# CONTRIBUTION TO THE EUROPEAN PROSPECTIVE OF THE SOCIAL POLICIES FOR THE AGED PERSONS

## GENERAL SURVEY

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***« As far as time elapses more and more countries – even the developing ones – will know aging problems. In fact many developing countries are already in this first phase of aging and must take measures to adapt and modify their structures because of the modifications of the population pyramid. The politic solutions may be different according to the countries. The real situation depends on the social economic and cultural environment of the people. These aspects also play an important role to take up the challenges of our XXI rst century.*** [1]

[1] Bruxelles, le 18.3.2002 COM(2002) 143 final
COMMUNICATION DE LA COMMISSION AU CONSEIL ET AU PARLEMENT EUROPÉEN

The citizens in the EU are older and older. In 2020 20% of the population will be over 60 and one person of 14 will be over 65. This quiet revolution of the population pyramid in Europe occurred slowly and quietly and the people hardly took notice of it; the political decision makers only took notice of this evolution in these early times.

Parallel to aging we state a deep change in the way of living and in the meaning of aging. Retirement does not mean like before the immediate access to the world of the aged persons and even this expression “aged person” sounds like an anachronism.

With a longer life expectation, the seniors live longer and longer and their life conditions are sounder and for this reason their fragility limits are pushed further away. These changes in the population pyramid, their better health status and occupational schemes deeply change aging and its natural characteristics

In this first phase of the elaboration of the European Programme « SCALITY LEAQUAL” we based our study on the following statement that the economic and cultural background play a determining role in the social policies followed by the EU in field elderly persons. These social economic and cultural waivers are such that even if comparable philosophic situations exist and determine the various social policies, no coordination is possible.

In this first study the will of the monitoring team was to build up a document gathering up all information examining the dispositions implemented in the EU in order to compare them with the social economic, politic and cultural competencies as background.

For these reasons and thanks to this survey it is clear the environmental context (and more particularly the place of the aged persons in a society) enhances the specificities of the services which are implemented.

# The place of the elderly persons in the public policy of the EU countries

# PRELIMINARY

## Foreword :

More than 70 million people in EU are over 60 that is to say just 1 of 5 persons. About one third of the population consists of very elderly persons who are over 80; therefore there are more and more persons who can be ill and become dependent. In 2020 about 20 million persons will be 80 or more in EU. This is to say we shall record 300% more in this age group if we compare with the figures issued in1960. The birth and death rates are very low. We have less children but more seniors. To replace the generations il would be necessary that each woman gives birth to 2.1 children but the birth average in the EU is 1.59 children. The health services in the EU are proud that the death rate strongly decreased during the past 30 years. In some countries life expectation rose for example by 10 years for the women in France, Italy and Spain

Therefore this decrease of the death rate of the aged persons brings a stronger demand in health cares and social assistance. Population ageing becomes a challenge for the decision makers because pensions are the largest consumers of the social insurance budgets. At first it concerns the countries which had to reform the public pensions and are now confronted to the double headed problem of ageing and the acquisition of pension benefit entitlement all the more because the financial problems of pensions and others linked to the social security must urgently find a solution.

An exhaustive collection of the social policies was impossible but we could make a sampling on the base of the information we had. However we can say that aging in the various countries we examined is due to the low rate of fecundity and a longer life expectation. The “baby boom” is another determining reason because it causes a large distortion between the age groups. The different migrations can also affect this process [2]

As long as ageing trends to become an universal phenomenon in the next decades we shall state a large variety in the ageing periods of the various societies and in the rhythm of the demographic transfers, the economical and social backgrounds and the coming up challenges.

**PROCEDURE**

The procedure validated by the partners shows the determination to implement an efficient organization in order to enhance the value of the collected information.

[2] presented in the annex subjected to the elaboration and validation process managed by the coordinator and partners

➔ Organization

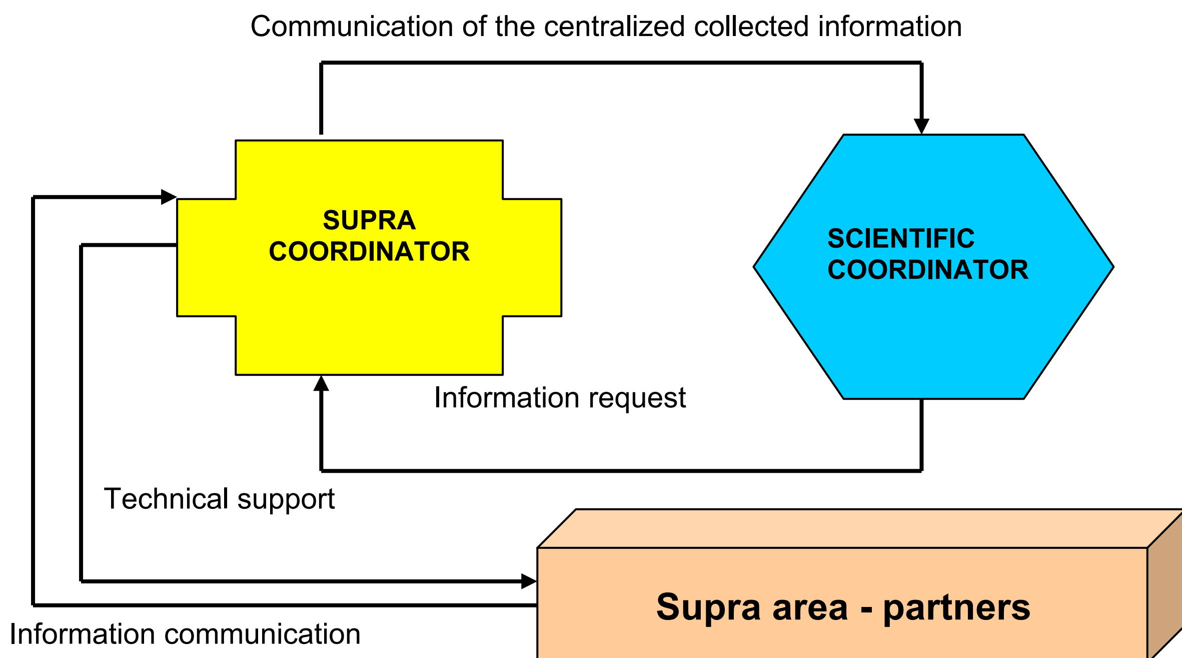
Between the scientific coordinator collecting information and the ground operators we foresaw a middle level : the supra coordinator

He is in charge of the supranational coordination and of course through the definition of areas in which his interventions are possible. The ground operators have therefore a referent agent who gives them all practical and necessary information

Moreover the supracoordinator, in addition to the transmission of the information and as a partner of the scientific coordinator also centralizes the answers and elaborates a progress report

The scientific coordinator has to insure the synchronisation of the operations and to check the content of the cards and to write a two-part general survey aiming at setting a balance report (bound by the limits of the investigations on the ground) of the social policies for the aged persons in the different EU states and afterwards to elaborate a report on the base of these data to determine the necessary linkage between social, political, economic backgrounds and the social policy applied in the area subject to this review.

**Management process**



➔ <u>Elaboration phases of the collected information</u>

It was necessary to define and implement a procedure consisting of the following phases :

- Implementation and validation of a block of questions for information collection by means of pertinent criteria (contents and practice in each country)[3]
- Elaboration of a dictionary (definition of concepts and words used in this block)
- Identification of the ground operators in charge of this collection
- Tests and validation by the supracoordinators
- Logging the answers by the ground operators
- Centralization of the supracoordinators and progress report
- Interim report set by the scientific coordinator
- Validation by partners
- General end report by the scientific coordinator

[3] presented in the annex subjected to the elaboration and validation process managed by the coordinator and partners

# SITUATION PER SUPRA – ZONE

**Preliminary** :

In this first part we decided to propose significant abstracts on the social policy in the examined area and to report the remarks noted by the supra-coordinator in his blocks with the largest fidelity. We make reference to the comprehensive documentation joined to this document as well as the comments presented in the second part.

## BELGIUM

- **Aged persons and their wishes ; home care prevails**

More than 90% of the aged persons prefer home care but we state a change. More and more prsons cannot stay at home all life long. We must know it and it is a challenge for the future whether the families can continue to help them or not. The surveys show that more and more persons will be alone and/or without children.

- **Never beyond one's income**

Most of the aged persons can choose the type of services they wish (public or private ones) If the senior disposes of enough money he has too great a choice. If he needs state assistance and aid he has to require services covering his own needs. It is more and more difficult to require expensive services and his family has to share the monthly accommodation expenses.

In Belgium there are various financing systems : in some cases money is directly paid to the retired person who can spend on his own and in other cases the State offers services.

More often the funds come from compulsory fees paid to an insurance company (or in the form of a plan) ; preferently insurance policies are subscribed like the pension funds and the State grants tax exemption. This financing system based on the solvency of the person is widely used.

It tries to adjust State financing and need increase to each other

- **A large range of operators**

The government mostly offers community services but there are neither non profit nor profit organisations.

- **Placement needs permanently increase**

We have various residential structures for elderly persons meeting the different levels of needs and services.

The coming up needs trend to the creation of structures with large medical services because we have many dependent aged persons. As a result home care will become more difficult to provide.

- **A standard national policy**

The national health department set standards which determine the applicable requirements for all care structures offering accommodation and fix the limits of the person cares and/or medical services for the various structures. These standards also precise the conditions required for the implementation of these activities, the limits of the social life limits, claims/complaints, the environmental conditions, the personnel category and the management required for such services. Each town or village owns its social services which assist the old people; they offer the seniors the best services or care; they analyse the need and offer the most adequate structure.

A national programme specifies how to assess the number of places in each institute. We also have various categories of users. The whole programme is part of a larger state policy dedicated to the cares to aged persons.

- **Conclusion**

The analysis clearly shows elderly persons want to get home care. Nevertheless the solvency system which requires a voluntary contribution as well as the evolution of the families demands other solutions. It is why we need new structures for aged people who are more and more dependent.

## GREECE

- **A global social policy**

The general policy of the Greek government for the aged persons is contained in a sort of social package included in a national plan.

A state programme aiming at the creation of care structures for the elderly persons – it also concerns the dependent ones - was launched these past years.

- **The political philosophy in Greece for the seniors**

*Our vision is a society composed of all age groups in which anybody has a sound and independent way of life in a sure environment. We do our best to allow this age group to participate the social activities. We want to create a service network to bring the persons having difficulties or living in a critical situation towards suited forms of intervention*

*As a result we wish*

- *Insure life conditions that an elderly person can continue his activities at home or in his family*
- *Reduce the medical assistance in a medical centre as much as possible*
- *Relieve dependency and loneliness*
- *Strengthen the links between the generations and solidarity out of the family circle*
- *Promote and develop the participation and involvement of the community*
- *Increase the surveillance of the conditions and needs inside the*
- *population* '[4]

We must state here that the structure of the health services has changed in these past years. The Greek state has taken into consideration that the elderly persons want to stay at home and have supported measures of alternative solutions. It is why the family policy was improved in order to maintain the aged persons at home or in their families.

[4] general policy declaration when the budget 2004 has been presented.

Other examples prove the success of the policies followed to aid the elderly persons

- The creation of centers for any elderly person offering preventive services and a psychosocial assistance

- Full access to the health services such as accommodation for the poorest seniors

- **A dynamic home care policy with positive social results**

Programmes for free assistance and home care services were launched to essentially insure a certain standard of living to the poorest persons and to preserve their independency. They aim at maintaining the activity of the elderly persons in their familial and social environment. This policy gives the possibility to reduce the number of persons in the structures with medical assistance or in hospitals.

- **State financing**

These programmes are directly supervised by the Health Ministry and the State. They are financed by the latter as well as by the public authorities in charge of decentralization.

- **Main providers : the municipalities and the associations**

These programmes are enforced by the health care services or the municipalities which have to engage specialized working force (a social worker, a nurse, home assistants who go to the aged persons') The volunteers of the non governmental associations or others also play a major role

The regional services of the health ministry and the state are in charge of this operation. Most of these programmes of aid and assistance which offer services to the elderly persons are started at national level but the regions and the municipalities are in charge of their implementation. [5]

- **Private structures : a secondary role**

They also control private health care structures and the quality of the services offered by the residences. The percentage of persons living in these structures represents 1% of the seniors: it shows that the paramount role is still played by the family or the neighbours. Most of the residences for seniors are private and offer all available places i.e about 6000.

- **The decisive action of the family in its role of elderly person assistance**

Surveys stated the public services were inappropriate to meet the needs of the aged persons and the number of structures is too low. They highlight the determining role of the family in this matter. Women generally play this role.

[5] See in the annex for more details on home keeping oriented programs

- **First concern : Solvency of the senior**

For 50 years the Greek system has been undertaking many changes. We feel that the financial system is either unbalanced or divided and the pension system looks very generous in terms of investment rates.

The government took some measures to reduce the complexity of our institutions and increase the performance of pension systems in order to preserve the citizens from poorness

- The pension system (public level) proposes different schemes which also depend on the occupation. There are 17 main funds approximatively and any other auxiliary funds which pay the pensions and give some benefits and provide assistance. They protect the old people against poorness: they want to insure a minimum annuity level; furthermore the additional funds also pay a sum of money ; these funds are financed by a contribution system.

- Another system of pensions is available; it is based on capitalization and paid by the companies

- Life insurance funds are also available and these contracts are individual and bought by the involved persons.

The secretary of state for employment supervises the use of these funds. The social partners take part in the management of these funds which are subject to the general income tax system. Most of them are of public type and are regulated by special laws and make the regulation of the others unclear.

The first pension fund is financed by the tax collection, other contributions, the PAYG
The second one is financed by a system of various contributions and is fully paid.

As a result a national survey reveals that 94% of the Greek seniors like to live at home (54% in Europe). This wish can be fulfilled because economic, cultural and family conditions are available in Greece but it also states that the Greek structures change and as a result shall be changed in the future.

## UK

After a strong policy of welfare state UK was the first country in Europe to adopt a radical change and promote a more liberal policy at the beginning of the 80s. The credits for public collective accommodation were sharply reduced and the local authorities stopped the erection of new social buildings. On the contrary the state government promoted the private initiative. Social assistance credits were also available for the private sector and allowed the extension of the senior homes with medical assistance or not during the 80s. The associations have insured the erection of social housing structures instead.

- **An uneven situation where private initiative plays the first role**

The elderly person is confronted to very different situations. If it finds accommodation in a senior home or a care center for aged persons it must face the financing conditions required by the structure regulation.

If it cannot afford such services because its income is too low and the various aids are unable to fill the gap the family has to pay. In the event the family is unable to pay the difference a senior must find a personal financing coming in addition to the basic one or find a cheaper structure.

The financing sources covering the needs of the senior in terms of care depend on the personal case of each senior and on his insurance cover. It is the reason why everybody has to seek the appropriate advice before asking for an admission of a member of his family for whom he may be unable to cover the accommodation fees.

- **Distribution of the responsibilities in the country in matter of health policy**

The government is in charge of the health care policy which is applied by the local authorities. The government gives a budget for the application of this policy but the standards and the quality of the services may be quite different as far as the local authorities are involved.

- **Approximative information about social policies**

The information is a part of the governmental measures but not always available but the governmental policy does not include counsel's opinion which is necessary for the aged in some cases. These may get some information for their placement and means of financing beside non profit or charitative organizations.

- **A more and more ageing population**

In 2002 the British population had 19.8 million persons who were over 50 that is to say a 24% increase in 40 years.

This figure will be 37% in 2031 with approximatively 27 million in the 50 age group. In the past 40 years we stated large changes in the distribution of the aged by age groups. The + 80 rate rose from 0.7 % in 1961 to 1,9% in 2002 whereas the 50/50 age group shot down from 13.2% to 12.7%.

The prospective figures for 2031 show the ageing of the population will increase during the next 60 years. The persons over 85 will represent 3.8% of the global population. Life expectation is longer for women, in the same way death rate is higher for men than for women.

There were 28% women more (in comparison with the number of men) but only 18% in 2002. The prospective shows that this difference will be reduced by 2031 with 14% women more in comparison with the number of men over 50. We also state that women live longer. Nevertheless the difference will reduce by 2031.

- **Characteristics of home care**

Home leaving for a senior means dependency. The health care option shall offer the senior the possibility to stay at home as long as possible.

Standards set out in the document are core requirements which apply to all care homes providing accommodation and nursing or personal care for older people. They apply to homes for which registration as care homes is required, including currently registered residential care and nursing homes, new facilities, local authority care homes and establishments currently exempted under the Registered Homes Act 1984, for example Charter Homes. They cover choice of home, health and personal care, daily life and social activities, complaints, the physical environment, staffing and management.

**National Service Framework for Older People**

Older people are the main users of health and social care services but sometimes services have not adequately addressed need. This National Service Framework is the first ever comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people. It is a 10 year programme of action linking services to support independence and promote good health, specialised services for key conditions, and culture change so that all older people and their carers are always treated with respect, dignity and fairness.

The NHS and social care services in England lead the world in many aspects of care for older people. We have already taken action to:

- ➔ Improve standards of care: in care homes, through the new National Care Standards Commission, and through the Better Care, Higher Standards Charters.

- ➔ Extend access to services: Free NHS sight tests for those aged 60 or over, improved access to cataract services, extension of the breast screening programme to women aged up to 70. Carers' needs are particularly important: their access to services in their own right has been ensured through the Carers and Disabled Children Act 2000.

- ➔ Ensure fairer funding of long term care: Nursing care will be free from this year for people in nursing homes.

- ➔ Develop services which support independence: New intermediate care services to help people avoid an unnecessary hospital admission and to speed recovery and rehabilitation are being put in place. The Promoting Independence Grant supports councils to help more people to retain their independence for longer. Supporting People is a new initiative to help vulnerable people live independently in the community by providing a wide range of housing support services.

- ➔ Help older people to stay healthy: Free influenza immunisation for everyone aged 65 and over. Action is being taken to improve oral health in older people and increase access to dentistry. Keep Warm, Keep Well campaigns are helping to prevent deaths from cold each winter.

It is true though that services sometimes fail to meet older peoples' needs - sometimes by discriminating against them, by failing to treat them with dignity and respect, by allowing organisational structures to become a barrier to proper assessment of need and access to care, and because best evidence-based practice is not in place across important clinical areas.

This National Service Framework sets out a programme of action and reform to address these problems and deliver higher quality services for older people. There will be more consultants, nurses and therapists working for older people and better access to high-tech surgery and community equipment. New national standards will be put in place to modernise NHS and social services and promote new ways of working.
This National Service Framework is the result of extensive consultation with older people, their carers and the leading professionals involved in the care of older people.

The Government is determined to deliver real improvements for older people and their families. Pensioners are sharing in the rising prosperity of our nation, and we're looking after the poorest first. Now, through this National Service Framework we will see improvements in health and social care services for older people across the country.

- **Social Service Ratings**

1. Social Services star ratings were first published in May 2002 by the Social Service Inspectorate, and were 'refreshed' with additional information in November 2002. The ratings have been refreshed for 2004.

2. Since 1 April 2004 the Commission for Social Care Inspection is now responsible for publishing the ratings for social services. Combining the SSI functions with the social care functions of the National Care Standards Commission, and incorporating the work of the SSI/Audit Commission Joint Review team, the Commission strengthens the public accountability of social services and will drive forward further improvement.

3. The star ratings draw on evidence from performance indicators, inspections, reviews and monitoring information for each council, and using a set of published standards as a framework to guide judgment. The ratings are issued in conjunction with a performance report for each council, and give a rounded picture of each council's performance in carrying out their social services functions. Further information is available at www.csci.gov.uk.

4. The ratings will continue to form a part of the comprehensive performance assessment of local councils, led by the Audit Commission.

- **Regulation of Care Insurance**

The government announced on 22 October 2001 that it proposed to make the sale and marketing of all long-term care insurance (LTCI) a regulated activity under the Financial Services and Markets Act 2000 (FSMA) and therefore subject to regulation by us (the FSA). This followed a report by the Royal.

Commission on long-term care for the elderly in 1999 and HM Treasury's own consultation paper on LTCI in 2001, both of which favoured regulation.

En conclusion nous pouvons constater que le système britannique provoque des situations très inégales entre les personnes âgées. La politique familiale semble être trop absente des préoccupations d'accompagnement des aînés

## CZECH REPUBLIK

- **Introduction of a social policy prioritizing the home care service system**

In 2002 the Czech Ministry of Health started a long-term program called "Improving state of health of the inhabitants of the Czech Republic - Health for *everybody".* As it is a long-term program most of the objectives are to be fulfilled by 2020. There is one part dedicated to senior population.

There are several objectives concerning the above mentioned issues.

- ➔ to prioritize home care over placement (home care at the moment is not sufficient)
- ➔ to increase the efficiency and usefulness of health services for senior population
- ➔ to play an active part in EU project called ''EU Care and Management of Services for Older People'' - a European Network (CARM EN) - European network oin integrated care for older people; to implement the findings from the project in the Czech Republic
- ➔ to play an active part in EU project called EU The Study of Ageing, health and retirement in Europe (AGIR), to implement the findings from the project in the Czech Republic

The overall objective concerning senior population is to support independent life in natural surroundings - at home, in different communities.

If an elderly person's income is below the set minimal income, this person is entitled to certain social benefits and assistance. Such person may, for instance, be getting prescribed medication for free. There are various schemes but the trouble is that many pensioners do not know about them and do not know they are entitled to certain benefits. Doctors themselves, can, for instance, inform their elderly patients about the possibility of getting the necessary medication for free but they very rarely do that.

Legal services are usually provided by private organizations (who provide services to anybody, it is not only to pensioners) or by non-profit organizations - usually various pensioners' associations. There might be various interest groups and also - among pensioners there are people with various work experience and thus there might be some lawyers who help the others with their legal problems.

- **Financing of protection and pension system**

All working population pays social insurance and part of it goes to financing services for elderly people and pensions. Nowadays people can pay private pension, insurance which enables them to get some additional money to their state pension

- **Direct financing from State to seniors**

Public administration is owner and provides the service

Subsidy : the right of somebody to receive the service
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Very often people have to use a private service provider as the state services cover really the necessary minimum. For old disabled people there are various non-profit organizations which provide their services for free. These exist mostly in towns and cities, village people do not have such advantages (there are, of course, exceptions).

- **Modification of the social structures since 1980**

After 1980 the number of people aged 65-79 did not increase as in previous periods as the birth rate during the WW1 was quite low. Only in the second half of the 1990 did the number of this age group start to increase as in 1920 the birth rate was quite high (due to the fact that the war was over). Due to political and socio-economic changes after the "velvet revolution there was the attention was paid to this issue and problems concerning senior population were not felt to be that important.

From the mid 1990 the number of elderly people has been increasing and the assumption is that it will accelerate. As a consequence of the change of the age structure of the whole population more money from the state budget will have to be spent on services for elderly people.

- **Variable management with family support**

Different institutions (retirement homes, etc.) are usually financed by the state, sometimes the money is partly allocated to individual regions and local and district authorities. Volunteers also contribute by giving money to various non-profit organizations. All economically working people pay social insurance form which some part goes to the state pension scheme.

The official data claim that the capacity of retirement houses is used only up to 96-97%. This is, nevertheless, an average and especially in bigger towns and cities elderly people apply for a place in a retirement house much earlier than they actually need it in order to be sure that they will get the place once they actually need it. Old but able people can either stay at home or in a retirement house (situation described above).

For old and disabled people the situation is worse, they usually end up in Hospitals for Terminal Illnesses which is usually very discouraging. The common perception is that one goes there to die. This has, of course, a very negative effect both on physical and mental health of the patients. They feel they were left by everybody and nobody cares anymore. On the other hand, it is very difficult for a family to take care of the old and disabled members when they need assistance 24 hours a day. Other family members have to go to work and not many people can afford to pay for a private professional care or nurse.

- **Characteristics of social policies**

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- **Demographic trend**

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- **Funding systems**

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- **The different types of home care**

➔ Old but able people :

Home care services are quite complex and it usually depends on the need of individual persons what they decide to choose. An important aspect is the financial side. Private service providers are sometimes partly paid from the budget of local authorities and then the services are more accessible. For the authorities this is one of the ways of providing care for elderly people. They have a contract with an external private provider who then charges just a symbolic price to the elderly people and the rest is paid by the authorities.

There are also various non-profit organizations who provide care for free (then the range of services is limited) or they charge symbolic amount of money. Elderly people very often feel that all services are too expensive and then prefer help from their neighbors (not knowing that their neighbors may charge much more).

➔ Disabled people :

As above
There are also non-profit organization providing services and help to disabled people.

➔ For persons with Alzheimer disease :
As above

Czech people usually prefer not to move very often and this is especially true for elderly people. The program “Improving state of health of the inhabitants of the Czech Republic – Health for everybody” launched by the Czech Ministry of Health has, among other objectives, plans for supporting pensioners in such a way that they can live in their own flats or houses as long as possible. Therefore more and more attention is planned to be paid to home care services so that not many elderly people have to leave their homes and go to retirement houses.

These days, however, the home care services are not sufficient and thus pensioners are sometimes “forced” to live in retirement houses. If this is the case, they, of course, prefer to go to a retirement house in their surroundings, not somewhere far where they do not know anybody. Therefore even if the statistics say that the capacity of retirement houses is used only by 96%, one has to take into consideration a simple fact, that there are certain remote places where no one wants to go and thus theses institutions do not use their whole capacity. On the other hand, retirement houses in big towns have insufficient capacity.

## SPAIN

As far as Spain social policy is strongly decentralised in Spain it was appropriate in our opinion to set responses in function of general characteristics.

Galicia and Andalusia seem to be typical examples.

### GALICIA

- **Basic plan of social service**

Community programs

1. Assistance, advising and information program : 322.536 users
2. Social insertion program :14.849 users
3. Movement, prevention and social cooperation: 1.204 volunteers
4. Alternative Units for live together program :1.450 users
5. Home care program: 32.724 users

- Domestic service
- Personal service
- Family services
- Technical services

2 levels

Community :
Financing: regional administration (basic plan of social services), local administration, council and users.

Specialized :
Financing : assistance check

Special services and programs

1. Grow old with quality by means of autonomy and activity programs

  - Social Tourism
  - Thermal social tourism ( in collaboration with IMSERSO national administration )
  - Elderly persons holidays ( in collaboration with IMSERSO national administration )
  - Health holidays
  - Communication and creativity
  - Adults training
  - Social and cultural activity
  - For live together program

2. Care for home and environment maintenance

  - Home care ( community home car program complement)
  - Adapted transport
  - Economic aids (low rents)
  - Temporal accommodation in retirement houses
  - Persons with dementia and their keepers support
  - Daily care centres services
  - Family Alternative Units for live together

3. Alternative accommodation

  - Guidance homes
  - Community homes
  - Retirement homes

4. Solidarity and social involvement

5. Introduction FASE programs

- Assistance check
- Regional elderly persons council
- Elderly persons phone

Health and social coordination

Regional care plan to Alzheimer disease and others dementias
Coordination program with retirement houses
Interdisciplinary unit in psychiatry program
Cmbd-ss (information and functional valuation system): 1.257 users in 2000

Regional plan of elderly persons 2001-2006

Objectives (in home care)

Prioritized maintenance at home or in other hand guarantee institutional placement
Responsibility : Regional and local administration in agreement with private and non profit in coordinated way.

Service developing for dependence persons in public vacancies

- From 0.66% - 2000 to 1.40% - 2006
- From 3.491 users -2000 to 7.361 - 2006

Restructuring from normal to dependence vacancies

## ANDALUCIA

- **Home care at first**

All the institutions/experts interviewed agree that there is more political interest in promoting care at home because is less expensive and there are not enough residences.

The care at home does not currently cover all the needs for old people. There is not a real policy of placement as long as there is an important lack of residential resources available. Public Administration only considers policy of placement like last possibility

- **Evolution of the public answer**

There are not really institutions dedicated to elderly but able people. Normally, they attend at day centers. In fact it is no necessary for them, we have to promote care at home. If Public Administration creates Residences for able old people finally is became for disabled old people because there is not enough residential resources. There are few residences for this people. We need more residences for old people with mental health problems; the mean problem in care at home that there is not a package of care different by groups. It only depends on social workers/ home care technicians prescriptions.

- **Pilots projects to experiment new services to better integrate elderly people**

There are public open calls of proposals to contract home care services by Local Public Administration.

Social Workers From Community Social Services at local level and Health Services (from regional government) they are daily improving the services and theirs characteristics as long as they manage them daily.

There are some experimental programmes in this sense promoted by regional government. Anyway, there is not a definitive result.

On the other hand, there is an important University Accommodation Programme in Andalusia. Students are living along with old people in their own houses, and these students provide support and care in return.

Regional Government creates few residences. Regional Government establish the requirements (human resources, buildings requirements…) and the procedures and profit and non profit organizations provide the placement.

There is a territorial principle of planning but it is no followed in some cases due to political pressures by Local Authorities.

- **Social assistance essentially based on home care services**

The care at home policy is the most prioritised. There is not insurance policy but assistance policy that is especially strong in the medical aspects.

- **Financing authorities**

Regional and local Public Administrations have the most important role in financing home care and residential services but we can not forget the national public body in redistribution and control of financial resources.

Profit organizations have an important role as placement providers but non profit organizations are more important in home care provision.

The principle of funding both home care and placement is not clear among experts but is clear that public administration controls the services.

- **Administrative management of structure creation**

The processes for creating residences and home care services are strongly controlled by Public Bodies.

- **Organigram of home services**

The Local Public Administration specially provides the management and coordination of the home care services and Regional Public Administration specially provides the management and coordination of the placement

Family Participation in caring old people is very important as long as there is not enough resources for old people. The participation of “natural aidants” (people who help and care naturally the elderly person such as family, friends …) is not so clear among experts.

## HUNGARY

In Hungary elderly people are often perceived as a burden on society. The main reason is the system of pension: pension is financed from the current contribution to the National Pension Insurance Fund of active population.

Many of the young workless people think, that elderly people occupy workplaces from them. The economy does not respect their professional experience; it keeps their knowledge out of date. Elderly people, the vindication of their interests as a social stratification, their united appearance practically not existing in Hungary, society does not handle these organizations seriously, politics handle them as a part of the political scene.

- **Widowhood**

To live as a widow in Hungary means a poorer income condition.
As “closed” human relations are typical in the Hungarian society, therefore the fear from loneliness and solitariness is closely attached to widowhood.

The tradition of clubs and social organizations are weak, therefore they can only assure limited suitable places for widows to defeat loneliness.

- **Retirement**

Burden on society because of little economical contribution and little social participation.

- **Active senior cycle life**

- Every pensioner (except disabled pensioners in their active years) can undertake a work
- There are clubs and social organizations, which assure active social connections for elderly people.
- High percentage of elderly people visit churches, they are usually member of a Church.

- **Physical decaying**

Comparing to other Middle-Eastern- European countries sanitary, Hungarian Health Care System is on high level. Principal: to assure free of charge-available for everybody- high level medical care. Although, medical suppliers are badly financed, therefore black market exists: doctors and nurses expect from patients to give them money illegally. Patients inquire informally about the rate of a doctor or a medical attendance. Because of this to be ill in old ages is a serious financial encumbrance for the family and it could be a serious financial danger for elderly people.

Medicines are financed by cash and they are expensive. Elderly people often cannot buy their complete monthly medicine portion.

- **Death**

Like anywhere in the world: loss, loneliness, pain.

There are no organizations to help “restart” their life alone, to handle solitariness.

Hungarian society and culture has gone through significant changes since 1990. Society has had a polarization, the poor and rich social stratifications, and the advantageous and disadvantageous stratifications have developed. Pensioners are socially in a disadvantageous statement and most of them belong to the poorer social stratification. After a work of a lifetime, it disturbs them that younger generation grows rich quickly. They do not understand the way of this, often they think that the possibilities of growing rich legally are questionable.

A part of active young workers condemns the low amount of retirement pay and that after a work of a lifetime elderly persons have to live in poor conditions and poor financial circumstances.

The smaller part of active young workers are inclined to accept the opinion, that actual retirements financed from the actual contributions of active workers, therefore they do not like elderly people (although the extremity of this opinion depends on the bringing-up of a person, the social stratification and the education of the young person). On this other side, those whose relatives, parents are retired, are faced the difficulty and poor conditions of being retired, so they will hardly accept this opinion

To enter an institution means serious illnesses and is a bad feeling. Not because of the circumstances, but to face being old, illness and death, which is hard to elaborate for the society in Hungary.

For elderly persons being in a normal physical-health condition, nowadays there are many high level residences. Visitors have acceptable feelings about the circumstances here, and most of the cases they feel that their elderly relatives are in safe.

- **Social policy for the care to elderly people has been set up from those social data**

1, Capacity of home care services and hospice services are not enough. In order to solve the problem it would be necessary to estimate the number of elderly people concerned problems like that, to define there needs clinically and elements of care. It would be necessary to make estimation of real costs of this type of care and to find a good system for financing these services. Situation nowadays used (financed by the NHIF and by the person by cash) is not good, because it causes the feeling of uncertainty.

2, Number of houses for elderly people are not enough in Hungary. It would be necessary to determine the system of these houses (owner, professional criteria, standards and protocols of care and financing of services)

## LITHUANIA

- **A social policy orientated toward home keeping**

Lithuanian government in 2003 year confirmed the strategy of health care institutions shake-up. One of three main goals is medical nursing and long-term treatment services development. The main attention is given to elder people health care system perfection.

Everything depends on persons incomes. If incomes are below the minimal incomes, the person is entitled to certain benefit and assistance. For example: tree medication, sanatorium and other.

Legal services are provided by private organizations. Municipalities provide free legal services, but this function does not meet the needs.
Working people obligatory pay 33% of incomes to social insurance fond also 3% is paid as income-tax. Part of this money is used to finance services for elderly people.

In Lithuania old and disabled people can get free treatment, but if a patient needs some special assistance ( Alzheimer disease, dementia and other ) people are looking for private social care institutions, because public services are not very high quality.

Lithuanian government is trying to change its attitude towards home care services. Governments goal is to give more support to home care services so that elderly people can live in their natural surroundings.

A strongly urban population

On 6 April 2001, the usually resident population was 3.5 million, of which 2.3 million in urban and 1.2 million in rural areas. The population has decreased as a result of the negative natural increase, emigration and temporary migration of the usually resident population.

The main reasons for this decrease are as follows:

- Residents of the Republic of Lithuania who were temporarily absent (went abroad on tourist visits, for studies or work and stayed there) were not enumerated;
- The census allowed eliminating the number of population centrally added during the last soviet census.
- Soviet Army personnel and members of their families who left the country after the restoration of independence without formalities of registration.

**CHYPRE**

- **Social characteristics relative to elderly people**

**Aging :** Perceptions are often contradictory. On one hand, the traditional perceptions depict older persons as wise and respectful. On the other hand, modern images often depict older persons as inactive without a meaningful role in the family or the society.

**Widowhood :** There are two types of perception, one for the people living or grew in rural areas and one for the city dwellers. A city widow is a person who has the chance to run her life the way she always wanted but while with a partner couldn't, whereas a rural widow is a person in distress who has lost everything. A widower is a person who waits to dye to meet his lost partner no matter of what background.

**Retirement :** Sometimes, it is perceived as a new start for personal development, sometimes as a period of boredom and inactivity. Well paid employees (Government, Government Businesses, Banks …) can not wait for the time they retire in order to collect a pension which is most of the times above the average wage.

**Active senior cycle life :** Although government policy and programs promote active senior cycle life the male senior spends most of his time in the coffee bars for men while the females stay at home taking care of the grandchildren or watching TV.

**Physical decaying :** Is something that every senior person fears. Cypriots cannot accept easily the loss of independence of others. Physical decay speeds up the end of life.

**Death :** It is more socially accepted when connected to old age. Otherwise, it is considered extremely unfortunate. Nobody wants to die!

A person is considered old if is over 65, has grey or no hair and holds a walking stick.
An elderly person doesn't fall in love nor has a relationship.

As 80% of the population is Christian Orthodox the belief that once dead, the soul remains and when the person's acts on earth are judged by God then the soul is punished by going to Hell or awarded by going to Paradise. Resurrection for all is strongly believed so death is not the end.

For the Christian Orthodox all is written in the bible and explanations to everything are provided by the clergy. There are no taboos. Euthanasia is unacceptable as relatives want their own to stay alive as long as possible

Although times are changing is still expected that older persons are to remain in the family and cared by the family. It is considered a sin and a disgrace to a family if they do not take care of their elder parents or brothers or any other close relative.

Whereas the care of an older person used to be the sole responsibility of the family, there is an increasing demand for formal types of care. Wealthy families hire a maid to help in caring for the older parents or place them in care homes.

- **Priority is given to the policy of home keeping**

Care is offered in by the welfare office only to old people with low income. (less than C.P. 300 (€ 180 per month) if is one person or less than C.P. 400 (€ 240 per month) if is a couple).

- **Non equal solvency**

Not all the senior citizens have private insurance because is not obligatory to have one.

According to the Public Assistance and Services Law 8/91, a person who is not capable of meeting his/her special needs (including need for care), is entitled to free care (home-, day- or residential care).

The Public Assistance and Services Law 8/91, secures a minimum standard of living for all persons legally residing in Cyprus. Assistance may be provided in the form of money and/or services to persons whose resources do not meet their basic and special needs as determined by the Law. It makes special provisions for people who are vulnerable to social exclusion (persons with disabilities, single-parents, parents with four or more children and families in risk of dissolution) and may include a rent allowance, home-care etc. Rates for public assistance are reviewed annually to keep in line with the rising cost of living.

- **Service Provider**

Although in recent years private companies are promoting pension contracts among occupational groups, the pension system in Cyprus is almost entirely public. Therefore very little, if anything, can be said about the public-private mix of pensions.

The private sector dominates the health services market in Cyprus, accounting for around 70% of total health expenditure. It treats patients on ‘a fee for service’ basis and is open to all individuals who can afford to pay.

At the moment the government provision of health services is funded out of general taxation, with the exception of a small part financed from charges imposed on some services. As said earlier, the private health sector is open to anyone affording its services.

The state, in its capacity as employer, provides free health care to all civil servants. For others eligibility for free public health services depends on their income and demographic characteristics.

Individuals earning less than €10350 pa, households earning less than €17250 pa or with more than three children. Individuals with income between €10350-€15500 pa and households with income between €17250 and €24200 pa are entitled to health care services at 50% of the prescribed rates.

At accident and emergency departments medical care is provided free of charge to everyone in need, irrespective of income or nationality.

- **Restricted intervention of public funding**

Public administration helps only the people with low income. All the others pay by themselves or are helped by their children.

➔ **Financing sources**

The financing sources of social protection in Cyprus vary between the different parts of the system.

➔ **Schemes other than health**

· *Social Insurance,* financed by earnings related contributions; for employees the contributions to social insurance represent 16.6% of earnings, for the self-employed persons 15.6% and for voluntary insured persons 13.5%.

· *Social Pension* paid out of general taxation and reviewed each year to take into account the increase in wages and the cost of living.

· *Child Benefit,* financed out of general taxation and adjusted according to the cost of living index. The same applies to *Mother's Allowance*.

· *Provident Funds* schemes, financed by contributions paid by employees and employers and assessed on employee earnings.

· *Supplementary Pension* schemes, financed by employers.

· *The Termination of Employment Scheme,* financed by employers and covering all persons employed under a contract of service.

Old age pension is payable at the age of 65 (at the age of 63 for women born before 1/1/1935) and is not conditional on retirement from regular employment (i.e. a person does not have to be retired in order to receive old age pension as long as she/he fulfils certain requirements). The old age pension is composed of the basic

pension and supplementary parts, calculated in the same manner as the invalidity pension.

- **Demographic characteristics in Cyprus**

There is an ageing trend in the population. Whereas today, persons over the age of 65 comprise 11.9 % of the population, it is expected to reach 19.3 % by 2027.

Cyprus is a divided island, with its Northern 36% occupied by Turkey. The population in the government controlled part of the island was 671.3 thousands in 2000 (Table 1.3, see annex 1). When the Turkish Cypriots living in the occupied areas are also included this figure rises to 759.1 thousands. This, however, does not include a large number of Turkish settlers living in the occupied areas. In general, the Cyprus government has no access to information concerning the occupied part of the island.

The population of Cyprus has increased by 4.03% over the period 1995-2000. The male population has increased by 4.2% while the female population by 3.9%. Cyprus exhibits the demographic characteristics of an ageing country: a declining rate of population growth, a sharp decline in the proportion of the population aged less than 15 years and an increasing proportion of the population aged more than 65 years, due to increased life expectancy.

Life expectancy at birth is around 75 years for men and 80 years for women. At the age of sixty, life expectancy is around 20 years for men and 23 years for women. Furthermore, life expectancy at birth remained unchanged for men and increased for women over the period 1994 to 1999. The demographic dependency ratio has decreased from 0.56 in 1995 to 0.52 in 2000. However, since this decrease is mainly due to the decline in the proportion of younger people in the population, it is a matter of time before the demographic dependency ratio in Cyprus will start rising.

- **Répartition des compétences ministérielles en matière d'organisation et d'administration de la politique sociale en faveur de la personne âgée**

The Council of Ministers has overall responsibility for the State part of the social protection system in Cyprus. It exercises this authority through the Ministry of Health and the Ministry of Labour and Social Security and, to a smaller extent, through the Ministry of Finance.

The Ministry of Labour and Social Insurance is responsible for the implementation of government policy for employment, social insurance, social welfare and industrial relations. It is organised into departments and manpower development institutes.

The *Department of Social Insurance* is responsible for:

- the 'Social Insurance Scheme', compulsory for all employed and self-employed persons and providing for maternity allowance, sickness benefit, unemployment benefit (not to the self-employed)7, old-age pension, invalidity pension, widows pension, orphans benefit, missing persons allowance, marriage grant, maternity grant, funeral grant and benefits for employment accidents (not for the self-

employed) and occupational diseases such as injury benefit, disablement benefit and death benefit;

- the 'Social Pension Scheme', providing pensions to persons who have completed the age of 65, and who are not entitled to a pension from another source and satisfy the residence conditions specified in the Law;

These conditions are: (a) residence in Cyprus for at least 20 years from the date the claimant reaches the age of 40, or (b) residence in Cyprus for at least 35 years from the date the claimant reaches the age of 18.

The *Department of Social Welfare Services* is the official agency of the state for the provision and promotion of social welfare services. The main programmes of the Department are the 'Family and Child Services', the 'Community Work', the 'Public Assistance and Services for the Elderly and Disabled' and the 'Staff Development and Programme Planning Services'. It also administrates the following three Laws: (i) the 'Public Assistance and Services Law', guaranteeing a minimum acceptable standard of living in keeping with human dignity for every person legally residing in Cyprus; (ii) 'Homes for the Elderly and Disabled Law', requiring non-government homes for the elderly and disabled to be registered and inspected; and (iii) 'Children Law and the Centres for the Protection and Recreation of Children Law', requiring non-governmental day-care centres and child-minders to be registered and inspected.

The *Department of Labour* is responsible, among other things, for the 'Service for the Care and Rehabilitation of the Disabled Persons', 'Severe Motor Disability Allowance', 'Special Financial Assistance to the Disabled Persons', 'Financial Assistance Scheme for the Purchase of wheelchairs for the Disabled'.

The Ministry of Health is mainly responsible for the organisation of the health care system in Cyprus and the provision of health care services financed by the state. The ultimate objective of the organisation is to promote and protect people's health.

The Ministry of Health is organised into various departments and manpower development institutes including: (i) *General Laboratory,* providing laboratory analysis services, including the inspection of food, water, medicine, police evidence and drugs investigations (but not services for clinical purposes); (ii) *Pharmaceutical Services,* responsible for the testing, supply and pricing of pharmaceuticals, the inspection of pharmacies …; (iii) *Medical and Public Health Services,* responsible for services in the fields of precaution, primary, secondary and tertiary health care; (iv) *Dental Services;* and (v) *Mental Health Services.*

The range of services offered through the government health scheme is comprehensive and includes visits to general physicians, specialist consultations, impatient stays, medical care given abroad in specialist fields not offered in Cyprus and all drugs prescribed.

Also offered are special health care schemes covering specific sections of the population such as :

- medical services (mostly primary health care) provided by Trade Unions to their members through the use of mainly private sector health facilities; and

- various employer-sponsored arrangements providing free medical care, mainly through the health facilities in the private and public sector.

The Ministry of Finance is responsible for the administration of :

- the 'Mobility Allowance', a means tested benefit granted to disabled workers and students to cover travelling expenses for work/college;
- the 'Provisions of Special Grants', where the applicant's entitlement is determined by the degree of his/her blindness; and
- the 'Provision of Financial Assistance to Persons with Disabilities for the Purchase of a Car', for which entitlement is determined by the degree of disability.

- **Occupational schemes**

Many employees in the private and government sectors are covered by occupational schemes which provide benefits, in addition to those of the statutory Social Insurance Scheme.

The occupational schemes take the form of either provident funds or occupational pension schemes. The benefits from provident funds are lump sum money payable on termination of employment, invalidity, retirement or death.

A few provident funds (e.g. those for bank employees) also provide a guaranteed lump sum payment against inflation. Provident funds for employees in the private sector are mainly established voluntarily within a system of free collective bargaining. However, once agreed, a provident fund has to be registered and operated in accordance with the Provident Fund legislation.

- **Home care**

Out of a total of 86.900 older persons, 6.193 are public assistance recipients. About 81.5 % of public assistance recipients over the age of 65 years are provided with care services.

No data exist for home care services for older persons who do not receive public assistance.

Home care may be provided to any person who is not in a financial position (as determined by law) to meet this need. The state of a person´ s health is not a criterion for the provision of home care.

For persons with Alzheimer the care is offer only by volunteers, there is no help from the state.

- **Characteristics of retirement homes**

The government encourages NGOs and Community Welfare Councils (non-governmental bodies at a local level) to develop care services at a local level when there is a need for such services.

## ITALY

The diffusion of the care home services is still insufficient and it is not homogeneous on the national territory

- **A social policy assistance based and not insurance based**

The assistance policy differs on the basis of the individual income. People over 65 years with a law annual income, do not pay anything for medical treatments and care. Thresholds for payment rates are stated at national level according to given indicators. To give an example, a familiar nucleus over 65 (that means a couple, not a single individual) with an income lower than 36.517, doesn't have to pay for the health expenses.

The others pay a small percentage of the medical and care expense (called "ticket").

- **Types of Services Providers**

**Legal**: it is not clear what is meant under this item.
If the rights of persons with diseases (elderly included) are at stake, we have a national policy, under the Ministry of Justice jurisdiction, which assigns specific tasks and responsibilities to different figures (judges, patronages, Courts of Justice for ill people, syndicates, regional courts of justice…).

If "legal" means assistance to have information on rights, services, structures for elderly people, the local administrations fulfill these tasks. Some of them, especially in the wider cities, have a dedicated info-desk.

- **Financing of social policy**

**Financing**: In the Italian system, the government gives out funds to the Regions (and therefore it is the main indirect financial source). The Regions distribute these funds to the Municipalities belonging to their territorial area according to their socio-sanitary plans. The Municipalities use these funds, together with their own integrations, to provide and pay the concrete services.

**Home care financing:** a recent national law (328/2000) encourages the Municipalities to sub-contract the management and provision of the services to the Third Sector, maintaining a role of control and supervision.
It has also been spreading the "Benefit" system, already experimented in Rome and in other Italian towns.

It is important to stress that the main financial and care burden weighs on the families (much more than on the public services).
In Italy the public system has a central role in this matter. Anyway, nowadays the public system isn't able to guarantee the financing of elderly people care

- **Characteristics of placement in retirement homes**

Estimation of total number of homes at a national level (all types) : **5010**
*Source: 14th General Census of Population and Houses - 2001*

Anyway, when talking about public or accredited private structures, the situation is the following:

- Structures offering places in geriatric sectors: 160 public and 38 private (for a total of about 9000 geriatric structures beds and 14.000 long-term patients beds).
- Residential structures: 1687
- Semi-residential structures: 241

*Source: Ministry of Health, year 2000*

The public home care and residential services in Italy show one of the lowest rates in Europe: about the 2-3%, while in the Scandinavian countries is about the 20%, in GB is about the 15%, in Germany the 10%.

The Ministry of Internal Affairs signals a shortness of structures for elderly people, as well as of care personnel.

At the 1st January 2003 over 65 people were estimated around the 19% of the population, and ISTAT projections foresee an increase of this percentage to the 34.4 of the total population in 2050.

According to the official data from Ministry of Health, in the 2000 191.489 elderly people benefited from the home care service, corresponding to the 1.9% of the elderly population over 65. Anyway, recent surveys demonstrate that the number increased to 270.852 in 2002 and to 324.806 in 2003.

Old but able people :

- Family members provide affective and emotional support, help in the performance of bureaucratic matters, for buying things and eventually for meals preparation.
- Private or public home care: hygiene of the environment, preparation of meals, company to go out.
- Voluntaries: only for company (chatting, reading something to the user, walking outside….)

Disabled people :

- Family members, public home care service, private assistance by “badanti”: they all help the user in the personal hygiene and in keeping the house clean. They also provide psychological and affective support against loneliness and depression.
- Public health services: when the user needs daily or periodical treatment (injections, physiotherapy, wounds dressing…).

For persons with Alzheimer disease :

As for the above category of disabled people, but the family has the heaviest burden of care.

The National data do not imply a homogeneous distribution in Italy. To give some figures with respect to the provision of home care in different towns, you can consider in Emilia-Romagna municipalities the rate it is around 7 out of 1000 elderly people, while in Chieti is 4 out of 1000 ones.

Besides, it has to be considered the spreading phenomenon “badanti”, i.e. not regularly employed extra-community carers, who make the data difficult to quantify.

- **National policy**

The national law on social services emphasises the central role of the local administration in the provision and experimentation of new services aimed at guaranteeing the well-being of the citizens, leaving wide opportunities to the different administrations in the choice of the most suitable models or services.

There are, therefore, different experimentations and examples in various parts of Italy that cannot be considered the results of national guidelines but the product of local sensibility and efficiency.

An awareness campaign, named “adopt an elderly person”, has started to be discussed and advertised even in TV talk shows and newspapers, but it cannot be considered a national pattern yet.

- **Existence of a procedure for new institutions**

These kinds of services can be created:

- On initiative of the private sector (NGO, associations of citizens, research centres), who usually present their ideas to the public bodies for financial support;
- On initiative of the local administrations themselves;

Under a financial point of view, the Community Initiatives Programmes and the public funds available play an important role in the experimentation of these new services.

- **Placement policy**

The national law (328/2000) assigns the legislative power to the regions, giving general indication on the aspects the regional laws have to regulate, but leaving them the choice of the better strategies according to their characteristics and needs.

The greatest part of the Regions have presently issued regional laws regulating the social services provision system and, even if differences at regional level are noticed, the main principles are common to all the territorial area, and consist in having the Regions as main sources of financing, coordination and monitoring, while the third sector and the local bodies have a main role in the management and provision of the services.

- **Procedure for the building of new structures**

There is not a national policy stating that for a given number of citizens a given number of care/rest/protected houses is needed.

The decision is made at local level, according to the needs, the demands, the geographical area and many other factors (not least the financial availability).

- Once more, it is mainly on the initiative of the local bodies, in collaboration with the health system and often with the third sector, that such placement services are created.

**Protection of the person**

A legal tutor is assigned by the Court of Justice to those persons with acknowledged inability of understanding and will, while a curator is assigned in case of partial inability. In both the cases they can be family members or public officers. Their fee is decided by the Court of Justice and is paid by the beneficiaries, when their financial situation allows it, otherwise by the Government.

This is why we indicated both national and other, this second option referring to private financing, when the elderly persons pay by themselves.

## FINLAND

Demography in Finland has trended to a Papy boom for the next 30 years but the policies in progress aim at the anticipation of such a situation and at insuring the largest quality of life to the aged persons.

The reference idea is based on the principle that anybody can stay in a living environment and among his relatives to insure him quiet ageing

Ethic and human considerations (essentially proper to the Scandinavian countries) are included in an economical perspective presenting two aspects

- limited fix structure costs
- A reduced « consumption » of cares with the help of the social and familial structures

- **Home keeping at first**

Finland recommends home keeping for elderly persons; 90% of the seniors over 75 live among their relatives (familial responsibility type)

A person who does not belong to the family can come to the senior's in order to take care of him. (private sector essentially)

This system is mostly spread in Finland. The governmental details seek for full adequacy between needs, services, quality and relevance of management, ethics and respect to the senior and the concern to fully integrate the person in the society as far as possible (supermarkets, administrative steps etc...)

Type and sort of administrative steps are not specified in the available documentation.

- **Home types**

5/7% of the persons over 75 live in homes, 3/5 % in homes where medical assistance is available : there are only a few structures. These homes are financed by the municipality (public sector) and the homes with medical assistance by a specific association RAY (public and private sectors)

The municipalities must provide their residents with appropriate structures. The objectives must be quantitative (each senior must be provided with the most appropriate assistance and aid without structural constraint) and qualitative (fundamental rights, ethics, rehabilitation, cooperation between carers and relatives etc...)

The public sector plays a determining role in the first and last phases of this process :

- the strategic forecasts in conformance with the directives of the government and the local background
- providing of public structures appropriate where necessary or demanded
- Home care and intermediate structures if they seem to be in connection with the public sector (price determination in particular) must be controlled by the private sector

- **Financing the dependent elderly persons ?**

The fix structure cost is covered by the public sector and the mobile ones by the private sector
The Alzheimer disease is only notified in the available official documentation if it is considered as a transfer from the familial competence to an institutional support.

## FRANCE

At first the social policy on account of the aged person has been more precisely oriented to home keeping in France since 1982 and considered as an alternative institutionalization

- **Home keeping**

For this purpose a collaboration between the state and the "departments" aims at creating around the aged person some lines of authority and nets in order to promote home keeping. The family largely makes its contribution to the assistance of the dependent aged persons. More than 60% of them stay at home thanks to the assistance of their relatives. However as more and more women go to work and population aging is growing this fundamental role can be questioned in the future.

The social policies take the familial conditions of the aged persons into account in some ways : through various aid measures for families and via fiscal and social special measures. Moreover familial solidarity is framed by some legal duties.

It is clear that these actions were not implemented to meet the specific needs of the familial environment : need of time, psychological assistance, respite, financial aid and needs of services. In a few cases the more the assistant helps the less the community supports him. It is the reason why local initiatives were developed in order to meet the verified deficiencies.

In a frame of priority given to home keeping for aged persons, it seems to be essential to admit the role played by the familial environment and to develop it. If one must maintain the civil obligations of the family the present actions could be coherent and improved in order to meet the needs of the familial assistant. It is planned to take several assistance measures for the familial assistants in the frame of a familial policy on account of the old persons according to the following directions

To know and inform the assistant,
To adapt the services to his needs
To take up the load of the assistant,
To protect his familial and professional life

Among these measures we must mention an « assistance check book » allowing the assistant to have respite, the increase of the places for temporary care facility, the right of the assistant for free checking up as the health conditions of the aged person are checked up, the right for specific vacations in order to reach a balance between assistance and professional activities.

- **Awareness of the advantage of a quick home return**

A slight handicap at home can become a malignant dependence at the hospital, in a senior home or at any other place where the old person cannot find his way about. It is the reason

why the hospitals which receive old persons in their urgency facilities try to keep them less one a week –max ten days – in order to avoid a total dependence.

A home assistance service favourably keeps the autonomy of the elderly person. It is better than a hospital.

The hospital services have the necessary equipment for quick and reliable taking over of a patient but any admitted person must respect a strict regulation. Cardiology, traumatology and neurology services cannot be adapted to the needs of the patient, the patient must find a deal with the hospital services.

A weak old patient cannot withstand a hospital regulation which is suddenly going to force him his daily time table, set up the times for clinical cares, for bath and meals. After a few days she looses his autonomy.

In a web the old person stands in the middle of the web spun around him and he gives this web its unit. On the contrary at the hospital the patient cannot choose : he is subject to the organisation of his medical treatment

The home assistance around a dependent aged person is a specific combination of a voluntary and a paid work.

This combination of specialists and volunteers – when it is possible – this web – makes this assistance effective

At the beginning of 2006, Jean-Jouis Borloo, Minister for employment, social cohesion and private housing matters creates the ensigns for human services.

Another solution is the admission to a retirement home. The average age for these persons is 85 and 80 % of the residents are women.

The reasons of this decision are :

- A home follow up is impossible and the charges are too high
- An all day long attendance,
- A constant assistance even in the situations of physical or psychic dependence and in particular in the event of psychic, Alzheimer diseases
- Keeping free activities
- Good accommodation conditions according to precise accommodation specifications such as the access to convenient toilets and located at the same level as the room, local catering...
- Resocialisation in front of solitude : group stimulation, entertainment and projects

The choice of an establishment can bring the children closer.

# ANALYSIS AND PROSPECTIVES

# INTRODUCTION

***« Population ageing : a constant evolution in the world »***

In 2050 the elderly persons will represent 33% of the population and 19% today. The average age will increase by 9 years and reach 46.

Moreover there will be some differences in the developed and developing regions. In the former ones in which we already have a strong proportion of seniors after a strong increase of the inhabitants and more particularly in the post war years we shall state a continuation of this phenomenon but its tempo will be slower than in less developed countries. We can admit that this pace is directly linked to the development of the economy. In the frame of this survey this notice is important for we must consider that the new EU members and the new entrances will be made by countries whose economies have not the same development grade as in the old EU members.

Wordwide we state that, though the populations are very young at present these countries should know a very quick ageing due to a low fecundity rate and a quick increase of longevity. By 2050 we forecast the number of aged persons in the less developed countries shall be 4 times higher than to date (3400 million in 2000 and 1 570 million in 2050) This age group will represent 19% of the population in the less developed countries for 8% to date; the average age should increase by 11 years and reach 35 years.

As we noted it in the first pages it is necessary to take this phenomenon into account to integrate the demographic data of the Eastern European countries which are going to enter or should be ready for the integration. We have to bowdlerize these consequences on considering the place in these countries reserved for the seniors in their society and the evolution resulting of the social mutations due to the economical developments.

Among the so called developed countries Europe and Japan will record the highest ageing rates till 2050 – the 60 age group will represent 37% in Europe and will be higher in Japan and only 27% in North America where the population will still increase very quickly. Inside the 60 age group we will register a strong increase of the number of the very elderly people i.e those over 80. If the very old ones represent 3% of the European population at least 10% of the global population will be over 80 by 2050 in 11 out of the 15 states, the to date's members of the EU. The age differences between men and women will be significant. In Europe the life expectation for a woman exceeds man's one by 6 years.

The 60 year old women group is twice as important as men's. In the 75 age group 70% of these persons are single women. The enlargement process of the EU should not have any impact on the ageing phenomenon. Though the ratio of elderly persons in Middle and Eastern Europe is lower than in EU-15 it should increase and reach the average level in the EU till 2050. At present most of the candidates have very low rate of fecundity. For example France needed 115 years to double the number of aged persons and goes up from 47 to 14%[6]. In China this phenomenon should only take 27 years.

**Typology of the environmental background**

➔ **Preliminary**

It now seems to be necessary to set preliminaries to determine the frame of our reflection which we want to present. In fact this one directly comes in the orientations presented by the commission and elaborated on the base of the statements available.

➔ **Demographic ageing in Europe :**

Even if we properly cannot say these countries are developing countries when we examine the countries of the Eastern block it is clear that their economies do not have the characteristics of the post industrial ones and as a result the market economy whose installation is now in progress is not fully effective yet and in particular the transformation of a production economy into a full consumption economy based on services and entertainment.

These economic events will take place with a politic background of democratic type. There is no doubt about it, the pressure of the populations will play on account of a quick increase of the social policies and more particularly on account of the social protection. All these elements will have a direct impact on demography and age pyramids. We can only suppose that population ageing will be quicker in these new member countries than in the "old" ones.

➔ **How can the EU meet this demand ?**

European orientations for a national response

[6] Asia and South America see the quickest ageing process and will have 20 to 25% of their populations till 2050 while sub-Saharan Africa for instance should only reach half of this percentage because of the pandemic disease of the VIH/Aids and the social and economic difficulties

As Europe was the first country concerned by ageing, it elaborated a large series of politic measures [7] to meet it. This phenomenon appeared in the XX century. Politic deliberations were taken only at national level for a long time. Nevertheless we understood very quickly that those problems were common to all countries and this awareness became more intensive since mid 90s and the cooperation between the members to give a response was larger during these past years.

As the European Commission presented in 1999 a communication[8] about the political solutions in this matter (as an own contribution to the international year of the seniors) and said that the Members would take advantage of a narrower cooperation to handle these questions at an European level, it only had a little understanding of the problem and its possible solution. However during the following years the member states promise to examine this problem in the frame of a sound public financial policy[9] , employment, social protection and sustainable development and at the same time to maintain the policies applied in these sectors by their national jurisdictions and taking the differences of the situations into account in this matter. Moreover the fight against age discrimination is part of the EU Treaty as well as the charter for the human rights which also mentions the rights of the Seniors.

However the legislative jurisdiction almost exclusively depends on the Member States. In fact in some cases important jurisdictions are available at regional and local level as well as at national level. Nevertheless the EU can play an important supporting role for these policies conducted at appropriate level on stimulating brain storming and experience exchanges. Though the range of this role in its financial support is relatively limited it can sometimes be of significant importance. The Commission considers that it must be a catalyst, a facilitator, a regulator in this domain of know how and experience exchanges. The commission is not a project leader; it only tries to support the initiatives of the partners whatever the level may be.

Active ageing supporting :

The approach of the EU in ageing matters aims at taking advantage of all abilities in all age groups. It thinks that the measures in ageing matters must go further than the consideration for the present generation to be more efficient.

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[7] Europe can be considered as a pioneer : it implemented a social policy through a large series of institutional responses to face population ageing (pension, pension systems, special health services, residential cares, activity centers, etc.).. The policies on account of the aged persons were mainly developed in the European countries

[8] "Towards a Europe for all age classes", COM (1999) 221 final.

[9] Common forecast and control activities which are integral with these studies induced some innovative analysis covering the EU-15.

The main practices in this matter include basic education and all life education, a longer active life, a later retirement and more progressively the possibility for elderly persons to be active during retirement time to train their abilities and preserve their health.

These practices aim at improving the average life quality of the person and take part in the activities of a society, in growth increase and make dependency burden lighter. At the same time they will be essential by reducing the pension costs as well as health care expenses. They have only advantages for all age groups.

The Commission proposed similar orientations in its contribution to the International Year for aged persons 1999. Their implementation requires that all interested parties take part in an environment of exchanges and partnership. In the frame of these various initiatives aiming at the improvement and modernisation of the European social system and more particularly in social protection matters, social integration and employment the Commission supports cooperation between all concerned elements and includes the non governmental organizations and the social partners, etc.[10]

Main challenges

Within the general frame of the EU approach of ageing problems we have some common challenges the EU and the member states have to meet: facing the economical incidences resulting of ageing in order to preserve growth and good public finances.

- ✓ Three big challenges connected to ageing must be at once taken into consideration.
  - At first to keep a good level of the work force to cover the needs of a population having more and more retired. It is then necessary to create the conditions necessary to keep the persons in activity as far as they physically can do it.
  - Secondly : how it is possible to maintain the costs for such services in the limits of the financial possibilities of the public sector and as a result of the

[10] As indicated in the coordination guidelines of the economic policies and the European Social Agenda, this response includes the effects of ageing on the economy, employment and social questions. The main orientations of the economic policies which make up the key tool to coordinate them and offer a framework to express recommendations and to follow up the implementation of these recommendations invites the member nations to develop global strategic systems to meet the economic challenge caused by population ageing. The Social Policy Agenda which lists the non preventive points in the EU in the domains of employment and social matters shows how the member nations by developing mutual policies in matters of employment, social care and economy can face the effects of prolonged ageing on social and professional life.

economy as a whole, including the risks for fiscal stability and global economic viability

- Third point, how can we solve the problem of poorness of the elderly persons ; this problem remains a big problem in many countries of the world where a large number of persons and in particular women do not get an adequate income, and in which social aid and health insurance are slender. In spite of the different types of situations all over the world ageing is a phenomenon whose characteristic is a larger range of differences between men and women[11].

✓ ***Social protection systems still delicate***

The health assurance systems in the PECO have a double problem. In the one hand the social costs resulting of the adaptation of the ancient planned economy system to the market economy laws enhance the question of the social protection systems, their nature and their capacity to meet the needs of the population.

On the other hand these systems must be adapted to the European standards adopted by the EU. The PECO have inherited the old systems of social protection which are totally inadapted to the transition period for they have no incitation levers and cannot be financially maintained. In a planned economy system, social protection was for everybody and insured a whole life job. It was centralized in the companies, it insures children nursing, housing and health care. The social policies at the beginning of the transition period widely depended on the heritage of the ancient system. At first social aid systems were created to meet the general price level loss resulting of the stabilization policy and job adaptation in progress. Financing problems and deletion of various aids paid in the old economical system were a shock for the different populations. Moreover inflation played an important role on reducing the real amount of the diverse benefits which were paid later and later.

To date the social protection systems in the PECO are quite different according to the countries but we find common characteristics. They have characteristics which look like ours in Western Europe even if the background determined by the transition changed them. Generally speaking the social systems of the PECO were inspired by the Bismarck's system (compulsory assurance connected to employment). In Slovenia universal elements were introduced. They are financed by taxes and social dues essentially paid by the employers. They also have characteristics proper to decentralization, the local authorities interfere in the attribution of these benefits and in a few cases in the definition of the policy (Poland, Slovenia and Czech republic)

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[11] The Surinam resolution on the situation of the aged women in the society which was adopted during the 56th session of the general assembly of the United Nations is a useful contribution which takes the equality dimension into account between men and women in aging process

The political decisions are made at government level. However cooperation has a relevant role to exchange experiences and support the best practices worldwide considering the diversity of the national entities. To respect this principle and in this environment we developed this information block, the evaluation sheet SCALITY and the certification document LEAQUAL.

# TYPOLOGY TESTING

**Data cross examination :**
**Public policy and Social-economical / cultural policy**

In fact the main problem is apparently to know in which extent the quick changes happening in

- The age pyramids,
- In the social and cultural panorama (place of the senior in society, role of death and ageing concept …)
- In the social and economical data (such as evolution of the family circle , costs for housing, the number of women in occupational life)

Can be managed in order to maintain the quite high solidarity level between the generations in the EU and to continue to insure the social integration of the aged persons in their families.

This issue creates problems : which place has an elderly person in our modern society ; it is essentially a cultural problem

For this reason it seems to be necessary to compare the statements of our blocks with the sociological survey led by the MYRTHA group. With this comparison we have the proof that the place located by a society or a group to these elderly persons will be not only one of the most important and relevant parameters in the social policies involved but also an important economical element with economical and budgetary consequences for a nation.

**Constant feature :**

We have at first to underline that the policy maintaining the seniors at home will remain a constant value whatever typology may be.

We do not want to examine the details of such a representation but we state typologies in the answers found in the blocks completed by our partners.

As a result we can find two groups at the end of the typologies

**A typology of the « extremes »**

➔ <u>Groups with a strong social integration of the seniors :</u>

We state in the survey led by our partners of programme SCALITY LEAQUAL that the familial solidarity plays an important role when the place of the senior is correctly identified. As a result we can set the main features for a public policy on account of the seniors.

- ✓ **A home care service with strong medical cares :**

The financial need and medical home cares is mostly insured by the family and therefore limited.

- ✓ **Nursing homes with strong medical assistance**

Placement in a nursing home has at first a connotation "strong medical assistance" but does not mean medical and social assistance. We have to create structures with strong medical assistance based upon a team of carers.
A mental and social assistance is not so important.

- ✓ ***A public aid policy without categories :***

Parallel to this characteristic we can state that the management of the social policy on account of the elderly persons is concentrated to social assistance and not connotated "insurance"

At the same time management and administration of these policies is often managed by separated authorities or by different regional levels
We state that in such a type of society the social policy on account of the senior is mostly integrated in a general social policy and not in a sectional one.

At last we have to not that the initiative for the creation of home care structures is mainly supported and implemented by the public authorities.

➔ <u>Group with a strong sociologic categorization</u>

We are here in front of social groups which have left the first category identified because of very bad economical conditions (cost of housing, working conditions, other different social priorities…)

From this economical background on the social position of the senior was shifted and became peripheral; as a result the public authorities had to bring other solutions.

- ✓ **Looking for solvency of the senior**

As far as the senior is placed in the peripheral section of the social concerns his solvency must be managed. For this purpose the public authorities required that he buys old age insurance.

These systems are all the more developed that we address a society living in urban areas. It is clear that this factor has a stronger impact.

- ✓ **An « insurance » policy combined with an « assistance » policy**

As far as the financing systems for seniors became institutions, accompaniment of seniors based on familial assistance is replaced by a collective solidarity system; as a result the senior is cut off his natural and familial environment. It is then necessary to build up a care network with better management taking health cares of course into consideration but also covering psychic social needs. As a result a policy promoting assistance is absolutely necessary

- ✓ **A diversification of the services available with a priority : promotion of staying at home**

*We have a larger panel of responses to the demands of the seniors who have a large choice; the natural solidarity is counterbalanced by society.*

- ✓ A response of the public authorities associated with private initiative

There are so many identified needs that the public authorities have to associate some partners mandated by the public services to their own responses. In this group we state a true concern as for the creation of structures.

*In fact we find more qualified responses between two extreme typologies. However we have to state that this movement began 10 years ago towards a single direction, from the first one to the second one.*

**Typology disruption**

Nevertheless this phenomenon can be disrupted for important modifications in the social structures take place right now.

We can note two of them

New characteristics of ageing

- ✓ Generalised ageing

The European Commission supports the efforts to the United Nations for the elaboration of a global action frame concerning ageing. A long term world strategy has to define the objectives to reach after a given time within the limits of the

capacities of the government and the citizens. Considering the reliability of the demographic projections we own to date, we say by 2022.

Ageing : new characteristics

Parallel to population ageing we state a deep modification at the end of this XX century in the way of feeling and living ageing. Retirement does not mean any longer an entrance in the world of the old aged and use this word to refer to elderly persons is more and more an anachronism. With longer life expectation, elderly persons live longer and sounder and as a result the fragility period comes later. These changes in the age pyramid, the health condition and the employment schemes transform the nature of ageing to give birth to a new society.

The economic value must be shifted to other activities than production ones. We have more and more aged persons in the service activities and this market shall be more and more sectioned. It is the reason why the responses shall be more and more variable. In prospect the responses of the European Commission reflect these orientations.

To reach the general objective of an employment rate of 70% in 2010 set by the European Council of Lisbon in March 2000 the number of working elderly persons must be higher. In Stockholm 2001 and Barcelona 2002 two objectives were set:

- Half of the European population of the 55/64 age group should be at work by 2010 (Stockholm 2001).
- The effective average age of the work stopping people in Europe should progressively increase by 5 years (Barcelona 2002) till 2010

The low employment rate of the old workers in Europe represents a loss of life opportunities for the person and a loss of potential for the society. With a longer life expectation working time could be distributed all over the complete life cycle offering partial working times and career breaking

For the economy as a whole the increase of the employment rate of old people is critical to maintain the economical growth, income tax level and the social assistance systems including an appropriate level of the pension rates considering the decrease of the population of the working force.

In 2006, the EU countries are divided into groups considering these two objectives :

- The countries close to or beyond the Stockholm objective : Sweden, Denmark, GB, Estonia, Eire, Cyprus and Portugal
- countries for which we have some concerns and where less than 35% of the elderly persons where less than 35% are still at work : Slovakia, Slovenia, Poland, Belgium, Hungary, Luxembourg, Italy, Austria and France.
- The middle group, close to the average figures in EU: Germany, Czech, Finland, Lithuania, Spain, Holland, Greece and Latvia.

The age of the workers leaving the employment market varies from 56.9 in Poland to 63.2 (Sweden). The age difference between men and women is generally low. On the contrary as for the employment rate there is a large difference (an average of 48,9% for men and 19.1% for women) This employment rate is quite different according to the country 22.8 % in Slovakia and 68% in Sweden.

## Degeneration diseases of psychic social type

As life expectation is developing, there are more and more diseases related to the Alzheimer's one; it is the reason why the public authorities shall have change their present responses. These spreading illnesses will require appropriate structural and service responses. The above mentioned typologies must find a quick adequation and adopt other forms of responses and organisation : the priority will be the medical aspect and the accompaniment at life termination of this type of patients and demand psychosocial responses.

# PROVISORY CONCLUSION

In conclusion we can say that the available census and modelling must change before long. We must have a technical synthesis of the available patterns. The aged person could as a result find again a central position in the European societies but this positioning could take place in another context based on a community practice and not on assistance and offer in fact a new structural solidarity.

Even if the societies belonging to the second group can more easily operate this new modelling system, they have to implement optimized assistance practices and techniques offering the personnel adaptation and more time for communication and evaluation of the capabilities of the assisted persons to mobilise the rest of the bodily autonomy of the patients

This SCALITY LEAQUAL takes this issue into consideration in the application of its programme; at first an evaluation block of the different steps, then the practices and define the improvement direction before it can offer a sort of quality assurance grid to give a general procedure for each contribution; it is the only guarantee for the permanency of the quality covered by the LEAQUAL grid.

These different orientations will of course have an impact on the practices of the carers and require the implementation of a module training programme in addition to the already available diploma.