is the only factor that influences per capita health care spending. The country's health care funding system is another very important factor.

1985 to 1995). The European expenditures remain lower and deliver better protection than the US system.




Source: OECD Health Data (1996)

**Figure 3.3** Relationship between health expenditure (as % of GDP) and GDP (in $, PPP) per capita for the OECD countries, 1985-1990-1994

## 4. Summary of the macro-characteristics of the social protection systems

The following table aims to give a summary overview for each country of the main characteristics of social protection. GDP per capita is used to give an indication of the wealth of each nation. Expenditures on social protection are divided into three main categories: expenditures on pensions as a percentage of GDP, public health care expenditures for the total population and for older people as a percentage of GDP, and social expenditures for the elderly as a percentage of GDP.

In addition to relative figures on these expenditures, the amounts spent per year in ECU can also be found in this table.

Information on pensions is extended to the 'second pillar': What proportion of the population is covered by the 'second pillar', and what amount of assets does this 'second pillar' represent?

Finally, we have tried to give a typology of the pension system and the care system in each country.

**Table 3.2** Macro-characteristics of social protection in old age, 1995

| | Austria | Belgium | Denmark | Germany | Greece | Spain |
|---|---|---|---|---|---|---|
| GDP, value per capita (1994, ECU) | 20,979 | 19,168 | 24,620 | 21,385 | 7,476 | 10,384 |
| **Ageing** | | | | | | |
| % population over 65 | 15.1 | 15.8 | 15.1 (1996) | 15.4 | 14.8 (1993) | 14.8 (1994) |
| **Pensions** | | | | | | |
| Retirement age | 65/60 | 65/60 | 67/67 | 65/65 | 65/60 | 65/65 |
| Orientation of pension system | Bismarck Large Public | Bismarck Large Public | Beveridge Basic Public | Bismarck Large Public | Bismarck Large Public | Bismarck Large Public |
| Total pension benefits (old age + survivor) as % of GDP | 15.5 | 9.10 (1994) | 10.02 (including early retirement and supplementary schemes) | 12.2 (1994) (including supplementary schemes) | 10.2 (1994) (including supplementary schemes) | 11.10 |
| Pension per older person (in ECU) | 16,281 | 11,227 (1994) | 9,913 (public old age pension) | 8,707 (1987) | 5,169 (1994) (including supplementary schemes) | 5,425 |
| Net replacement ratio | 75% (employees) | 63% (1993) | 86% (incl. occupational pensions) | 69% (1989) | 114% (1989) | 98% (1989) |
| Assets of second pillar: % of GDP | 0.05 (1993) | 21.2 | 52 (1991) | 23.4 | 7 (1991) | 6 (1991) |
| Coverage of second pillar (% of labour force) | 6.3 (1993) | 31 (private sector, 1996) | 51.5 (compulsory occupational) 7.9 (civil servants) | 46 | 5 | 15 |
| **Health** | | | | | | |
| Public health expenditures as a % of GDP | 5.9 | 7 | 5.3 | 8.2 | 4.4 | 6 |

**Table 3.2** Macro-characteristics of social protection in old age, 1995. Continued

| | Austria | Belgium | Denmark | Germany | Greece | Spain |
|---|---|---|---|---|---|---|
| % of public health expenditures for population over 65 | ±50 | 31.3 (1987) | 44 (1994) (60+) | | | 40 |
| Public health expenditures for population over 65 as % of GDP | 2.9 | 2 (1987) | 2.4 (1994) (60+) | | | 2.6 |
| Social expenditures for population over 65 in million ECU | | 318 (2) (1993) | 2,309 (60+) (1993) | 4,963 (1990) | | |
| Social expenditures for population over 65 as % of GDP | | 0.19 (2) (1993) | 2.0 (60+) (1993) | 0.40 (1990) | | |
| Orientation of care system | Bismarck | Bismarck | Beveridge | Bismarck | Bismarck | Bismarck |
| | Cash oriented | Limited cash oriented | | More cash oriented | Cash oriented | Cash oriented |
| | | Service oriented | Service oriented | Limited service oriented | | |
| | Universal | Universal | Universal | Universal | Universal | Universal |
| | | Limited means-tested | | Relatively under-developed | | |

**Table 3.2** Macro-characteristics of social protection in old age, 1995. Continued

| | Finland | France | Ireland | Italy | Luxembourg |
|---|---|---|---|---|---|
| GDP, value per capita (1994, ECU) | 17,446 | 19,493 | 12,351 | 14,907 | 30,011 |
| **Ageing** | | | | | |
| % population over 65 | 14.3 | 14.7 (1994) | 11.5 (1994) | 16.4 | 14.3 (1991) |
| **Pensions** | | | | | |
| Retirement age | 65/65 | 60/60 | 66/66 | 62/57 | 65/65 |
| Orientation of pension system | Bismarck Large Public | Bismarck Large Public | Beveridge Basic Public | Bismarck Large Public | Bismarck Large Public |
| Total pension benefits (old age + survivor) as a % of GDP | 7.9 (1994) | 12.2 (1994) | 2.74 | 15.7 | 11 (1994) (including supplementary schemes) |
| Pension per older person (in ECU) | 9,502 (1994) | 10,952 (1993) | 5,430 | 14,333 (1994) (including supplementary schemes) | 15,276 (for men); 8,149 (for women) |
| Net replacement ratio | 60% (1993) | 80% (1993) | 64% (1989) | 92% (1989) | 70 to 100% (private sector) |
| Assets of second pillar: % of GDP | | 28.7 | 71 (1991) | 2 (1991) | |
| Coverage of second pillar (% of labour force) | 15 | 90 | 46 | 5 | 35 (private sector) |
| **Health** | | | | | |
| Public health expenditures as a % of GDP | 5.8 | 8 | 5.1 | 5.4 | 6.5 |
| % of public health expenditures for population over 65 | 37.9 (1990) | 40.4 (1989) (60+) | 30 (1993) | | |

**Table 3.2** Macro-characteristics of social protection in old age, 1995. Continued

| | Finland | France | Ireland | Italy | Luxembourg |
|---|---|---|---|---|---|
| Public health expenditures for population over 65 as % of GDP | 2.4 (1990) | 2.6 (1989) (60+) | 1.9 (1993) | | |
| Social expenditures for population over 65 in million ECU | 973 | 1,364 (1989) | | | |
| Social expenditures for population over 65 as % of GDP | 1.03 | 0.15 (1989) | | | |
| Orientation of care system | Beveridge | Bismarck | Beveridge | Bismarck | Bismarck |
| | | More cash oriented | | Cash oriented | More cash oriented |
| | | Service oriented | Service oriented | | Service oriented |
| | Universal | Universal | Universal | Universal | Universal |
| | Income-related | Underdeveloped | Income-related and means-tested | | Limited means-tested |

**Table 3.2** Macro-characteristics of social protection in old age, 1995. Continued

| | The Netherlands | Portugal | Sweden | UK | Norway |
|---|---|---|---|---|---|
| GDP, value per capita (1994, ECU) | 18,487 | 7,456 | 20,326 | 13,984 | 24,493 |
| **Ageing** | | | | | |
| % population over 65 | 13.1 (1994) | 14.8 | 17.4 (1994) | 15.7 (1994) | 15.9 (1996) |
| **Pensions** | | | | | |
| Retirement age | 65/65 | 65/65 | 65/65 | 65/60 | 67/67 |
| Orientation of pension system | Beveridge Basic Public | Bismarck Large Public | Beveridge Basic Public | Beveridge Basic Public | Beveridge Basic Public |
| Total pension benefits (old age + survivor) as a % of GDP | 11.4 (1994) (including supplementary schemes) | 7.2 | 8 | 10.4 (1993) (including supplementary schemes) | 6.2 |
| Pension per older person (1987, in ECU) | 8,784 (1994) | 2,082 | 10,062 | 3,852 | 10,054 (including state occupational pensions) |
| Net replacement rate of first and second tier pensions | 77% | Maximum 80% | 70% (1989) | 57% | 54% (incl. national supplementary pension) |
| Assets of second pillar: % of GDP | 141.5 | 8 (1991) | | 145.9 | |
| Coverage of second pillar (% of labour force) | 85 (1994) | < 5% of white collar workers | 83.5 | 48 | Nearly 100% (public) About 40% (private) |
| **Health** | | | | | |
| Public health expenditures as a % of GDP | 6.8 | 5 | 5.9 | 5.9 | 6.6 |
| % of public health expenditures for population over 65 | 40 (1987) | | 45 | 47 (1987) | 45 (1994) |
| Public health expenditures for population over 65 as % of GDP | 2.4 (1987) | | 2.7 | 2.3 (1987) | 2.9 (1994) |

**Table 3.2** Macro-characteristics of social protection in old age, 1995. Continued

| | The Netherlands | Portugal | Sweden | UK | Norway |
|---|---|---|---|---|---|
| Social expenditures for population over 65 in million ECU | 3,725 (1991) (3) | | | 1,946 (1) (1987-1988) | |
| Social expenditures for population over 65 as % of GDP | 1.52 (1991) | | | 0.3 | |
| Orientation of care system | Bismarck | Bismarck | Beveridge | Beveridge | Beveridge |
| | More cash oriented<br>Universal<br>Means-tested and income-related | Cash oriented<br>Universal | Service oriented<br>Universal<br>Income-related | Service oriented<br>Universal<br>Means-tested and income-related | Universal<br>Income-related |

Remarks: (1) Includes residential care, day care and home care
(2) Only Flanders
(3) Includes old age homes and home help services

Source: Country reports
OECD Health Data (1997)
Bouten R. and Pacolet J. (1998) (forthcoming)
European Commission (1997)

# *CHAPTER 4*
# *The variety, scope and coverage of health and social services for the elderly: the welfare pluralism*

In this chapter we deal with the scope and variety of the care mix for the elderly. This constitutes the social quality of our welfare state. But quantity goes before quality. The first aspect even considered in studies on quality of services is the availability of services, the number of places and the number of caring personnel, etc. The second aspect should be affordability, the cost for the elderly. However, it is impossible to go into detail, and it is even impossible to characterise the 50 services or institutions in each Member State as being more oriented in this or that direction. For instance, is the welfare state in the Mediterranean countries more oriented to informal care than other countries when in some central or Nordic welfare states several schemes of payment for the informal care are present? The intention of the following discussion is to synthesise the information collected from the national reports and to allow the facts and figures to reveal the welfare pluralism of the European Union.

It is remarkable that the innovation and emergence of new systems has occurred particularly in the field of care for the elderly. This will probably evolve in the direction of private solutions. The question is how to maintain the level of provision and how to fill in certain remaining gaps.

## 1. Variety

For the services we were able to define, based on the systems present in each country, we found 8 categories of permanent residential and semi-residential services, 17 temporary residential and semi-residential services, and no less than 22 community services. This illustrates the fact that the last sector is the most diversified and has been the subject of the greatest amount of innovation during the last decade. However, social protection also includes more intangible aspects such as charters of rights for the elderly, the right of representation, the right of appeal, protection against fraud and misuse, the right of self-determination of care, and the right of determination of care by the family and advisory bodies. Informal care, which is the most important in quantity (4 to 5 times as important as formal care in number of hours) and of course in quality, is also becoming more and more

formalised, a fact which leads to certain implications, such as the obligation to help, payment for care, and the care contract or care plans.

The level of social expenditure illustrates not only the maturity of the welfare state, but also the diversity.

One problem which occurs immediately is the gathering of comparable data. Although this report is already a third exercise in collecting comparative data on services for the elderly and we have tried insofar as possible to harmonise definitions, categories and characteristics, the problem remains the lack of data. This should be one of the first conclusions of this report: the commitment to collect unidimensional data on output, financing and clients of social and health services (for the elderly and others).

The following tables indicate whether or not a certain 'service' exists in the countries under consideration - in some cases with a long tradition, and in other cases as a new, emerging and innovative service.

**Table 4.1** Availability of permanent residential and semi-residential services for the elderly

| Type | A | B | DK | D | GR | E | FIN | F | IRL | I | L | NL | P | S | UK | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Nursing homes | + | + | + | + | | + | + | + | + | e | + | + | + | + | + | + |
| 2. Psychiatric nursing homes | + | + | + | | + | | + | | + | | + | + | + | | + | + |
| 3. Housing for the disabled | + | + | e | | | | + | | | | | e | | + | | + |
| 4. Old age homes | + | + | | + | + | + | + | + | + | | + | + | + | + | + | + |
| 5. Multilevel homes for the elderly | | + | | + | | | | | | + | | | + | + | + | |
| 6. Sheltered housing | e | + | + | + | | + | + | + | + | + | | + | e | | + | + |
| 7. Service flats | e | + | | | | + | + | + | | + | + | + | + | | | + |
| 8. Innovative services | e | e | | | | | + | e | | | e | e | e | e | + | + |

\+ service is existing
e service is emerging

**Table 4.2** Availability of temporary residential and semi-residential services for the elderly

| Type | A | B | DK | D | GR | E | FIN | F | IRL | I | L | NL | P | S | UK | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. General hospitals | + | + | + | | + | | + | | + | + | | + | + | + | + | + |
| 2. Geriatric units in general hospitals | + | + | + | + | | + | + | | + | + | | + | | + | | + |
| 3. Long stay wards in general hospitals | | + | | | | + | + | + | + | + | | | | | | |
| 4. Medium stay wards in general hospitals | | | | | | | | + | + | | | | | | | |
| 5. Psychiatric wards in general hospitals | + | + | + | | | | + | + | + | + | | + | | | + | |
| 6. Geriatric hospitals | | + | | + | | + | + | + | + | | | | | + | + | |
| 7. Psychiatric hospitals | + | + | + | | | + | + | | + | + | | + | | + | + | + |
| 8. Psycho-geriatric wards in mental hospitals | | + | | | | | + | | + | + | + | + | | | + | |
| 9. Rehabilitation homes | + | + | | | | + | + | | + | + | | + | | | | |
| 10. Short-term nursing homes | | | + | + | | + | | + | + | | + | | | + | + | + |
| 11. Short stay in old age homes | e | + | | + | | + | + | + | + | | | + | | | + | |
| 12. Geriatric day hospital | e | + | | + | | + | + | + | + | + | | + | | + | + | |
| 13. Day care | e | + | + | e | | + | + | + | + | + | + | e | + | + | + | + |
| 14. Nightly care in old age homes | | + | + | | | + | + | | + | + | | e | | + | | |
| 15. Social centres for the elderly | | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| 16. Innovative services | e | | | | | | + | e | | | | | e | | e | |
| 17. Preventive services | | | | | | | | | | | | | | | + | |

\+ service is existing
e service is emerging

**Table 4.3** Availability of community services for the elderly

| Type | A | B | DK | D | GR | E | FIN | F | IRL | I | L | NL | P | S | UK | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. District nursing | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| 2. Paramedical care | + | + | | | + | | | + | + | + | | + | | + | + | + |
| 3. Mental health services | + | + | | | | + | + | | + | + | | + | | + | + | + |
| 4. Health advisory services and health education | + | + | | + | + | + | + | | + | + | | + | | | + | + |
| 5. Social work | + | + | + | | + | + | + | + | + | + | | + | + | + | + | + |
| 6. Home help services | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| 7. Cleaning services | + | + | + | | | + | + | e | + | + | | | | + | + | |
| 8. Odd job services | + | + | + | | | + | + | e | | | | | | + | | |
| 9. Domestic help | + | | | | + | | + | e | + | + | | + | + | + | | + |
| 10. Meal distribution | + | + | + | + | + | + | + | e | + | + | + | + | + | + | + | + |
| 11. Foyer restaurant | | | + | + | | | + | e | | | | + | | | | |
| 12. Transport services | + | e | + | | | + | + | e | + | + | + | + | + | + | + | + |
| 13. Care of terminally ill relatives | | e | + | | | + | + | | + | + | | | | + | + | + |
| 14. Family placement | | e | | + | | e | + | e | + | + | | | + | | + | |
| 15. Sitting/respite services | + | e | + | | | + | + | e | + | | | | | + | + | + |

**Table 4.3** Availability of community services for the elderly. Continued

| Type | A | B | DK | D | GR | E | FIN | F | IRL | I | L | NL | P | S | UK | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16. Housing for pensioners | + | + | + | | | + | + | | + | + | + | + | + | + | + | + |
| 17. Home improvements | + | + | + | | + | e | + | + | + | + | + | + | | + | + | + |
| 18. Tele-alarm and telecommunication services | + | + | + | + | | e | + | + | + | + | + | + | | + | + | + |
| 19. Aids, facilities:<br>Technical aids<br>Telephone<br>Purchase of wheelchair | + | + | + | | | + | + | e | | | + | + | | + | + | + |
| 20. Social benefits and other initiatives | + | + | | | | + | | | | | | | | | + | + |
| 21. Other innovative services | | e | | e | | e | + | e | | e | | | | | + | |
| 22. Preventive services or activities | | | + | + | | e | + | | | | | + | | | + | + |

\+ service is existing
e service is emerging

## 2. Availability

We have categorised a selected list of services for the elderly: permanent and temporary residential and semi-residential services, and community services. The figures are not complete, although for several countries it is already the third similar exercise.[1] In Figures 4.5 and 4.6 we compare some of the earlier results with the recent information. We display here in the first place quantitative figures because they are what really matter: they illustrate the availability of services. We then focus on certain aspects. There are countries with well developed services, such as the high levels of residential services in Denmark, Netherlands, Belgium and Finland. Some countries have better organised housing for the elderly or housing for pensioners, such as the UK and the Netherlands.

To quote some of the extremes: the number of available beds in nursing homes differs from 1.22 places per 100 persons of 65+ in Belgium to 4.6 in Denmark. The latter has a high number of staffed and unstaffed housing units for the elderly, as well as old-age homes. Some countries continue to rely on traditional old-age homes. The numbers of living units in old-age homes may differ from 2 per 100 65-plusers in Austria to 6.76 in Belgium. In previous years some other countries, such as the Netherlands, were much more oriented towards institutional care, and so in one decade the relative position of a country can shift. However, changes are slow and not always in the expected direction: the number of residential units in the Netherlands remains high, even after years of stimulating de-institutionalisation. In Belgium, the number of residential units increased substantially, even during a period of increasing support for the idea of community care. Most situations remain unchanged, however, or they change because other categories are included in the overview.

Another extreme of the care continuum is community care. The intensity of community care is defined by the number of personnel per 100 65-plusers. The highest intensity is found in the Scandinavian countries. The personnel in district nursing varies in terms of the number of personnel per 100 elderly from almost none in Austria to 0.92 home nurses per 100 persons in Flanders above 65 years of age. The number of personnel for home help and house cleaning varies from around 1 person per 100 65-plusers to more than 7 in Sweden, but in many other countries it ranges from 1.5 to 2 per 100 elderly persons above age 65. The fact that for some countries only one category of personnel is used illustrates again the fading borderline between the two forms, i.e. the despecialisation or integration in the sector (see Figure 4.4). In Sweden all the community care personnel are qualified as home help. In France, home help is called 'social work', but by this is meant personnel from the social sector (as opposed to the health sector). In Denmark, all

[1] Nijkamp P., Pacolet J. & Spinnewyn H. (1991); Pacolet J., Versieck K. & Bouten R. (1994); Pacolet J., Bouten R., Lanoye H. & Versieck, K. (1998)

the personnel are categorised under 'social' (work), regrouping all the other categories but also including persons working in residential services. Hence the figure overestimates the community care in that country. It illustrates that the borderline between residential and community care has disappeared since the services are provided by the same (local) 'operator'.

In Figures 4.1 to 4.6 we give some information on the quantitative availability and the actual utilisation of a selected list of services (see figures also in Annex 3).

A wide variety of services for the elderly and a growing 'market' of care provisions for older persons may be observed in the sixteen countries.

Some Member States are continuing to have more places in residential care than community care. This is the case in Belgium, Denmark, France, Luxembourg, the Netherlands and the UK. Residential facilities are still rather scarce in countries like Greece, Spain, Italy and Portugal, i.e. in countries where many families are involved in caring for the elderly.

Permanent residential and semi-residential services are generally available in all the countries. It should be noted that in some countries the large number of 'integrated (independent) housing accommodations and care facilities', which are of a permanent but mostly semi-residential character, are coming more and more to replace the purely residential services. This innovation is in different stages of development in the different countries. In Denmark, for instance, it has been important since 1988. In Belgium (Flanders) a special programme was launched in 1991 and again in 1995. It is an important issue in the most recent report in the Netherlands on policy relating to the elderly. In France there are a significant number of experiments under way in this sector. This type of service has been developed in Norway in recent years and service flats are a rather innovative housing opportunity for the elderly in Austria.

The integration of all kinds of residential services in one grouped setting also seems to growing in importance. It is explicitly mentioned in the 'multilevel homes' ('Mehrgliedrige Einrichtungen') category in Germany, but the trend towards this type can also be observed elsewhere.

The opposite trend can be observed in the degree of medicalisation of services. The purely medical services are coming more and more to be classified as temporary services, although in some countries significant groups of services are still available on a long-term basis.

We have classified the spaces in general hospitals under 'temporary provisions'. In the traditional permanent residential services for the elderly there is a reverse evolution taking place in comparison with the health sector. The spaces are becoming more medicalised, or at least the need to move in that direction is being observed. This can be caused by three elements: first, the ageing of the population implies an ageing of the residents in these services; secondly, the tendency to stay longer at home means that there is a further acceleration of the dependency of the residents in the services because the elderly are older and more dependent when

they leave their home to enter an institution; finally, there is a flow of dependent elderly persons from health services to old-age services.

The overview of the temporary residential and semi-residential services relates primarily to the short-term provisions in general hospitals, psychiatric hospitals and geriatric institutions. Innovations in all these institutions include the provision of day and night care and, in some countries, the temporary relief of the informal carer. This short stay is possible in Austria, Belgium, Spain, Finland, Ireland, the Netherlands and Sweden, for instance, but explicit legal instruments are also provided in other countries (e.g. Germany). Although these tables do not give a dynamic picture of the care supply, they do illustrate the emerging importance of certain systems just by virtue of the fact that they are mentioned more often.

The list of community services can be even longer because it is here that the most innovations have emerged. This reflects the recent attention being given to home care, which is not only a political priority, but is also attracting the attention of numerous service providers and associations. However, not all these initiatives are equally representative. The basic services are present in the sixteen countries. The new services include odd job services in particular, several aspects of transport and telecommunication, family placement and sitting services, a number of social benefits and initiatives to improve the quality of life of the elderly and to promote their integration into society.

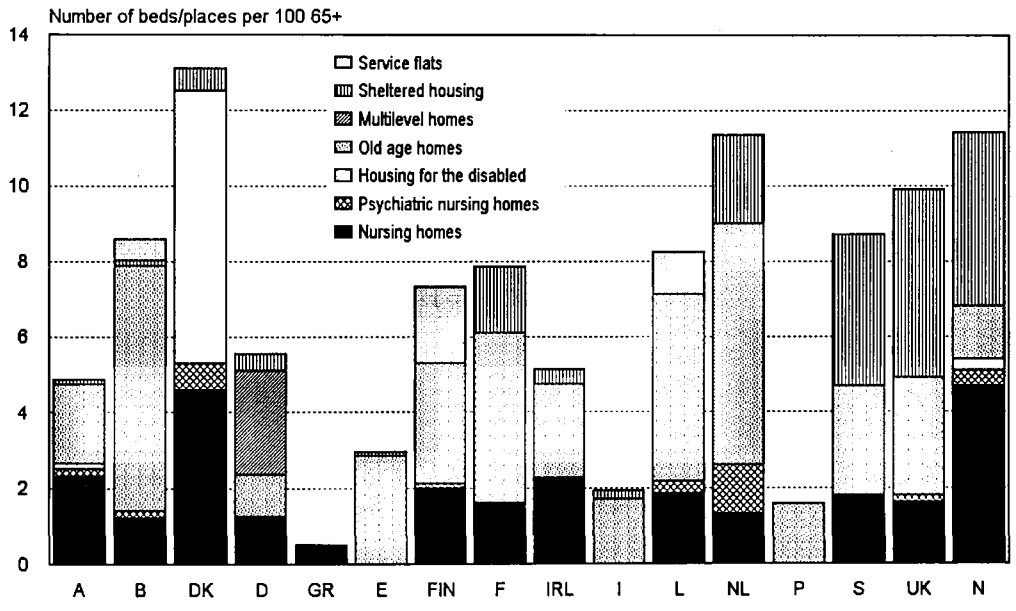



**Figure 4.1** Availability of a selected list of permanent services for the elderly

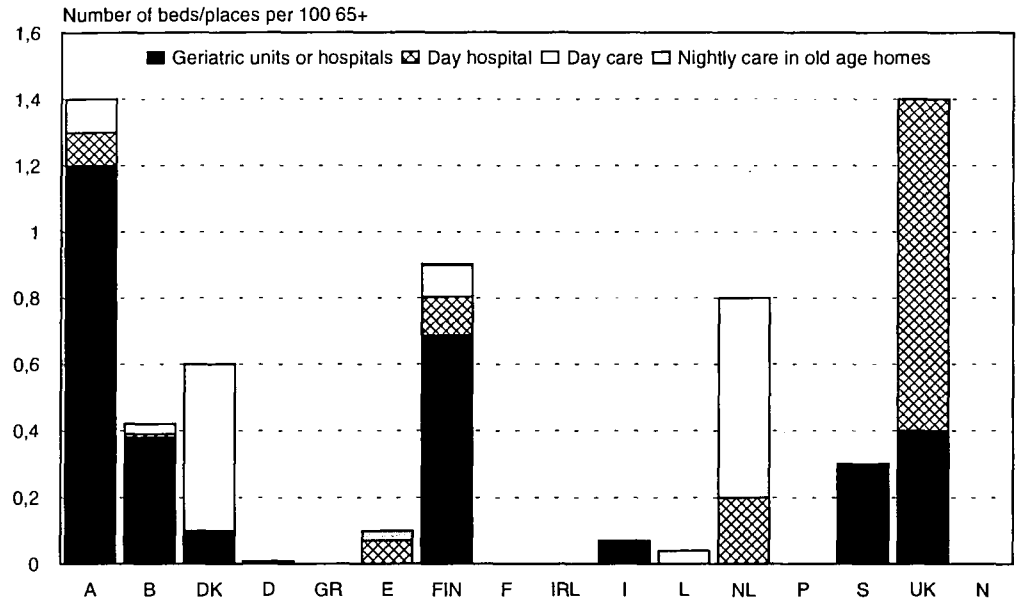



**Figure 4.2** Availability of a selected list of temporary services for the elderly

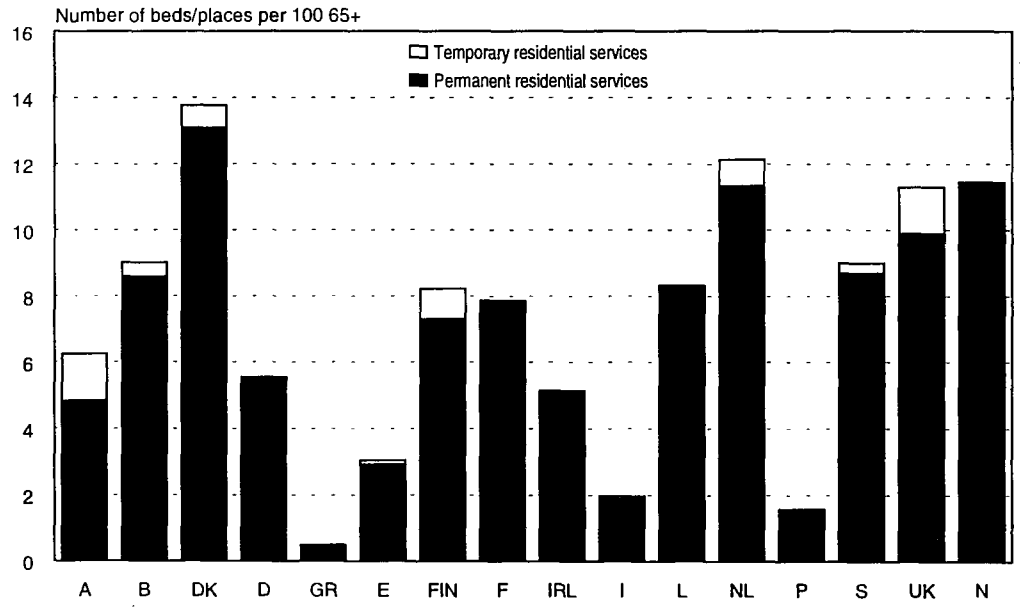



**Figure 4.3** Availability of permanent and temporary services for the elderly

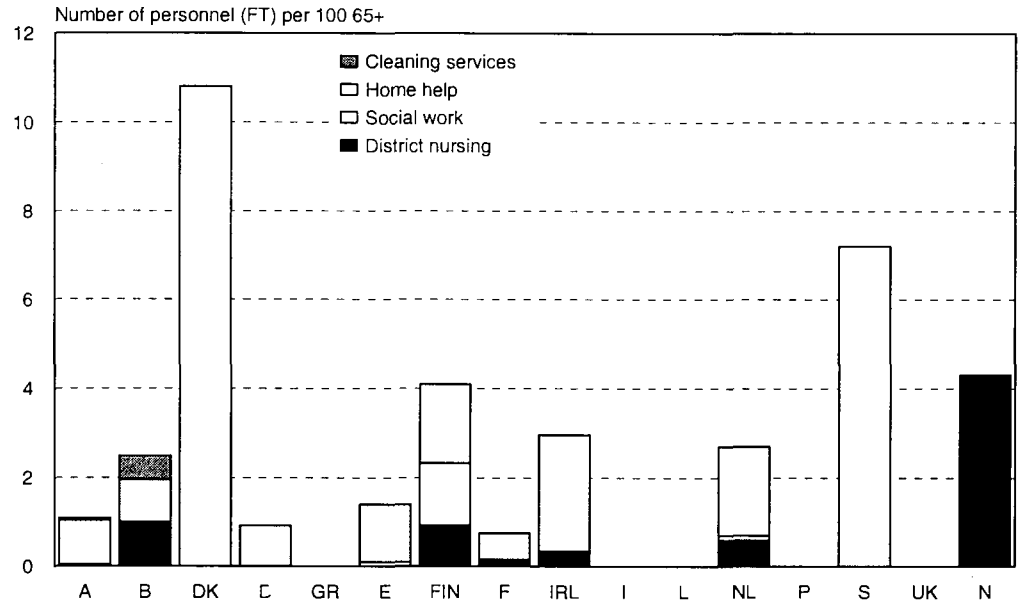
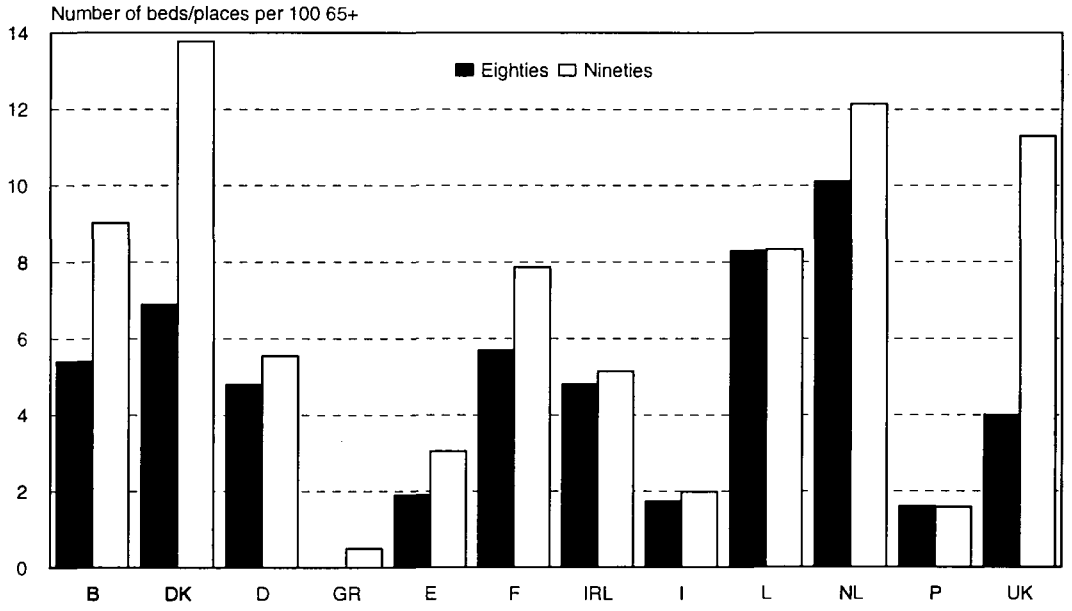
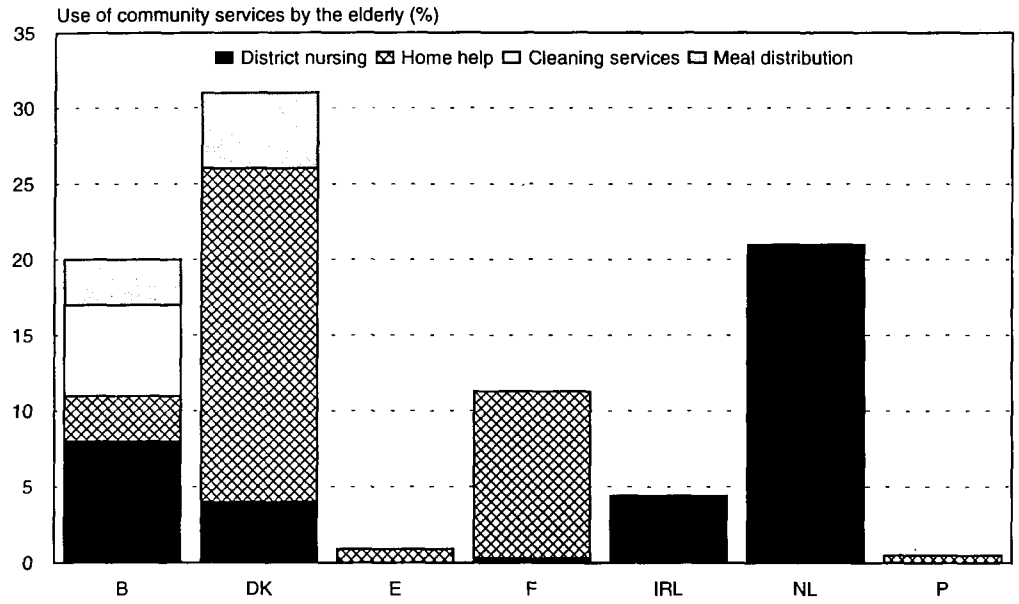



**Figure 4.4** Availability of a selected list of community services for the elderly




Source: See figure 4.1 and Winters, 1991 (p. 131)

**Figure 4.5** Availability of institutional services for the elderly, 1982-1997




Source: Spinnewyn, 1991 (p. 99)

**Figure 4.6** Availability of community services for the elderly, 1989

## 3. Affordability

The other element of relevance in addition to availability is affordability: this is determined by the level of public financing, which in turn determines the level of payments made by the users of the services. It is interesting to observe how those services are financed. Theoretically, it is to be expected that the more cure-intensive services will be publicly financed and the more care-intensive services will require more co-insurance. The cure-intensive services are similar to or identical with health services, and obtain as a 'merit good' more public financing. In the more care-intensive personal social services this is not the case in many countries. This is the case for most old-age homes, which are mostly financed by the elderly, although some countries provide high levels of public financing. In all the countries, this public financing is higher for the nursing homes, which are able to provide medical care. The future, however, will bring convergence again between these two systems (old-age homes and nursing homes), since the profiles for the persons entering both types of institutions will become the same. In Belgium, for this reason, arguments are being made in favour of establishing similar financing rules. Home help, which responds to instrumental ADL, is to a large extent publicly financed, although the differences between the countries are substantial. District nursing is publicly financed. The trends toward joint supply of these services will again, however, bring both schemes together, since they are sometimes performing the same activities.

There are substantial differences in financing between countries: old-age homes are substantially financed by the elderly themselves in Belgium, Spain and (to a

growing extent) the Netherlands, but remain largely publicly financed in the Scandinavian countries. This is even more pronounced in nursing homes, following again the rationale that the more medical a service becomes, the more public financing is involved. For this reason, in most of the countries district nursing is strictly publicly financed (health insurance), while more personal or household help implies more co-insurance. Nevertheless, the level of public financing is high and approaches the health care figures (about 80% to 85%). In some countries there is even a convergence towards more public involvement in home help.

The exercise of using case studies to compare an older person with a certain degree of dependency and income (since some of these services are conditional on income or dependency), reveals significant differences in coverage. Particularly in an international comparison, such detailed analysis may be needed because it can change the first impression of certain levels of protection. For example, it is becoming clear that in some countries free old-age homes are compensated by a deduction from a person's pension, leaving the elderly with only pocket money. In doing so, this changes the initial perception of a system being generous into a situation where the system reveals itself as being more restricted. This is analysed further in Chapter 5.

**Table 4.4** The financing of some specific services, percentages of costs paid by the elderly and their relatives (E), the public authorities (P) and others (O) - on average information

| | Residential | | | | | | Community | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Old age homes | | | Nursing homes | | | Home help | | | Meals-on-wheels | | | District nursing | | |
| | E | P | O | E | P | O | E | P | O | E | P | O | E | P | O |
| A | 20-30 | 60 | 10 | 20-30 | 60 | 20 | 20-30 | 60-70 | 5 | 20-30 (5) | 60-70 | 5 | 20-30 | 60-70 | 5 |
| B 1989 | 70 | 30 | | 50 | 50 | | | | | | | | | | |
| 1993, Fl. | 65.3 (3) | 34.7 | | 55.9 (3) | 44.1 | | | | | 77 (4) | 23 (4) | | | | |
| 1993, Wal. | | | | | | | 14 | 86 | | | | | | | |
| 1994 | | | | | | | | | | | | | 0 | 100 | |
| 1994, Fl. | | | | | | | 20 | 80 | | | | | | | |
| DK 1989 | | | | 2 | 98 | | 0 | 100 | 0 | 40 (1) | 60 | 0 | 0 | 100 | 0 |
| 1993 | | | | 20 | 80 | | 0 | 100 | 0 | | | | 0 | 100 | 0 |
| 1995 | | | | 4 | 96 | | 0 | 100 | 0 | (5) | | | 0 | 100 | 0 |
| D | | | | | | | 22 | 35 | 43 | | | | 12 | 32 | 56 (2) |
| GR | | | | | | | | | | | | | | | |
| E (1995) | 50 | 50 | | 20 | 80 | | 30 | 70 | | | | | 20 | 80 | |
| FIN (1992) | 19 | 81 | | 12 | 88 | | 7 | 93 | | 67 (6) | 33 (6) | | 0 | 100 | |
| F | Income and institution-related | | | | | | Income-related participation of the elderly | | | | | | Social security | | |
| IRL (1996) | 25 | 75 | 0 | 100 | 0 (8) | 0 | 33 (10) | 66 | 0 | 33 (10) | 66 | 0 | 0 | 100 | 0 |
| | | | | 40 | 60 (9) | 0 | | | | | | | | | |
| I | Income and institution-related | | | | | | | | | Local agreements | | | | | |
| L (1995) | + | + | | + | + | | 33 | 66 | | + | + | | 0 (7) | 100 | 0 |
| NL 1989 | 10 | 90 | 0 | 5 | 90 | 0 | 50 | 25 | 25 | | | | 15 | 85 | 0 |
| 1994 | 38 | 62 | 0 | 11 | 89 | 0 | | 81 | | | | | 14 | 86 | 0 |

**Table 4.4** The financing of some specific services, percentages of costs paid by the elderly and their relatives (E), the public authorities (P) and others (O) - on average information. Continued

| | Residential | | | | | | Community | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Old age homes | | | Nursing homes | | | Home help | | | Meals-on-wheels | | | District nursing | | |
| | E | P | O | E | P | O | E | P | O | E | P | O | E | P | O |
| P | Income and institution related | | | | | | Income-related participation of the elderly | | | | | | Social security | | |
| S 1995 | 12 | 88 | 0 | 12 | 88 | 0 | 6 | 94 | 0 | 6 | 94 | 0 | 0 | 100 | 0 |
| UK | 30 | 70 | 0 | 30 | 70 | 0 | 9 | 91 | 0 | 60 | 40 | 0 | 0 | 100 | 0 |
| N 1994 | 15 | 85 | 0 | 15 | 85 | 0 | 5 | 95 | 0 | | | | 5 | 95 | 0 |

Remarks: E = the elderly and their relatives, P = government and social insurance, O = others: private insurance, sponsors, charities

(1) Food cost
(2) Social security and volunteer organisations
(3) Is in reality higher since supplements for special services - to be paid by the elderly - are not included
(4) Only concerns meals distributed by public centres for social welfare (='OCMW')
(5) The elderly pay at least the food cost
(6) Refers to auxiliary services
(7) Only for conventional nursing tasks; for corporal and hygienic care the elderly have to contribute
(8) Pure private nursing homes
(9) Maximum public subvention for private accommodation
(10) Varies by health board and by community care area.

Source: Country reports

## 4. The fading borderline between housing provision and services

In the care systems, a distinction is very often made between housing, hotel cost, housekeeping, care and cure aspects. Services oriented to certain aspects are specialised from the beginning (for example, 'meals-on-wheels' is oriented only towards 'catering' for the elderly staying at home). Other services are tending to focus their activities more and more. For example, outsourcing occurs in residential services that want to concentrate only on housing aspects, with nursing aid provided from outside by district nurses. Some services reorient themselves or sometimes cluster once again, regrouping into 'multi-product' initiatives in which housing and care are integrated to a varying degree; (the most broad type could be the so-called 'multi-level services'). Those organisational shifts or differences have basic economic and financial implications. Housing and hotel costs are considered to be private expenditures and ought to be paid out of the pockets of the elderly themselves. Housekeeping and home care are somewhat less so and health care should be almost completely publicly financed. At the same time, however, housing receives substantial public support in almost all welfare states, and the same is true for social and health care. We will document how the boundaries between housing and services are fading, perhaps coming closer to the reality of the daily life of the elderly, where all these aspects are and should be integrated.

### 4.1 Elements of social protection and the special situation of housing costs

Social protection of the elderly is initially concentrated on income protection. There is one element in this category that is sometimes forgotten as a factor of social protection, but which is of ultimate importance: housing conditions and housing costs. For those who own their home, this element can be defined as pension saving 'avant-la-lettre'. For the others, the cost of renting a dwelling can be a significant burden on their income. A significant part of the total costs in the care sector go to financing housing accommodation for the dependent elderly in need either of temporary or permanent help, or in need of adapted housing. Parts of those costs are - or can be - covered by the general housing policy (including tax and other instruments for acquiring and owning a house, the organisation and financing of the social housing sector, or policy interventions with rent control or rent subsidies). The elderly can be a special target group within these fields.

Significant portions of housing support and implicit income support are situated in social housing policies and budgets. Substantial public support for housing is also embodied in tax relief or subsidised loans for housing acquisition, mostly during the economically active period of the family life cycle. This disappears when the home is acquired, so that most of the elderly are no longer receiving these benefits. The burden of this expenditure on public spending will lessen as populations get older. In some countries, social housing is explicitly mentioned as a part of the social protection system. This happens in a positive way in Ireland, where categories of social housing are explicitly mentioned: social

housing from local authorities, sheltered housing and voluntary social housing. Also in Belgium (Flanders), an explicit category within social housing has been created for the elderly. In a negative sense we have to conclude that in the UK social housing is becoming a residual sector as the broad social housing sector is being reduced to an instrument of policy for reducing poverty.

Almost all countries use rent subsidies to improve the housing conditions of the elderly and/or to support income (see table).

A third large category of social expenditure for the elderly is health and social services. We have concentrated here on specific services for the elderly, and especially on the housing aspects. We distinguish three different types of services for the elderly: permanent residential services, temporary residential services and community care services. The latter sector includes adapted housing and other forms of support intended to help the elderly remain in their own homes.

## 4.2 Adapted housing and support services for the elderly

**Table 4.5** Support services for housing

| | Rent subsidies (*name*, level (amount) and availability) | Home improvements (name) | Tele-alarm and telecommunication services (name and number of persons connected per 100 65+) |
|---|---|---|---|
| A | (housing and heating benefits from social assistance) | Subsidies in some provinces | Notruf (0.2 (1992)) |
| B | *Huurtoelagen*: granted to low income pensioners (net taxable income below 12 509 ECU/year (1995)) when moving from unadapted to adapted housing<br>Subsidies are dependent on the paid rent and the income (rent subsidy = rent x (12 713 ECU - income)/12 713) | Huursubsidie en installatiepremie<br>Aanpassings- en verbeteringspremie<br>La domotique: ± 100 houses in 1994 | Personenalarmtoestellen/Biotélévigilance<br>Fl.: 3,100 systems are subsidised (1987-1993); Wal.: 44 OCMW services (1994) |
| DK | *Rent subsidy*: dependent on income and rent. Flat max. 65 m² for singles and 85 m² for couples. For low income pensioners rent may not exceed 10% of income. For average income pensioners rent subsidy = 2,174 ECU for singles and 951 ECU for couples (1994). 50% of people renting apply for rent subsidies | Boligændringer | Omsorgsalarmer |
| D | Subsidies for rent and other housing costs are dependent on income | - | Emergency phone calls |
| GR | - | Improvements, housing accommodation | |
| E | - | Adaptación del Hogar | Telealarma (1 (1995)) |
| FIN | *Eläkkeensaajan asumistuki* (26,266 pensioners in 1994): subsidies are dependent on the size of the dwelling, rent and other housing costs, income and place of residence<br>Rent subsidy = 261 ECU/month for singles on low income (428 ECU/month);<br>153 ECU/month for singles on average pension (858 ECU/month);<br>293 ECU/month for couples on low income (747 ECU/month);<br>129 ECU/month for couples on average income (1,232 ECU/month)<br>A housing allowance can also be granted to low income pensioners owning their own house (41 ECU/month for singles and 71 ECU/month for couples) | Parannus- ja kunnostustyöt | Hälytus- ja puhelinpalvelut (2.1 (1991)) |
| F | *Aide au logement (Allocation logement à caractère familial, allocation de logement sociale et aide personnalisée au logement)*: the allowance for social housing is dependent on income (± 107 ECU per month on average) | Amélioration du confort des logements | Télé-alarme |
| IRL | (fuel allowance) | + | + |

**Table 4.5** Support services for housing. Continued

| | Rent subsidies (*name*, level (amount) and availability) | Home improvements (name) | Tele-alarm and telecommunication services (name and number of persons connected per 100 65+) |
|---|---|---|---|
| I | + | Edilizia popolare | Telesoccorso |
| L | - | Services d'adaptation du logement | Télé-alarme |
| NL | *Individuele huursubsidie (IHS)*: dependent on income (14,000 ECU for singles and 18,500 ECU for couples) and rent (max. subsidy= 40% of rent) | Woningverbetering/renovatie/aanpassing | Tele-alarm |
| P | Subsidy covers all rent increases. If invalidity is more than 60%, complementary rent subsidies are granted for a limited period | | |
| S | *Housing allowance* (2,045 ECU/year on average, 1995) Subsidies are dependent on rent: 83% of the rent costs between 12 - 470 ECU per month are paid | Home adaptations (40,000 users in 1995) | Security alarm (54,000 in 1992) (3.5 (1992)) |
| UK | *Housing benefit/Council tax benefit*: granted to persons receiving income support of max. 82.1 ECU per week. Subsidies are dependent on charges and income (Cold Weather Payments) | Improvement in housing conditions, 'staying put' schemes | Public, private or charitable providers. Fee depending on need and income |
| N | *Housing allowance*: subject to needs testing, income-related | Utbedringslån og-tilskudd | Omsorgsalarmer |

**Table 4.6** Special housing for the elderly

| | Name | Number | Number of places per 100 65+ |
|---|---|---|---|
| A (1993) | Seniorenwohnungen = Altenwohnungen | Small number | 0.04 |
| B (1993) | Bejaardenwoningen | Fl.: ± 17,000 | Fl.: 1.96 |
| DK | Ældreegnede boliger (1) | 43 300 (1) | 5.4 (1) |
| D | - | | |
| GR | - | | |
| E (1995) | Hogares del Pensionist | | 0.03 |
| FIN (1995) | Vanhusten asunnot | | 0.15 |
| F | - | | |
| IRL | + | Number increases | |
| I | - | | |
| L (1995) | Pensions de famille | 150 | 0.3 |
| NL (1993) | Bejaardenwoningen | ± 215,000 | 10.4 |
| P | - | | |
| S | + | | |
| UK | Special housing in Scotland developed since 1960. Less well developed in other regions | | 5 |
| N | Trygdeboliger (2) | | 4.6 (2) |

Notes: +: existent; -: non-existent
(1) including housing for the disabled
(2) including sheltered housing/service flats

## 4.3 Relation with services for the elderly

The priority for community care explains the large number of services to support the elderly at home. Some services are especially aimed at improving the quality of the home environment, or at making the elderly feel more comfortable at home. Examples of such measures include those for home improvements and alarm systems, both of which are mentioned in almost all of the countries studied. Some of these innovations (although now already widespread), are being placed within the broader concept of adapted housing for the elderly (or handicapped persons). This form of housing is sometimes defined as an alternative to residential services, or often tends towards it. In between are the semi-residential or temporary services.

The residential and semi-residential services are ranked according to the decreasing degree of medical support that is available. Some slight differences might occur continuously in the dominant characteristics of the patients of each service, so the nature of the services can change over time. For example, services originally provided for independent older persons, such as the 'service flats' in Flanders, can change by nature when the elderly who enter the service flat become older, stay in the service and become more dependent. Even the difference in qualifications of

the personnel in these services can imply that the character is different because, for instance, less qualified or less nursing personnel per group of residents is used.

The permanent residential and semi-residential services are generally available in all the countries. However, it should be noted that in some countries the large number of 'integrated' (independent) housing accommodation and care facilities, which are of a permanent but mostly semi-residential character, are increasingly replacing the purely residential services (see above).

### 4.4 Unbundling of housing and care in theory and integrated services in practice

Many of the countries emphasise the distinction between care-intensive nursing places and housing. In these countries, the traditional old-age home is disappearing, though in some other countries it is still the dominant residential care system (Belgium, the Netherlands, Germany, France and Luxembourg). But in these countries, as well, plans exist to transform these traditional old-age homes either into nursing homes or sheltered housing. In Belgium, for example, the building of new old-age homes has declined and over the next 5 years one third of all spaces in the existing old-age homes will be transformed into nursing home beds.

At the same time, and more precisely in Flanders, there is a strategy to shift from residential care to sheltered housing for the elderly: the so-called 'service flats'. These flats are meant for the independent elderly, and their construction is subsidised by the Flemish government. New financial instruments were developed last year to stimulate investment by the elderly in this product (especially by tax exemption of the invested capital), though at the same time the public subsidy decreased. The promoters of these 'service flats' argued that there was a risk either of the product becoming unaffordable for lower income groups or of the project becoming unprofitable. At the same time, the question is being raised as to whether the service flat can be kept exclusively for the independent elderly, since those entering the system will become increasingly dependent after some years, thus requiring more in-house services.

It was decided in the Netherlands in 1990 that part of the old-age homes should evolve into nursing homes and the rest should evolve into sheltered home facilities. In 1994 a Commission on 'Modernising care for the elderly' studied the problem of maximum substitution and the relation between housing and care. There were too many old-age homes since the elderly should stay longer at home. This implies that the rent subsidies should be raised. A new borderline was drawn between the elderly living in institutions and thus belonging to the care sector, and the elderly living at home and thus belonging to the sphere of public housing. The division between old-age home (social sector) and nursing home (medical sector) seemed to be of no relevance. Both are now covered by the Exceptional Medical Expenses Scheme, which also covers home care and district nursing (which

integrated these services into a single providers system). We have the impression that decades of discussion about what are social services and what are medical services is coming to an end here, and even the housing aspects are covered (at least for the institutional aspect) by an 'Exceptional Medical' scheme.

In the UK, as well, from 1988 onward (quoted in Bond, p. 37) it has been recommended that housing and care needs should be treated separately. A similar movement has occurred already in Denmark where beginning in 1988 a strategy has been developed to disassociate housing and care (Gottschalk, 1991, p. 25-27). The aim was to upgrade the housing function and to achieve a more flexible service system. In 1988 a large programme was launched to improve the quality of housing for the elderly. The nursing homes were replaced by modern housing, but some years later it was discovered that the new housing did not take into account the fact that the elderly living in this type of accommodation would need more service facilities after some years. More funding was made available recently to include more care facilities with this type of housing.

### 4.5 Housing and care: one continuum

Together with the disappearance of the traditional old-age home, the emergence of increased demand for adapted housing can be observed. The further development of welfare states and the new market of an ageing population creates increasing variety in accommodation for the elderly, demonstrating the emergence of new care and housing combinations. This brings us to a new system of categorising housing for the elderly. The first group could be described as integrated housing and care facilities of an institutional type, oriented to (medical) care aspects. There will be a growing convergence between old-age homes and nursing homes. In many cases there may only be a difference in name and not in content of these services.

The second group also combines housing and care facilities, but these are independent housing types. It is mostly a grouped accommodation, but the elderly have their own apartment, combined with an alarm system, common rooms and facilities, and the presence of some staff. Sometimes more facilities such as kitchen, dining room and bathroom are shared, but they remain housing facilities. Historically, these services start with a low-care component and gradually develop a larger care component.

The third group of special accommodation for the elderly is adapted housing. Adapted housing is characterised by being barrier-free and having wide doorways and big bathrooms; it is adapted for wheelchairs (sometimes also in the kitchen). There is no in-house ward or service, but it is possible to call for home care and day and night help. The distinction is not always made between housing for handicapped persons and housing for the elderly. As this housing form appears, it will become less and less distinct from traditional housing, if one takes into

account the new interest in lifelong housing which is to be found in the UK. Housing should be built which is adapted to all needs (or should be adaptable).

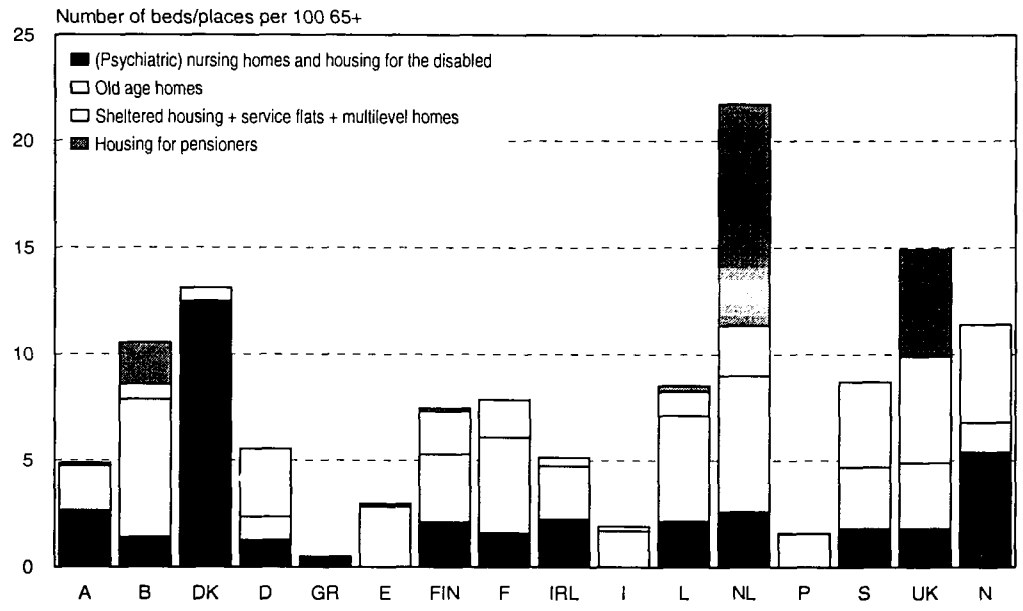



**Figure 4.7** Availability of some services for the elderly (number of places per 100 65+)

## 4.6 Housing as a means of financing care

Several other aspects of the relationship between housing and care became evident in our comparative study. The way (social) housing providers are more and more finding themselves confronted with an ageing population on their own premises is one of these aspects. This leads providers to become more involved in housing for the elderly and to recognise the need to organise care, (either by themselves or in collaboration with care providers).

Housing is at the core of other aspects of care for the elderly. The question as to whether this aspect needs to be included in long-term care insurance is under discussion in many countries. However, this is only one issue. Whether people should use their assets, including their house, to finance the long-term care is another issue.

Proposals have been made in the UK in line with this concept, such as to institute reversed mortgages or (posthumous) recall on the inheritance. 'Only 50,000 of the 2.5 million owners over the age of 70 have taken up mortgage annuity schemes' (around 1990, see Bond, p. 38). There seems to be clear opposition in public opinion to such a strategy. It is too reminiscent of means-testing solutions and social assistance instead of long-term care (social) insurance.

Up until now this reasoning has not been common in the welfare states of the EU, as it might be more accepted thinking in the USA (and also in Australia).[2] The old thinking in fact remains in force in the EU. One good example is the financing of 'service flats' in Flanders.[3] Although this financing vehicle was intended to attract private money, it stimulated savings by the 'seniors' by tax exemptions on the revenue and on inheritance. This means that wealth can be transferred to the heir without being taxed, instead of using private assets. Perhaps this aspect can serve as a good example for other countries, since it is also aimed at increasing the (financing of the) supply of adapted housing for the elderly.

The possibilities of trade-offs between elements of income support, housing, and social and health care services are substantial. Housing is at the core of care for the elderly. A further analysis of these housing conditions is warranted. We have shown that there is an increasing variety of residential and community services where housing and care aspects converge. The increasing variety reflects the maturity of a welfare state, but at the same time it reflects the emerging maturity of the (mass-)market of (housing and services) for the elderly. Although in many EU Member States theoretical and political debates have taken place to distinguish the housing aspects from the care aspects - just as the same debate has taken place on the distinction between medical and social services - the reality is moving in the opposite direction. Housing combined with a varied (and increasing) care supply seems more and more to be the case, even though the experiment started with the emphasis on housing. The borderline between residential and community care, as well as between housing and care in general, is fading in organisational terms - and in some cases also in financial terms.

2 See Colloquium Long-term Care Insurance in Sydney, August 1997.
3 See Pacolet J., Lanoye H., 1997.

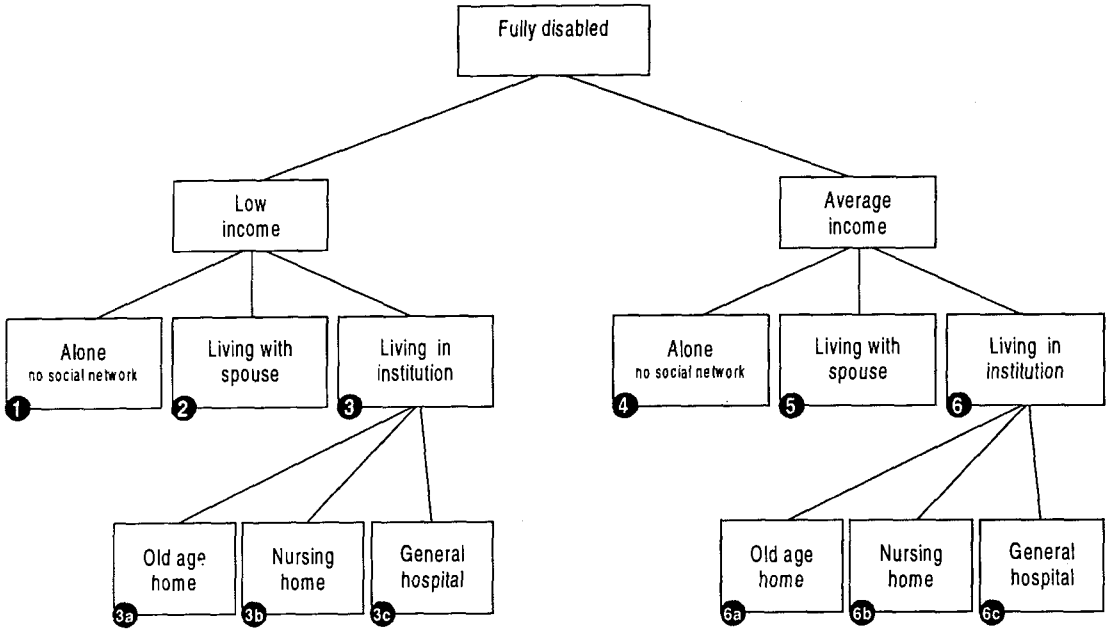
# *CHAPTER 5*
# *Differences in treatment of similar categories of need*

## 1. Methodology

To achieve a more comprehensive understanding of the macro-economic, institutional and policy information collected in the other chapters, we have opted to supplement the study with a description of the social protection arrangements of a limited number of specific cases. The reasons for including these case studies are twofold: firstly, it is a very convenient methodology for comparing the level of social protection and the eligibility of services for elderly persons in similar objective situations, but living in different countries, and secondly, it makes the report easier to understand. The examination of case studies can also help to reveal hidden features of the welfare system.

It should be made clear, however, that the case studies are only illustrative and cannot be supposed to represent the entire elderly population. Therefore we make no claim to be comprehensive. However, in choosing the case studies, we selected those which probably appear most frequently in practice. In this way, despite the lack of comprehensiveness, a large share of the elderly population is covered by the case studies.

The focus of the study on the elderly who are (1) dependent, (2) over normal retirement age, and (3) in need of long-term care constitutes the general framework within which the case studies have been developed. The four most relevant dimensions of dependency - the physical, the mental, the economic and the social - are the basis for the definition of the thirteen case studies (see Figure 5.1).




7 Widow, female, +80 years, 'survivor' (has never been in employment), income spouse low, fully disabled (in need of long-term care), living alone, no social network.

8 Demented elderly person, physically able, average income, living with spouse.

9 immigrant, elderly person with foreign nationality who has stayed in the country for a shorter period than needed for insurance record or shorter than minimum period of membership, further tot be defined by the country according to rules (facultative).

**Figure 5.1** Definition of types of cases

### 1.1 Physical dimension

Because the focus of the study is on dependent people in need of long-term care, each case study in the present research project refers to elderly persons who are to a large extent disabled or physically dependent. For a clear description of who is 'to a large extent disabled or physically dependent', we refer to Chapter 1.

In the case studies of couples living in the community, only one of the two older persons is considered to be fully disabled.

### 1.2 Mental dimension

Only one case study takes into account the mental dimension: case study 8, which includes persons who have been medically assessed as demented patients.

### 1.3 Economic dimension

Two categories were retained in defining the cases:
- low income category;
- average income category.

Only the pensions the elderly receive are taken into account when the term 'income' is referred to. In order to keep the case studies simple, no other personal incomes or assets or other personal resources are taken into account.

The low income category is supposed to receive the minimum income legally guaranteed in each country to single elderly persons or to two older persons, depending upon the case study considered. By comparing the legal minimum guaranteed income with the poverty lines according to EU norms, the degree of social protection in terms of cash benefits can be assessed. The average income category is the group of elderly persons who receive approximately the average income in each country for retired private sector wage earners who have retired at the legal pension age (complete career).

The differences in low and average income represent differences in the insurance record of the older person, since the pension level is to a large extent determined by the previous occupation of the older person or his/her spouse. In every case study, except the special 'widow' case study, one (and only one) older person is supposed to have a personal insurance record. This means that, in the case studies of persons living alone, the person him- or herself has been in employment. In cases involving couples, only one of the older persons is supposed to have been in employment. We assume that this is the most common situation for dependent older couples at the present time (male worker who has been in employment while his wife is financially dependent). We realise, however, that in the future these 'single career' pensions will be less and less representative.

Because this group of elderly persons appears frequently in reality and because it is especially vulnerable to poverty, the case of a very old widow is included in order to represent the large group of female 'survivors' who have never been in employment and thus have no personal insurance record.

### 1.4 Social dimension and living situation

The following categories are included because they are considered to refer to the most common living situations of elderly people:

- living alone, no social network available: the older person cannot rely upon relatives for help and care or financial assistance;
- living as a couple in the community;
- living or staying in an institution:
  - living in an old-age home;
  - living in a nursing home;
  - staying in a hospital.

### 1.5 Age

Age is normally considered to be the best index of dependency, though it is usually combined with the physical dimension: the older the person, the more he/she

becomes physically dependent; especially after the age of 85 the need and use of care services because of physical dependency increases rapidly. It is not age in itself, but rather the increase in physical dependency that usually accompanies ageing, that is relevant for the research.

Because only highly disabled people are considered and because no discrimination on the basis of age (in any case, not above the age of 65) is supposed to be made for the availability of services, further distinctions based on age - which would multiply the number of case studies - are considered unnecessary.

### 1.6 Gender

No distinctions have been made on the basis of gender (except for the case of the widow, though even here it is not the gender but rather the fact that the older person is a 'survivor' that is important). The omission of gender is again inspired by our efforts to limit the cases, since in terms of the right to social security, differences might exist in practice.

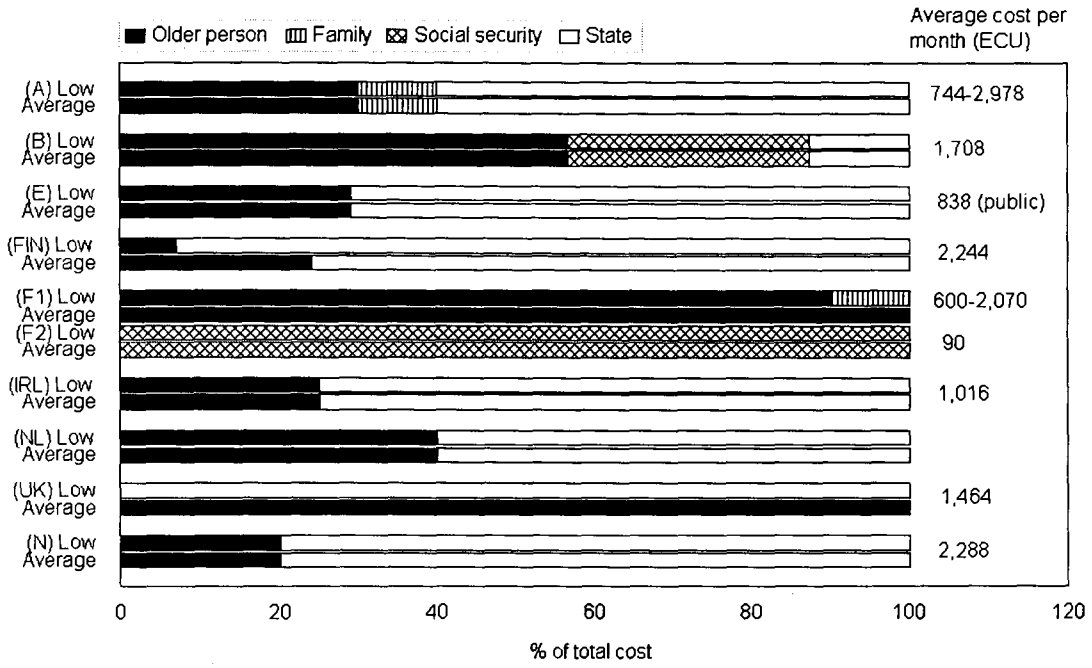
## 2. Cross-country comparisons: differences and similarities in social protection

### 2.1 Differences and similarities in average costs and financing of care

With the aid of graphs we have attempted to discuss the following issues for six services (old-age homes, nursing homes, general hospitals, district nursing, home help and meals-on-wheels):

- the average cost of the service;
- the financing of the service: who contributes and how much:
  * the state at the local, regional or national level, or social assistance (in the graphs shortly referred to as 'state');
  * the social security system;
  * the person himself, voluntary or compulsory private insurance, or dependency insurance;
  * relatives of the elderly person;
- the extent to which the services are income-related and/or means-tested.

### 2.1.1 Old age homes and nursing homes



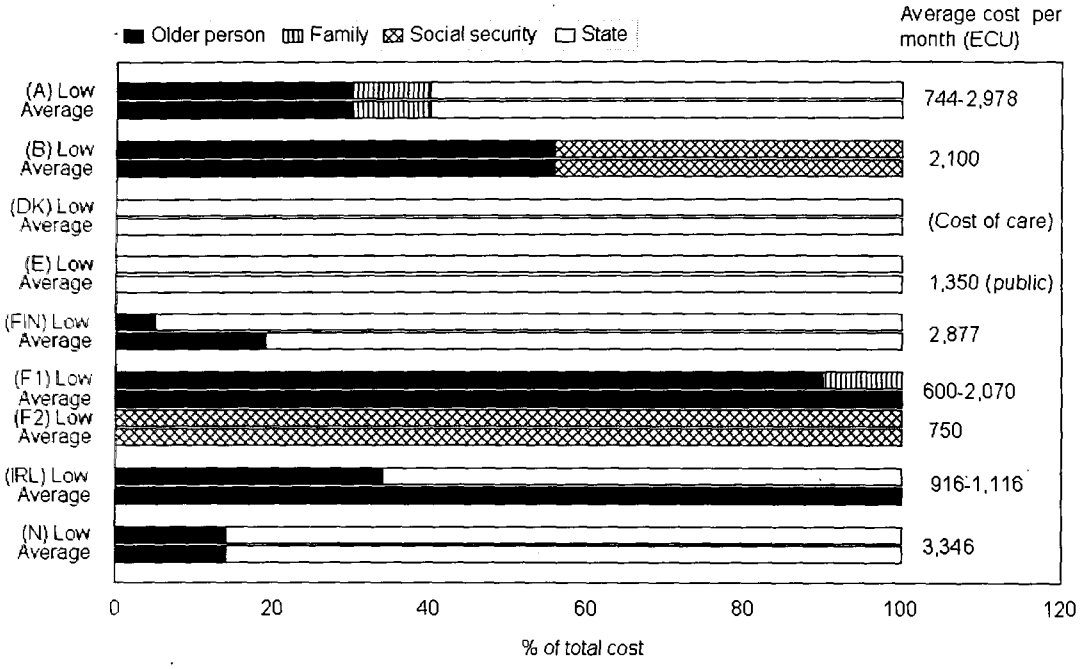

(E) 71% state ánd social security financing
(F1) refers to hotel costs
(F2) refers to costs of care

Additional information about financing for countries not appearing in the graph:
I: health aspects of dependency are completely covered by the state; other costs have to be paid for by the older persons themselves or by their relatives
L: older person and his relatives have to pay for accommodation; social assistance intervenes in case of insufficient income and assets
P: means-tested personal contributions for care and lodging
S: pensioner pays 70% of total income for housing, care and services including cleaning, hair-dressing and pedicure

**Figure 5.2** Average cost of old age homes per month and estimated contribution of different partners to the financing of the old age homes (according to income category: low or average income)

The average cost of old-age homes varies between 700 and 2,980 ECU per month. Even within a single country, the range between which average costs of old-age homes vary is very large, as for example within Austria and France.

In most countries, the financing of old-age homes consists of a mix of state or social security involvement and personal or family contributions. In the UK, pensioners on average income, in contrast to low income pensioners, receive little or no public financing for support in homes. In France and Finland, pensioners on low income pay a lower share of the cost of accommodation than pensioners on average income.




(E) 100% state ánd social security financing
(F1) refers to hotel costs
(F2) refers to costs of care

Additional information about financing for countries not appearing on the graph:
D: financing of social security + social assistance (income-related and means-tested)
I: health aspects of dependency are completely covered by the state; other costs have to be paid for by the older persons themselves or by their relatives
L: older person and his relatives have to pay for accommodation; social assistance intervenes in case of insufficient income and assets
NL: pensioner pays 11% of income + social security financing
P: means-tested personal contributions for care and lodging
S: pensioner pays 70% of total income for housing, care and services including cleaning, hair-dressing and pedicure

**Figure 5.3** Average cost of nursing homes per month and estimated contribution of different partners to the financing of nursing homes (according to income category: low or average income)

The range between which average costs of nursing homes vary is even wider than for old-age homes, namely between 744 and 3,346 ECU per month. Again, there may exist wide differences within a given country (for instance in France, the UK and Austria).

When comparing old-age and nursing homes, the situation in Spain and Ireland is particularly striking. In contrast to public old-age homes, public nursing homes require no personal contributions at all from Spanish pensioners. In Ireland, pensioners on average income must completely rely on their private resources (including probably some family involvement) to pay for costs of a nursing home.

In Austria, France, Italy, Sweden, the UK and Norway, there are no differences in the level of social protection for an elderly person who lives in a nursing home or one who lives in an old-age home. In the Netherlands, on the other hand, until January 1, 1997 there was an important difference in the social protection of elderly persons staying in nursing homes and those in old-age homes. For a stay in an old-age home, people had to invest their own income and assets. People with a low income, however, might keep a certain amount as pocket money. Only when assets were no longer available and the individual was unable to cover the costs with his/her income (public and private pension), was social assistance granted.

For a stay in a nursing home, pensioners had to contribute a share of their income (maximum amount defined) and not of their assets.

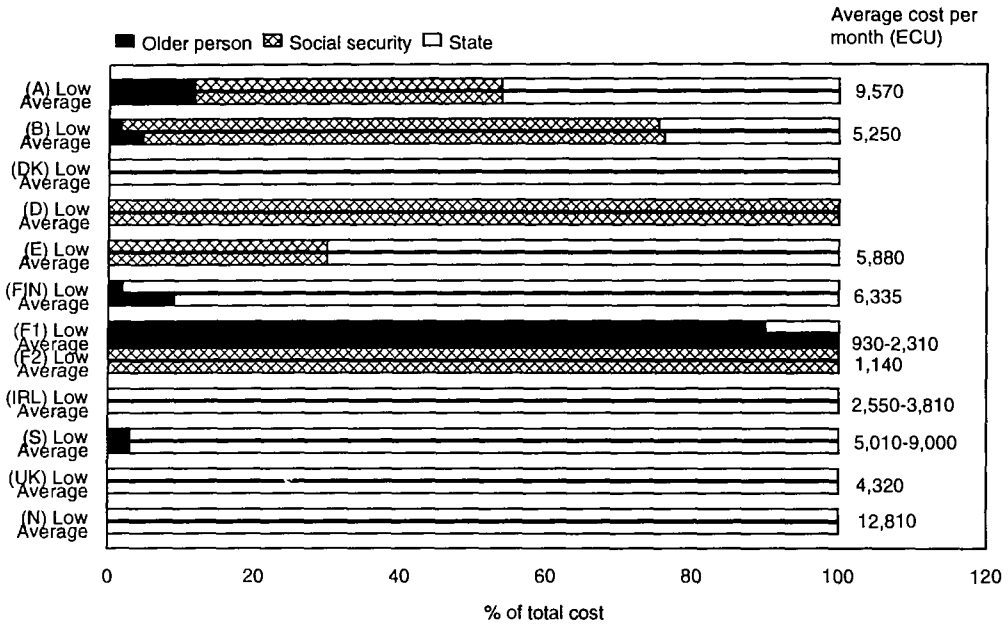
In some countries, such as Belgium, Denmark, and France, pensioners (or those on private insurance or dependency insurance) have to pay for the hotel costs of a stay in a home. If income is insufficient, then in Belgium pensioners are granted pocket money by the social assistance agency. In France the low income pensioner can keep 10% of his or her income. Except for the fact that the contributions of pensioners for care are higher in nursing homes than in old-age homes in France, there are no differences in the level of social protection of a pensioner in an old-age home and a pensioner in a nursing home.

In Austria, Ireland, Portugal, the United Kingdom and Norway, the pension of the older person is paid directly to the institution when a person is admitted to an old-age or nursing home. The older person receives pocket money from the institution, and the remainder of the pension is retained by the home. In Ireland, nursing home residents not only have 75% of their income withheld, but they also pay any shortfalls between the public subvention (determined by a means-test) and the cost of stay and care.

Low income categories in Belgium, Luxembourg and Germany also have to use their total income when staying in a home and are left with pocket money. In Finland, as well, the pension of low income categories is reduced due to institutionalisation.

In Austria, Belgium, France, Italy and Luxembourg, relatives of pensioners on low incomes who live in old-age homes or nursing homes are required to cover the accommodation costs. This is also the case for relatives of pensioners living in nursing homes in Ireland. In the UK, relatives are able to top up the amount of income support which a low income pensioner receives for a stay in a nursing or residential home so as to secure better facilities (e.g. single room), but they are not obliged to do so.

## 2.1.2 General hospitals



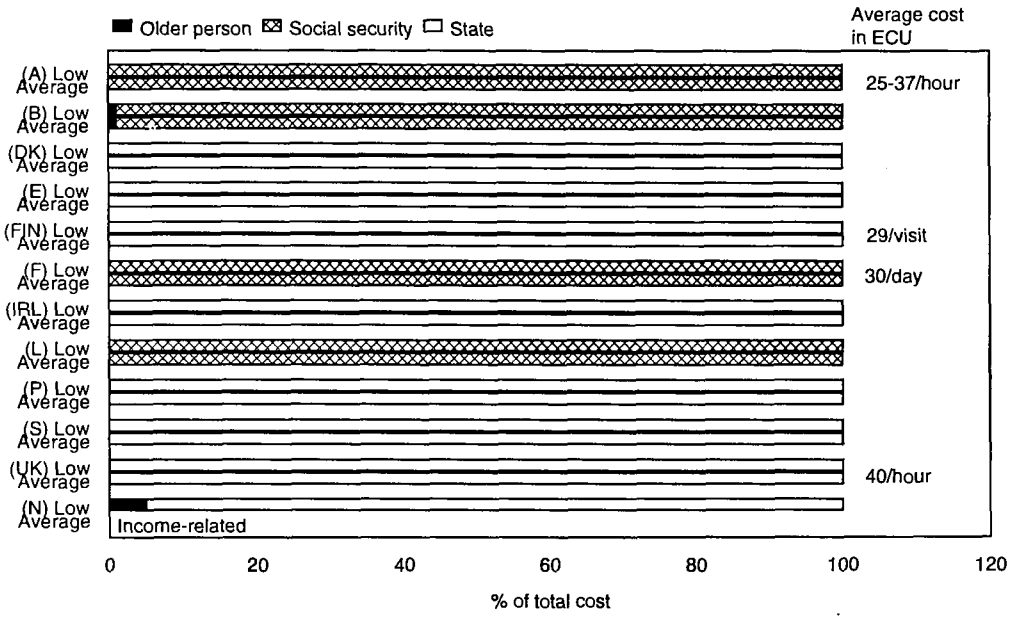

(D): pensioner pays during max. 14 days 6 ECU/day
(F1) refers to hotel costs
(F2) refers to costs of care
(IRL) pensioner pays 25 ECU per day during max. 10 days in any year

Additional information about financing for countries not appearing on the graph:
(L) pensioner pays for accommodation after 3 to 6 months; social security pays for accommodation before 3 to 6 months; state pays if pensioner cannot pay
(P) no private contributions of pensioner

**Figure 5.4** Average cost of general hospitals per month and estimated contribution of different partners to the financing of general hospitals (according to income category: low or average income)

From the above figure it immediately becomes clear that general hospitals are a much more expensive care form than old-age homes and nursing homes: the average cost per month varies between 2,070 ECU (France) and 12,810 ECU (Norway) per month. State and social security financing is also much larger in general hospitals than in old-age and nursing homes. In Denmark, the United Kingdom, Portugal and Norway, no private contributions of pensioners are even required. France is the only country which mentions obligatory contributions of relatives.

### 2.1.3 District nursing, general practitioners and pharmaceuticals




E: 100% state ánd social security financing

Additional information about financing for countries not appearing on the graph:
D: financing of social security (+ social assistance for low income categories)
NL: financing of social security + contribution of the older person to the district nursing organisation

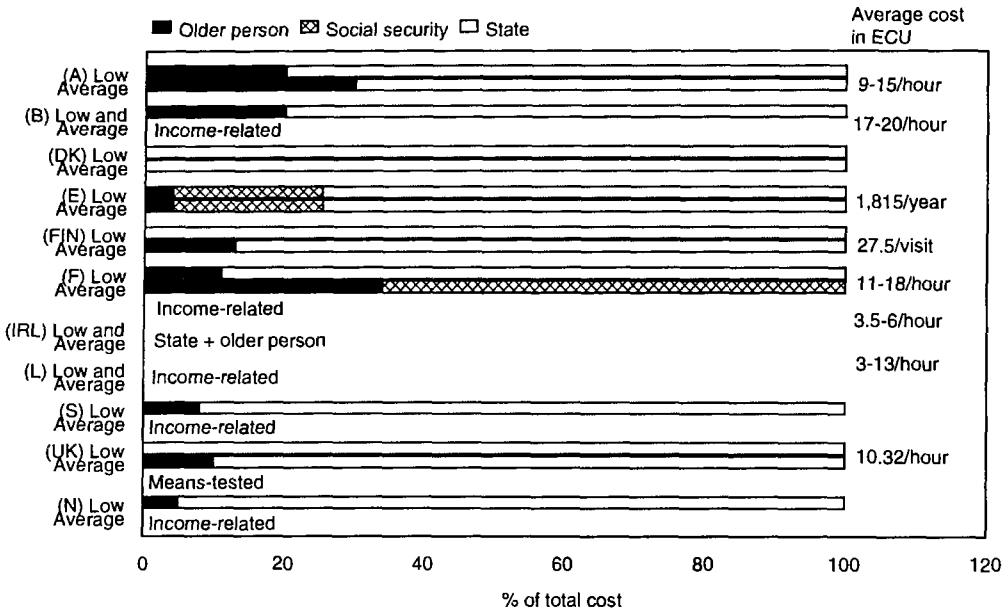
**Figure 5.5** Average cost of district nursing and estimated contribution of different partners to the financing of it (according to income category: low or average income)

Norway is the only country where district nursing is income-related. In all the other countries district nursing is almost completely financed by the government or by social security.

In almost all countries, the cost of health care is, to a large extent, financed by social insurance or government subsidies. For pharmaceuticals, however, personal contributions are common. In Austria, Denmark, Belgium, Luxembourg, the Netherlands, Portugal and Sweden, the elderly have to cover a certain percentage of the cost, and this is frequently income-related. In Spain, Finland and the UK, on the other hand, all pensioners are given free prescriptions. Low income categories in Ireland and the Netherlands are also given free medicines.

Consultations of general practitioners are free in Austria, Denmark, Portugal and the United Kingdom. They are also free for low income categories in Ireland and the Netherlands.

### 2.1.4 Home help



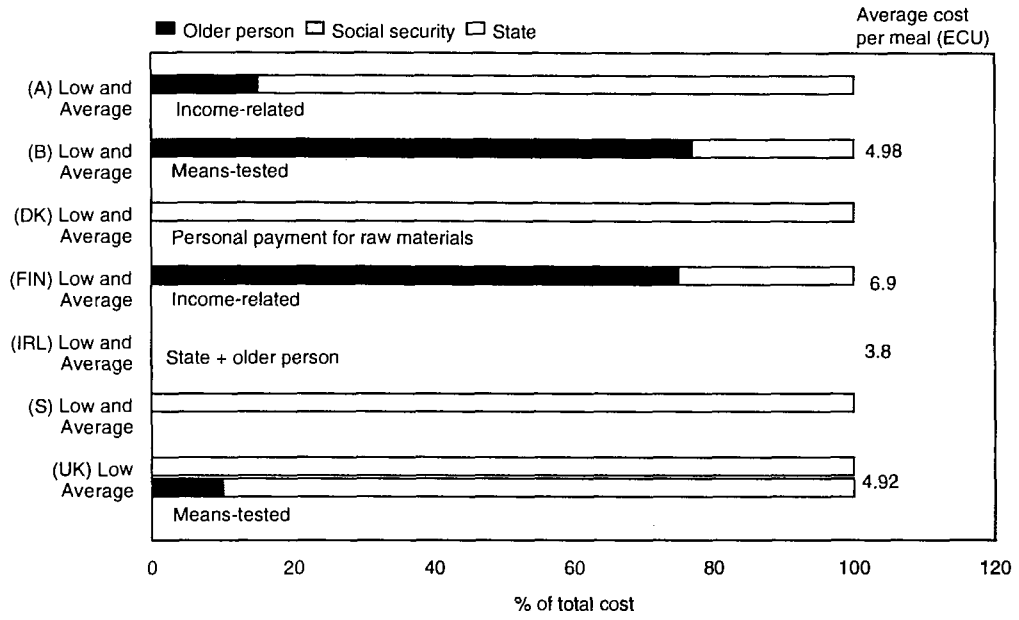

Additional information about financing for countries not appearing on the graph:
D: no means-testing
NL: financing of social security + older person (income-related)
P: means-tested

**Figure 5.6** Average cost of home help and estimated contribution of different partners to the financing of it (according to income category: low or average income)

Denmark is the only country where home help does not require personal contributions from the pensioners.

Only in Spain and France is there social security financing.

## 2.1.5 Meals-on-wheels




Additional information about financing for countries not appearing on the graph:

D: no means-testing
F: financing of social security + state + older person (means-tested)
NL: financing of state + older person (income-related)
P: income-related (25% of monthly income)
N: state + older person

**Figure 5.7** Average cost of meals-on-wheels and estimated contribution of different partners to the financing of them (according to income category: low or average income)

Meals-on-wheels is mostly income-related, except in Denmark and Sweden. Neither family contributions nor social security financing (except for France) is mentioned for this service.

For social services that are more oriented towards aid in daily life activities (meals-on-wheels or home help), personal contributions are common. However, it is important to note that, especially for the care of the elderly, the trend is towards an integration of health and social care as, for example, in nursing homes. In various countries, such as Belgium and France, a large share of the accommodation costs in nursing homes is therefore paid by the pensioners themselves, while the costs for care are covered by social security or state budgets.

## 2.2 Differences and similarities in the organisation of care

### 2.2.1 Formal versus informal care

A preference either for formal or for informal care can be detected in two ways: firstly, by analysing the differences between elderly persons either with or without a social network and, secondly, by the availability of additional allowances for the carer.

In Belgium, the presence of a social network is taken into account when providing district nursing and home help. The availability of other social services for elderly persons living in the community does not differ according to the presence of a social network or spouse. In Denmark, when allocating home help, meals-on-wheels and the installation of an emergency alarm, the local authority considers the ability of the spouse. In Germany, home nursing aid can partly be provided in cash instead of in kind when a social network is available. In Finland the package of services is reduced when informal care can take over some duties. In France, one of the eligibility conditions for receiving home help is that the spouse must be incapable of providing informal care for his or her partner. In Spain, access to health and social services is in general dependent upon family circumstances. In Ireland, the presence of a spouse reduces the likelihood of some public services, particularly home help services. In Italy, no home help is provided when a social network is available. The spouse has an important task in taking care of the disabled. In Norway, couples often receive less formal help than singles. In Norway, family members (beyond the spouse) normally have no formal obligation for care and economic support. However, children, in particular daughters, are important care providers.

In several countries, additional allowances for the carer are available: this is the case in Luxembourg, Finland, Ireland, Italy, Sweden and Norway.

The differences between the social protection situation of pensioners with or without a social network are mostly minimal or non-existent. However, it can influence the choice of the elderly persons themselves for institutional or community care, which places them in different situations. It can also influence the choice for in-cash or in-kind benefit, as is the case in the German 'Pflegeversicherung'. In Germany, the older person can receive home nursing care in the form of in-cash help instead of in-kind, if he can count on relatives or friends to care for him or to help with household activities. In France, the newly created allowance is not only taking into account income and dependency, but also the informal care provided. In Austria, Luxembourg and Sweden, there are no formal differences in the protection of pensioners living either alone or with their spouse. In the UK, however, notwithstanding the fact that the eligibility for health and social services of pensioners does not differ according to whether they live alone or with a spouse, there is a special state retirement pension level for couples when only one of the two has made the necessary contributions and when the person

who has made the contributions has not died. There are also special pensioner premiums and severe disability premiums for couples (both partner and spouse eligible for attendance allowance). In Denmark, when both marriage partners are pensioners, each partner has a lower public pension than a single pensioner, and the pension supplement is higher for pensioners living alone than for pensioners living with a spouse. However, with the exception of home help, there are no differences in the availability of services between single and married people. In Spain, the level of contributory pensions differs between couples and single persons. In Finland, couples each receive a smaller pension than does a pensioner living alone.

### 2.2.2 In kind versus in cash care

The largest differences noted in the case studies relate to the degree to which the pensioner is charged for the use of the services. In some countries, such as the UK, many services are provided free of charge, while in the Netherlands, for example, most services are charged for (up to a maximum amount), though at differing rates according to the income level of the pensioner. The difference in personal contribution should not be interpreted as a lower level of social protection in the latter country, since it provides other kinds of support, such as benefits and additional income. The difference illustrates that the UK is more in-kind oriented, while the Netherlands is more in-cash oriented.

A Belgian pensioner who enters an old-age home covers quite a large share of the costs, (more in particular the accommodation costs, which are 53% of the total costs), while British pensioners who receive income support lose their income when they enter an old-age home, but receive services completely free of charge. When making comparisons between countries which are oriented towards either in-cash or in-kind aid, it is thus important to consider the income of the pensioner, in addition to the degree to which he/she has to contribute to cover the costs of the use of health care or social services. It has also become clear from the case studies that not only the pension should be considered, since in many countries this is topped up by additional benefits and income.

In Denmark, until 1995 both systems (in-kind and in-cash) could be used for the financing of the same service (the nursing homes). Either pensioners lost their general old-age pension when entering the nursing home to pay for housing, clothes, food and social services and received pocket money to cover additional expenses, or they continued to receive the general old-age pension and paid a fee for housing and electricity. Services that they were free to choose (social services such as cleaning, meals, etc.), were charged for when utilised. From January 1995 on, the system of 'pocket-money' in Danish nursing homes has been abolished. All nursing home residents now keep their general old-age pension and pay about 15% of their incomes in rent and a fee for housing and electricity. Services that

they are free to choose (social services such as cleaning, meals, etc.) are now always charged for when utilised. Denmark has thus become more cash-oriented.

### 2.2.3 Universal systems versus selective systems

Negative features of the welfare system that were identified are:
- The importance of means-testing or income-related contributions which, at first glance, seem to change universal systems into very selective ones.
- The fact that in Austria, Ireland, Portugal, the UK and Norway (and up until 1995 in Denmark) retirement benefits are withheld from pensioners who have been placed into the care of an institution. These pensioners are given only pocket money. This system does not contribute to their independence, nor is it indicative of real public responsibility. In fact, pension resources pay for the care and thus the resources of the pensioners themselves. This occurs in nursing homes as well as in old-age homes.

It is difficult to make a clear distinction between welfare systems of the Beveridge type and those of the Bismarck type, but one main feature of the Beveridge-based system is that, although universally defined, the services are to a large extent means-tested or income-related. In the Bismarck-based system, priority is given to applying new types of (universal) insurance, unrelated to income or means, so as to avoid what in these countries is described as a deterioration towards social assistance. Another characteristic in these countries is that when new proposals emerge, reference is made by preference to in-cash benefits. This is certainly clear in France, as well as in Belgium and, to a lesser degree, in Germany.

The cases are examined to see whether or not there is a universal system. There is no discrimination as far as entitlement is concerned, but the use of needs and income determines charges for a lot of the services. In most countries there is a tendency towards non-discriminatory services. This should help to improve the older persons' freedom of choice, but it limits the scope for providing incentives to seek alternatives. Illustrative of this non-discriminatory trend is the fact that new proposals talk about not channelling more resources into residential care than into community care. This conflicts with a cost-oriented subsidising system, and when different costs occur it may hamper neutrality. There is also less discrimination than before when alternating between formal and informal care. In the proposals in which a universal in-cash benefit is awarded, there is no discrimination; in other cases, a lower but significant amount of income is available where informal care is used instead of the professional variety.

# *CHAPTER 6*
# *Debate on long-term care insurance*

## 1. Present situation of social protection of the elderly and discussion for change: an overview of the main characteristics of each country

(A) Some form of long-term care insurance (in the form of 'Pflegegeld') has existed since 1 July 1993 at the federal level. This guarantees an additional income related to the degree of dependency; it is mostly paid for by the pension scheme and is defined as payment for care. It can also be used, however, to pay for additional services (community or even residential). The regions ('Länder') have agreed to improve the supply side for these services.

(B) After a period of status quo in the debate on long-term care insurance because of budgetary and institutional considerations, recently (mid 1997, beginning 1998) new regional initiatives have been announced. In the meantime, several step-by-step adaptations are taking place of existing (federal) financing systems and can accommodate for most of the financial problems: installation of 'social franchise' (limit on co-insurance for chronically ill); increased number of old age homes converted to rest and nursing home beds with better financing conditions from health insurance; proposal for a better (legal) statute of the main informal carers; substantial enlargement of the staffing of health and elderly services after new action by the trade unions (asking more than 70,000 new jobs in the social and health sector of about 280,000 persons); improvement of protection of chronically ill persons in health insurance; and increased financing of services at regional level. The Flemish Government is formulating explicit proposals on a long-term care insurance.

(D) The introduction of long-term care insurance ('Pflegeversicherung') on January 1, 1995 for community care and on July 1, 1996 for residential care as a fifth 'pillar' of social security, and structured according to the same principles of financing and universality. The financing is based on solidarity among the total population (including pensioners) and the principle that prevention and rehabilitation come before nursing care, and that home care comes before institutional/ residen-

tial care. Support for the development of supply - and especially of infrastructure - remains the responsibility of the regions ('Länder'). (A large-scale programme for upgrading the quality in the new 'Länder' has been launched). There is ongoing debate regarding the level of the benefits, still leading to recurrence of social assistance. There are also discussions on the borderline between long-term care insurance and health care insurance and insurance for the handicapped. The formula of in-cash help in the community care field has met with unexpected success. Substantial job creation (more than 70,000 jobs) has occurred. Financial situation due to large solidarity is under control (expenditures will only increase to 2.5% of wages in 2030), but even from the start, additional financing is limited (due to the reduction of expenditures for social assistance, one paid holiday in exchange for employers contribution).

(DK) Discussion on the future financing of pensions and raising the retirement age; attempt to improve the quality of housing and home services for the elderly, including the introduction of rights to complain, a better national financing, and even privatisation.

(E) There is debate on the viability of the pension system, together with indications that the care system for dependent older persons (which until recently relied on informal carers) is insufficient. Up till now this has not led to a general demand for dependency insurance. The National 'Plan Gerontológico' seems to propose a selective dependency insurance system covering most of the traditional care services, though with an optimistic view of the overall cost.

(F) Several propositions for long-term care insurance are under consideration, though no final and substantial choice has yet been made. These propositions are a response to long-term discussion and to increased social expectations. Sector reorganisation and job creation are expected from voucher-like systems of long-term care insurance.

Meanwhile, the quantitative and qualitative deficiencies remain clear. These include the lack of professional help available, without limiting the autonomy of the elderly. Proposals exist involving several different systems of social security, as well as involving the reform/creation of existing and new systems of dependency allowances at the national or regional the level. Discussion continues as to whether this support should be recoverable from the family, and whether the support should by preference be in-kind.

On December 18, 1996 new (but transitory?) legislation was adopted on a long-term care insurance system ('Prestation spécifique dépendance') organised at the regional ('Département') level. It is income tested, dependency and care-plan related (with a proper assessment), recoverable from inheritance, oriented to community and residential care, though without any clear additional financing. One of the advantages will probably also be the stimulation of more co-ordination in the sector.

(I) Debate has concentrated on reforming the pension system and moving it more in the direction of a funded, income-related, mixed system. Health care is mixed responsibility of national and regional authorities causing some problems. The reform of care for the dependent elderly should be a combination of health care and social aspects.

(IRL) The reform proposals under discussion are based on the principles of a holistic and comprehensive approach, with priority given to community care, public financing and private competitive services. The public financing, however, is of a front-end character (long-term care limited to one year), to be supplemented with private insurance.

(GR) Despite the high replacement ratio and the high level of expenditure on pensions, there is high level of poverty amongst the elderly. Despite the free access to health care, there is an increasing incidence of (often illegal) additional patient payments. There is a low level of residential services, and an emerging system of community care.

(L) Concrete plan for introducing a public long-term care insurance system structured along the lines of the German scheme (Law accepted on June 19th, 1998).

(NL) After several reforms of the health insurance system, new definition and task divisions have been drawn up for health insurance and the system for exceptional medical expenses. The latter was originally meant to be long-term care insurance. It includes both health and care components, as well as housing aspects. Organisational reforms are bringing together social and medical disciplines in a common provider, under a common system of regulation, thus illustrating that the borderline is becoming less and less clear.

(POR) The (to a large extent private) sector of elderly care, especially residential, is underdeveloped and, if available, it is very costly to the elderly. For the majority, pensions for the elderly are low (with exception of civil servants). Some income support comes from rent subsidies and even rent control. The dependent elderly can obtain additional rent subsidies, attendance allowances or in-kind help.

(UK) There is ongoing debate on the reform of the state pensions and additional private or occupational pensions; this is resulting in a convergence of both political opinions to create a mixed system. There is conflict between the universal NHS solution and the income-/means-tested personal social services solution for long-term care. The first seems to have the support of public opinion and this may result in a final choice for a continuation of the existing systems of free (health) care. A Royal Commission on Long Term Care was installed in 1998.

(FIN) There is debate both on the quantitative and on the qualitative levels of the care system. There is emerging support for more rehabilitation and freedom of

choice, but also for more co-payment. Special attention is being given to housing for the elderly. There is a general need to reshuffle the supply in the care system towards more community based services; (for instance, there are still long-term beds in hospitals and the residential care is expensive for the elderly because their income is reduced to pocket money).

(SWE) The care system has undergone a substantial qualitative and quantitative shock, having been 'downsized to the level of the 1960s' (which can also be seen in health expenditures, see above), and this has created widespread discontent with the availability and quality of services (no good quality standards), and the fear of an even larger care gap by the year 2010. The threats of a newly emerging party of the elderly changed the policy in 1996. In the meantime, 'privatisation by default' has occurred in the realm of long-term care insurance: this failing public system has resulted in the emergence of a market for private long-term care insurance, offered by the major insurance companies from 1997 onward and welcomed by public opinion. In contrast to many other Member States of the EU, this state-oriented system most clearly welcomed a private insurance solution.

(NOR) There has been debate on the pension scheme (ambitions to raise pension age) and on the quantity and quality of health and social services. The complete scope of dependency is insured, but limited resources, which are causing the welfare state to become more selective (for instance, less housing costs covered, basic care first), is challenging all aspects.

## 2. Main characteristics of the political discussion on present and future old age protection. Context of changing welfare states

**Table 6.1** Political- socio-economic context of the discussion on dependency insurance

1. Purchasing power available (self insurance possible)
2. Decline of the welfare state
3. Demographic pressure increasing and impact of dependency
4. Privatisation in insurance
   Privatisation in provision
5. Macro-economic perspectives considered as getting worse in future
6. Towards informal care
7. Older persons have become relatively more affluent: higher degree of co-insurance possible
8. Selective social protection or increased means-testing
9. Others

## 3. Changing needs

In all of the countries taken into account in this overview, changes are evident in the care of the elderly. These changes are aimed mainly at diminishing the financing problems by substituting more expensive care with cheaper care models (home care), or by integrating informal care. Despite these efforts, the total costs have continued to increase due to the increasing need for care.

In the following tables these changes are illustrated for each country separately and in general terms.

**Table 6.2** Changing needs in the social protection system: summary

| | |
|---|---|
| Income | Increasing importance of private pensions, though in many countries these are reminiscent of the old principles of social insurance |
| Housing | Quality standards are rising, but are prohibitively expensive for most private individuals |
| Hotel cost | Higher co-payment |
| Cost of care | Limitation to basic personal care needs |
| Cost of cure | Increasing medicalisation of services |
| Informal care | Reaching its limits; increasing requests for remuneration |
| Legal rights | First initiatives are emerging |

Most problematic is the increasing medicalisation of the services, which implies, for example, increases in the direct cost for nursing staff. This trend can be observed in France; it is also the main reason that Germany has been considering establishing an old-age insurance system, and it is a distinct and rapidly developing trend in Belgium, where the cost of old-age services is one of the most rapidly increasing elements in the health insurance system. Some groups are even not fully covered by this care (the self-employed).

In some countries there is a clear strategy aimed at upgrading the quality of housing for older persons. In Denmark, this is to a large extent being financed collectively. In Flanders, programmes for better housing (service flats) have been initiated, but they have become unaffordable for most of the older population. In the Netherlands there is also renewed attention being given (1993) to the relationship between housing and care.

The evolution towards community and informal care, and the means of supporting these forms of care, have become the objects of intense scientific and public scrutiny. There are legislative aspects to the issue of protecting certain rights of the main carer within the family. There are minimum support systems for the volunteers. On the basis of the principle of non-discrimination between people who rely on formal care and those who rely on informal care, reimbursement for the informal care is being demanded. Such a system could be organised by giving the dependent elderly in-cash payments so that he/she can buy the care he/she

wants. Such a scheme could take the form of a voucher system, as suggested in Belgium.

It is worth noting that the trend towards payment for informal care has developed most extensively in the Scandinavian countries, probably because in these societies the need for compensation for the opportunity cost has been clearest due to the high level of female labour market participation. But even here, although there is a tradition of paying informal carers, there are in fact very few of them relative to the numbers of professional care providers (and unpaid family care) (S.O. Daatland). The carers are mostly female, and therefore some people are against such payment for care because it might force women into this role. A point worth noting in the study of Evers et al. (1994) is that there is a similar trend in the US towards giving priority to payment for care, so that here, for once, we find the public (Europe) and the privately-oriented (USA) systems moving in the same direction.

In most countries, discussions about the nature of care for the elderly and the best ways to organise it can be observed. Should it be social or health care? Should it be provided in-kind or in-cash? The Report of the European Observatory (Walker A., Alber J., Guillemard A.-M., 1993) gives a good summary of the discussion concerning whether social or health care should be provided. A clear (institutional) distinction has been made between the two. In the Netherlands, where there is a tendency towards more integration, it remains less clear. In Belgium the situation is ambiguous. Health and social services are separated and are financed at different levels. However, a lot of the care that is dispensed combines health and social services, so that there is a need for co-ordination of the organisation of health and social care, but the question as to whether this ought to be done at the national or at the regional level remains unanswered. In France the same distinction occurs, and it is called 'sterile'. In Ireland a comprehensive system is advocated. In Finland there is a strong trend towards integrated care systems, and special programmes at the regional and local levels have been launched to attain or promote this goal. There is a joint Ministry of Health and Social Affairs in that country and about 20% of the Finnish municipalities have integrated even their welfare and health boards. In most municipalities, however, the integration takes the form of functional collaboration and co-ordination between the welfare and the health authorities in the planning and provision of care.

The above mentioned discussion relates to shifts either from income support to services, or else back to more income support.

There are also shifts in the dimension of social insurance versus social assistance. When social protection becomes means-tested, there is a shift towards welfare assistance. In many countries, there has been a call for a dependency insurance to avoid the trap of social assistance. There is a shifting from social security towards (sometimes) more locally organised services. For several aspects, there is a trend towards more privatisation in a number of ways: private markets are discovering the possibility of insuring new risks; private initiatives are being taken to

mobilise the capital of the elderly so that it can be used for reimbursing the care; and private initiatives are being taken to organise new services for the elderly. The commercial sector is discovering the potential of a growing group of older persons with (in some cases) growing purchasing power.

We describe below some of the common trends (or the lack of a common trend) more in detail.

**Table 6.3** Changes in the more Bismarck-oriented systems of social protection

| | Belgium | France | Germany | Luxembourg | Austria |
|---|---|---|---|---|---|
| Income | | 'Solvabilisation' of large groups of older persons | | | Reform characterised by conservation of principles of social insurance |
| Housing | Rising standards (service flat) but unaffordable: 1/3 receives support for residential care from social assistance | Upgrading quality, especially private institutions; widespread rent subsidy exists (±450,000 elderly) | | | |
| Hotel cost | Increasing co-financing | | | | |
| Cost of care | | Underprovision of residential and community care | Limited group has coverage, for others social assistance was required before the 'Pflegeversicherung' (70% in old 'Länder', 100% in new 'Länder') | Fragmented financing system, services oriented | |
| Cost of cure | Harmonisation of fixed medical rates intended for old-age homes and nursing homes | Increasing medicalisation of services, whose increasing costs are not being met | | | |
| Informal care | Requests for social scheme<br>Propositions for payment for care | Several proposals for payments in cash and change of existing systems | | | |
| Legal rights | New law on managing funds of the elderly | | | | |

**Table 6.3** Changes in the more Bismarck-oriented systems of social protection. Continued

| | Belgium | France | Germany | Luxembourg | Austria |
|---|---|---|---|---|---|
| Others: | Increased attention for quality aspects | Dependency is recognised as a major social risk requiring a general solution | | | |

**Table 6.4** Changes in the more Beveridge oriented systems of social protection

| | United Kingdom | The Netherlands | Ireland |
|---|---|---|---|
| Income | Pension mix not sufficient to guarantee decent pensions.<br>Bad experience with private pension saving | Increasing importance of occupational or individual pensions | Need for comprehensive coverage of housing, income and care ("talk broadly, finance narrowly") |
| Housing | Privatisation (voluntary sector) of old-age homes or private old-age homes is subsidised<br>Increasing ownership among pensioners, but houses of poor quality | Rising number of owners but still large amount of people receiving rent subsidy.<br>Discussion on housing and care | |
| Hotel cost | Included in 'topping up' | | |
| Cost of care | | | Need for coverage of home help, long-term residential care |
| Cost of cure | Increasing age rationing | | Need to enlarge to paramedical care |
| Informal care | 'Community care is care by the community' | Attempt to substitute professional care by informal care | Need for explicit financial support (recognition) |
| Legal rights | Regional, local differentiation growing; discretionary assessment | | |
| Others | | | Payments in cash could empower the elderly; now supply driven demand |

**Table 6.5** Changes in the Nordic systems of social protection

| | Sweden | Denmark | Finland | Norway |
|---|---|---|---|---|
| Income | Modernising pension system postponed | Increase of after-tax income from 1994 on<br>High and continued early retirement, although intentions to change it | Current system is widely accepted | Proposal to return to more flat rate pensions, but without much support from public opinion<br>Incentives to work until official pension age (67)<br>Reduction of tax credits for pensions |
| Housing | | Important programmes of upgrading housing standards<br>Rent subsidies for elderly reduced from 1997 on (the proposal has not been implemented, but it is still the intention of the Government) | Increasing new forms of service housing for the elderly<br>Advocating the idea that the general housing policy should dictate the design of housing and housing areas so that they better fit the needs of the elderly residents as well | Housing covered privately; services publicly; but: new subsidies for improvement of nursing homes and services housing<br>Relatively expensive: 3/4 of income needed to pay 10 to 15% of actual cost of residential care |
| Hotel cost | | | Some discussion about separating hotel costs from care costs in the residential care forms | |
| Cost of care | Emerging 'care-gap' around 2010 (all else equal)<br>Sweden is dropping back to the level of the 1960s Municipalities are looking for new resources | Prioritising personal care instead of help with housework | There is a common objective to use the resources available as economically as possible to ensure sufficient care for the elderly | Medical and social aspects already integrated in existing LTC complaints about shortages, bad quality and regional inequalities |

**Table 6.5** Changes in the Nordic systems of social protection. Continued

| | Sweden | Denmark | Finland | Norway |
|---|---|---|---|---|
| Cost of cure | | Medicalisation of services in new housing for elderly is necessarily (but nursing home places have been substituted by special dwellings) | Same concerns of efficient use of the resources are mentioned.<br>Some discussion about prioritisation of cure expenditures according to the diseases.<br>Some claims for age discrimination, but no research evidence to back them up | |
| Informal care | Systems exist | | Various efforts to support carer at home, such as home care allowance with support services and experiments with vouchers in organising support of informal carers | |
| Legal rights | Deteriorating quality of care | Better possibility of appeal<br>More influence for the elderly in nursing homes by means of the board of residents | The current framework legislation widely accepted; new legislation implemented on clients rights | |
| Others: | Concern about service inefficiency (no value for money – not doing the right things) | A general sense that there are shortages (of institutional places, of household help) | Quality of care: efforts and programmes to improve quality of care in health and social services | Selectivity: standards raised at the expense of access |

**Table 6.6** Changes in the systems of social protection in Mediterranean countries

| | Greece | Portugal | Spain | Italy |
|---|---|---|---|---|
| Income | Low pensions despite high replacement ratio; high risk of poverty (80% of private pensions are below the poverty line) | Average low income for the retired. The need to increase the importance of the 3rd pillar | Sustain viability of pension scheme<br>Social pensions are being increased for dependency | Relatively high number of persons receiving pensions (including the so-called 'baby pensions'); high difference in replacement rates as well as declining value; shift towards a more earnings-related pension, topped up with a second pillar pension |
| Housing | | To increase the quality and capacity of the elderly housing schemes | | |
| Hotel cost | | | | |
| Cost of care | Low level supply of residential and community care | Social services are means-tested | Dependency is considered as exceptional. Lack of co-ordination between health and social system | |
| Cost of cure | Increased user charges for health care (sometimes illegally), although in principle it is 'free of charge' | Low, but a long time lag to satisfy medical needs | | |
| Informal care | | Need to increase home help services | Is the main care system, far much more important than professional care, changing rapidly because of increased labour market participation of women | |
| Legal rights | | Better protection for the elderly | | |

**Table 6.6** Changes in the systems of social protection in Mediterranean countries. Continued

| | Greece | Portugal | Spain | Italy |
|---|---|---|---|---|
| Others: | | a) Need to increase family solidarity to support the elderly and to extend it to neighbours and the local community<br>b) Need to avoid the social and cultural uprooting of the elderly (migration to urban regions has caused decline of solidarity network)<br>c) Substantial regional differences in supply and take-up of services | Special situation of many older persons in urban areas<br>Institutional debate about federal and regional competences | |

## 4. Covered costs

Both a narrow and a broader definition can be used when referring to dependency. The narrow definition is limited to functional, physical and mental criteria; the wider definition includes physical, mental, economic and social aspects. The evolution in the actual debate in the EU seems to be in favour of the wider definition. What are the basic needs to be covered? The systems of social protection for the elderly are not evolving in each country in the same direction, and certainly not always in a manner consistent with historical 'determinism'. We summarise this in the next table.

**Table 6.7** Components of the covered costs of dependency: recent trends

| Member state | Costs included |
|---|---|
| A | Inclusion of all extra costs in additional allowance (services, diets, housing, heating) |
| B | Narrow definition: public responsibility especially for medicalised costs, but again enlarging its coverage. |
| DK | Trend to prioritise help for P-ADL over I-ADL |
| D | Relatively broad definition (medical, social, informal) |
| GR | |
| E | Additional support for informal care |
| FIN | A broad definition covering social and medical care, and housing, as well as economic risks and informal care to some degree, though there is an emerging debate about unbundling financing |
| F | Preference for a global approach, but in reality: housing/hotel for the elderly, social care at the local level, and medical care via health insurance |
| IRL | Preference for comprehensive system |
| I | Health and social care combined; attendance allowance (no special reference to housing) |
| L | Relatively broad definition |
| NL | Definition again growing broader (covering social care, housing and medical costs) |
| P | Attendance allowance, supplementary subsidies for housing (and rent control), free health care, social care with contributions by the person him/herself: broad scope but low level of provision. |
| S | |
| UK | Preference for free health and social services; growing fear on the part of the individual of depletion of his/her own resources |
| (N) | Despite global (local) funding and organisation, attempts to narrow the definition |

In the countries where there has been some recent concern about the limits of the welfare state, there is a tendency to reduce coverage to the more primary needs (medical, P-ADL and not I-ADL), to the exclusion of housing and hotel costs and the reduction of quality of care while cutting on advanced services of integration and rehabilitation. This is also evident in the debate in the Nordic countries, for example about covering housing costs, despite the fact that they are coming from a

high level. Some may wonder why the complaints about quantity and quality of care are present in so many reports in these countries. Perhaps this feeling is based on comparisons with how things were earlier and with the ideal situation, which implies that it is partly a crisis of expectations, and partly also a crisis of resources, as quantity (access) is reduced, albeit from a rather high level (comment by S.O. Daatland). The debate on what the welfare state should provide and the issue of affordability has been on the agenda for more than 15 years in the Netherlands (e.g. the debate on the 'Dutch disease'), but the new evidence gives the impression here that once again a wider (more generous, inclusive) definition of the needs to be covered by social protection is being used.

The debate in the much less developed Bismarkian-type welfare state (compared to the Nordic model) is pending, however, due to broad definitions of the cost of care (cure, personal care, housing and even paid informal care) and the public coverage of these elements.

## 5. Institutional arrangements for long-term (old age) care within (or beyond?) the existing systems of social protection

In the Netherlands a great deal of attention is being paid to substituting more expensive care with cheaper care, but most of the needs are nonetheless being covered. This has become a reality since in 1980 the Exceptional Medical Expenses Insurance Scheme ('AWBZ') guaranteed the financing of most of the long-term care. As a consequence of this, there are no explicit new proposals for dependency insurance. The more general proposals for reform of the health care sector are intended to cover medical care, residential care, district nursing and home care. What is new, is that (similar to the UK reform) insurance companies and service providers are signing contracts for the delivery of care and they are having to compete. This should result in better quality and lower costs - or at least this is what is hoped for.

In Denmark, which is already characterised by a high level of social provision of care for the elderly, there is also no discussion about additional protection in terms of long-term care for the elderly. Most of the long-term care is available to the population at a price that is highly subsidised by public funds, yet is organised at the local level. The same is the case for Finland. In Denmark, additional attention is being given to the housing component.

Although there are countries where, at present, no explicit proposals for dependency insurance exist, this does not mean that there is no discussion taking place about the financing of long-term care or that there are no problems.

France and Germany have been - and continue to be - clearly confronted with under-insurance and have chosen to provide additional systems. The German system is oriented towards financing additional services, although with the 'Pflegeversicherung' is has also become open for support via informal care and in-cash support. The French initiatives are often oriented towards providing additional

income. This was the first choice, but after some new experiments, it has also resulted in some preference for services. The Austrian case could also be oriented to more care in-kind for the elderly, although it is a 'Pflegegeld'.

The Belgian situation is far from clear. In the mid-90s there were a number of insurance proposals, as well as some experimental forms of social insurance by the health insurance organisations, some private insurance initiatives, and some marginal support initiatives by local authorities. Later there were some proposals to create an insurance system either through a public insurance company or to organise it explicitly at the federal level. This has been announced in the present governmental declaration. Also on the regional level (Flemish region), proposals exist to improve the financing of services (the supply). However, other schemes have been proposed for more explicit long-term care insurance to be provided by the health insurance organisations (and possibly also by private insurers), with contributions subsidised by the government. There has also been some popular discussion or preference for in-cash ('vouchers', 'cheque de service') systems of dependency insurance. The latest proposals of the federal and Flemish governments are returning to better financing of regular services. The 'in-between' situation of Belgium is probably due to the reasonably well developed social protection system already in place, which, if retained, will limit the need for additional insurance. Further improvements have been observed during recent years: 25,000 old-age home places have been converted into better (publicly) financed rest and nursing home places; in 1998 the health insurance system will enlarge its coverage of costs for chronically ill persons. Evolving along these lines, Belgium could achieve an implicit long-term care insurance within the existing health insurance system.

In some countries (Ireland for instance), the point is being emphasised that giving money to the patient would 'empower' him, and therefore this system should be adopted. Others (such as in Belgium and in the UK) recommend that means-testing should be avoided, since this results in using up the only wealth people have (and want to leave to their heirs), because having a certain amount of wealth sometimes gives people a certain (sense of) empowerment.

In the other countries, the (expressed) need for additional insurance seems even more limited. In the UK, even in recent reforms, attention is being focused on the provision of required care in-kind. Additional support is being provided for housing aspects, and for the main carer a system of 'attendance allowance' is provided. However, in this same country a discrepancy between the cost of care and the available pension continues to exist. About 56% in additional support is needed to pay for residential care (OECD, 1996). The reforms that have been proposed in the UK are oriented towards the organisation of the health sector: it remains nationally financed, but competition in the provision of services is being looked for at the local level. Contracts between the health insurers (who assess the need) and the care providers are being proposed. The UK system has retained a lot of in-kind aid, which makes it almost an example of a Beveridge-type system.

However, in recent years there are indications of a growing 'care gap' (Walker, 1993, p. 48).

**Table 6.8** Explicit proposals (or existing systems) relating to dependency insurance systems

| | Belgium (proposals) | Germany (existing) | France (experiments?) |
|---|---|---|---|
| Initiative | Minister of Social Affairs<br>Several proposals by social organisations<br>New proposals in Flemish government | Minister of Labour | Several commissions, parliamentary initiatives<br>Current experiments<br>a) compensating allowance for help from third persons<br>b) supplementary allowance<br>c) specify dependency allowance (replaces partly a) from 1997) |
| Coverage | Most are new type of in cash allowance covering additional cost<br>New proposals in Flanders refer back to services | Nursing care at home and residential care<br>Social rights of main carer in cash and in kind | First preference for 'In-cash aid 'prestation dépendance'; now tendency to in-kind; can also be used for payment of informal care |
| Population (1995) | 10,131,000 | 81,539,000 | 58,038,000 (1994) |
| Total +65 (in %) | 1,550,003 (15.8%) | 9,677,709 (West) (15.4%) | 7,942,000 (14.7%) |
| Eligible persons (in thousands) | 90 to 220 | 1,650 | 271 to 321<br>For a) 210 elderly +65 |
| Estimated budget (in billions of national currency) | 10 to 20 BEF | 25.8 DM | |
| Financing | 0.15 to 0.3% of GDP | 1.7% of income of active and retired persons | a) general budget<br>b) social assistance should become social security |
| Private alternatives | Existing but limited | Are part of the scheme for those with private health insurance | Exists, but with limited success |

**Table 6.8** Explicit proposals (or existing systems) relating to dependency insurance systems. Continued

| | Luxembourg (existing) | Austria (existing) | The Netherlands |
|---|---|---|---|
| Initiative | Government<br>(Law of 19th June 1998 on 'assurance dépendance') | Federal government<br>completing existing regional initiatives | Government<br>(Exceptional Medical Expenses scheme) |
| Coverage | Regroups a number of existing, fragmented financing mechanisms. Covers from 1.1.1999 on institutional care, formal and informal care in the community; priority for in-kind (part of in kind support can be transformed to in cash help) | Cash allowance transferable (increased political support) to in-kind institutional and community care.<br>Since installation, fees for services have increased substantially | |
| Population (1995) | 385,000 (1991) | 8,053,000 | 15,382,000 (1994) |
| Total +65 (in %) | 14.3 (1991) | (13.1) | (13.1) |
| Eligible persons (in thousands) | Total dependent population | Dependent population above age of 2 years; (334)<br>7 categories based on care (number of hours) required | - Everyone resident in the Netherlands<br>- Everyone subject to Dutch income tax legislation |
| Estimated budget<br>(in billions of national currency) | | | |
| Financing | 1) state budget: 45% of total expenditures;<br>2) a 'special contribution' levied on the electricity sector (contribution of the firms)<br>3) additional (special) contribution of the individuals ('contribution dépendance') on total income (labour income, replacement income and revenues on assets); fixed yearly (for 1999 on 1%) | Taxes<br>Increased (federal) allowance is compensated by increased fees or reduced local financing | Contributions paid by employers and the self-employed |
| Private alternatives | | Are emerging as providers (since attendance allowance can be used to pay them) | |

**Table 6.9** Implicit solutions for dependency insurance

| | United Kingdom | Ireland (proposals) |
|---|---|---|
| Coverage | Included in NHS and National Assistance Act<br>Under-insurance of residential and community care | Health insurance covers medical care and residential care<br>Should be enlarged to a comprehensive insurance |
| Population (1995) | 57,808,000 (1991) | 3,571,000 (1994) |
| Total +65 (in %) | (15.8) | (11.5) |
| Eligible persons (in thousands) | | |
| Estimated budget | | |
| Financing | | |
| Private or public alternatives | Increasing supply to younger people (personal pension plan, reversed mortgages, dependency insurance)<br>(Partial) Equity Release schemes<br>National Care Insurance Scheme proposed by Joseph Rowntree Foundation (1.5% of earnings) | |

**Table 6.10** Implicit solutions for dependency insurance in the Nordic countries

| | Denmark | Finland | Sweden | Norway |
|---|---|---|---|---|
| Initiative | Public Health Insurance Act<br>Increasing financing of care facilities in dwellings | Included in Social Welfare Act, Primary Health Care Act, Act on Specialised Health Care and Act for Services and Assistance for Disabled Persons | Debate on LTC not. started seriously | Long-term care included in existing protection, but pressure for additional funds (in 1990: +1 billion NOK)<br>Medical and social is already integrated |
| Coverage | | | 'Care gap' diagnosed in 1996 (all else equal)<br>In January 1997, 10 billion SK for 'service, care and schools') and strategy to use employment schemes to support care system | |
| Population (1995) | 5,251,027 (1996) | 5,116,826 (1995) | 8,816,000 (1994) | 4,369,957 (1996) |
| Total +65 (in %) | (15.1) | 732,417 (14.3) | (17.4) | (15.9) |
| Eligible persons (in thousands) | | | | |
| Estimated budget (in billions of national currency) | | | | |
| Financing | Taxes | | | |
| Private alternatives | | There is potential interest<br>Could be allowed in top segment<br>Should be more important as providers, to improve competition | From 1997, private insurance started marketing LTC insurance<br>Some contracting out | Some private proposals are emerging<br>Contracting out for service provision |

**Table 6.11** Implicit solutions or no debate relating to dependency insurance systems in the Mediterranean countries

| | Greece | Portugal | Spain | Italy |
|---|---|---|---|---|
| Initiative | Improvement of services under way, for instance, in Open Care Centres for the Elderly (KAPI)<br>No explicit proposals for dependency insurance | No explicit proposals | Since dependency is not considered to be a major risk, no proposals have been put forward<br>Political and scientific support for improvement of existing system and doubts that explicit new schemes are realistic<br>Plans of INSERSO, 1996, for improving allowances for caring families, increased pensions for dependent elderly (exists for some), support for caring families, improvement of community and residential services | Improved pension system (preference for two 'pillars')<br>Ambitious project (started in 1992) on 'Protection of the elderly', mobilising all policy levels<br>No explicit proposals, but welfare state is evolving in the direction of more selectivity |
| Coverage | | | | |
| Population (1995) | 10,368,000 (1993) | 9,927,000 | 38,662,000 (1994) | 57,140,000 |
| Total +65 (in %) | (14.8) | (14.8) | (14.8) | (16.5) |
| Eligible persons (in thousands) | | | Eligible for increased pensions: 825<br>Could be limited when restructuring existing resources | |
| Estimated budget (in billions of national currency) | | | | |
| Financing | | | | |
| Private alternatives | | | Almost non-existent in insurance, but mentioned especially as providers | |

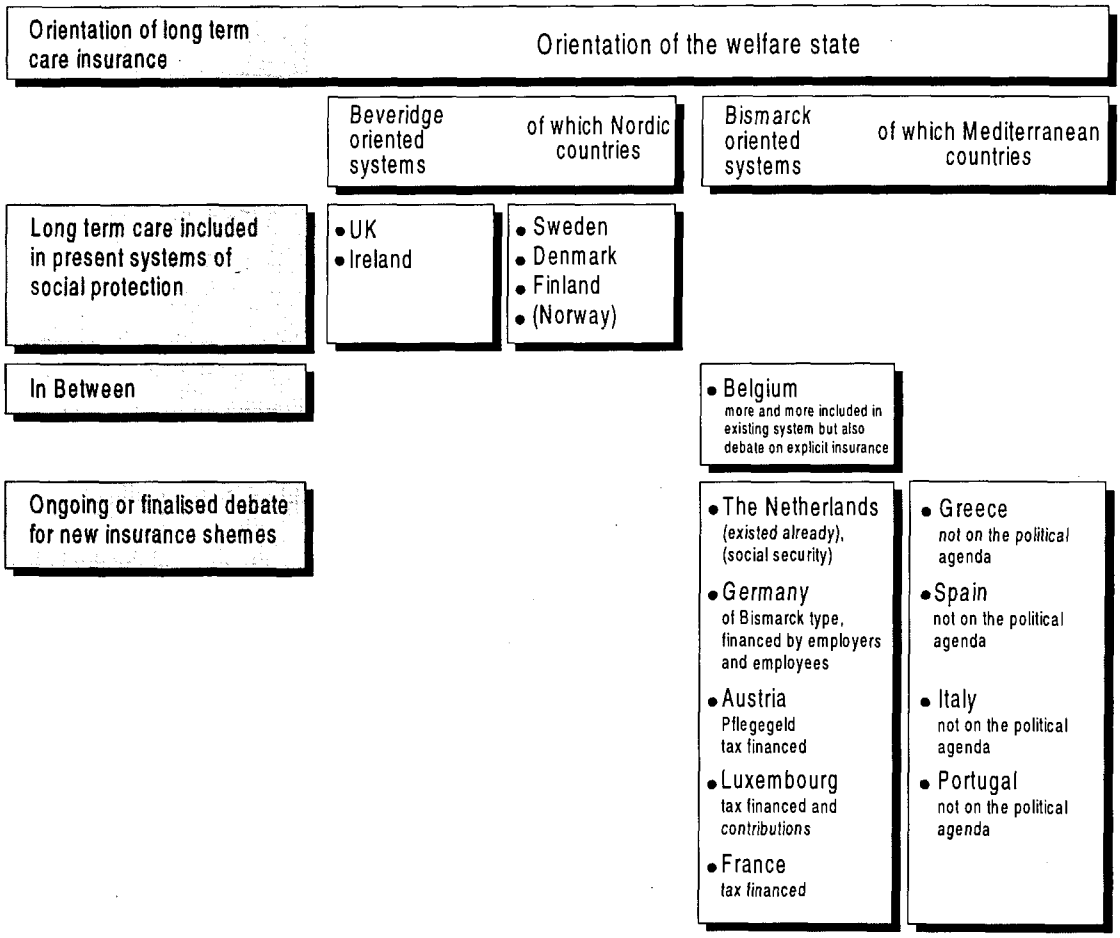



**Figure 6.1** Relation between type of the social protection and type of the long-term care insurance

## 6. Common tendencies in the European project

The exceptional German solution of traditional social insurance has spread to several countries that are either close to realising a long-term care insurance system (Luxembourg, Austria) or that have at least initiated the debate that went on for more than 20 years in Germany (France, Belgium). This finalisation of the social protection system is concentrated in the Bismarck oriented welfare states of the core regions. In the Nordic countries and in the Netherlands an all inclusive protection system seems to exist already. In the southern part of Europe this is not the case. Some parts of the care system, especially related to social services (institutional and community care), are provided to a lesser extent, even in relation to the demand in those countries. More or less the same picture is evident in Portugal, Greece, Italy and Spain. There is a low level of provision for residential and community care. This is probably influenced by cultural factors, such as the priority being given to staying at home and the preference for care by the family. This factor explains why the topic of expansion of these services came late on the

agenda. The explicit choice of the population is not clear because there are complaints about availability, quality, accessibility and affordability. Confronted with the problem of budgetary deficits, it is not clear if new systems of social protection can be introduced in the years to come. Spain has a more explicit interest in this problem, starting already with the debate on the gerontological plan.

We also do not have a conclusive picture for the Scandinavian countries. However, once again initial information confirms a trend toward further upgrading of the social protection, at the local as well as at the federal level. The reference to rehabilitation and activation announces an even further improvement. In Germany also, the reference to rehabilitation is strongly present. In this reading of what is happening in each country, we are far from the threat of trading off care for the elderly with other social expenditures. Nonetheless, the image of a highly developed, advanced and generous welfare state is not always confirmed.

There are some other aspects worth noting which indicate the substainability of these systems: broad definitions of needs are used to define dependency and long-term care. The real nature of this risk is not purely medical, but also includes other kinds of housing and care. For this reason, the distinction between social and health aspects is becoming less and less clear and there is a tendency to include other aspects. Of course this is not a general rule. In some countries there is a reduction of public money available for housing aspects. In others, the continued support for rent subsidy and (social) housing exists, (once again sometimes because policy-makers realise that substantial problems remain or can be caused by measures in others fields).

After years of hesitation, previous institutional, regulatory and professional barriers are being abandoned. The real nature of long-term care needs is broader than the purely medical, and this fact is eroding the barriers between previously existing operators. The need is both for medical and social care. But the risk is the same: in total high and ongoing expenditures. The potential for efficiency gains in this 'multi-product setting' on the supply side has to be further promoted, because at the same time there is a gain in quality (e.g. the need for co-ordinated service) from the demand side. The dichotomies between housing and care and between medical and social services that have been made for years is being replaced by combined supply and organisational structures; this leads to the same rules of financing being applied to all services.

In several systems, both ongoing and new support of formal care are supplemented by the recognition of informal care. In principle, this is accomplished by improving the legal rights of the informal carer, and even by installing systems of payment for care. There is also more focus on aiming for better quality care, implying that there is dissatisfaction with the present level of quality. A certain empowerment of the elderly can contribute to improving quality. However, this

optimistic view is hampered by the possible fear that there is a strategy behind it of substituting more expensive formal care by less expensive informal care. This is confirmed in the German and Luxembourg care insurance systems, in which the government is prepared to pay twice as much for in-kind aid as for in-cash help.

Nevertheless, in Germany there has been a substantial preference for in-cash support. In Austria, the introduction of 'Pflegegeld' has created a rise in the price of services. In Flanders, for example, there is a discussion as to whether the government should stimulate supply or demand. In France, (and this is similar to the debate on 'services de proximité'), there is the belief that creating purchasing power at the level of the client creates its own supply. In Germany, there was a substantial increase in the number of providers after the creation of the 'Pflegeversicherung'. This created an additional 70,000 jobs. In France, the new allocation promises coverage of new services without additional funding. But even the German case shows that a new insurance scheme is not a guarantee for new money (or additional costs), since a large part was recovered from other expenditures.

The stagnation in the development of the welfare state seems not to be confirmed by the first conclusions of this debate 'on the social protection of the dependent elderly', because it is indeed one of the rare fields in which expansion is taking place. However, this does not mean that the welfare state is not shrinking in other fields. A further confirmation of this reassuring observation is that in many countries the situation of the elderly during the past decade has been improving relatively more than for the population as a whole. But in many other countries - and this needs to be either confirmed or refuted - the creation of new care insurance systems for dependent elderly people has been delayed because of budgetary constraints, or is not even on the agenda. The fact that the development of such systems in other countries has sometimes required an 'incubation' period of decades can provide us with some comfort.

# *CHAPTER 7*
# *Some theoretical and policy conclusions*

## 1. The place of social insurance

Our study has been focused on social protection, which at the current time is mostly of a public nature. Alternative proposals have been made, however, and some private initiatives are either already in existence or are emerging. The explicit solutions in Germany, France, Belgium, Luxembourg and Austria are of a public character. Certain theoretical arguments are required to justify this public solution in a period of privatisation. Some of these trends can be interpreted by comparing them with the conclusions of a study on financing long-term care in the USA. There, the same theoretical arguments are used to contend that a larger public involvement is needed in health and old-age care. This is, in fact, the direction of the present health care reform movement in the USA. Although aspects of privatisation are visible in most countries, the question is being raised as to how widespread the phenomenon is. As is suggested by our picture of the level of public involvement in this social sector, the *private* level is so low that 'there is no place to go but up', as was suggested in a study on care for the elderly in the USA (Rivlin and Wiener, 1988). As far as the formal sector of care for the elderly is concerned, it is not clear whether there is an increasing amount of private organisation nowadays, since government is also involved in many new initiatives. The private informal sector (and we should not forget that even this sector is inspired by the same kind of altruism that also inspires the public initiatives), is being stimulated everywhere, but there is an increasing awareness that this sector is complementary to and supported by a significant formal sector. The limits of this support are becoming clear, and there is even emerging doubt as to whether we should go any further in this direction.

There are obvious limits to the trend towards personal responsibility. In countries such as Germany, Belgium and France, the fact is already being stressed that the cost of certain services is too high for some pensioners and that they risk having to fall back on a system of public assistance, (with the danger of losing all their private resources before they can call upon public help). This can also occur when services become too selective, so that the criteria for admission are too strict or

there is means testing. Depending on the income situation, greater co-insurance could be a way of making the services more selective and 'skimming' the purchasing power (as an alternative to progressive taxes). The consequence of making those services too selective, however, will be that the higher income groups - which are often also more assertive users (both as consumers and as an influence group at the political level) - will leave the public system of services and choose the private system (Barr, Glennerster, Le Grand, 1989, p. 6).[1] The public sector would thus lose possible public interest, both as a policy forum and in terms of individual consumers. The risk is of a further degeneration of the public sector, which could lead to the development of a dual care system of high quality but expensive private care and lower quality - though not necessarily lower cost - public care. (In macro-economic terms this is the case, for example, with health care in the USA, where a larger proportion of the GNP is required for a lower degree of protection for the total population, in comparison with systems where there is a higher level of public provision of services (see Rivlin and Wiener, cit.; Barr, 1987)). Public services and social security become public assistance and welfare services. In the United States this has been called the great contradiction in the current health insurance system, where a large part of the population is under-insured. When such a risk exists, Rivlin and Wiener conclude that there is room for a general, compulsory insurance, preferably included in the social security system.

Another risk associated with less state involvement in this sector is under-consumption by certain groups. Some form of co-insurance can to a certain extent, prevent over-consumption, which is conceivable in view of the increasing overall growth of welfare. But the risk of under-provision also exists. The impossibility of paying a decent living wage to employees in the sector, or of compensating for the often difficult working conditions, or of preventing people from leaving the sector, results in labour shortages.

How large will the relative shares of private and public provision of services be? This depends of course on the type of sector and on the definition of the services. One can again quote the American study in which the future share of the private/public provision of care for the disabled elderly is estimated. The public alternatives studied range from an enlarged welfare system, on the one hand, to public insurance, on the other. It is interesting that the authors support the latter strategy. 'This approach would provide near-universal coverage for the elderly and would explicitly recognise that using long-term care is a normal, insurable risk associated with growing old. Everyone should contribute to public long-term care insurance

1 Their conclusion is: 'All tax relief for private medical insurance, including that which currently exists, should be dropped' (Ibid., p. 7). This argument resembles the position of a large mutual health insurance organisation in Belgium (Christelijke Mutualiteiten) which was not in favour of great selectivity and any private re-insurance of the existing personal contributions of the patient.

and earn the right to needed benefits without having to prove impoverishment' (Rivlin and Wiener, 1988, p. 26). It is this broadest definition of solidarity that is used in the German 'Pflegeversichering', to which the total population is contributing (active employees and pensioners).

Another private solution could involve a private insurance scheme to cover the cost of old age care. In several countries, systems of individual retirement accounts have been introduced following the example of the United States. Individual insurance for care of the elderly is also currently being considered. In the USA, the Individual Medical Account and Long-Term Care Insurance have been studied, but for a number of reasons have not remained viable options (Rivlin and Wiener, 1988, p. 109-122). Interest in the issue is limited (due to the short-sightedness of the future elderly population), except when it is stimulated by fiscal instruments. Furthermore, it is not possible to insure against inflation and future technical progress when considering the higher care opportunities. Another problem is that not everybody has the purchasing power to buy this insurance (high premiums only payable with higher income). Thus for some groups it is conceivable, but the present lack of interest on the part of the insurance companies for this product proves that it is technically difficult to organise. Even private insurers are not interested because they cannot secure the cost of increasing demand in the future. Other risks, from the viewpoint of the elderly, are that private insurance will either restrict costs and thus diminish quality, or else it will move in the direction of adverse selection.

The conclusion was that even in a much less government-oriented system such as the American one, the private share of long-term care for the elderly can only increase to something like 10% to 15% of total expenditures, even assuming there would be tax subsidies for it. The overall macro-economic cost of this public provision of long-term care for the elderly is also limited, since it is concentrated on a limited part of the total population.

Rivlin and Wiener calculated that this cost is bearable; the present burden should increase from 1.6% to 2.94% of GNP, assuming all the anticipated increases in care. Similar figures in the European countries have been the subject of discussion. Again, the first evaluative report on the German long-term care insurance system concludes that the costs of the system are under control and will only rise from 1.7% (and this is already not at all completely new money) of income to 2.4% in 2030. (Bundesministeriums für Arbeit, 12.1997).

## 2. The social protection systems have reached maturity

The social protection systems are sometimes contested in several countries; at the moment they are coming to maturity and have to prove their superiority. They might not even have the chance to prove they are a superior efficiency device

(Barr N., 1987). 'Superiority' for us has to be defined in terms of outcome. The domestic objectives of economic welfare policy are growth of income, equity, full employment and price stability. This needs to be translated into the objectives of social protection. This objective can be the avoidance of and solving the problem of poverty, but it is also aimed at health and pension systems of a high level.

These are normative systems. The motives behind them, the history and the present organisation can all be different, but they all have reached the point of compulsory collective insurance and financing. The risks are becoming clearer only now, in this ageing 'process'. The risks of health care, long-term care and pensions are the major part (two-thirds) of social expenditure and are largely determined by age. In a recent publication on the 'social quality of Europe', several contributors came to the conclusion that economic growth is compatible with social protection (Beck W., van der Maesen L., Walker A., Eds., 1997). This was in line with the conclusions of the European conference in early 1997 in the Netherlands on 'Social Policy and Economic Performance' (Dutch Ministry of Social Affairs and Employment, 1997). The social protection of the elderly in many countries has also continued to follow this pattern of evolution. The standards and quality levels are determined not only by economic factors but also by political choices: these systems can be developed either to meet a basic, minimal standard or else to measure up to the standards of the evolution of economic welfare. There are indications that they are continuing to follow the latter path.

This continued support for the development of the social protection of existing and new needs (here the needs of dependent older persons) is probably explained by the implicit knowledge of the policy makers about the compatibility of the welfare state with economic development. This point was made more explicitly at the European level in the Dutch Presidency Conference 'Social Policy and Economic Performance: employment, activating the welfare state and economic competitiveness'.

There should be an even more explicit realisation that developed welfare states with high levels of formal services and caring personnel have created jobs in these health and social services, and, by definition, have created added value in these sectors, as well as economic growth in general. This explains once again why there need not be any incompatibility between economic development and social protection. This has been the case explicitly in the Nordic countries; it offers a huge opportunity for creating new services in the Mediterranean countries.

There is a convergence between Bismarck-oriented and Beveridge-oriented systems of social protection. This is probably due in part to the fact that the terms themselves are becoming less clear. When we refer to Beveridge-oriented systems we think of tax financed, flat-rate, basic (though not always), universal (total population), and sometimes also income or means-tested, state managed, and with some preference for in-kind help. When we refer to Bismarck-oriented systems we think of contributions-financed, with explicit social insurance, universal but limited to those contributing, social partners governed, with some preference for

in-cash support, and related to previous income (insurance). With so many dimensions it is easy to understand that no clear classification of the countries is possible. For this reason we use the term 'oriented'. These systems can differ in scope, financing and coverage, but the differences are not essential in economic terms, although they might be in political or institutional terms. The link to wages is not only a financing aspect, but is essential for identifying social insurance schemes and distinguishing them from tax financed assistance schemes. Whenever tax financed universal schemes relate to basic protection, they risk letting the various levels of protection be reduced to a minimal level, thus creating room for supplementary private solutions (in pensions and health care). The financing scheme cannot substantially change the burden of financing as long as new resources are not tapped, and national income is to a large extent only composed of capital and labour income. The financing cannot change the so-called 'burden' on added value. Sometimes health and family allowances or even basic pensions are discarded from labour. But in practice they, and other subsystems, remain interchangeable. Housing benefits, rent subsidies and so on are traded off against pension entitlements. Also for this reason, financing or even formula (in-cash or in-kind) does not matter, and universal treatment should be favoured. Not only new, but also traditional care systems have resisted the need for savings in public spending, but they have also continued to be developed, especially for the elderly. The same can be said for the pension and health care systems.

## 3. Conclusions for the EU project

Social protection for the elderly is less uniform than might have been expected at first sight. Income support and services for the elderly include a wide spectrum of protection systems that can change the relative circumstances of dependent elderly people in each country. The relevant points in this context include not only the perennial protection systems, such as pensions, health insurance and traditional services, but also additional income support, housing benefits and tax spending.

Only scattered, fragmented information about this protection and the budgets involved are available. And the exact amount of resources that society spends to sustain this solidarity with older people is not known. At the same time, this means that there is no clear evidence that indicates whether the system is being driven towards more or less social protection.

Information concerning the needs of older people is also sparse. No standardised intelligence-gathering system, such as the one utilised for the labour market, is available for investigating the dependency and needs of older people.

In this survey we have tried to throw some more light on the services that are available. As case studies show, there are sharp differences between the social protection systems in the countries under consideration. Most of the systems are now being improved. However, the changes that are being made tend to focus more on

diversification, innovation and experimentation with new forms of care, rather than on the provision of extra public resources and the quantitative spread of the available systems. This tendency can be observed in all countries, but especially in those countries where there used to be universal coverage. The trend towards diversification is indicative of the highly developed welfare state systems we have been examining, though the opposite tendency - towards cutting public spending - is illustrative of the overall trend towards 'less state'. When it comes to services for the elderly and long-term care needs, the trend runs counter to the demographic trend and the purchasing power of (at least) the oldest generations, (whose needs for care are the greatest). For this reason, in a lot of countries there is at the same time a trend towards quantitative enlargement, better paid systems (e.g. in Germany and Belgium), more care with medical help provided, (for instance France), and better housing and care for the elderly (Denmark, the Netherlands). Increased demand for social assistance to cover these needs has been noted in several countries. New proposals are being floated in many countries with a view to introducing a system of social insurance for long-term care. There is clearly a need for these sorts of proposals, even though they are being given political expression at an awkward time. It is in countries with Bismarck-type social protection where explicit proposals are more frequently being introduced. In welfare states where the Beveridge model is applied, no need seems to be felt for explicit supplementary insurance schemes. The policies in the latter countries tend to favour even more selectivity and conditionally. In the country where this model emerged - the UK - there is a general feeling of unacceptable rationing, so there is sure to be a debate on wider social protection systems to cover the risk of old age.

Under the terms of the subsidiarity principle adopted by the EU, social security matters are generally the responsibility of the Member States. This EU survey proposes not only harmonising the public social security systems, but evening out the various public support systems for the elderly as well. Retirement benefits, free in-kind services, or repayments of costs and additional incomes - are many variations on the same established theme of public protection or social security coverage. The fact that the needs of the elderly and the circumstances in which they find themselves vary to such an extent, is indicative of an urgent need for a more routine examination of the institutional factors and the real-life implications at the European level. This multiplicity will probably continue as the group becomes larger, the duality within it more open and the selectivity or conditionality of services more general. There is no doubt a willingness to achieve clear-cut, universal and non-discriminatory systems, but the lack of clear information in all areas, the trend towards innovation and the creation of new institutions will produce further complexity and a risk of discrimination.

This report on social protection for dependent elderly persons proves that, to a large extent, the policy for elderly care returns the discussion of the problems to where it belongs: within the context of the debate over the established social security systems.

There will always be new needs and new care systems, but the vast majority of all these dependency needs can be reduced to the normal social security needs: the need for income and the need for health and other (social) services, which to a large extent are triggered by medical aspects and in many countries assessed by a medical or a multi-disciplinary team. The best way to develop a dependency insurance for these old-age risks is not to create a new system, but rather to consolidate and/or upgrade the existing systems.

In a lot of EU countries, as well as in other OECD countries, there is an ongoing debate concerning the financing of the long-term care of dependent elderly persons. This debate is in fact a debate on the sustainability of the social security system. 'La prise en charge des personnes âgées dépendantes', 'Die Soziale Sicherung bei Pflegebedürftigkeit': these are all concerned with the increasing cost of these services due to increasing dependency and the non-existence of a separate insurance system, or even the trend to exclude some of these costs, (which exists in countries such as the UK and Belgium).

For example, upon examining the Belgian discussion in more detail, the conclusion could be drawn that there is no substantial need for a dependency insurance system when the existing social security system continues to provide this care. This system will have the difficult task of covering the existing risks with a reasonable level of quality. Given the budgetary problems, the creation of new systems would be even more difficult. This is illustrated by the fact that the new system would have to take over important budgets from the existing system, thus creating no additional protection.

In several other countries, similar trends can be observed. When examining the German proposal in more detail, we see that to a large extent it is aimed at covering medical help, which in other countries is better covered by social security. It also tries to utilise parts of the existing systems. In France, the Schopflin Commission concluded in any case that the 'prise en charge' should consolidate the present system of financing mechanisms and organisations involved. The new allowance (the 'prestation spécifique dépendance') can be criticised because it wants to guarantee additional protection without generating additional money, and in some cases social protection is even reduced (M.E. Joël, 1998). The official Belgian proposal utilises significant parts of existing systems and there is limited space for new protection.

It is clear that when discussions are taking place in several different countries about old-age insurance, the context in each case may be completely different. In some countries the discussion brings to light a partial under-development of the social protection system and in other countries it relates to a further expansion of the system, while in still other countries it may reveal a trend towards substituting existing forms of social protection by private insurance. This implies that the solutions can also differ from country to country, being oriented either towards more in-cash or more in-kind aid, and towards more private or more public structures.

In the discussion concerning old-age care insurance, it might not surprise us that we are looking for solutions within the existing systems. We must not forget that this debate is certainly intermingled with the debate on private versus social solutions, on systems based on repartition versus funded systems, and on protection in-cash versus protection in-kind. The proposals also involve the all-important discussion of how to pay for informal care, (in fact, the financing of home labour). Do we make the systems universal (related only to dependency), or do we also take the elderly person's resources into account? In other words, do these systems become means-tested or not? Almost none of the new emerging systems refers to means or even income, except in France, where eligibility is conditional on income and benefits are recovered from inheritance. In all the other cases it is not used. Which care model we want to promote is also one of the decisions that must be made. These elements are important in terms of putting the previous observations into perspective. They are essential for the social protection of the elderly, a burden that is probably destined to consume a significant share of our national wealth. The choice we make regarding the social protection of the dependent elderly must lie in the same direction as the choice we make regarding health and old age.

The social protection of the elderly, sometimes envisioned in the new systems, aims at dealing with the same risks that were initially targeted in the traditional subsystems of, for example, health insurance. These 'new' risks are the result of the traditional risks maturing over time. However, other rules are suddenly being used. The planned systems are excluding the risks of the older persons, although it was precisely for these risks that they were initially created. Aspects that were unthinkable in the social security system, (such as means-testing and first using the person's own resources), are now sometimes being proposed, especially when the care of the elderly is under discussion. There is no reason why social protection for the elderly should be organised differently than social protection for the rest of the population. The creation of new insurance based on age involves the risk of creating new forms of discrimination based on age. The way in which the nature of social protection runs the risk of being changed is an example of implicit or explicit age discrimination of a very structural and far-reaching kind. This also is an argument - and politically speaking, perhaps even the best argument - for keeping old-age insurance within the existing universal systems of social security. This equal treatment is the best guarantee for the social integration and re-emancipation of the elderly. It is a solid foundation for autonomy instead of dependency.

Until now, the evolution towards privatisation (in many definitions) of social protection of care for the elderly has been limited, demonstrating a common sense of maintaining the present form of social protection. The European debate on the competitive power of this system supports these observations. This result is not universal or generic. In more market-oriented systems of social protection, such as the USA and Australia, the emergence of funded and private systems has been

larger (Institute of Actuaries of Australia, 1997). Solutions such as reversed mortgages and using wealth (Why not pension capital?) to buy insurance against the risk of dependency is, for some, an attractive financial innovation. The use of these new financial products is being stimulated by financial institutions looking for new markets. The 'baby-boomers' still have 15 years before they retire, and another 15 years before they become severely dependent (D.M. Holland, 1997). This is, by definition, a huge market (three decades for the largest cohorts) for the banking and insurance industry. Previously, the lack of competition in these industries ensured that they did not enter this market. The increasing competition, stimulated by the internal market of the EU and globalisation, and the over-capacity in these industries will speed up this process. The solution of over-capacity in one business might be the privatisation of social protection. However, this situation does not emerge from our comparison of the systems of social protection of the elderly in the European Union.

The political debate is still focused on the traditional principles of the social protection systems that until now have proved their viability. These principles are:

- long-term care is included in social expenditures, or, more precisely health insurance, organised in the same way as the rest of the social protection system;
- especially in the Bismarck-oriented system, a certain willingness (though not absolute commitment) is present to define a new 'pillar' for long-term care;
- broad definitions of the risk to be covered are maintained, since there is an increasingly unclear borderline between social services and health;
- prioritising in-kind provision, or at least not rendering it unaffordable; (for example, Germany has double the amount of resources available for in-kind help as are available for the in-cash insurance scheme);
- very often (though to a varying degree) including housing costs in the covered risk;
- enlargement of the welfare state by (supplementary) systems of payment for care or support for informal care;
- resistance to including income testing in social assistance systems or to placing too much emphasis on it, and retaining a preference for social security schemes. There is less willingness to apply the rules of calling on the family to help with financial costs, the depletion of the person's own resources, and the recovery of costs from the inheritance;
- almost no presence of funded systems. Most of the solutions are pay-as-you-go publicly financed (or social security) systems. Some countries have chosen funded pension systems, but the 'funded' solution is almost totally absent in the practical European debate on long-term care;
- after a period of rationalisation in health care expenditures there is again an expansionary trend in expenditure, while services for the elderly continue to grow in variety and availability. This happened during a period when the European Union began a process of budgetary discipline in the context of

Monetary Union. A further development of the social Europe seems to be compatible with this.

This generally positive conclusion does not prevent us from paying attention to the problems of under-protection, deteriorating quality and uncovered needs, or to the fact that the social protection system is falling behind the rest of the economy. Although the positive picture is based on facts and figures at this moment in time, it can also change, as illustrated above. For this reason, these phenomena will have to be closely monitored.

# *Annexes*

# Annex 1. List of institutions of national correspondents responsible for national reports

| | |
|---|---|
| Austria | Kai Leichsenring<br>Europäisches Zentrum für Wohlfahrtspolitik und Sozialforschung |
| Belgium | Jozef Pacolet, Hilde Lanoye, Ria Bouten<br>HIVA-Higher Institute of Labour Studies<br>Katholieke Universiteit Leuven |
| Denmark | Eigil Boll Hansen<br>AKF, Institute of Local Government Studies |
| Finland | Vappu Taipale/Marja Vaarama/Mikko Kautto<br>STAKES<br>National Research and Development Centre for Welfare and Health |
| France | Marie-Eve Joël<br>LEGOS Université Paris-Dauphine |
| Germany | Bernd Schulte<br>Max-Planck-Institut für Ausländisches und Internationales Sozialrecht |
| Greece | John Yfantopoulos<br>Athens University of Economics and Business<br>Department of International and European Economic Studies |
| Ireland | Eamon O'Shea<br>University College Galway<br>Department of Economics |
| Italy | Francesco Belletti/Harmke Keen<br>CISF-International Center for Family Studies |
| Luxembourg | Nicole Kerschen<br>Ministère de la Sécurité Sociale |
| The Netherlands | Norma Schuijt-Lucassen/Kees Knipscheer<br>Free University Amsterdam<br>Faculteit SCW<br>Vakgroep Sociologie |
| Norway | Svein Olav Daatland<br>NOVA - Norwegian Social Research |
| Portugal | Manuel de Almeida/J. Manuel Nazareth<br>Universidade Nova de Lisboa<br>Faculdade de Ciências Sociais e Humanas |

| | |
|---|---|
| Spain | Gregorio Rodriguez Cabrero<br>Professor Sociology Universidad Alcala<br>Universidad de Alcalá<br>Facultad de Ciencias Económicas y empresariales<br>Departamento de Fundamentos de Económia e Historia Económica |
| Sweden | Lennarth Johansson<br>Socialstyrelsen (The National Board of Health and Welfare) |
| United Kingdom | John Bond<br>University of Newcastle Upon Tyne<br>Centre for Health Services Research |

# Annex 2. List of invited experts for consultation on the project

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|---|---|
| Austria | Christoph Badelt<br>Vienna University of Economics and Business Administration<br>Social Policy Unit |
| Belgium | Xavier Leroy<br>Service d'études socio-économiques de la Santé<br>Université Catholique de Louvain |
| Denmark | Georg Gottschalk<br>Statens Byggeforskningsinstitut (SBI)<br>Danish Building Research Institute |
| Finland | Simo Koskinen<br>Associate Professor<br>University of Lapland |
| France | Hannelore Jani-Le Bris<br>Director of Research<br>CLEIRPPA - Centre de Liaison, d'Etude, d'Information et de Recherche sur les Problèmes des Personnes Agées |
| Germany | Roland Eisen<br>Johann Wolfgang Goethe-Universität Frankfurt am Main<br>Institut für Konjunktur, Wachstum und Verteilung |
| Greece | Panos Tsakloglou<br>Athens University of Economics and Business<br>Department of International and European Economic Studies |
| Ireland | Freda Donoghue<br>Policy Research Centre<br>National College of Industrial Relations |
| Italy | M. Ferrera<br>University of Pavia<br>Department of Political Studies |
| Luxembourg | Andrée Kerger<br>Centre d'Etudes de Population, de Pauvreté et de Politiques Socio-Economiques (CEPS) |
| The Netherlands | Theo Miltenburg<br>Instituut voor Toegepaste Sociale Wetenschappen ITS |
| Norway | Kari Wærness<br>University of Bergen<br>Institute of Sociology |
| Portugal | A. Bruto Da Costa<br>Universidade Catolica Portuguesa<br>Faculdade de Ciencias Humanas |
| Spain | - |

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|---|---|
| Sweden | Mats Thorslund<br>Stockholm University<br>Department of Social Work |
| United Kingdom | A. Walker<br>University of Sheffield<br>Department of Sociological Studies |

# Annex 3. Availability and relative importance of a selected list of services for the elderly

**Table A3.1** Availability and relative importance of a selected list of services for the elderly

| | Measure | A (1992) | B (1994) | DK (1995) | D (1992) | GR (1988) | E (1995) | FIN (1995) | F (1996) |
|---|---|---|---|---|---|---|---|---|---|
| **Permanent** | | | | | | | | | |
| *Residential services* | | | | | | | | | |
| 1. Nursing homes | Number of beds per 100 65+ | 2.3 | 1.22 | 4.6 | 1.26 | (19) | + | 2 | 1.6 |
| 2. Psychiatric nursing homes | Number of places per 100 65+ | 0.2 | 0.18 | 0.7 (1994) | - | + | - | 0.11 | - |
| 3. Housing for the disabled | Number of places per 100 65+ | 0.15 | Very small | 1.8 (staffed) 5.4 (unstaffed) (2) | - | - | - | + (20) | - |
| 4. Old age homes | Number of beds per 100 65+ | 2.1 | 6.48 (1997) | - | 1.09 | 0.5 (19) (nineties) | 2.83 (including nursing homes) | 3.19 | 4.5 (1994) |
| *Semi-residential services* | | | | | | | | | |
| 1. Multilevel homes | Number of places per 100 65+ | - | + | - | 2.74 | - | - | - | - |
| 2. Sheltered housing | Number of places per 100 65+ | < 0.1 | 0.15 | 0.6 | 0.44 | - | 0.1 | + | 1.76 (1994) |
| 3. Service flats | Number of housing units per 100 65+ | Very small | 0.56 (Fl., 1996) | - | - | - | + | 2.01 | + |
| **Temporary** | | | | | | | | | |
| *Residential services* | | | | | | | | | |
| 1. Geriatric units or hospitals | Number of beds per 100 65+ | 1.2 (units for internal medicine) | 0.38 | 0.1 (1994) | + | (19) | + | 0.687 (number of patients per 100 65+) | + |
| *Semi-residential services* | | | | | | | | | |
| 1. Day hospital | Number of places per 100 65+ | < 0.1 | 0.01 (Fl., 1989) | - | + | - | 0.07 | 0.117 (estimate, 1992) | + |
| 2. Day care | Number of places per 100 65+ | < 0.1 | 0.03 (Fl., 1996) (16) | 0.5 | 0.008 | - | + | 0.095 (in old age homes) | + |

**Table A3.1** Availability and relative importance of a selected list of services for the elderly. Continued

| | Measure | A (1992) | B (1994) | DK (1995) | D (1992) | GR (1988) | E (1995) | FIN (1995) | F (1996) |
|---|---|---|---|---|---|---|---|---|---|
| 3. Nightly care in old age homes | Number of places per 100 65+ | - | + | + | - | - | 0.03 | 0.003 | - |
| 4. Social centres for the elderly | Number of persons served per 100 65+ | - | + | 13.2 | 0.937 | + | 0.05 | 1.3 (1993) | + |
| | Number of centres per 100 65+ | | 0.01 (Fl., 1995) | 0.07 | | | | 0.0055 (1993) | |
| *Community services* | | | | | | | | | |
| 1. District nursing | Number of personnel (FT) per 100 65+ | 0.04 (Vienna, 1993) | 1.00 (1991) (1) | + | + | + | + | 0.932 (6) | 0.154 |
| 2. Social work | Number of personnel (FT) per 100 65+ | + | + | 10.8 (3) | - | + | 0.1 | 1.397 (7) | + |
| 3. Home help | Number of personnel (FT) per 100 65+ | 1.0 (Vienna, 1993) | 0.95 (1990) (1) | + | 0.48 (1996) (21)<br>0.92 (1997) (21) | + | 1.3 | 1.763 (all personnel) | 0.6 |
| 4. Cleaning services | Number of personnel (FT) per 100 65+ | 0.04 (Vienna, 1993) | 0.54 (Fl., 1991) | + | - | - | + | + (17) | + |
| 5. Meals-on-wheels | Number of meals per 100 65+ | 2.4 per day (Vienna, 1993) | 510.16 (Fl. + Wal, 1991) | + | + | + | + | 10.011 (estimate, 1992) | + |
| 6. Family placement | Number of persons served per 100 65+ | - | + | + | + | - | + | 0.012 | + |
| 7. Housing for pensioners | Number of houses per 100 65+ | 0.04 (1993) | 1.96 (Fl., 1993) | (2) | - | - | 0.03 | 0.15 | - |
| 8. Alarm systems | Number of persons connected per 100 65+ | 0.2 | + | + | + | - | 1 | 2.075 (1991) | + |

**Table A3.1** Availability and relative importance of a selected list of services for the elderly. Continued

| | Measure | IRL (1991) | I (1991) | L (1995) | NL (1994) | P (1987) | S (1995) | UK (1994) | N (1995) |
|---|---|---|---|---|---|---|---|---|---|
| **Permanent** | | | | | | | | | |
| *Residential services* | | | | | | | | | |
| 1. Nursing homes | Number of beds per 100 65+ | 2.25 | | 1.84 | 1.3 | + | 1.8 | 1.6 | 4.7 |
| 2. Psychiatric nursing homes | Number of places per 100 65+ | + | | 0.31 | 1.3 | + | (estimation) | 0.2 | 0.4 (estimate) |
| 3. Housing for the disabled | Number of places per 100 65+ | - | | - | + | - | (17) | - | 0.3 |
| 4. Old age homes | Number of beds per 100 65+ | 2.5 | 1,69 | 4.98 | 6.4 | 1.57 (1986) (15) | 2.9 (est.) | 3.1 | 1.4 |
| *Semi-residential services* | | | | | | | | | |
| 1. Multilevel homes | Number of places per 100 65+ | - | small number | - | - | + | 4.0 | (8) | - |
| 2. Sheltered housing | Number of places per 100 65+ | 0.39 (1986) | 0.22 | - | 2.34 (1990) | + | (estimation) | 5.0 | 4.6 (4) |
| 3. Service flats | Number of housing units per 100 65+ | - | small number | 1.11 | + | 0.01 | | - | |
| **Temporary** | | | | | | | | | Short-term stay + day care is provided within the frame of nursing homes (±10-15% of beds are used for short-term stay) |
| *Residential services* | | | | | | | | | |
| 1. Geriatric units or hospitals | Number of beds per 100 65+ | + | 0.07 (1994) | - | + | - | 0.3 | 0.4 | |
| *Semi-residential services* | | | | | | | | | |
| 1. Day hospital | Number of places per 100 65+ | + | + | - | 0.2 | - | + | 1.0 (est.) (9) | |
| 2. Day care | Number of places per 100 65+ | + | + | 0.04 | 0.6 | - | + | 5.0 (10) | |
| 3. Nightly care in old age homes | Number of places per 100 65+ | + | - | - | + | - | + | - | |

**Table A3.1** Availability and relative importance of a selected list of services for the elderly. Continued

| | Measure | IRL (1991) | I (1991) | L (1995) | NL (1994) | P (1987) | S (1995) | UK (1994) | N (1995) |
|---|---|---|---|---|---|---|---|---|---|
| 4. Social centres for the elderly | Number of persons served per 100 65+ | + | + | + | + | 1.58 | + | 2.0 | 15.0 - 20.0 |
| | Number of centres per 100 65+ | + | + | 0.04 | + | + | + | + | 0.05 |
| *Community services* | | | | | | | | | |
| 1. District nursing | Number of personnel (FT) per 100 65+ | 0.34 | + | + | 0.6 | + | 0.0016 | 18.0 (11) | 4.3 (5) |
| 2. Social work | Number of personnel (FT) per 100 65+ | + | + | - | 0.1 | + | + | + | + |
| 3. Home help | Number of personnel (FT) per 100 65+ | 2.62 (18) | + | + | 2 | + | 7.2 | 5.3 (12) | 4.3 (5) |
| 4. Cleaning services | Number of personnel (FT) per 100 65+ | | + | - | - | + | + | 7.0 (13) | + |
| 5. Meals-on-wheels | Number of meals per 100 65+ | 2.96 | - | + | + | + | + | 5.1 (14) | + |
| 6. Family placement | Number of persons served per 100 65+ | 0.03 (1986) | - | - | - | + | - | + | - |
| 7. Housing for pensioners | Number of houses per 100 65+ | + | - | 0.3 | 10.4 (1993) | - | + | 5.0 | (4) |
| 8. Alarm systems | Number of persons connected per 100 65+ | + | + | + | + | - | 3.5 (1992) | + | + |

+ service exists, but no quantitative information; - service is not available in this country

(1) estimation; in absolute terms
(2) housing for pensioners included in housing for the disabled
(3) services for elderly people in total, including residential services
(4) housing for pensioners included in sheltered housing
(5) figure refers to home help and district nursing
(6) 0.270 of which are in home nursing (1992)
(7) there are no 'earmarked' social workers for the elderly; the figure refers to all social workers and includes therefore also those who may not work with the elderly
(8) residential and nursing homes can be registered as dual purpose homes
(9) trend toward hospital at home and community rehabilitation
(10) % in previous month
(11) first contacts per 100 aged 65 or over (district nursing + community psychiatric nursing) (6.0% seen in last month)
(12) clients per week per 100 aged 65 or over (8.0% seen in last month)
(13) % who received private home help in last month
(14) 3% of elderly aged 65+ received meals on wheels in last month
(15) public old age homes. There are also profit homes, but no information is available on the number and characteristics
(16) number of accommodation units per 100 65+
(17) part of auxiliary services
(18) home help in Ireland is predominantly part-time. Figures relate to both full-time and part-time
(19) figure refers to residential care.
(20) the available figures are not classified by age. Total amount of places for all disabled was 6,300 in 1995
(21) Figures for 1996: country report; for 1997: B. Gerste, I. Rehbein, 1998, Tabel 8, 9.

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