FERPA COMPARATIVE STUDY ON

Dependency in the Member States 2010

Fédération Européenne des Retraités et Personnes Agées

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Foreword

Since FERPA's last Congress held in May 2007, this is the third research study published by FERPA, confirming a strong will and intense research activities and in-depth analysis of social issues related to the elderly and pensioners in Europe.

The two previous studies were dedicated as follows: the first one to the theme of "Loss of purchasing power of pensions", and the second to a reflection on "Living in Europe as retired: How much does it cost?".

Both publications, circulated among the FERPA members and brought to the attention of all EU institutions, have elicited great attention and a considerable positive feedback.

This year the research theme selected is a "Comparative study on non-self-sufficiency in the Member States". Even if the definition of "non-self-sufficiency" is translated by different terms in the various countries (dependency, invalidity, disability, etc.), the issue in question is absolutely clear and extremely topical.

Of course, these are issues that affect not only the elderly and retired people, but it can certainly be stated that a majority of the "non-self-sufficient" persons are to be found amongst the over 65 and that, because of population dynamics, this presence is bound to grow.

It is therefore of interest to FERPA and its affiliates to be aware of the size and the implications of the issue and, above all, to be informed on the "best practices" in Europe, which could set an example and an incentive to follow by countries (and regions) who are still experiencing serious shortcomings and difficulties.

It is very important that the contents of research may have been used, in addition to the existing official sources, as a primary and original source, like the one provided by the FERPA affiliates who responded to an extensive questionnaire, enabling researchers to make use of direct and unmediated information.

To all those who have given their support a grateful thanks.

We talk about topical issues, on which the European Union and major international actors, such as the World Health Organization, are focusing their attention and their efforts.

Over time, every human being is bound to experience a decline in his or her health condition and suffer some degree of disability. So when we speak of "dependency" or "non-self-sufficiency", we talk about a universal experience.

And above all, it is a social problem and not just a medical one.

For those who like us believe in the values of a modern trade union, it is a matter of SOLIDARITY.

Good reading.

Bruno COSTANTINI
General Secretary of FERPA

1. Introduction

The principles of equality and solidarity, which constitute the underlying structure of the entire constitutional edifice of a state, are enshrined in numerous European basic laws, and represent the strong nucleus from which social rights originated and then developed.
The rules of such Constitutions operate in two ways: for one, they call on the state to make constitutional provisions applicable and effective; and secondly, as the other side of the coin and as a complement to the legislative structure, they recognise an extensive "range" of individual rights for citizens that are in turn recognised by case law and legal doctrine as social rights.
This is not to say that the plethora of social models stemming from different European democracies can be reduced to a single source. In spite of the evidently non-shared historical and political origin of the individual national systems and of what will be said presently, it is nonetheless now possible to identify and to indicate points of contact between them, whereby the principles of equality and solidarity are attributed in their own right to the fundamental nucleus, to that least common denominator of the European constitutional heritage.
Solidarity and equality have therefore represented the ground layer from which the other social rights have originated and developed, at least in a large number of European countries. We should therefore not forget the demands which led to the recognition and articulation of social rights in the legal systems of various countries, giving rise to the modern welfare states, namely to: fight against poverty and to transfer certain relevant risks from the individual to the community through social security.
Even with all the changes that occurred in time, the conviction nonetheless persists that the reason for any welfare system consists chiefly, if not exclusively, of a double attempt to reduce inequalities in the economic and social sphere and to offer security to individuals.
To such an extent that, however different the national experiences which make all attempts at comparison difficult, the role of the welfare state still remains unchanged. It is the risks, the characteristics thereof and the entities that are changing and developing, bringing about "new social emergencies" which the countries are having difficulties in tackling with concrete and above all uniform answers.
The connection between effective inequality and social protection gives rise to a need to assess, at the national and supranational level, how the responses of the system stack up against the emerging risks, so as to avoid disbanding the Community *acquis* achieved in these years during the (difficult) process of convergence towards a European social model. Whether a social model can be recognised to constitute a nucleus, shared by the governments of the 27 EU Member States, on the importance of the welfare state in combating social exclusion and poverty and the lingering inequalities has long been discussed.
A reflection on this point, and therefore on ways to tackle the new emergencies such as that of dependency cannot, in our view, be separated from an analysis of the existing situations in what are fundamental dimensions for each country, i.e. legislation, demographics, the economy and social vulnerability.

2. Traditional welfare models. Considerations

As already mentioned, although concerned in large measure with the same social risks, national welfare systems deal with them in different ways and thus use differently the resources allocated to take up the challenges that they face.
The levels of spending on social protection, as well as the financing methods actually vary widely from one EU Member State to the other, through different systems which, for the sake of convenience, are grouped into 4 models.

In the **Nordic model,** the state defines the general framework for the organisation of the labour market and leaves it up to the social partners to define the individual relations. The aim is to secure equality, cohesion and homogeneity for the social groups through a fair redistribution of resources. The underlying premise of this concept is universal social protection seen as a civil right. The Scandinavians, long considered as having the (quasi) ideal types of the welfare state, have historically preferred a system of high taxation, built around two fundamental actors, individuals and the state, geared to financing high social spending to provide a substantial offer of services to families and to children, with protection systems for the most destitute which are extended to the entire population.

The **Continental model** is based above all on social insurance. The relatively generous social benefits for the workers guarantee a certain independence from the market in case of risk. The amount is linked to the level of the worker's salary. Social insurance is mandatory. Those not covered by contributions may obtain minimum benefits financed by taxes, provided that their income does not exceed a certain amount.

Continental European countries are nonetheless characterised by quite a substantial level of social spending. In countries like Germany, France and the Netherlands, spending on social protection has always been generous (ca. 30% of GDP), and is financed chiefly through taxes levied on employers and employees. Social spending moreover finances unemployment benefits, healthcare and disability to a substantial degree compared with other welfare systems.

The Mediterranean model is similar to the continental model as regards guaranteed income benefits. Family policies on the other hand are not very developed, while pensions constitute the largest item of social spending. In the final analysis, the social protection system of Mediterranean countries, although faced with different situations, differs from the afore-described systems both in terms of allocated resources and of beneficiaries of the resources. These systems are characterised by an overall lower level of spending (ca. 25% of GDP), by the choice of sectors for which it is earmarked, and in general by the allocation, in terms of resources, to the family and children, both in terms of GDP and overall spending. This situation is paradoxical, for it is found in countries that are traditionally "family-oriented" where those vested with the responsibility of ensuring well-being are individuals and the families but, if the data are anything to go by, they do not seem to attach a great deal of importance to the family and to children.

In the **Anglo-Saxon model**, social protection has to be completely free from the right to work and state intervention is marginal. Benefits in cash (severance pay, sick pay, disability pay, etc.) provided by the national insurance system are on a flat-rate basis, and lower than those paid in Scandinavian

countries. This explains in particular the important role attributed to private insurance schemes and to company pension schemes. Nevertheless, those without sufficient income are entitled to welfare benefits, financed to a large degree by taxes, based on a means test. The social policy reform has focused on two priorities: reducing welfare state costs to bring down the public deficit and taxation and social security contributions; greater efficiency for social protection, in particular a reduction of the waiting list in the healthcare system and the fight against disincentivisation to work.

3. Social protection in the EU Member States

The economic crisis that has hit the world economy has immediate repercussions for all citizens, not only in strictly monetary terms, but also from the social point of view. More specifically, the prime consequence of the lack or shrinkage of income is the reduction of personal "investments" in healthcare, aggravating the differences and inequalities in healthcare between countries and between citizens belonging to different social groups. The first to feel the effects of such a situation are precisely those belonging to the most vulnerable segments of the population (the poor, the disabled, those without job security, and the elderly).
In such a context, the expenditure by EU Member States for social protection assumes even greater importance. Social protection expenditure naturally refers – in line with the Eurostat definition – to all social benefits (transfers in cash or in kind) granted to individuals or families to protect them from situations of risk or of need, the operating expenditures of the overall protection system, and other spending.
Studies that analyse the protection scenarios in the different countries must bear in mind that during a period of scarce monetary resources on the part of individuals, the States must assume more of the burden for the security and assistance of their own citizens. The same applies also to the methods for funding social protection expenditure.

3.1. SOCIAL PROTECTION EXPENDITURE

An analysis of the percentage of GDP allocated by the EU Member States for social protection shows that the average in the EU 27 over a two-year period (from 2005 to 2007) was about 1.1%. Unfortunately, although examined recently (the study dates from mid January 2010), the Eurostat data do not cover the last two years. It would be interesting to observe whether in the years of economic crisis, in an effort to make the fight against exclusion situations effective, the Member States have reversed such a negative trend by increasing the "allocations" for social protection.
More specifically, the States that allocate the highest percentage of GDP for social protection are (in 2007) France (30.5%), Sweden (29.7%), Belgium (29.5%) and Denmark (28.9%). At the opposite extreme are some of the countries that joined the EU in the last waves of enlargement: Latvia, with scarcely 11% of GDP allocated for social protection, Estonia (12.5%), Romania (12.8%), and Lithuania (14.3%).
Conversely, if attention is focused on the increase in allocations for social protection in the last decade, it is the countries that can be classified as falling under the Mediterranean welfare model that have tended to increase rather substantially the percentage of expenditure for such important social aspects: Portugal: +4.6% (from 20.2% to 24.8%), Greece: +3.9% (20.5% to 24.4%) and Italy: +2.4% (from 24.3% to 26.7%).

Scandinavian countries have on the contrary cut down part of their GDP historically allocated for social protection: Finland: – 6% (from 31.4% to 25.4%); Sweden: -3.4% (from 33.1% to 29.7%); Denmark: -2.3% (32.1% to 28.9%).
The countries belonging to the other models have essentially maintained the line of expenditure undertaken at the end of the last century, veering away from the year taken as a reference in this analysis by a few decimals of GDP.

Social protection expenditure in percentage of GDP

Geo\time	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
EU (27 countries)	0	0	0	0	0	0	0	0	0	27,1	26,7*	26,2*
EU (25 countries)	0	0	0	0	26,5	26,7	27	27,4	27,2	27,3	26,9*	26,4*
EU (15 countries)	27,8	27,4	27	26,9	26,8	27	27,3	27,7	27,6	27,7	27,3*	26,9*
Belgium	28	27,4	27,1	27	26,5	27,3	28	29	29,2	29,6	30,2	29,5
Bulgaria	0	0	0	0	0	0	0	0	0	16	14,9	15,1
Czech Republic	17,6	18,6	18,5	19,2	19,5	19,4	20,2	20,2	19,3	19,2	18,7	18,6
Denmark	31,2	30,1	30	29,8	28,9	29,2	29,7	30,9	30,7	30,2	29,3	28,9
Germany	29,4	29	28,9	29,2	29,3	29,4	30,1	30,4	29,8	29,7	28,7	27,7*
Estonia	0	0	0	0	13,9	13	12,7	12,5	13	12,6	12,3	12,5
Ireland	17,6	16,4	15,2	14,6	13,9	14,9	17,5	17,9	18,1	18,2	18,3	18,9
Greece	20,5	20,8	21,7	22,7	23,5	24,3	24	23,5	23,5	24,6	24,5	24,4
Spain	21,5	20,8	20,2	19,8	20,3	20	20,4	20,6	20,7	20,9	20,9*	21*
France	30,6	30,4	30,1	29,9	29,5	29,6	30,4	30,9	31,3	31,4	30,7	30,5*
Italy	24,3	24,9	24,6	24,8	24,7	24,9	25,3	25,8	26	26,4	26,6*	26,7*
Cyprus	0	0	0	0	14,8	14,9	16,3	18,4	18,1	18,4	18,4	18,5*
Latvia	0	15,3	16,1	17,2	15,3	14,3	13,9	13,8	12,9	12,4	12,3	11*
Lithuania	13	13,7	15,1	16,3	15,8	14,7	14	13,5	13,3	13,1	13,2	14,3*
Luxembourg	21,2	21,5	21,2	20,5	19,6	20,9	21,6	22,1	22,3	21,7	20,3	19,3
Hungary	0	0	0	20,3	19,6	19,2	20,3	21,2	20,6	21,9	22,4	22,3
Malta	17,5	18	17,9	17,8	16,9	17,8	17,8	18,3	18,8	18,6	18,2	18,1
Netherlands	29,6	28,7	27,8	27,1	26,4	26,	27,6	28,3	28,3	27,9	28,8	28,4*
Austria	28,9	28,8	28,4	29	28,4	28,8	29,2	29,6	29,3	28,9	28,5	28
Poland	0	0	0	0	19,7	21	21,1	21	20,1	19,7	19,4	18,1
Portugal	20,2	20,3	20,9	21,4	21,7	22,7	23,7	24,1	24,7	25,3	25,4	24,8
Romania	0	0	0	0	13	12,8	13,6	13	12,7	13,2	12,5	12,8
Slovenia	23,5	23,9	24,1	24,1	24,2	24,5	24,4	23,7	23,4	23	22,7	21,4*
Slovakia	19,5	19,8	20	20,2	19,4	19	19,1	18,2	17,2	16,5	16,3	16*
Finland	31,4	29,1	27	26,3	25,1	24,9	25,7	26,6	26,7	26,8	26,2	25,4
Sweden	33,1	32,2	31,4	31	30,1	30,8	31,6	32,6	32	31,5	30,7	29,7*
United Kingdom	27,4	26,9	26,3	25,7	26,4	26,8	25,7	25,7	25,9	26,3	26,1	25,3*

This shows what we maintained in the introduction: All EU Member States are recalibrating their social protection expenditure. To get to the bottom of the reasons for such shifts, it is necessary to examine the expenditure items in turn. As already noted, the macro-item "social protection" is composed of several types of spending: these include expenditures for disability, old age pension, survivorship benefits, unemployment benefits, family allowances including maternity and paternity allowances, sickness and healthcare coverage, housing subsidies and spending not considered in the afore-indicated categories (known as expenditures not elsewhere specified (NES).

Social benefits per category:
(* = provisional value)

DISABILITY				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	8*	8,1*
EU (25 countries)	0	8,3	8*	8*
EU (15 countries)	8,5	8,2	7,9*	8*
Belgium	8,7	9,3	6,6	6,6
Bulgaria	0	0	9,1	8,3
Czech Republic	7,8	7,7	8,6	8,1
Denmark	10,7	12	14,9	15
Germany	8,2	7,8	7,7	7,7*
Estonia	0	6,6	9,5	9,3
Ireland	5	5,3	5,3	5,5
Greece	4,8	4,8	4,7	4,9
Spain	7,6	7,9	7,6*	7,6*
France	5,9	5,9	6	6,1*
Italy	7,2	6,1	5,9*	6*
Cyprus	0	3,4	4	3,7*
Latvia	0	7,9	7,3	7*
Lithuania	9,2	8,4	10,6	10,4*
Luxembourg	12,7	13,4	13,2	12,3
Hungary	0	9,6	9,8	9,6
Malta	5,2	5,8	6,2	6,3
Netherlands	12,2	11,8	8,7	9,1*
Austria	9,8	9,7	8,3	8
Poland	0	14	9,9	9,6
Portugal	12,6	12,7	9,9	10
Romania	0	8,3	8,9	10
Slovenia	8,5	9	8,2	7,8*
Slovakia	6,4	7,6	8,5	8,5*
Finland	14,7	13,9	12,7	12,6
Sweden	11,7	13,2	14,9	15,3*
United Kingdom	10,5	9,4	9,5	9,8*

OLD AGE PENSION				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	39,2*	39,6*
EU (25 countries)	0	40	39,2*	39,5*
EU (15 countries)	37,6	39,9	39,1*	39,4*
Belgium	31,8	33,6	36,6	35,3
Bulgaria	0	0	47,8	46,8
Czech Republic	35,5	38,8	38,8	39,7
Denmark	38,8	38	37,9	38,1
Germany	31,7	33,7	35,5	35,4*
Estonia	0	43,4	44,4	43
Ireland	19,5	19,5	22,6	22,8
Greece	49,9	46,4	43,2	43,6
Spain	40,4	41,6	31,8*	31,9*
France	37,4	38,4	38,1	38,7*
Italy	51,8	52,5	50,8*	51,4*
Cyprus	0	41,8	40	40,6*
Latvia	0	56,9	45,9	44,9*
Lithuania	43,8	43,7	41,1	43,3*
Luxembourg	40	36,8	26,8	27,4
Hungary	0	35,8	36,3	37,8
Malta	40,3	39,8	42,1	42,3
Netherlands	33,7	37	35,2	35*
Austria	37,7	39,8	41,3	41,7
Poland	0	44,5	49,5	49,1
Portugal	36,9	37,6	42,1	42,9
Romania	0	41,4	41,7	43,2
Slovenia	44,1	43,2	38	39,3*
Slovakia	31	32,2	38,5	38,3*
Finland	29,9	31,8	34,3	35
Sweden	36,8	37	37,9	39*
United Kingdom	40,1	44,4	41,2	41,8*

SURVIVORSHIP				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	6,7*	6,6*
EU (25 countries)	0	6,7	6,7*	6,7*
EU (15 countries)	7,2	6,7	6,7*	6,6*
Belgium	10,7	10,6	10,2	10
Bulgaria	0	0	4,8	4,6
Czech Republic	5	4,5	4,3	4,2
Denmark	0,1	0	0	0
Germany	9,5	8,7	7,9	7,7*
Estonia	0	2	0,9	0,8
Ireland	6,2	5,9	4,9	4,6
Greece	3,3	3,3	8,1	8,4
Spain	4,3	3,1	9,5*	9,4*
France	6,2	5,9	6,7	6,6*
Italy	11,3	10,7	9,6*	9,7*
Cyprus	0	6,9	6,3	6,1*
Latvia	0	3,1	2,2	1,9*
Lithuania	3,4	4,1	3,7	3,7*
Luxembourg	3,6	3	9,9	9,9
Hungary	0	5,7	5,9	6,1
Malta	10,2	10,8	10,3	10,1
Netherlands	5,8	5,4	5,3	5,2*
Austria	9	8,3	7,3	7,2
Poland	0	10,8	11,3	11,1
Portugal	7,5	7,1	7	7,1
Romania	0	4,3	4,6	4,1
Slovenia	2	2	7,5	7,4*
Slovakia	5,5	5	5,4	5,5*
Finland	3,9	4	3,6	3,5
Sweden	2,4	2,2	2,1	2*
United Kingdom	3,9	4,3	3,2	3,1*

HOUSING				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	2,3*	2,3*
EU (25 countries)	0	2,2	2,3*	2,3*
EU (15 countries)	2,2	2,2	2,3*	2,3*
Belgium	0	0,1	0,5	0,5
Bulgaria	0	0	0	0
Czech Republic	0,2	0,7	0,4	0,3
Denmark	2,4	2,4	2,3	2,5
Germany	1	1,1	2,3	2,3*
Estonia	0	0,7	0,3	0,2
Ireland	3,4	2,4	1,8	1,6
Greece	2,8	3,1	2,2	2
Spain	1,2	0,8	0,8*	0,9*
France	3,2	3,2	2,6	2,6*
Italy	0	0	0,1*	0,1*
Cyprus	0	3,1	2,7	3,5*
Latvia	0	0,7	0,8	1,2*
Lithuania	0	0	0	0*
Luxembourg	0,1	0,6	0,9	0,8
Hungary	0	2,9	2,4	4,1
Malta	2,5	1,1	1	1,3
Netherlands	1,4	1,5	1,4	1,4*
Austria	0,3	0,3	0,4	0,4
Poland	0	0,9	0,6	0,5
Portugal	0	0	0	0
Romania	0	0	0	0
Slovenia	0	0	0,1	0,1*
Slovakia	0	0,3	0	0
Finland	1,3	1,5	1	1
Sweden	3,1	2,1	1,7	1,7*
United Kingdom	6,9	5,7	5,7	5,8*

UNEMPLOYMENT				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	5,6*	5,1*
EU (25 countries)	0	6,1	5,6*	5,1*
EU (15 countries)	7,9	6,1	5,7*	5,2*
Belgium	12,8	11,8	11,9	11,7
Bulgaria	0	0	2,2	2
Czech Republic	2,6	3,5	3,2	3,5
Denmark	13,8	10,5	7,2	5,6
Germany	8,6	7,5	6,7	5,8*
Estonia	0	1,3	0,9	1,2
Ireland	15,5	9,6	7,6	7,7
Greece	4,2	6,2	4,6	4,5
Spain	14,5	11,6	12*	11,7*
France	8	7,2	6,7	6,1*
Italy	2,8	1,7	2*	1,8*
Cyprus	0	7,2	5,9	4,8*
Latvia	0	3,8	3,7	3,3*
Lithuania	2	1,8	1,9	1,9*
Luxembourg	3,4	3,2	4,9	4,9
Hungary	0	4	3,1	3,4
Malta	2,4	2,6	3,4	2,8
Netherlands	10	5,1	5	4,3*
Austria	6	4,9	5,8	5,3
Poland	0	4,6	3	2,2
Portugal	5,8	3,7	5,5	5,1
Romania	0	7,6	2,7	2,2
Slovenia	4,3	4,3	3	2,3*
Slovakia	3,5	4,8	3,4	3,6*
Finland	14	10,5	8,5	7,8
Sweden	10,3	7,1	5,5	3,8*
United Kingdom	4,9	3	2,5	2,1*

FAMILY/CHILDREN				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	7,8*	8*
EU (25 countries)	0	8,3	7,8*	7,9*
EU (15 countries)	8,4	8,3	7,8*	7,9*
Belgium	8,7	8,8	7	7,1
Bulgaria	0	0	7,4	8,6
Czech Republic	11	8,5	7,6	9,2
Denmark	12,4	13,1	13,1	13,1
Germany	10,1	11,2	10,4	10,6*
Estonia	0	11,9	12,1	11,6
Ireland	13,1	13,7	14,7	14,7
Greece	8,7	7,4	6,2	6,2
Spain	2,3	4,9	5,9*	6*
France	9,9	9,1	8,5	8,5*
Italy	3,5	3,8	4,5*	4,7*
Cyprus	0	6,3	10,8	10,8*
Latvia	0	10,2	10,1	11*
Lithuania	7	8,8	8,9	8,7*
Luxembourg	13	16,6	16,9	16,6
Hungary	0	13,2	12,9	12,8
Malta	11,8	9,4	6,2	5,9
Netherlands	4,4	4,6	5,4	6*
Austria	10,9	10,7	10,4	10,2
Poland	0	5	4,3	4,5
Portugal	5,3	5,4	5,1	5,3
Romania	0	11,8	14,3	13,2
Slovenia	8,5	9,2	8,6	8,7*
Slovakia	12,4	9	10,5	10*
Finland	12,5	12,5	11,6	11,6
Sweden	10,7	9	10	10,2*
United Kingdom	8,9	6,9	5,9	6*

SICKNESS/HEALTHCARE				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	29,1*	29,1*
EU (25 countries)	0	27,4	29,1*	29,2*
EU (15 countries)	26,8	27,5	29,2*	29,3*
Belgium	24,6	24,2	25,6	26,5
Bulgaria	0	0	26,1	27,1
Czech Republic	36,9	33,6	34,4	33,9
Denmark	17,7	20,2	21,6	23
Germany	30	29,4	28,9	29,8*
Estonia	0	32,1	31,2	33,4
Ireland	35,2	41,4	41,1	41,1
Greece	25,1	26,5	28,7	28,1
Spain	28,9	29,4	31,2*	31,2*
France	28,2	28,8	29,9	29,9*
Italy	23,2	25,1	26,9*	26,1*
Cyprus	0	27,2	25,8	25,2*
Latvia	0	16,7	29	29,7*
Lithuania	30,3	29,8	32,2	30,7*
Luxembourg	26,1	25,4	25,4	26
Hungary	0	27,9	28,8	25,5
Malta	26,5	29,3	29	29,2
Netherlands	27,6	29,3	32,7	32,5*
Austria	25,1	25,6	25,4	26
Poland	0	19,6	20,3	22,1
Portugal	31,5	32	29,2	28,3
Romania	0	25,9	25,3	23,8
Slovenia	30,8	30,7	32,2	32,1*
Slovakia	37,5	34,9	30,2	30,8*
Finland	21,4	23,8	26,2	26,3
Sweden	22,1	27	26	26,1*
United Kingdom	24	25,5	31,4	30,6*

NES EXPENDITURE				
Geo\time	1996	2000	2006	2007
EU (27 countries)	0	0	1,3*	1,3*
EU (25 countries)	0	1,2	1,3*	1,3*
EU (15 countries)	1,3	1,2	1,3*	1,3*
Belgium	2,6	1,7	1,6	2,3
Bulgaria	0	0	2,5	2,5
Czech Republic	1	2,7	2,7	1,1
Denmark	4	3,7	3	2,6
Germany	0,8	0,5	0,6	0,6*
Estonia	0	2	0,7	0,6
Ireland	2,1	2,1	2,1	2
Greece	1,2	2,2	2,3	2,3
Spain	0,8	0,6	1,3*	1,3*
France	1,2	1,5	1,6	1,6*
Italy	0,1	0,1	0,2*	0,2*
Cyprus	0	4	4,7	5,2*
Latvia	0	0,7	1	1,1*
Lithuania	4,2	3,4	1,6	1,3*
Luxembourg	1	0,9	2,1	2,1
Hungary	0	0,9	0,7	0,7
Malta	1,1	1,3	1,8	2
Netherlands	4,9	5,3	6,2	6,4*
Austria	1,3	0,7	1,1	1,1
Poland	0	0,6	1,2	0,9
Portugal	0,4	1,4	1,1	1,2
Romania	0	0,6	2,4	3,5
Slovenia	1,8	1,6	2,4	2,3*
Slovakia	3,9	6,2	3,5	3,3*
Finland	2,3	2	2,2	2,2
Sweden	2,9	2,3	2	2,1*
United Kingdom	0,8	0,7	0,7	0,7*

4. The ageing population problem

Europe will in the near future be faced with a problem consisting of the growing ageing of the population and a drop in the number of births. This situation will prove decisive for the new welfare policies, because a crisis in the pension systems is looking more likely.

According to Eurostat data, the EU population, which amounted to 495 million people on 1 January, will reach 521 million in 2035, then drop to 506 million in 2060.

As to the general data, however, a consolidation is expected in the drop in the number of births as of 2008, which will be exceeded by the number of deaths by 2015. The effects have up to now been offset by immigration, but Eurostat forecasts a return to the drop in births already as of 2035, with an increase of the elderly population, which will go from 17.1% in 2008 to 30.0% in 2060. Furthermore, the elderly population composed of those aged over eighty will go from 4.4% in 2008 to 12.1% in 2060.

According to these projections, the demographic dependency ratio – i.e. the ratio between those aged over sixty-five and the workforce – is bound to vary considerably, being reduced to only two workers for every pensioner within the coming fifty years.

When the data are examined in greater depth, however, the situation appears to vary widely according to the countries taken into consideration. Strong growth in population is expected in Denmark, Ireland, Cyprus, Luxembourg and the United Kingdom, due above all to migration flows that will bolster the workforce and the fertility rate; conversely, in countries with a high rate of emigration such as Bulgaria, the Czech Republic, Latvia, Lithuania, Poland, Romania, Slovenia and Slovakia, the demographic dependency ratio could reach 1.5 workers for every pensioner.

According to Eurostat, the most populous EU Member State in 2060 will be the United Kingdom with about 77 million inhabitants (compared with 61 million in 2008), while the population of Germany, currently the country with the highest number of inhabitants (82 million), will drop to 79 million in 2035, and to 70.7 million in 2060. Furthermore, projections show that the other EU Member States with the largest number of inhabitants will be France (72 million), Italy (59 million) and Spain (52 million).

The Eurostat data have induced the European Commission to assess seriously the forecasts, by considering attentively all the problems relating to the ageing of the population (starting with healthcare and pension costs) and the new requirements of the European populations of the future. All the Member States will have to give serious consideration to the changing demographic conditions, together with the impact and consequences of globalisation and climate change. This scenario requires stability in public finances, a highly inclusive labour market, and far-seeing reforms of the healthcare (including long-term care) and pension systems.

As has already happened in the United Kingdom, immigration might be able to contain the phenomenon, although many EU countries are sceptical about the movement of workers as a solution to the problem. The European Commission is currently assessing the situation as it is now and as it is projected, with the discussion on the "Pact on Immigration and Asylum" to define common rules on immigration and to promote labour market reforms. .

Total population (in thousands)

	POPULATION AS AT 1 JANUARY			GROWTH AS OF 1 JANUARY 2008 (%)	
	2008	2035	2060	2035	2060
EU27	495 394	520 654	505 719	5,1	2,1
Belgium	10 656	11 906	12 295	11,7	15,4
Bulgaria	7 642	6 535	5 485	-14,5	-28,2
Czech Republic	10 346	10 288	9 514	-0,6	-8,0
Denmark	5 476	5 858	5 920	7,0	8,1
Germany	82 179	79 150	70 759	-3,7	-13,9
Estonia	1 339	1 243	1 132	-7,2	-15,4
Ireland	4 415	6 057	6 752	37,2	52,9
Greece	11 217	11 575	11 118	3,2	-0,9
Spain	45 283	53 027	51 913	17,1	14,6
France	61 876	69 021	71 800	11,5	16,0
Italy	59 529	61 995	59 390	4,1	-0,2
Cyprus	795	1 121	1 320	41,1	66,2
Latvia	2 269	1 970	1 682	-13,2	-25,9
Lithuania	3 365	2 998	2 548	-10,9	-24,3
Luxembourg	482	633	732	31,3	51,7
Hungary	10 045	9 501	8 717	-5,4	-13,2
Malta	410	429	405	4,5	-1,4
Netherlands	16 404	17 271	16 596	5,3	1,2
Austria	8 334	9 075	9 037	8,9	8,4
Poland	38 116	36 141	31 139	-5,2	-18,3
Portugal	10 617	11 395	11 265	7,3	6,1
Romania	21 423	19 619	16 921	-8,4	-21,0
Slovenia	2 023	1 992	1 779	-1,5	-12,1
Slovakia	5 399	5 231	4 547	-3,1	-15,8
Finland	5 300	5 557	5 402	4,9	1,9
Sweden	9 183	10 382	10 875	13,1	18,4
United Kingdom	61 270	70 685	76 677	15,4	25,1
Norway	4 737	5 634	6 037	18,9	27,4
Switzerland	7 591	8 798	9 193	15,9	21,1

The ageing population phenomenon, and the increased effect in the levels of disability strictly related to the prolongation of life, give rise to a need essentially throughout Europe for valid and comparable cross-sectional data on health, among young and elderly people alike, so as to create an ample empirical base for analyses and the planning of development policies and strategies. The ageing of the European population is strictly linked to the improved health of people who tend to be more active and to live longer. In its Communication on the Demographic Future of Europe, the European Commission highlights four salient demographic trends:

1. The average number of children per woman is below the replacement rate of 2.1 required to stabilise the population in industrialised countries, and tends to decrease subsequently;
2. The consequences of the post-war baby boom on the population;
3. The high increase in life expectancy as of 1960;
4. Even with regard to migrants of working age, immigration will not compensate the effects of the low fertility and extended life expectancy.

The overall effect of these trends is an increase of the elderly population. There are currently 18.2 million people aged over 80 in the EU 27, accounting for 4.4% of the population, and Eurostat projects that this figure will amount to about 18% by 2035.
The number of people aged 65 to 79 has increased significantly since 2000, and the trend will continue as such until 2060 (cf. table below).
At the same time, however, the health trends, in particular the decline in deaths from infectious diseases and better access to healthcare, appear to provide valid support for the debated concept of "mortality compression," or the fact that disability and health problems occur in advanced age. According to a recent report of the UN Department of Economic and Social Affairs, this demographic transition is a global phenomenon which, as it occurs in various countries in different ways and at different times, will cause substantial geopolitical tensions between developed and developing nations in the coming decades.

Senior population

COUNTRY	PERCENTAGE OF PEOPLE AGED +65			PERCENTAGE OF PEOPLE AGED +80			DEPENDENCY RATE (%)	
	2008	2035	2060	2008	2035	2060	2035	2060
EU27	**17.1**	**25.4**	**30.0**	**4.4**	**7.9**	**12.1**	**25.4**	**53.5**
Belgium	17.0	24.2	26.5	4.7	7.4	10.2	25.8	45.8
Bulgaria	17.3	24.7	34.2	3.6	7.1	12.8	25.0	63.5
Czech Republic	14.6	24.1	33.4	3.4	7.9	13.4	20.6	61.4
Denmark	15.6	24.1	25.0	4.1	7.7	10.0	23.6	42.7
Germany	20.1	30.2	32.5	4.7	8.9	13.2	30.3	59.1
Estonia	17.2	22.8	30.7	3.6	6.8	10.7	25.2	55.6
Ireland	11.2	17.6	25.2	2.8	5.0	9.6	16.3	43.6
Greece	18.6	26.3	31.7	4.1	7.9	13.5	27.8	57.1
Spain	16.6	24.8	32.3	4.6	7.2	14.5	24.2	59.1
France	16.5	24.4	25.9	5.0	8.5	10.8	25.3	45.2
Italy	20.1	28.6	32.7	5.5	9.1	14.9	30.5	59.3
Cyprus	12.4	19.0	26.2	2.8	5.3	8.6	17.7	44.5
Latvia	17.3	23.7	34.4	3.6	6.7	11.9	25.0	64.5
Lithuania	15.8	24.3	34.7	3.3	6.4	12.0	23.0	65.7
Luxembourg	14.2	21.3	23.6	3.5	5.8	8.9	20.9	39.1
Hungary	16.2	23.1	31.9	3.7	7.6	12.6	23.5	57.6
Malta	13.8	24.8	32.4	3.2	8.3	11.8	19.8	59.1

COUNTRY	PERCENTAGE OF PEOPLE AGED +65			PERCENTAGE OF PEOPLE AGED +80			DEPENDENCY RATE (%)	
	2008	2035	2060	2008	2035	2060	2035	2060
Netherlands	14.7	25.9	27.3	3.8	8.0	10.9	21.8	47.2
Austria	17.2	26.1	29.0	4.6	7.2	11.4	25.4	50.6
Poland	13.5	24.2	36.2	3.0	7.7	13.1	19.0	69.0
Portugal	17.4	24.9	30.9	4.2	7.6	12.8	25.9	54.8
Romania	14.9	22.9	35.0	2.8	6.2	13.1	21.3	65.3
Slovenia	16.1	27.4	33.4	3.5	8.4	13.9	23.0	62.2
Slovakia	12.0	23.0	36.1	2.6	6.4	13.2	16.6	68.5
Finland	16.5	26.4	27.8	4.3	9.4	10.8	24.8	49.3
Sweden	17.5	23.6	26.6	5.3	8.1	10.0	26.7	46.7
United Kingdom	16.1	21.9	24.7	4.5	6.7	9.0	24.3	42.1
Norway	14.6	22.6	25.4	4.6	7.1	10.0	22.1	43.9
Switzerland	16.4	25.2	28.0	4.7	7.7	11.1	24.1	48.5

The pressure on European healthcare systems will be substantial and could undermine the principles of equality, solidarity and universality. Inasmuch as the ageing of the population is accompanied by an epidemiological change –from a prevalence of infectious diseases and a high mother-infant mortality rate to an increased prevalence of non-transmissible, especially chronic diseases -- the health systems will have to be recalibrated to deal with the increasing number of people with disability.

In more general terms, as underscored by the European Commission in the Disability Action Plan 2006-07, ageing is highly correlated to the prevalence of disability. About 30% of people aged between 55 and 65 report a disability, and 63% of people with a disability are over 45 years old.

This could aggravate a problem that empirical evidence shows to be ever topical: the risk of poverty for the elderly population.

The table below shows how the risk of poverty for those over 65 in the European Union has remained virtually unchanged since 1996, with a reduction of poverty which started with very unfavourable economic conditions (Greece, Portugal) and, conversely, a substantial worsening of the risk in economically more solid countries (Germany, Netherlands, Italy, France); Denmark and Austria should be considered virtuous countries, at least from this point of view.

Poverty risk rate for people over 65 (%)

geo\time	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
EU (27 countries)										19	19	19
EU (25 countries)			18	17	17	16		17	18	19	19	19
EU (15 countries)	20	18	18	17	17	18		19	19	20	20	21
Belgium	25	23	22	22	24	26		23	21	21	23	23
Bulgaria					15	15	14	14	16	18	18	
Czech Republic						6				5	6	5
Denmark						24		21	17	18	17	18
Germany	17	12	12	11	10	12				14	13	17
Estonia					16	18	16	17	20	20	25	33
Ireland	22	27	33	34	42	44		41	40	33	27	29
Greece	33	34	35	33	31	33		29	28	28	26	23
Spain	14	16	15	16	19	22	28	28	30	29	31	28
France	18	17	18	19	19	11	10	11	15	16	16	13
Italy	18	17	17	14	13	17			21	23	22	22
Cyprus								52		51	52	51
Latvia					6					21	30	33
Lithuania					14	12				17	22	30
Luxembourg	9	9	9	8	9	7		11	8	7	8	7
Hungary					8	12	8	10		6	9	6
Malta					20					21	19	21
Netherlands	7	4	4	7	6	8	8	7		5	6	10
Austria	21	22	21	24	23	24		16	17	14	16	14
Poland					8	7				7	8	8
Portugal	36	37	35	33	33	30			29	28	26	26
Romania					17	19	19	20	17	17	19	19
Slovenia					21	20	19	19		20	20	19
Slovakia										7	8	8
Finland	12	12	16	16	19	18	18	17	17	18	22	22
Sweden						16	15		14	11	12	11
United Kingdom	28	25	25	21	24	27	26	24		26	28	30
Croatia								31				
Turkey							23	21				
Iceland									10	9	10	15
Norway								21	19	19	18	14

This is leading to continuous changes in public spending related mainly to the ageing of the population. Cf. the table below.

Table 2: Public expenditure related to ageing, 2007-2060, GDP variations in percentage

	Persions		Health services		Long-term assistance		Unemployment benefits		Education		Total		
	Level	Varia-tion	Level	Varia-tion	Level	Varia-tion	Level	Varia-tion	Level	Varia-tion	Livelo	Varia-tion	
		2007		2007		2007		2007		2007		2007	
	2007	2060	2007	2060	2007	2060	2007	2060	2007	2060	2007	2060	
BE	10,0	4,8	7,6	1,2	1,5	1,4	1,9	-0,4	5,5	0,0	26,5	6,9	BE
BG	8,3	3,0	4,7	0,7	0,2	0,2	0,1	0,0	3,3	-0,2	16,5	3,7	BG
CZ	7,8	3,3	6,2	2,2	0,2	0,4	0,1	0,0	3,5	-0,3	19,7	5,5	CZ
DK	9,1	0,1	5,9	1,0	1,7	1,5	1,0	-0,2	7,1	0,2	24,8	2,6	DK
DE	10,4	2,3	7,4	1,8	0,9	1,4	0,9	-0,3	3,9	-0,4	23,5	4,8	DE
EE	5,6	-0,7	4,9	1,2	0,1	0,1	0,1	0,0	3,7	-0,2	14,3	0,4	EE
IE	5,2	6,1	5,8	1,8	0,8	1,3	0,8	0,1	4,5	-0,3	17,2	8,9	IE
GR	11,7	12,4	5,0	1,4	1,4	2,2	0,3	-0,1	3,7	0,0	22,1	15,9	GR
ES	8,4	6,7	5,5	1,6	0,5	0,9	1,3	-0,4	3,5	0,1	19,3	9,0	ES
FR	13,0	1,0	8,1	1,2	1,4	0,8	1,2	-0,3	4,7	0,0	26,4	2,7	FR
IT	14,0	-0,4	5,9	1,1	1,7	1,3	0,4	0,0	4,1	-0,3	26,0	1,6	IT
CY	5,3	11,4	2,7	0,5	0,0	0,0	0,3	-0,1	5,1	-1,2	15,4	10,8	CY
LV	5,4	-0,4	3,5	0,5	0,4	0,5	0,2	0,0	3,7	-0,3	13,2	0,4	LV
LT	6,8	4,6	4,5	1,1	0,5	0,6	0,1	0,0	4,0	-0,9	15,8	5,4	LT
LU	8,7	15,2	5,8	1,2	1,4	2,0	0,4	0,0	3,8	-0,5	20,0	18,0	LU
HU	10,9	3,0	5,8	1,3	0,3	0,4	0,3	-0,1	4,4	-0,4	21,5	4,1	HU
MT	7,2	6,2	4,7	3,3	1,0	1,6	0,4	0,0	5,0	-1,0	18,2	10,2	MT
NL	6,6	4,0	4,8	1,0	3,4	4,7	1,1	-0,1	4,5	-0,2	20,5	9,4	NL
AT	12,5	0,9	6,5	1,5	1,3	1,2	0,7	0,0	4,8	-0,5	26,0	3,1	AT
PL	11,6	-2,8	4,0	1,0	0,4	0,7	0,1	-0,1	4,4	-1,2	20,5	-2,4	PL
PT	11,4	2,1	7,2	1,9	0,1	0,1	1,2	-0,4	4,6	-0,3	24,5	3,4	PT
RO	6,6	9,2	3,5	1,4	0,0	0,0	0,2	0,0	2,8	-0,5	13,1	10,1	RO
SI	9,9	8,8	6,6	1,9	1,1	1,8	0,2	0,0	5,1	0,4	22,9	12,8	SI
SK	6,8	3,4	5,0	2,3	0,2	0,4	0,1	-0,1	3,1	-0,5	15,2	5,2	SK
FI	10,0	3,3	5,5	1,0	1,8	2,6	1,2	-0,2	5,7	-0,3	24,2	5,3	FI
SE	9,5	-0,1	7,2	0,8	3,5	2,3	0,9	-0,1	6,0	-0,3	27,2	2,6	SE
UK	5,6	2,7	7,5	1,9	0,8	0,5	0,2	0,0	3,8	-0,1	18,9	5,1	UK
EURO ZONE	11,1	2,8	6,7	1,4	1,3	1,4	1,0	-0,2	4,2	-0,2	24,3	5,2	EURO ZONE
EU 27	10,2	2,4	6,7	1,5	1,2	1,1	0,6	-0,2	4,3	-0,2	23,1	4,7	EU 27
EU 15	10,2	2,4	5,9	1,5	1,3	1,2	0,6	-0,2	4,3	-0,1	23,5	4,8	EU 15
EU 10	9,7	1,0	4,9	1,4	0,4	0,6	0,2	0,0	4,2	-0,6	19,2	2,1	EU 10
EU 25	10,2	2,3	6,8	1,5	1,2	1,2	0,6	-0,2	4,3	-0,2	23,3	4,7	EU 25

5. The new European emergency: dependency (loss of autonomy)

It is not easy to provide an unequivocal definition of dependency. Just as it is not evident to understand immediately what is meant by care or long-term support.
On the first issue, the differences from country to country are enormous; they range from Italy, where there is a national law recognizing a monthly subvention for non-autonomous persons but no standards for the entitlements to social sanitary services, to countries like Spain which in 2007 enacted avant-garde legislation on alternative forms and procedures to tackle dependency, or Luxembourg where, although there is no precise definition of the problem, the small number of inhabitants allows for a case by case assessment of the needs of the individual.
To try to compare the experiences of the different countries, therefore, it is necessary to take as a reference a definition that comprises all the aspects of the problem. The most suitable definition to that end appears to be that which was drawn up in the USA and which is used in the United Kingdom – and is included in all insurance contracts. This definition classifies human activities into main activities (which refer to the ability to dress and undress; to wash; eat and drink; move in one's own home; go to the bathroom, move from wheelchair to bed and vice versa); and instrumental activities (prepare meals, clean house, wash one's clothes, take medicines, visit places beyond walking distance, go shopping, manage one's own savings, and use the telephone/internet), and derives the degree of disability from them.[1]
On the second issue, or what should be understood by long-term care, an acceptable definition is that which considers a well planned and well organised set of care services and programmes geared to the multidimensional needs/problems of a specific client or a category of people with similar needs/problems.[2]
In the final analysis, it is difficult to give a "single" definition that can provide a precise description of the EU framework for dealing with such problems. More specifically:

1. The services are often divided between the different tiers of government and intervention (national, provincial, regional, local);
2. Long-term care services are influenced by the different structures of informal or family care (as already mentioned above, countries of what is known as the Mediterranean welfare model have used the family system far more than the average of European countries, and have developed far less the system of institutional long-term care);
3. Allocations for the individual expenditure items in the overall social protection expenditure are changing (pertaining to reforms and reorganisations, chiefly on the expenditure side, in Nordic and central countries, and conversely to strong expansion in countries in the South);
4. When it comes to care and support social services for people, the local context is far more relevant than the national or European context;

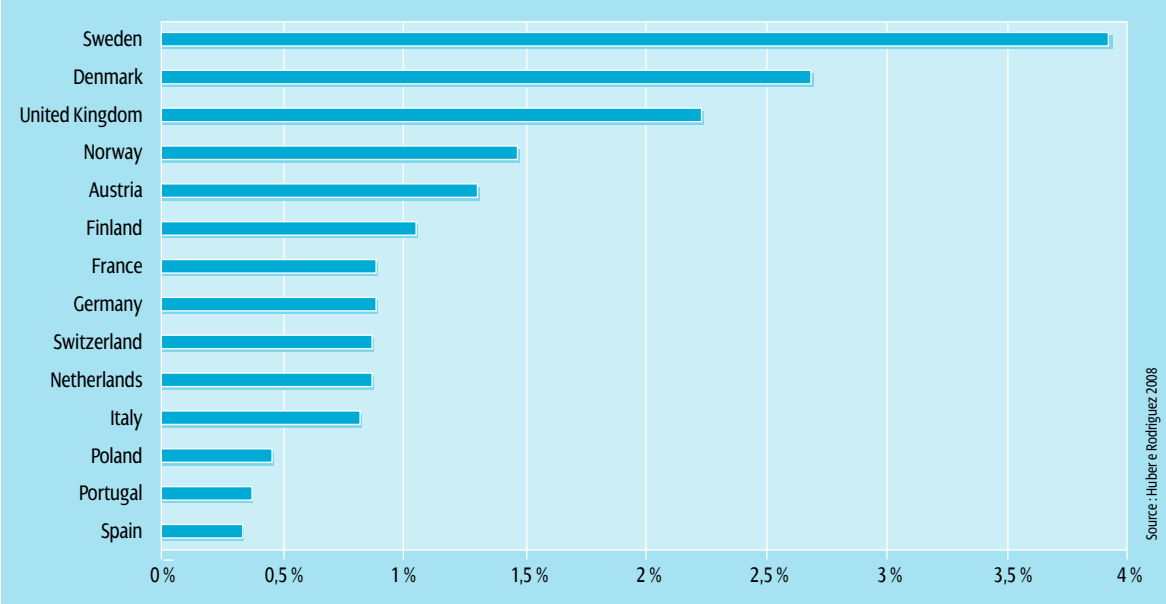
[1] The Instrumental Activities of Daily Life (IADL) are contained in OECD Working paper no 477; ECO/ WKP (2006).
[2] Here too, it would be necessary to specify what is meant by "care" or by "long-term" – definitions which, as can be imagined, differ from country to country. Cf. the country sheets drawn up from the questionnaires returned to FERPA by the member federations. For the OECD, the term long-term care services refers to "the organisation and delivery of a broad range of services and assistance to people who are limited in their ability to function independently on a daily basis over an extended period of time." Long-term care may include rehabilitation, basic medical care, nursing aid at home, welfare aid, accommodation and services such as transport, meals, occupational assistance and help with daily activities.

From the point of view of the provision of services, it may be stated that assistance is generally provided to people with physical or mental disabilities, to underprivileged members of society, the elderly and those who need particular help in their daily activities;[3] and, as already mentioned, from the moment when European citizens are living longer, public resources for health and long-term care have become the second component of social protection expenditure, right after old-age and survivorship pensions. With the increase of the average life expectancy among Europeans, the demand for long-term care services, either at home or in public facilities, is bound to grow subsequently.

To come closer to the reading of the country sheets drawn up on the basis of replies provided by the national federations to the FERPA questionnaire questions, it is worth bearing yet again in mind that every time that compared data are used (including on welfare and care services), a certain dose of caution is needed, since different definitions of the same subjects are used in different countries and different projects.

The starting point of a possible comparison may certainly be considered to be the establishment of public spending aggregates, which show that percentage of GDP allocated to long-term care in the individual countries.

Figure 5 – Public expenditure on long-term care in % of GDP (2005)



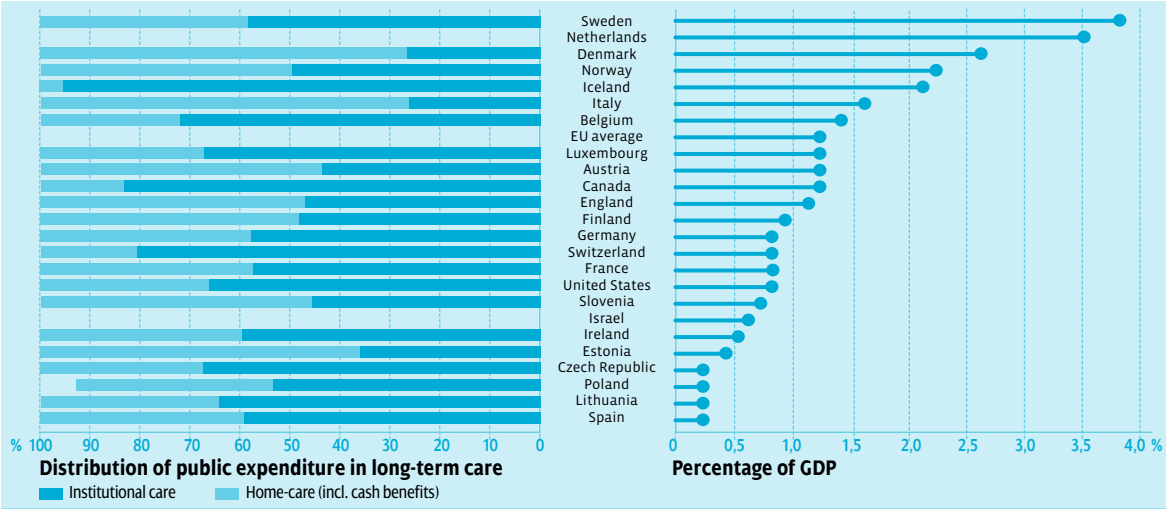
A glance at the composition of long-term expenditure confirms, albeit in comparative terms, the difference in the composition of expenditure between the different countries considered in the report.

The following peculiarities can be gauged: where direct payments dominate (attendance allowance, etc.) residential and homecare services can be noted.

[3] According to the OECD "Long-term care needs are most prevalent for the oldest age groups who are most at risk of long-standing chronic conditions causing physical or mental disability."

Country	Sources	Total expenditure (in % of GDP)	Institutions (% of total expenditure)	In-kind home care (% of total expenditure)		Cash-allowances (% of total expenditure)	Old-age expenditure (in % of GDP
Belgium	OECD	1,5%	72%	27,9%			-
Czech Republic	National sources	0,3%	67,7%	32,3%			-
Denmark	Eurostat NOSOSCO	2,7%	27%	73,3%		0%	1,7%
Germany	OECD Eurostat	0,9%	57,7%	17,8%		24,4%	
Estonia	OECD	0,5%	35,8%	4,5%		59,7%	0,1%
Ireland	National	0,6%	60%	40,4%		19,6%	
Spain	National	0,3%	59%	27%		13,9%	0,2%
France	National	0,9%	57,4%	42,6%		20,7%	-
Italy	National	1,7%	26,2%	31,7%		42,1%	1,1%
Latvia	National	0,3%	-	-		-	0,1%
Lithuania	Eurostat	0,3%	64%	5,3%		32,3%	0,1%
Luxembourg	OECD national	1,3%	67,2%	32,8%		2,1%	-
Netherlands	National	3,6%	-	-		-	2,5%
Austria	National	1,3%	43%		57,3%		-
Poland	National OECD	0,3%	53,8%	34,6%		4,4%	-
Slovenia	National	0,8%	25,7%	74,3%		27,5%	-
Finland	Eurostat NOSOSCO	1%	48,3%	45%		6,7%	0,7%
Sweden	Eurostat	3,9%	58,7%	38,1%		3,3%	2,4%
England	National	1,2%	47,4%	24,2%		28,5%	1,2%
EU average	(k)	1,3%	-	-		-	1%
Iceland	Eurostat NOSOSCO	2,2%	95,2%	4,8%		0%	1,8%
Norway	OECD, Eurostat	2,3%	50,2%	41,9%		7,9%	1,6%
Switzerland	OECD, Eurostat	0,9%	80,4%		19,6%		-
Canada	OECD	1,3%	82,8%	17,2%		0%	-
United States	National	0,9%	66,3%	33,7%		0%	0,9%

This can be shown as follows in graph form:



6. Responses of the Member States

The question of long-term care is tackled by pursuing three mutually agreed and inter-connected objectives for the services offered: universal access, high quality and long-term sustainability.
There is a general consensus that access to healthcare should not be limited to a person's ability to pay, nor depend on people's income or wealth. The need for care should not lead to poverty or to financial dependence.
Nevertheless, universal rights do not always guarantee universal access, and obstacles and inequalities persist. Obstacles range from lack of insurance coverage and certain types of assistance, to extremely long waiting periods, insufficient information and overly complex administrative procedures, that may vary even from one region to the other in the same Member State. Ensuring the necessary continuity for care to people who need it may prove difficult. The extensive efforts made in certain countries to help patients to recover maximum self-reliance through rehabilitation care, for instance, may be undermined when certain elements of long-term care are not considered reimbursable in certain social healthcare services.
Costs too constitute a barrier, especially for low-income groups, who may have to incur part of the expense themselves. Many countries, such as Cyprus, Estonia and Ireland, have introduced systems of contribution towards the expenditure for long-term care. In Germany, a small segment of the population (currently 1.1% of the population, but with an upward trend) has developed voluntary additional private insurance to cover accommodation expenses in rest homes. All this adds up to specific insurance mechanisms for long-term care and social assistance. There are various programmes to reduce the direct cost of care for citizens, including:

- Exemptions and contributions based on income;
- Additional financial aid and welfare benefits for the elderly, addicts, persons with disabilities and the chronically ill;
- State coverage of long-term care for low-income nuclear families;
- Uniformity of contributions at national level;
- State subsidies for the use of private services.

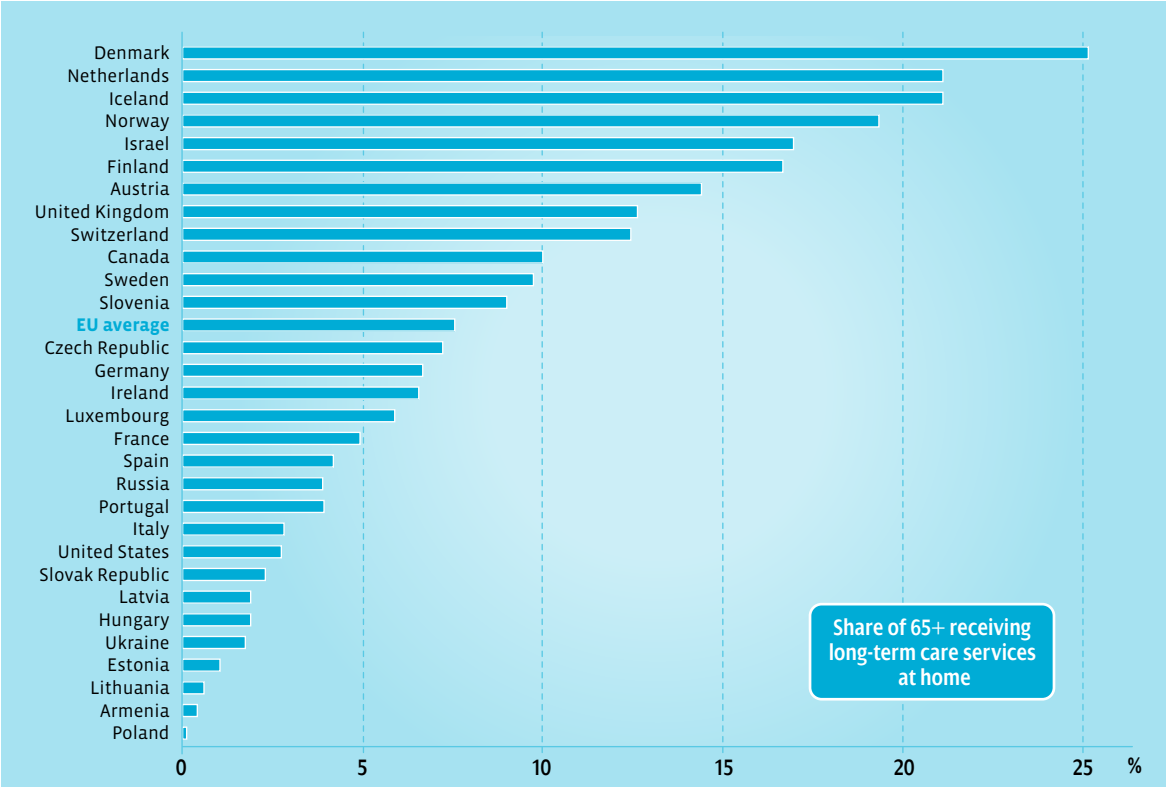
The general tendency is a shift from traditional care (with the exclusion of the most serious cases) towards the development of customised homecare services based on the territory, supported by modern technologies such as electronic healthcare systems, telemonitoring, telemedicine and independent life systems. In this way, citizens, especially the elderly, have a greater freedom of choice as to the assistance they need and can continue to live as long as possible in a family environment, in their own homes, close to their friends and family, whilst enjoying institutional care where possible.
The table below clearly shows how the trend is perceptible in most countries.

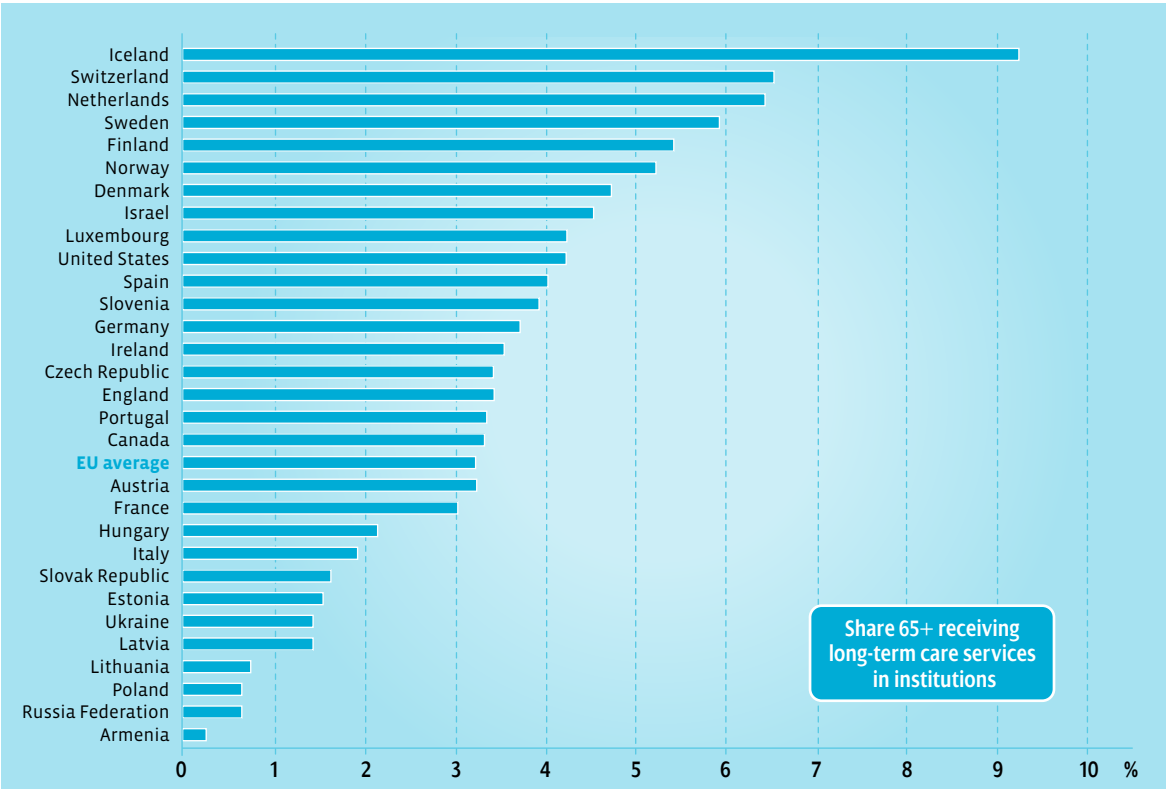
	Mid 1990s				Most recent date			
	Source	Total	Home-care	Institutional care	Year	Total	Home-care	Institutional care
Czech Republic [a]	National	11,4	8,0	3,4	2006	10,7	7,2	3,5
Denmark	National	24,1	20,0	4,1	2007	29,8	25,1	4,8
Germany	OECD	10,6	7,3	3,3	2006	10,5	6,7	3,8
Estonia	National	2,7	1,5	1,2	2005	2,6	1,0	1,6
Ireland	National	10,0	5,6	4,4	2004	10,1	6,5	3,6
Spain [a]	National	3,9	1,1	2,8	2006	8,3	4,2	4,1
France [b]	National	4,8	2,5	2,4	2007	8,1	4,9	3,1
Italy	National	4,0	1,8	2,2	2004	4,8	2,8	2,0
Latvia [a]	National	1,7	0,3	1,4	2007	3,4	1,9	1,5
Lithuania	National	1,5	0,8	0,7	2007	1,3	0,6	0,8
Luxembourg	OECD				2006	10,2	5,9	4,3
Hungary [a] [b]	National	3,8	2,0	1,8	2005	4,1	1,9	2,2
Netherlands	National				2006	27,7	21,1	6,5
Austria [b]	National	16,0	13,2	2,8	2006	17,8	14,4	3,3
Poland [b]	OECD, national	-	-	-	2006	0,7	0,0	0,7
Portugal [a]	National				2007	7,3	3,9	3,4
Slovenia [a]	National	12,5	8,5	4,0	2007	13,0	9,0	4,0
Slovak Republic [a] [b]	National				2005	4,0	2,3	1,7
Finland	National	20,7	15,6	5,1	2005	22,1	16,6	5,5
Sweden	NOSOSCO, national	20,4	12,0	8,4	2007	15,7	9,7	6,0
England	National	18,1	14,2	3,9	2006	16,1	12,6	3,5
EU average	[c]	10,2	7,2	3,0		10,8	7,6	3,3
Armenia [a] [b]	National	-	-	-	2006	0,6	0,4	0,3
Iceland	NOSOSCO	30,8	19,2	11,6	2005	30,4	21,1	9,3
Israel	National	18,6	14,0	4,5	2004	21,5	16,9	4,6
Norway	National	23,9	18,2	5,7	2007	24,7	19,3	5,3
Russian Federation [a] [d]	National	-	-	0,6	2001	4,6	3,9	0,7
Switzerland	OECD	19,8	13,0	6,8	2006	18,9	12,4	6,6
Ukraine [a] [d]	WHO, national	-	-	-	2000	3,2	1,7	1,5
Canada	National	14,0	10,3	3,7	2003	13,4	10,0	3,4
United States	National	8,3	4,2	4,1	1999/2000	7,0	2,7	4,3

Legend: (a) may include those approaching the 65-year threshold (for Hungary, only for hospital care); (b) include beneficiaries over 60; (c) average weighting of the different years; (d) includes beneficiary over 55

To this end, close cooperation is needed by and between the national, regional and local authorities and with partnerships entered into with the private and volunteer sector. In the absence of such an integrated approach, the ensuing fragmentation of services and the administrative obstacles may prevent citizens from getting the care they need. For example, persons discharged from hospital should be able to have access to customised homecare or similar services on the territory; if no such services are available, the accessibility to personalised long-term care is limited. Germany is dealing with this situation by assigning a case manager to patients in need of assistance during the transition from the hospital to their home or to another facility. Every aspect of organising long-term care to provide support has been tackled as of 2009, and consultants will be available for all patients irrespective of the way that care is provided.

The tables below show the percentage of the population over 65 that receives long-term care services at home, and the percentage of those over 65 who receive the same type of care services in institutions.





The quality of long-term care services varies widely. It comes as no surprise therefore that studies and reports have revealed cases of dissatisfaction and have drawn attention to gaps, from the inadequate accommodation and lack of privacy in rest homes to the undue use of force and coercion. Due also to these complaints, the Member States are drawing up or amending rules and regulations that can guarantee the adoption of and compliance with sufficiently high standards.
On the other hand, it is not easy to assess the quality of the various long-term services provided; whereas this is true for formal facilities like rest homes and hospitals, it is infinitely more so in informal contexts that range from the patient's home to the homes of friends or relatives.
The OECD classifies the various indicators used on the basis of the facility (size of the rooms and relations between staff and patients), the process (assessments and mechanisms used), and the results (prevalence of certain medical conditions); they show that fortunately, quality is improving on the whole.
As regards long-term care, emphasis is increasingly being placed on formal compliance with the requirements for a complete quality guarantee that will consider, in particular, the rights of the patient and continuing training for the staff. At the same time, the standard indicators for assessing the quality of care, such as relations between staff and patients and the suitability of training, may not be appropriate for assessing homecare by informal care providers.
The national authorities are faced with the problem of having to measure improvement in quality in different ways. Some countries (the Netherlands, Slovakia) use quality accreditation measures, supported by monitoring systems (Cyprus, France, Germany, Greece, the Netherlands). Other countries (Germany, Luxembourg) use clinical guidelines derived from medicine, based on efficacy tests. To prevent regional inequalities in the provision of long-term care services and arbitrary assessments of patient requirements by the regional and local authorities, many countries (Estonia, Germany, Latvia, Lithuania, United Kingdom, Czech Republic, Slovenia, Spain, Sweden) apply uniform quality assurance mechanisms.
The practical parameters for assessing the quality of care provided are becoming increasingly more sophisticated and more reliable, but are still not fully satisfactory in many Member States. The factors considered vary from support by informal care providers to an increase in the choice available to patients, from the guarantee of the capability of those operating in the long-term care field to technologies that can prove useful.
The assessment of the level of care that patients receive is also difficult, especially if it is provided in an informal rather than an institutional context and if such assessment is -- as is often the case – based on measuring the degree of satisfaction and the needs not satisfied.

6.1. HOMECARE SERVICES

Countries in the Mediterranean area (Greece, Spain, Portugal, Italy) have a lower percentage of use, form and offer of disciplinary services. The reduced percentage of users tends to concentrate on particularly vulnerable older people: the beneficiaries of homecare services in such countries actually have quite higher "functional and cognitive compromise" rates than all the other European countries.
From the beginning of the 1990s, the southern region of Europe registered high growth, even if use has remained meagre compared with the rest of Europe. The value has quadrupled in terms of percentage (from 1 to 4%), but the distance from the other countries, although reduced, continues to be very wide. Southern Europe has made considerable progress during these years, but not the "leap forward" needed to close the initial gaps and to come significantly close to the rest of the continent.
Unlike what happened in the South, the percentage of use in Northern Europe has remained substantially stable since the beginning of the 1990s. Already at that time, in fact, the public offer was decidedly extensive there, reaching 14% of older people; the table contains the Scandinavian countries with the highest percentage of users (Denmark) and the lowest (Sweden). The extreme dissemination of homecare services in Denmark – the highest percentage in Europe – has made it possible to accelerate deinstitutionalisation policies in particular.

A law was enacted in 1987 that prohibits the construction of subsequent residential facilities, stipulating that in case of inappropriate hospitalisation owing to the lack of homecare services, the entity responsible for the latter, i.e. the municipality, would assume the expense. Sweden, on the other hand, adopted – in particular in the second half of the last decade – a strategy of "less users and higher intensity," illustrated above, whereby the reduction of use was accompanied by increased access for the more vulnerable older people; the same strategy is applied in the United Kingdom.
Central Europe has registered substantial growth, since, in the second half of the past decade, structural reforms were introduced in Belgium, Germany, France and Luxembourg. Overall use has gone up by a third, from 6% to 8%, and the increase has affected in particular social homecare services, which were particularly limited there. All the reforms implemented in central Europe have been geared to the State assuming greater responsibility, especially financial responsibility.

Homecare services in Europe, % of elderly users

Macro-area/country	Start of the 1990s	Start of 2000s	Mid 2000s
Northern Europe	14	15	13
Denmark	20	25	21
Sweden	9	8	9
Central Europe	6	8	8
Germany	3	7	7
France	2	6	8
Southern Europe	1	2	4
Spain	1	2	4
Italy	2	3,8	4,9

6.2. RESIDENTIAL SERVICES

A difficulty arises in finding specific and updated data concerning residential services in Europe. In one of the recent studies conducted in the European Union (which unfortunately still refers to 15 countries), the non weighted average of older people receiving care in residential facilities is 5.1%. Central and Northern European countries (Belgium, Sweden, Netherlands, France) tend to exceed 6%, while the use of residential services for older people in southern Europe (Greece, Italy and Spain) is less than or equal to 4.0% (cf. table below).

Table 9 – Older people receiving care in residential facilities in Europe. Mid 2000s

Position	Country	% of older people receiving care in residential facilities	Position	Country	% of older people receiving care in residential facilities
1	Belgium	8,1	9	Ireland	4,6
2	Sweden	7,5	10	Denmark	4,4
3	Netherlands	6,9	11	Spain	4
4	Portugal	6,7	12	Luxembourg	3,9
5	France	6,3	13	Germany	3,9
6	Austria	5,5	14	Italy	3
7	United Kingdom	5,1	15	Greece	1
8	Finland	4,9		Europe (average not weighted)	5,1

Note: Belgium's data improperly consider also users aged 60-64; Portugal data refer to beds.
Source: Pesaresi (2005), ISTAT (2008b), Imserso (2006), OECD (2005, 2008), Corens (2007), Pita Barros & De Almeida Simoes (2007), De Boer (2006).

In the last decade, the growth trend has been reversed in most EU countries, and the percentage of older people receiving care in residential facilities has dropped. The phenomenon is quite significant because it is the result of specific policies pursued by various countries (in Scandinavia first and foremost), but especially because it has never happened before. The reasons should be sought in the interest shared by the public authorities and older people, to reduce the cost of care and to guarantee a better quality of life for older people in their own homes. Conversely, in Southern Europe, residential care continues to increase in Spain and Portugal, especially by virtue of the fact that the offer of services is still far lower than the European average.

7. Expenditure and financing of policies against dependency

The long-term sustainability of public spending on healthcare, and in particular on long-term care services, will come under enormous pressure because of the ageing of the population. Such pressure may however be relieved if citizens stay in good health as they age. A preventive approach capable of integrating health and long-term care services through the use of new technologies and ICT could also help to keep costs under control.

The **financing of long-term care** varies in the EU because of different traditions and priorities.
Four factors come into play:

1. The programmes and population covered by long-term care services;
2. National mechanisms for the financing of the care system;
3. The degree of financial contribution by private individuals;
4. The demarcation line between public and private responsibility for long-term care.

Public broad-spectrum programmes can be financed by:

- Social insurance (Germany, Luxembourg, Spain);
- Taxes (Latvia, Nordic countries);
- Mechanisms subject to particular conditions of income (Cyprus, United Kingdom);
- Mixed financing systems that combine resources from insurance mechanisms and taxes with various budgets and institutions responsible for the provision and purchase of long-term care services (Belgium, France, Greece).

Aware of the need to secure a solid financial base for long-term care services, many Member States (Germany, Luxembourg, the Netherlands, Sweden) are moving in this direction by creating universal social insurance contributions and programmes or through taxation (Austria, Sweden).
In view of the allocations needed, the Member States are assessing a mix of public and private participation, in particular in the social sector.

PREVENTION AND REHABILITATION POLICIES

Promoting an active and healthy lifestyle bears significant benefits for individuals, in addition to the potential broader advantages for society in general by reducing the costs for public health, enabling people to remain active longer, and preventing a drop in productivity rates owing to sick

leave. Most EU countries have vaccination and screening programmes as well as campaigns to promote healthy ageing. However, even though these are an important step forward, it is too early to assess their impact whilst proper coordination between the various care providers geared to promoting prevention policies is essential.
Rehabilitation care services are vital in helping patients to achieve maximum self-reliance, to live as normally as possible, and to return to a satisfactory work environment. As the Member States have realised, the efficient promotion of such care services cannot be dissociated from qualified and properly trained staff and the efficient use of information and communication technologies.

COORDINATION OF CARE SERVICES

The coordination of care services is vital for guaranteeing the high quality of the care provided, the efficient use of resources, and the customised and continued treatment needed by certain patients. Coordination between national, regional and local authorities and services is indispensable to be able to anticipate and to overcome any obstacles stemming for instance from the presence of separate budgets for financing different services, the organisation of the provision of services, and the multiple bodies involved in the health and social sector.
The measurement of success in providing continuous care is the capacity of health and social services to complement each other in order to meet the specific needs of each patient.
Two elements are important to that end: the provision of services and better management when moving between different settings (the home environment, the hospital and the rest home).
National authorities are currently paying greater attention to measures introduced to improve the capacity of the different services to cooperate efficiently.
National strategies and priorities have been charted and set to guarantee uniformity in the provision of services: a particularly important element, in view of the fact that long-term care has generally been developed and is managed at local and regional level (United Kingdom, Spain, Sweden). Similar objectives may be set in framework agreements between insurance companies and providers of long-term care services, as is the case in Germany.
The provision of long-term care services can be integrated by means of single points of access or territorial assessment teams integration (the Netherlands, United Kingdom), or through the decentralisation and integration of services at regional and local level (United Kingdom, Spain, Sweden). Many countries have initialled (Belgium, Finland, Germany, Spain) or are in the process of drawing up (Latvia, Malta, Poland, Hungary) agreements to integrate the provision of long-term care services and to secure the continuity of care.

There are various examples of countries that bring the financing of long-term care in line with components of healthcare and social welfare:

- Austria: has integrated the allowances for formal and informal long-term healthcare;
- Germany: has introduced comprehensive insurance programmes for long-term care to provide support to formal and informal care providers;
- The United Kingdom: Most of the funding for social services is devolved locally, and hospitals can ask local authorities for contributions in cases where a patient cannot be discharged because there are no long-term care services;
- Spain: has coordinated the regional funding for social and healthcare services;
- Sweden: has integrated the municipal funding for care for patients with acute conditions and for long-term care.

Other initiatives include policies to improve the coordination of care, especially between healthcare and social welfare budgets (France, Ireland, Latvia, Luxembourg, Poland, Portugal, Spain), and plans for joint mechanisms for ascertainment and assessment by multidisciplinary teams so as to

determine which care programme to adopt (Belgium, Denmark, Estonia, Finland, Germany, Ireland, Italy, Latvia, Portugal, United Kingdom, Slovakia, Spain, Sweden).

An important aspect to be given careful consideration is that care, whether provided in the field or in a public facility, is a labour-intensive sector, where labour costs account for the largest share of the expenditure.
Attracting the "right" personnel, especially in view of the medical competencies and social sensitivities required, is one of the main concerns of the authorities, which have to take into account the shortage of qualified labour force. Training becomes a key and decisive factor, particularly important when developments in medical and technological knowledge require an almost constant updating of the skills and qualifications of the labour force.
Long-term homecare gives rise to several concerns, as it is generally provided by family and friends, who often lack specialised training.
Faced with such deficits, many Member States (France, Lithuania, the Czech Republic, Spain and Sweden) have introduced policies to boost the number of people who wish to go into nursing, to improve training and to offer instructional programmes for healthcare and social welfare professionals in order to meet the rising demand.
Other countries (Estonia, Latvia, Poland) plan to improve working conditions and wages to discourage specialised personnel from seeking work abroad.
Informal care providers must be given adequate support that includes information, training, counselling, relief aid, the formalisation of social welfare and financial support. Other forms of assistance are moreover available:

- Financial aid (Austria, Denmark, Estonia, Finland, France, Germany, Ireland, Italy, the Czech Republic, Slovakia, Spain, Sweden, Hungary);
- Tax credits and exemptions (France, Germany, Greece, Luxembourg, Spain);
- Leave to help family members (Austria, Finland, Germany, the Netherlands, Spain);
- Recognition of pension contributions for care providers during care periods;
- Formalisation of the care provider status and inclusion thereof in social welfare systems.

8. National situations

8.1 LOSS OF AUTONOMY IN FRANCE.

The French tradition of care and the fight against dependency

Attention for citizens in difficulty is a characteristic of French legislation, going as far back as 1796 with the creation of the "bureaux de bienfaisance" (welfare bureaus). This characteristic has not been lost through the years: there are numerous laws down to the present day that establish and regulate the organisation of social work in France. For our purposes, Act no. 647/2001 stipulates that every older person aged at least 60 residing in France, who has difficulties in dealing with the consequences of the lack or loss of self-reliance because of his or her physical or mental state, is entitled to a personal allowance in consideration of the individual income, to enable them to meet their needs adequately.[4]

[4] Although it does not define dependency, French legislation (Act of 11 February 2005 on equal rights and opportunities, participation and citizenship of persons with a disability) provides a definition of disability: "For the purposes of this piece of legislation, disability shall refer to any limitation of activity or restriction of participation in society experienced by a person owing to a lasting or definitive alteration in one or more physical, sensory, mental, cognitive or psychological functions, polyhandicap or a debilitating health disorder."

This allowance is granted under the same conditions throughout the national territory and is intended for people who, the care they are receiving notwithstanding, need help to carry out essential activities of daily living or are in such a state as to require regular supervision.
France uses the "*Autonomie Géronotolie Groupes Iso Resources*" (AGGIR), an application that takes into account different variables such as coherence, orientation, personal needs and communication, to classify patients into a scale of essentially six different degrees of dependence.

1. GIR 1 – People confined to bed or chair, who have lost their mental, physical, movement and social independence, and require continual care;
2. GIR 2 - Composed of two sub-groups: first, those confined to bed, whose intellectual functions are not totally affected, but who require assistance for most activities of daily living; second, those with affected mental functions, but who retain their ability to move around;
3. GIR 3 – People who have retained their intellectual faculties and part of their ability to move around, but who require assistance several times a day for their physical needs;
4. GIR 4 – People who require help with washing and eating, who cannot get dressed on their own, but who have no problem in moving around in their own home once they are up;
5. GIR 5 - People who are capable of eating, getting dressed and moving around on their own. They may need specific help with washing, preparing meals and doing housework.
6. GIR 6 – People who have not lost their autonomy for ordinary activities of daily living.

Only people classified between GIR 1 and GIR 4 can qualify for the *"Allocation personnalisée d'autonomie"* (APA) [Personal Care Allowance]. People classified under GIR 5 and GIR 6 may qualify for social welfare from the old-age insurance funds modulated by the person's so-called *ticket modérateur* or own contribution depending on his / her income and for assistance by communal complementary retirement funds (CCAS – communal centre of social action). For GIR 5 and 6, two new variables have just been examined: moving outside and use of means of telecommunication where needed.
The Act of 30 June 2004 has introduced a number of amendments to the legislation establishing the APA, creating a new regulatory organisation for the "*Caisse nationale de solidarité pour l'Autonomie*" (CNSA) [National Solidarity Fund for Independent Living] which has been able to show its importance and efficacy on several occasions.

Funding and allocation of resources

The funds for financing such policies come from various sources: from the health insurance and social security fund, from generalised solidarity contributions and the contributions for old-age insurance of the CNSA.
Although an equal allocation had been planned (50% by the State and 50% by the Departments), in reality 1/3 of the funding is assumed by the State and 2/3 by the Departments, which are experiencing difficulties in coping. Given the particular financing procedure, it is difficult to reconstruct the amount of the overall funding. State funding in the last four years has grown from €13.986 billion in 2006, to €15.2 billion in 2007, €17.09 billion in 2008 and about €19 billion in 2009.
These sums are attributed directly to the beneficiaries and to their guardians in case of homecare, and to residential services which provide care in other cases.
An "Alzheimer" plan was launched in October 2008 for a comprehensive approach that should come to a close in 2012. Furthermore, two pieces of legislation for personal social services (for all age brackets, including older people) were adopted in 2005 and 2008.
These measures are nonetheless still considered insufficient to deal efficiently with the problem of dependency.

A very interesting reform project is that known in France as the 5th risk, by reference to an article of the French social security code, but which has had difficulties in coming into being, probably because private insurance companies got wind of problems relating to dependency.
The efficacy of the measures is assessed solely at County Council level, which also makes the final decision about the pertinence and adequacy of the aid allocated. The results of the overall efficacy of the system (pertinence and application of the legislation, difficulties or hindrances of the care and guardianship system) on the other hand will be evaluated by the trade unions, associations and the "*Comité national des retraités et personnes âgées*" (CNRPA) [National Committee of Retired and Older People] established in the Ministry of Labour, the Family and Solidarity.

Structure of the legislation and prospects for reform

There is no legislation foreseen in France at departmental level to tackle the loss of autonomy.
Care for the loss of autonomy is currently being reorganized in France as part of ongoing reforms: Law on Hospital, Patients, Health, Regions (HPST); Reforms of local authorities; 5th risk.

Currently, who pays for what?

Among the costs borne by the dependent elderly and persons with disabilities, there are:

- medical care reimbursed by the health insurance and "*mutuelles" [mutual insurance societies];*
- costs related to the loss of autonomy (home services, adaptation of apartment or vehicle ...) supported in part by the CNSA (National Solidarity Fund for Autonomy) via APA (Personalized Autonomy Allowance) for persons aged 60 years and older with a loss of autonomy. The amount of APA varies depending on resources and the degree of dependence. For the handicapped, there is a PCH (Disability Compensation Benefit).
- costs of accommodation and food paid by the people themselves and their families. The non self-sufficient elderly who do not have sufficient resources can benefit from social assistance to pay their living expenses. People with disabilities receive the Disabled Adult Allowance (AAH) calculated according to the household income (capped at € 628.10 per month in 2009). Those who cannot work may receive additional resources (€ 179.31 in 2009) under certain conditions.

Example: The average costs in a senior residence amount to € 90 per day:
- € 25 for the care,
- € 15 € if the person is dependent, The own contribution of the dependent person is on average € 5 per day
- € 50 for the accommodation at the person's own cost.

What are the resources of the CNSA and how is it managed?

The C.N.S.A. (National Solidarity Fund for Autonomy) is a public administrative institution under the supervision of the national ministry responsible for seniors and persons with disabilities and of the Ministry of Budget.
All credits to offset the loss of autonomy due to age or disability are centralised in this body.

Its resources, which amount to €15 billion come from credits granted by:

- **The health insurance**, € 12.6 billion being used for the operation of facilities and services for persons with disabilities and elderly persons.
- **National Solidarity**:
  - 100% of the Solidarity Contribution for autonomy (National Day of Solidarity)
  - and 0.1% of the generalized social contribution (CSG) (which is a tax)

- **Contributions to pension insurance funds.**
  The collection of funds is therefore centralized by contrast to its management, which is based on proximity and personal assistance.

How the funds are collected

C.S.A. (Solidarity Fund for Autonomy), CSG and contributions of old age insurance funds contribute to the financing of:

- Individual aid to the person:
  – Personal autonomy allowance for the elderly (APA),
  – Compensation for persons with disabilities (PCH)
- The operation of departmental homes of disabled people (MDPH),
- Aid for the modernization of services to the persons,
- Actions, studies and research in the field of loss of autonomy,
- Operation of the C.N.S.A. (0.1% of total budget).

The C.N.S.A. attributes to the prefects of the department grants to schools and medical and social services on the basis of their priorities earmarked in a regional planning document (the PRIAC) and of the national priorities.

Funding for individual grants is subject to a payment by the CNSA of monthly allocations to the General Councils according to criteria defined by decree. The competitions for people with disabilities are administered by the departmental homes of handicapped and those in favour of the elderly are managed by the social services of the General Councils.

Reform prospects

The whole system in operation in 2009 is likely to be consolidated, although some minor adjustments will probably result from the implementation of recent laws or planned legislation. By HPST law (Hospital Patient Health Regions) of **21st July 2009**, the ARS (Regional Health Agencies) are required to coordinate the hospitals, general medicine (general practitioners and specialists) and **medical-social sector** (nursing homes, EHPAD - retirement homes for depending elderly).
A draft law on the reform of local government is currently under review and could change a number of competencies in maintaining close personal assistance.

Finally, the French President has announced decisions on the management of the 5th risk "by the end of 2010"

Three sources of funding are considered by the Government:

- **National solidarity** should remain the main pillar. The establishment of a mission to examine ways of improving mechanisms of financial equalization between the departments in charge of financing expenditures in management of dependence should be mentioned. The proposals of this mission are expected in mid-April 2010.
- **Family solidarity** is also encouraged and supported "without hesitating, as the minister put it, to ask such questions about the role that heritage can play in contributing to this support".
- **The individual and collective welfare** would be promoted, that is to say that the French could (or would be obliged to) insure against dependence, "reliable and approved contracts". "All innovative solutions in insurance, like a public-private partnership, will be welcome. "

8.2. LUXEMBOURG AND THE FIGHT AGAINST DEPENDENCY

The population that avails itself of social services against dependency represents about 2% of the total, although no "certain" figure can be provided given the lack of coordination for centralised data and the plethora of administrative authorities concerned by the problem.
According to the PSELL-3/2005 report of CEPS/INSTEAD on poverty in the Grand Duchy of Luxembourg, it is not always enough to protect against poverty or to resort to social welfare, especially among regular workers, since 22% of this category of workers are in such a situation, and among workers under contract for a specified period.
The same report draws another interesting conclusion: the risk of poverty is often transmitted between generations and the person who had financial problems during his or her adolescence is more often exposed to the risk of poverty once s/he becomes an adult. Family income should at any rate be considered when assessing the risk of dependency.
The need for assistance from a third person with daily activities must moreover be at least 3.5 hours per week and must be of a lasting or irreversible nature.
Social protection in the Grand Duchy of Luxembourg is focused on providing supervision, especially for the types of problems covered by social security in the strict sense.

For our purposes, two aspects should be considered:

1. Care and social welfare assistance under the auspices of the National Solidarity Fund;
2. Insurance against dependency, that provides assistance for dependent persons.

As regards the first point, it is worth bearing in mind that social welfare assistance is an expression of national solidarity and that it is not provided in counterpart to contributions, but is based solely on individual need.
Social welfare assistance consists of help provided by the public authorities to people with insufficient resources. The social welfare offices established in every municipality in the country are in charge of managing benefits for the poor and the distribution of assistance.

The National Solidarity Fund is in charge of the following services:

1. Old age care. Aid is provided to people cared for in facilities for an unspecified period who do not have personal resources to assume the costs of the accommodation sector and personal needs, and is paid directly to the host facility.
2. Heating allowance – Replaced, as of 1 January 2009 by the "cost of living" allowance for low income families.
3. The "cost of living" allowance granted, upon request, to low-income families, in accordance with the terms and conditions laid down by the relevant regulations.
4. The special allowance for persons with a disability pursuant to the Act of 12 September 2003.
5. Minimum Guaranteed Income (MGI). The amount of the MGI is fixed in accordance with the composition of the household. A person is considered as a member of a household if he or she is:
   - Living in the family of his or her descendants;
   - Adult with disabilities living in the family of his or her descendants, or brother or sister;
   - cared for out of pity.

The MGI varies in accordance with the composition of the household, the age of the members of the household, and supplements are provided for physical disability.

The different sums, with a basic index of €702.29, are: :

1198.67 €	First person
599.34 €	Second person
109.00 €	For infants
460.29 €	Supplement for disability

The main legislation stems from the Act of 19 June 1998, amended by the Act of 23 December 2005, governed by the social insurance code, a new branch of the compulsory social insurance.
Dependence is defined as "the state of a person who, owing to a physical, psychological or mental illness or a defect of a similar nature, has a serious and regular need for assistance from a third person with his or her daily activities." These include the following sectors: bodily hygiene, nourishment and mobility.

The benefits provided by dependency insurance are as follows:

- help and care with daily activities, bodily hygiene, nourishment and mobility;
- help with household chores;
- support activities geared above all to maintaining the beneficiary's self-reliance for daily activities, but also to guaranteeing planned individual assistance (ergotherapy sessions, physiotherapy, psycho-social support, homecare, supervision) or group activities (attending a daily psycho-geriatric centre, care in a day centre for the disabled, group activities in a facility);
- Training for daily life activities (to prepare the person to perform such activities independently) and advice for family members (helping to help without harming or being harmed);
- Aid and care products;
- Technical aids made available free of charge for the time needed (appropriate bed, wheelchair, chair lifts, lifts, etc.);
- Adaptations to the house to promote personal independence at home (adaptation of a bath, widening of doors, installation of ramps, etc.);
- Assumption of social contributions of those who take care of a dependent person.

When a dependent person receives assistance at home, the benefits in kind, i.e. those provided by a professional service, for daily activities and household chores, may be partially converted into a benefit in cash, which the beneficiary may then use to remunerate persons providing care; the two benefits can be combined.

Finally, there are other forms of assistance for persons who are not completely dependent, or who are below a certain income threshold. By way of example:

- The social fare;
- Contribution by the national solidarity fund towards the cost of old age care;
- Socio-educational advice and support.

Financing and assessment of the system against dependency

The financing is provided through contributions amounting to 1.41% of all income from work and from assets of working and retired people. There is also a contribution from the electricity sector. The State assumes 45% of all expenses. The tripartite committee of 2006 fixed this contribution at €140 million (This provision was to be revised at the end of 2009).
All the persons insured and members of their family are entitled to the benefits in case of dependence and can receive them independently of their income.

Table: Dependency insurance current revenues and expenditures as of 2004 (in millions of euros).

	2004	2005	2006	2007
Current revenues	317,5	380,1	379,7	472,9
Current expenditures	334,0	390,9	396,6	424,9

The Evaluation Centre (NCO) is a public service under the auspices of the Minister for Social Security. Composed of doctors, nurses, psychologists, therapists and welfare workers, it evaluates the need of the persons who request services and defines the benefits to which they are entitled.
The Luxembourg system has consequently not opted for a classification of persons with dependency, but for an individual assessment, based on care and aid requirements.
The particularity lies in the fact that all help and care taken into consideration for dependent persons are also established as of a lasting nature; the sum of the terms of the actions undertaken is an objective measurement of the dependence and defines the basis for the payment of benefits, the reference for the threshold and the various maximum levels of benefits.

The Evaluation and Orientation Centre has other missions, such as to:

- Propose rehabilitation or readjustment measures as and when necessary;
- Provide information and advice on all authorities represented;
- Check the quality of the services provided;
- Make sure that the services provided meet the needs of the dependent person.

To be able to operate within the framework of dependency insurance, providers of such insurance must undertake to provide dependent persons all the care and aid specified in the programme through its own staff or by subcontracting with another provider.
The law recognises four types of providers depending on the state of the beneficiary's health and the need to keep the person with a disability in his or her own home. New technologies such as bracelets and the implant of devices for persons with disabilities are also used.
The costs and the services are on a flat-rate basis. The municipalities contribute part of the expenditures for low-income people, and in certain cases assume such expenses in full.
The National Health Fund assumes the expenses for wheelchairs, walking frames, and lift beds on prescription.
Dependency insurance benefits and services are paid for directly to the provider of care and aid, unlike benefits in cash which are paid directly to the beneficiary.
The monetary value of the benefits is negotiated annually between the organisation that manages the dependency insurance and the organisation that represents care and help providers.
Certain associations operate in the sector as well. ADAPTH is an association that provides help and advice to dependent or disabled persons and supplies the technical means needed to adapt their homes.
Initially, qualified staff are hired and specific equipment for the recommended solution rented for a trial period before proceeding to acquisition.
There are good prospects for development in this sector: the projects of the "*Ambient Assisted Living*" programme are supported by *"Luxinnovation"* and the National Research Fund.
Dependent persons can be assigned permanent places in Centres as well as stays with periodic returns home, according to doctor's orders.

Organisation of dependency insurance

Dependency insurance is managed by the National Health Fund, which also manages the health services.

The National Health Fund assesses and decides on the individual instances and manages the dependency insurance budgets. The opinions on the attribution of services, supplies and quantifications are given by the Evaluation and Orientation Centre.
There is also an Advisory Committee composed of representatives of the insurance beneficiaries, of providers, the social partners and the managing organisation. It gives opinions on:

- Instruments of the anti-dependency measure, i.e. the evaluation questionnaire and the survey of care and assistance;
- Experimental actions to be conducted under dependency insurance, for the benefit of certain specific groups;
- A list of technical aids to be assumed with dependency insurance.

A Committee on the Quality of Benefits, set up by the legislator to address a widespread requirement, is in charge of defining quality guidelines and standards for all dependency insurance benefits and services. As already mentioned, this quality is controlled by the Evaluation and Orientation Centre.
Quality shortfalls may be sanctioned by the Supervisory Committee which is in charge of dealing with disputes that may arise between the managing organisation and the providers. The law provides for a periodic conference of the Ministers responsible for the Family, for Health and for the Budget, organisations operating in the health sector, the family and social work, as well as representatives of dependent persons. Convened by the minister for social security, it examines the operation of dependency insurance, the care and help networks, and the facilities, and makes proposals for improvements.

Conclusion and future government initiatives

The national trade union confederations in Luxembourg are the supporting pillars of social security in general. They are actually represented in various committees, directorates and different social security boards of directors, and can therefore exert influence on the decisions of these bodies.
The new government programme provides for a certain number of initiatives such as the transposition of the UN Convention on the Rights of Persons with Disabilities to guarantee their integration in society and the world of work.
The government will moreover extend, according to social criteria, the allotted services to older people, in particular to finance local services, improve their quality of life, and thus help to keep them at home.
Subsidiarily, there are plans to promote and develop new forms of accommodation and for the creation of hospital service facilities specialised in assistance for older people.
In conclusion, the government intends to introduce a bill to safeguard the rights and obligations of patients, and make it possible to create and manage complaints from patients, whilst establishing a mediation authority to deal with any patient complaints.
At times of economic difficulty, social security assumes a stabilising role by maintaining the purchasing power of a significant segment of the population and by guaranteeing employment and an income for people in the health sector and, above all, long-term care for dependent persons. The main strategic lines should be to:

- Guarantee the long-term viability of dependency insurance;
- Anticipate the future risks derived in particular from demographic developments;
- Improve the coordination of care through the homecare sector, the acute in-patient sector and the long-term care sector;
- Promote the quality and organisation of a benefit control system;
- Provide transparency in the financing of long-term care services.

This leads to a need to improve transparency in dependency insurance benefits and the price of the accommodation and housing sector. The aim, however, is not to reduce the volume of dependency insurance intervention, but to redirect, redefine and organise better the benefits as regards the minimum guaranteed income.
The government will proceed to revise this legislation which constitutes an uncontested pillar of the social protection system in Luxembourg.

8.3. DEPENDENCY IN ITALY

The context of social security and social welfare and the fight against dependency

Like the other European welfare systems, the welfare system in Italy is vested with ample processes for revision on the cultural and the economic and financial fronts. This has entailed a considerable delay in providing appropriate and homogeneous responses to the "third and fourth age" phenomena in the entire national territory.
It can be generally argued that social security is guaranteed through contributions paid by workers and public and private employers during the working period of each citizen. Social security includes healthcare through services provided by the National Health Service (Act no. 833/1978) and included in the Essential Levels of Care.
The social security system in Italy is governed by Act 328/2000, which is the first framework law for an integrated system of social welfare and services. Although it vests the State with powers to plan an integrated system of social services, it requires the regions, the local authorities and the municipality to implement it by developing area plans.
Public care services consist of: *a)* residential services (social care centres and social welfare centres) *b)* semi-residential services (day centres), *c)* homecare services (social homecare (known by the Italian acronym "SAD") and integrated homecare (known by the Italian acronym "ADI"), *d)* cash benefits (helplessness allowance and care allowances) and *e)* financial assistance for private care.
Against this background, public care services provided to dependent persons are still lacking. More specifically, the expenses incurred by Italian families in 2008 to provide care exceed the expenditure allocated by the State in 2007 for the helplessness allowance: 0.59% of GDP compared with 0.54%. The health component in public spending allocated to those aged over 65 represents 0.46% of GDP, while the municipal component comes to 0.12% (2007 data).
The legal framework on dependency is characterised by gaps, because although it provides a specific fund for dependency, laid down by article 15 of Act no. 328 of 2000, no national legislation has yet been approved to define and to indicate the characteristics of this concept.
In fact, dependent persons are assessed using scales, charts, health test, social health tests, etc., which are governed by different legislation and measures that are difficult to consolidate and centralise.
The existence of several mechanisms in Italy for assessing the need for care and for deploying responses (e.g. the National Social Welfare Institute is responsible for determining disablement and granting the helplessness allowance; access to health services is through the local health centres; social services are provided through the municipalities) currently stands in the way of aligning the provision of contributions with that of the other services.
One possible desirable solution could lie in the approval of a bill introduced by popular initiative in 2005 by the trade unions of retired people.
Although not approved, the bill has nonetheless succeeded in resurrecting the issue. With the advent of the current government to office, the problem of no legislation and no adequate resources for dependent persons -- which has been raised repeatedly by trade unions and brought to the fore by the recent demonstration this last June – has still not been addressed.
Only at the territorial level have some regions and provinces enacted specific legislation on dependency and have they provided a precise definition thereof, e.g. the law enacted by the autonomous

province of Bolzano, which, in article 2, defines dependent persons as follows: "*For the purposes of this legislation, the term dependent person refers to a person who is incapable, to a considerable and permanent degree, owing to illness or physical, psychological or mental disabilities, to carry out daily activities, e.g. eating, personal hygiene, excretory functions, mobility, psycho-social life and household activities, and therefore requires regular assistance from another person for more than two hours per day; whilst considering the possibility of improving the personal self-reliance of the applicant by using technical aids.*"
The intensity of the care and the allocation of resources are commensurate with the degree of dependency recognised by the multi-dimensional committee.

Care is needed in the face of the following requirements:

a. At least a diagnosis of a disease/disability that entails considerable dependency;
b. A functional limitation due to at least one of the profiles a) to e) indicated in article 2 of the dependency act;
c. The functional deficit should be considerable and permanent;
d. The act on the provision of care services for dependent persons indicates four possible levels of care on a chart, and more specifically:

- Level 1: when an overall need for care of more than 60 to 120 hours per month is recognised;
- Level 2: when an overall need for care of more than 120 to 180 hours per month is recognised;
- Level 3: when an overall need for care of more than 180 to 240 hours per month is recognised;
- Level 4: when an overall need for care of more than 240 hours per month is recognised.

In the final analysis, there is no plan to fight dependency, although such a plan was provided for in part by article 18 of Act 328/2000 within the national plan for social welfare and services and the subsequent Healthcare Pact.
The responses to this phenomenon tend to be regional: a "dependency fund" and implementing regulations have been introduced in only 10 regions, but there is no national legislation or system of reference.[5]
The legislative programming and guidance legislation is actually part of the National Health Plan. The regions can legislate and define resources, whilst for their part, the municipalities proceed to the management and provision of benefits and services.
The National Health Plan is not legislation, however, but action taken by the Ministry of labour, Health and Social Policy.
Conversely, the Regional Health Plans or the plans to fight dependency adopted by certain regions are legislative in form.

Financing and use of the funds

Economic intervention for the benefit of dependent persons was provided for the time by the Finance Act 2007 (Act no. 296/06) and then in the subsequent budget acts. This aid is allocated per region on the basis of certain indicators, and integrated in all the regions and in certain cases also in the municipalities, especially the larger ones that have their own funds.
As of 2007, the funding has amounted to €100 million for the first year, €300 million for the second year and 400 million for 2009.
Italy allocates 1.13% of GDP in social protection as follows:[6]

[5] In particular Emilia Romagna, Lombardy, Tuscany, Piedmont, Friuli Venezia Giulia, Veneto, Lazio and the Province of Bolzano, Sardinia.
[6] Government accounts 2009.

a. Health component: 0.46% (for health and rehabilitation services and nursing homes);
b. Helplessness allowance, allocated directly to the dependent person: 0.54%;
c. Local authorities' component: 0.12% (with a mixed composition between services and support for the dependent person);
d. Support for the family to provide care: 0.59.

Articulation of the actions and prospects for reform

As there is no appropriate organic legislation to tackle dependency in Italy, actions on this front are entrusted to the local authorities which provide services (e.g. day semi-residential centres) or carry out socialisation activities, such as social centres for older people and occupational therapy. In the same way, the inspection of services and benefits provided obviously reveals critical situations throughout the national territory. Monitoring is carried out by the National Agency for Regional Health Services (known by the Italian acronym 'AGENAS') only in certain more organised instances (cf. Province of Bolzano, Veneto, Emilia Romagna, Piedmont and Tuscany). An interesting example is provided by the social budget for the third age in Emilia Romagna which is being used as a model to chart similar courses in other regions.
The legal framework, organisation and quality of the services provided are deemed deficient, non homogeneous and non organic due particularly to a lack of a legislative system to ensure coherence and integration for the actions and enable all dependent persons to assert their rights.
Legislation that examines and solves the problem from every aspect should not be postponed any longer: definition, beneficiaries, resources and funding, services and efficacy of the action, even if this means starting again from the proposal made by the trade unions.

8.4. ANTI-DEPENDENCY SYSTEM IN ROMANIA

In Romania, Act no. 448/2006 on the protection and promotion (or emancipation) of persons with disabilities provides and regulates the system for tackling dependency -- even if, as can be expected, the Romanian system, like those of other European countries, does not seem to be capable of covering the new risks stemming from emerging social problems.
The same law defines persons with disabilities as persons who, owing to a physical, mental or sensory ailment, are unable to carry out daily activities, and require protection and support measures for recovery, integration and social inclusion.
The law considers many types of disability, ranging from physical to mental or psychological, or to disability relating to a sensory deficiency such as sight, hearing, or inability to speak; or even certain contracted diseases such as HIV/AIDS, or relating to some form of rare illness or disease. Each of these sensory alterations within the meaning of the law can occur in different forms, measured on a scale from slight to intermediate, pronounced and serious.
An ad hoc committee called the Committee for the Assessment of Adults with Disabilities is in charge of assessing adults according to different types and degrees of disability.
In Romania, all actions relating to care for dependent persons, as well as the management of funding for dependency are still the prerogative of the national system.
Within the meaning of Act no. 448/2006, persons with disabilities who apply to be integrated or reintegrated in a job, are entitled to free assessment and career guidance in relation to age, type and degree of disability. The same law provides financial aids for families of persons with disabilities. For example, families with a child/adult with serious disabilities receive a monthly allowance equal to 1/3 of the national minimum wage, and a personal supplementary budget equal to 15.1% of said national minimum wage. These benefits can come down to 27.6% and 11.3% in the case of beneficiaries with pronounced disabilities; in the case of intermediate disabilities, the beneficiary is entitled only to the personal supplementary budget at a rate of 5.58%.

Persons with serious disabilities, established on the basis of an assessment that takes medical, psychological and social aspects into account, are entitled also to a personal helper.
Families that have children with serious disabilities can apply for a personal helper or a monthly allowance equal to the national minimum wage.
The legislative system for providing care to persons with disabilities should be improved and an important step, in anticipation of a more in-depth discussion, could be the ratification of the Convention on the Rights of persons with Disabilities.
The National Authority for Persons with Disabilities therefore plans to include a proposal in its programme in the near future to overhaul the entire system for fighting dependency. Given the importance of the issue, this proposal can only be preceded by an extensive discussion open to all institutions, organisations and associations interested in the problem.

8.5. THE FIGHT AGAINST DEPENDENCY IN SPAIN

The Spanish social security system and the system of caring for dependent persons

Spanish social security legislation provides for the following benefits and services:

- Free healthcare for retired people;
- Help at home;
- Non-contributory pensions;
- Unemployment benefit
- Tele assistance services
- Day centres
- Residential services

The recent Spanish legislation on the matter defines dependency as a permanent situation in which persons find themselves owing to age, illness, and disability due to the lack or loss of physical, mental, intellectual or sensory autonomy, and thus require care from another person or persons, or sizeable help to carry out daily activities or, in the case of persons with intellectual incapacity or mental illness, other support for their personal autonomy.
Act no. 39 of 14 December 2006 on the promotion of personal autonomy and on care for dependent persons, stemming from a proposal of the UGT made to the government and accepted by all the political groups in parliament, provides for different degrees of dependency:

- Degree 1 – moderate dependency
- Degree 2 – severe dependency
- Degree 3 – serious dependency

with two levels within each degree (1 and 2).
The purpose of the law is to pay full attention to dependent persons in all aspects and circumstances of their environment. It provides for appropriate means for prevention, rehabilitation, as well as social and mental stimulus. Another important element of the law is the endeavour to keep the person, where possible, in his or her original environment, by calibrating the services to be provided in relation to all his or her requirements and activities. Finally, the law lays down the procedures for coordinating health and social services.
The degree and level of dependency are determined by applying, throughout the country, a single assessment scale approved by the government in a decree of 2007, and the actions to tackle dependency are carried out jointly at the national and regional levels.

Financing of the system and benefits and services provided

The system is financed by both the state and the autonomous local municipalities, with the difference that the first finances the basic coverage for the entire country.
In certain cases, however, the dependent person is requested to contribute to the expenses.
The overall financing in recent years has been as follows: 2007: €400 million; 2008: €678,685,396; 2009: €979,364,617; 2010: 1,160,330,812. A budget of €1,545,425,613 is foreseen for 2011.

The financial benefits provided are:

- **Financial benefits for the dependent person** – commensurate with the degree of dependency and economic capacity, they are attributable under certain ascertained requirements, with the proviso of using them for the necessary services;
- **Financial subsidies to family members** – attributed to family members who take care of dependent persons and who undertake to comply with an information and training programme charted by the social security institutions;
- **Financial benefits for personal care** – to develop the degree of autonomy of dependent persons so as, through personal care and for a fixed number of hours, to facilitate access to the world of work, education and a more autonomous life and the performance of daily activities.

The assessment of the efficacy of such actions is entrusted to signatories of an agreement: employers, trade unions and the government.
The law on dependency is assessed in positive terms by all institutions and by citizens. The law establishes also a series of mechanisms for cooperation between the central government and the autonomous communities, of which the creation of a territorial council for the system for autonomy and care for dependent persons is worth mentioning.

Prospects

A law on dependency is now urgently needed in all European countries. Attention to dependency is the reflex of greater social sensitivity stemming also from improved economic welfare that makes it possible to focus more on problems of human life, including the ageing of the population. It suffices to bear in mind that in Spain, a few years after its enactment, the law on dependency is considered the fourth pillar of social welfare. More specifically, the law has not only addressed the problems faced by persons with a certain degree of disability, but has also had the effect of creating numerous jobs in the long-term care system, quantifiable at 340,000 in terms of direct employment and 160,000 indirectly.
The procedure followed in Spain could be taken into consideration by other countries where legislation on the matter is lacking.
In conclusion, the professionalisation of personnel who provide care and adequate training in cases where the dependent person is helped by family members or by persons with no qualifications are to be considered of fundamental importance. Funding should come from the state, the autonomous communities and from the beneficiaries in accordance with their ability to pay, so that care can be provided to dependent persons for the entire duration of their illness or disability.

8.6. CROATIA AND THE SYSTEM AGAINST DEPENDENCY

The Croatian welfare system

The welfare system is governed by the Social Welfare Act which entered into force on 1 January 1998 to meet the basic daily requirements of people who, owing to unfavourable personal, economic,

social or other circumstances, cannot see thereto on their own or with the help of members from their family. The law distinguishes two groups of users:

1. The first group is composed of private individuals without personal income or income lower than the minimum level prescribed by law which is insufficient to meet their basic needs;
2. The second is composed of users who get assistance for needs caused chiefly by disability, old age, mental illness, etc. This group includes also children and young people without sufficient family care or with behavioural disorders or who are victims of violence in the family.

According to the relevant legal provisions, social welfare is financed by the city and the municipalities. Nevertheless, the general budget includes the financing of all the standard general welfare entitlements other than housing and food allowances. The decentralised governmental structures may, through their own resources, finance social services beyond the standard level guaranteed by the law, or recognise completely new rights/benefits/services.
The amount of all the financial benefits granted by the Croatian welfare system is calculated as a percentage of a minimum wage determined by government decision. This basic minimum amounts to 500 kuna at this time (€68).

The legislation provides for the following forms of assistance and subsidies:

1. Permanent assistance for persons with serious disabilities by providing different amounts depending on age and household composition;
2. The entitlement to aid for expenses relating to housing covers rent, electricity, gas, food, and comes to a sum up to half of that provided for permanent assistance.
3. The allowance for care and assistance which, depending on the state of health, recognises a right to a reduced or full amount for users.
4. Help at home is recognised for those who, owing to physical or mental ailments or other permanent disabilities, need such help and care from other people (this service is subordinated to income and the ability to organise such care in areas where dependent persons reside).
5. The right to a personal disability benefit is a financial annuity for persons with a high degree of disability. Different amounts are provided in this case too, and paternity/maternity leave or reduced working time is accorded to the parents of children up to 7 years of age.
6. A special authorisation is granted to unemployed persons with disabilities for as long as no change occurs in their employment situation. This is calculated at 70% of the basic rate (€48).
7. The condition of the parent that provides care for his or her own child is introduced as a new right by the Law amending the HealthCare Act (2007) for the benefit of a parent in cases where, under medical prescription, said parent is capable (or trained so as to become able) of carrying out certain technical and medical procedures in order to provide specific care to his or her own child or, in exceptional cases, when a child depends fully on parental care.
8. Care outside the family. Care outside the nuclear family is a residual possibility, in the sense that it is recognised only in cases where the person and his or her family cannot be considered beneficiaries of other forms of welfare assistance, or when such type of care is deemed more useful for education, training, rehabilitation, etc.
9. A subsidy may moreover be granted to a single person or a family which, owing to material difficulties, are not capable of meeting certain specific needs relating to the birth and upbringing of the child, illness or death of a member of the family, the acquisition of basic necessities for the family such as clothes, shoes, etc. The maximum amount is five times the basic minimum rate, i.e. €342. If the amount exceeds this limit, authorisation from the competent ministry is required. This subsidy may be granted in cash or in kind.
10. Advice and support to overcome temporary difficulties. This service includes the systematic and planned support to overcome various difficulties such as illness, old-age, death of a family member, childhood problems, disability or treatment for long confinement.

The Social Welfare Act stipulates that the right to welfare benefits may "be granted to a person who, owing to physical or mental disability, permanent change in his or her state of health, or old age, has urgent need of permanent help and care from another person because he or she is not capable of carrying out daily activities."
The care or support benefit is provided in full or reduced amount in the presence of another person that can take care of the dependent person. In Croatia, however, there are also specific health prevention programmes.
The Croatian system includes health prevention plans that stipulate rules and procedures for dealing with dependency.

Organisation and financing of plans to fight dependency

Most of the funding needed for actions to fight dependency is assumed at national level, and more specifically the Ministry of the Family, Veterans and Intergenerational Solidarity; at the local level, the regional units and even the cities and municipalities step in according to their own programmes, needs and possibilities.
As there is no single budget, it is not possible to quantify the financial resources used to fight dependency. One indicator could be the number of users which, in the last three years has gone from 72,550 in 2006 to 76,872 in 2008.
The funds are provided directly to the people who are eligible for the care and support benefit.
There are no codified assessment and verification procedures at this time, but permanent inspections exist, are planned and carried out on subsidies granted by the competent offices and authorised by national, regional and local self-government; citizens have access to all information and, naturally, are entitled to lodge complaints and appeals.
Of particular importance has proven the action of civil society organisations in Croatia which are making a proactive contribution to correct and to improve services geared to the elderly and to persons with disabilities.
There is no legislation, other than that at national level; nevertheless, every regional and local self-government unit may, within its purview and responsibility, adopt such a strategy, action plans and relevant funding as it deems more appropriate for policies to fight dependency.
The "care taking" Act (literally "adoptive care") (Official Gazette Narodne novine No. 79/07) for meeting the basic needs of a person is worth bearing in mind. Based on the decision of the social welfare centre on eligibility, the person that provides the care is authorised to a monthly allowance to meet the needs of the user under care.
The financial benefit, established by contract with the local welfare centres, varies depending on the number of users.

Prospects for reform

The Ministry responsible for social care has in recent years carried out a number of reforms to boost the efficacy of the overall social care system, including the care system for the elderly and for persons with disabilities. The line of inspiration is to rely on the decentralisation of care services for the elderly and for persons with disabilities inasmuch as central social care institutions are being reorganised to improve the quality of their work.
The Ministry of the Family, Veterans and Intergenerational solidarity has adopted the programme to develop services for older people in the intergenerational solidarity system 2008-2011. In this regard, it is pursuing two intergenerational solidarity programmes, i.e. "homecare for older people" and "daily residence and homecare for older people."
The Republic of Croatia has expounded its own commitments to programmes with plans for subsequent developments in the social care system in a pre-accession document entitled "Memorandum on Social Inclusion."

According to the Ministry, the legal framework of the Republic of Croatia as regards care for the elderly and persons with disabilities generally meets the needs taking into account the budgetary possibilities. The reform programmes provide for subsequent improvements, especially the development of services within the Community, by bearing down on decentralisation and other initiatives in a study phase.
Nevertheless, according to the SUH research study, 11.3% of retired persons in Croatia have asked for more homecare, and 34% require continuous care.
As we have already stressed, there are reform plans being pursued on the basis of research studies. A scientific research study conducted by SUH on the state of the health and social welfare of the elderly population in Croatia has shown that 15% cannot meet their expenses, and 2.5% are completely dependent, as they are unable to move and rely entirely on their family. The SUH has proposed many amendments of the legislation in force, especially in order to raise the level of subsidies and to study a national development plan for the protection of older people. Day centres for older people with disabilities should moreover be created, and pensions for persons with disabilities should be improved.
These issues require greater attention from the European Union as well. Such attention should lead to initiatives and programmes for a stronger and more transparent policy for the benefit of dependent persons, with a number of operating guidelines for all the Member States.
Another delicate issue concerns workers in the sector, who work in public services and are mostly women. They are not paid as in the other sectors and have few career possibilities; moreover more continuing training is needed. The competent ministry is counting on an improvement of the economic situation to be able to tackle the current problems and deficiencies as well as an increase in the number of people under care, including subsequent categories.
The assistance provided to the most vulnerable members of society is not considered as a professional career and is often not recognised, as can be measured from the low wages and difficult working conditions. The quality of service is usually very low.
In such a situation, it is not enough to declare that inspections are efficacious because criminal activities are detected, when no one is concerned about dependent persons who stay in their own homes and are exposed to various dangers, such as being forced to sign contracts and being robbed of all their property. Unfortunately, there are indications that some employees in the social care system are involved in such a "business."
Croatia has a very low level of care for dependent persons. By way of example, there are no hospitals that would admit, except for first aid, older people who become temporarily dependent. Furthermore, there are no geriatric departments in hospitals nor any organised palliative care in the country, and the care programme is not really supervised.
The intergenerational solidarity programmes of the Ministry of the Family, Veterans and Intergenerational Solidarity are intended to develop the services for older people within the international systems for 2008-2011, and are geared to additional and institutional forms of care for older people, as can be gauged from the titles of two key intergenerational solidarity programmes: " Care in the country for older people," and "Daily residence and care in the country for older people." Nevertheless, these programmes are actually in an initial phase and still geared to a rather small number of users.
The Croatian government and the European Commission have agreed on the following priorities: an enlargement of the network of social services for children, older persons and persons with disabilities (particularly in small cities and in rural areas); develop an action plan on homecare services for children and persons with disability (to stop the establishment of new institutions, enlarge the alternative forms of providing social services, and to reduce the number of users in social welfare institutions); bring the services as close as possible to the community in which the users live; develop a strategy to decentralise social services, promote choices and the harmonisation between life and work, especially for women, and promote prevention

8.7. UNITED KINGDOM AND THE FIGHT AGAINST DEPENDENCY

The social protection system and dependency

The welfare system in the United Kingdom is based on the Beveridge model which offers certain free universal services, alongside other support, subsidy and care measures.
The sector has gradually witnessed a growth in the weight of the private sector and of volunteers, to the detriment of the public sector, bordering on the regulatory role of the market. This role, however, has proven to be weak and often inefficient.
There is no legal definition of a dependent person in the United Kingdom, but only a few checks to be carried out which, if affirmative, entitle people to receive certain benefits and services. By way of example, access to homecare is granted after a careful assessment of the needs of the person. However, although there are four recognised categories of needs, many service providers currently attend only to those persons who find themselves in the two most extreme categories.
Homecare, however, is paid for by those who though in need, have an annual income exceeding £23,000.

The four recognised categories of need are:

- Critical – in case of danger to life;
- Considerable – when the person cannot carry out most of the personal care activities or domestic chores and there is no other person capable of helping;
- Moderate – when the person cannot carry out personal care activities, household chores, or assume his or her own role in the family or in society;
- Low – in this case, the individual is not capable of performing certain personal care activities and suffers from limitations in carrying out duties incumbent on him or her in the family or in society.

Some benefits not connected directly to the income of users are currently available for those aged over 65, who moreover have a physical or mental disability.
Depending on the degree of disability, these benefits amount to between £47.10 and £70.35 per week.

The two categories are:

1. Low index, in case assistance is required with frequent help during the day for normal bodily functions such as seeing, hearing, eating, etc.
2. High index, when assistance has to be continuous, prolonged, and repeated, including during the night.

How the system functions and prospects for reform

It is difficult to describe the system for fighting dependency in the country, as it is up to the government to determine the general policy, then asking the public territorial entities to see to the administration and effective management of said policies.
This may at times entail variations in the cost, availability and quality of the services.
The government, which is becoming aware of a social emergency for the risk of dependency, recently carried out an extensive consultation to open a discussion on the prospects for revising the system. The study phase should be definitively closed and we are in the phase of specific proposals which are planned for the beginning of this year. Nevertheless, in spite of the quite widespread opinion that the system in the UK is in urgent need of a profound reform, and notwithstanding the fact that all the political parties agree on the need to intervene immediately, in the trade union's opinion no credible changes can be expected before at least 5 years.

The entry into force of a new system could therefore unfortunately be very late to meet the needs of the current elderly population.
The new legislation is to generate a new National Care Service (NCS). The government intends to devise a care system that is fairer, simpler and more usable by those in need of care. This plan should necessarily be supported by laws, rationales and authorisations at the national central level, but answers must be personalised and appropriate as much as possible for the various needs.
Procedures for the financing and provision of benefits and services

Care services are funded through two main sources:
1. General income tax collected at national level;
2. Council tax, collected at local level and from various personal contributions.

The central administration generally allocates the funds to the territorial entity to provide care services in the area for which it is responsible.
For certain benefits and authorisations, the funds are received directly by the beneficiaries.
The social measures and long-term care provided in the United Kingdom can be summarised as follows:

DOMICILIARY CARE

- Around 1m older people receive some form of care in their own home, but around 2.5m have care needs.
- 80% of those in need of care at home do not get it from the state.
- The private and voluntary sector care providers receive around £9.3bn a year in public funding.
- An estimated £5.9bn is spent by individuals on social care either through private contributions or through charges.
- A huge unmet need and care gap exists between the services older people require and what they actually receive because services are being rationed. As a result, only those with high care needs qualify for assistance. This unmet need places an additional burden and strain on many relatives and friends who provide unpaid care (eg. 1.2m men and 1.6m women over 50 are unpaid carers).
- All care in the home is means-tested, and individuals need an annual income of less than £13,000 to receive services free of charge.
- The charges for those with income above this level vary widely depending on each local authority area, thus creating an unfair postcode lottery.

LONG-TERM RESIDENTIAL CARE

- In 2003, out of 500,000 care places, 69% were in the private sector, 17% in the public sector and 14% in the voluntary sector.
- Private care is worth around £6.9bn a year.
- There are around 448,000 care home residents, 60% of which are self-funders.
- 1 in 4 care workers leave their jobs every year and this high turnover is almost entirely due to poor pay and conditions of employment.
- Within care homes, only one member of staff is required to have an appropriate care qualification (but even they do not have to be situated on-site).
- Those with assets (including the value of their property) of more than £23,000 must fund their own care. Those between £13,000 and £23,000 are means-tested and pay a proportion whilst those below £13,000 have their charges paid by their local authority.
- In 2008, the average fees for care home residents across the UK were £34,528 per year for nursing care and £24,128 for residential care.

- The average cost of food in residential care is £3.50 a day.[7][2]
- Nearly 150,000 dementia patients each year are given anti-psychotic drugs unnecessarily. The figure represents four in five of all the people who are being prescribed the drugs in care homes, hospitals and their own homes.[8][3]

CARERS

- 2.8m people aged over 50 provide unpaid care.[9][4]
- Adult children provide their parents with 36 hours of unpaid care each month, estimated at a total annual UK cost of £39 billion.[10][5]
- Nearly a quarter of all carers aged 75 and over (24%) provide 50 hours or more a week of informal care.[11][6]
- The weekly Carer's Allowance is currently £53.10, but is not payable to those carers who are also in receipt of a state pension.

Since the initial draft of the FERPA Comparative Study of Dependency in Member States, the UK government has announced a new set of proposals, which they will enact if they are re-elected. If not, then the incoming Conservative government will have to outline its proposals.

The government proposes to introduce a National Care Service which will be phased in three stages:

STAGE ONE

- *Offer free care at home to around 400,000 pensioners with the most severe care needs from October 2010*

STAGE TWO

- *From 2014 people will receive free care if they need to stay in residential care for more than two years. They will still have to pay for their accommodation*
- *Set up a commission to advise the Government on the fairest and most sustainable way that people can make their contribution to a care system which is free when they need it.*
- *Enshrine in law for the first time nationally consistent eligibility criteria for social care helping to remove the postcode lottery of care that exists now.*
- *Introduce a quality framework including a body to drive up quality in social care.*

STAGE THREE

- *The introduction of a comprehensive National Care Service that is free when they need it for all adults with an eligible care need, funded by contributions.*

In the NPCs view the establishment of a national care service that is universally available to all in need, free at the point of delivery and paid for by all, is a significant step towards ending the era of means-testing and unfairness. A national care service can be afforded if we share the cost across society as a whole and pay for it through general taxation.

However, many older people and their families will not be able to wait until 2016 before they get any help. We must do more and faster to give financial help to the army of carers, improve the regu-

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7 [2] Inside Out, BBC South, 16.11.2009
8 [3] BBC News website, 12.11.2009
9 [4] Focus on Older People, ONS 2004
10 [5] LV Investment Group, March 2009
11 [6] Family Resource Survey 2006/7, DWP 2008

lation and standards of care provided and ensure care staff are properly trained and paid for looking after the older members of our society.

8.8. DEPENDENCY IN AUSTRIA

The Austrian care system

The Austrian social care system is a non-contributory "last resort" element of the social welfare system. There are measures to provide a minimum maintenance allowance in case of need and emergency, which is paid for from the general tax revenue. The main elements of the social care system are disability benefits, care and accommodation centres and cash contributions so that dependent persons can deal with difficulties arising out of their dependence, called *"Pflegegeld"* (long-term care benefit).
There is a legal definition of dependency according to the care needs in Austria known as the *"Pflegegeldgesetze" (Bundespflegegeldgesetz, Landespflegegeldgesetz)*. Different degrees of dependency are recognised and an assessment scale is used for the different levels thereof based on the specific care requirement.
They are defined on a scale of 1 to 7 according to increasing levels of need. Thus, if a dependent person needs more than 50 hours of care per month, he or she is classified in the 1st level of the scale and is entitled to a monthly benefit of €154. The higher the number of hours needed to deal with the care needs per month, the higher the scale, and the higher the monthly benefit will be to meet the needs caused by the dependency. In the highest level of the scale (no. 7), the need for care has to be greater than 180 hours per month and the dependent person must be unable to move his or her arms or legs. The benefit in such a case is €1,665.80 per month.
It is widely recognised that social welfare and the healthcare system are highly developed in Austria (WHO). In particular, there is a great deal of attention on dementia, also because of the increase of this disease in recent years.
There are already government programmes to deal with the impending problem of the ageing of the population, which in Austria (as in the rest of Europe) will increase the requirements for care and assistance.
The government's recent programme has concentrated on measures to finance the increase in requests for assistance and support for dependent persons. Attention is moreover being paid to improving services for dependent persons in Austria so that they meet the same standards in all the regions. The government is moreover setting objectives for measures to reconcile "work and the family" better for persons who take care of dependent members of their family. On the basis of the government's programme, new legislation for free social insurance (pension and health insurance) for people who take care of members of their family has already been enacted (the *Allgemeines Sozialversicherungsgesetz„* (ASVG)).
The recent government programme provides for measures to finance and to deal with the increase of demands for assistance and support.
The institutions, at national and regional/local level, integrate actions, according to their own competencies and responsibilities. "Funding is prevented on a national and local level".

The funding (data for 2008 – 2009 are not available) is as follows:

- For 2005: €1,566.4 million (federal government) and €294 million (states)
- For 2006: €1,621.4 million and €303.6 million respectively
- For 2007: €1,691.5 million and €312.5 million respectively.

The funds are essentially allocated directly to the beneficiaries.

As already mentioned, the government's effort is geared to homogenising the services on the national territory and to make the care more usable through more considerable funds, by balancing more efficiently work with care for dependent members of the family.

Other measures

In addition to the "*Pflegegeldgesetz„* already mentioned, and the "*Familienhospizkarenzgesetz„* which is geared to persons who take care of terminally ill members of the family, there is also legislation on (unpaid) leave. Measures provided by the legislation for "continuous care, 24-Hours-home12" are also worth mentioning.
A family allowance is also provided by law, as is unpaid leave as already mentioned (the "*Familienhospizkarenz*"). There is remuneration only in special funds (from a so-called *"Härtefallfonds„*).
Furthermore, there is a free social insurance (pension and health insurance) for persons who take care of members of their family under the "*Allgemeines Sozialversicherungsgesetz„* (ASVG).

Prospects for reform

A group of experts in the Ministry of Social Affairs is, under the current legislature, drawing up a plan to encourage useful decisions in order to secure the funding and sustainability of the social welfare system in the near future and for the longer term.
In the last legislative period, another group of experts had tabled proposals to reform the "*Pflegegeldgesetz„* for persons and children with psychological problems.
The results of these studies, which focus on the problems of persons, direct the government actions and help to improve the efficiency of dealing with disabilities.
We may conclude, by way of summary, that although well developed, the legislative system that deals with such an important matter, should attend better to the needs of dependent persons and their families, by making every possible effort to make adequate funding available for the actions taken to that end.
There is no lack in Austria of studies and proposals on the phenomenon of dependency, particularly in the field of dementia (*"Demenzhandbuch„, BMSK 2008*) and subsequent studies on how to finance the future needs of a dependent population that is registering continuous growth (*"der Pflegevorsorge, WIFO 2008).*
The Austrian Trade Union Federation (ÖGB) has also presented interesting proposals for reforms, calling for regulations for a better reconciliation of "family and work" for caring family members on the one hand and on the other hand there has to be put a focus on a well-developed-system of professional care with adequate pay and working conditions for the employees. Particular attention should be paid to a project for an integrated approach to the requirements of persons who need care, their family members and professional care providers, to secure working and pay conditions for the latter in line with the sacrifices required of them. The ÖGB has proposed "a *Pflegefonds„* to secure the future sustainability of the system based on other forms of funding and taxation.
In such prospects for reform of interest not only to Austria, but all the Member States, we believe that the European Union could play a very important role by charting a new programme to finance dependency in relation also to the increase of the population concerned. The European Social Fund (ESF) could be used to such end, for instance.
As already mentioned, the working conditions and the level of wages of workers in the sector do not seem to be adequate in Austria, and this problem deserves particular attention. It is necessary, first of all, to bear in mind that professional care is provided mainly by women and consequently the differences in pay between men and women assume an important role. In the final analysis, as women provide care to a dependent member of their own family, the question becomes a gender issue. The right solution must be found for funding that takes into account the requirements of greater social fairness and the sustainability of the entire system.

8.9. DEPENDENCY IN POLAND

The Polish social security system

Social care in Poland is governed by the Act of 12 March 2004 and is organised by the central and local units of the system, in cooperation with organisations such as foundations, associations, the Catholic Church and other churches, religious groups and employees (both natural and legal persons). The social care units are structured as follows:

- In the town and municipalities: social care centres;
- In the poviats (districts) – where family support is concentrated;
- In voivodships – regional social policy centres

The governmental administration at central and regional level moreover plays an important role in the social care system. The regional level is particularly responsible for the assessment of the activities, and the efficacy and quality of the services provided by the units that organise social care in the towns and districts.
The Minister for labour and social policy, who is responsible for the social welfare sector, is in charge of the social care strategy and policies and the development of regulations, and defines the services provided by the units that organise social care, and verifies the efficacy of the measures taken.
Most of the social care services are provided by the social care centres and the district centres for the support of the family. These two centres are responsible for providing the financial benefits or the non-financial assistance.
The regional level sees to the cooperation with social care providers and organisations (e.g. NGOs). NGOs provide a wide range of services such as shelter for migrants, facilities for single mothers, day centres, other support centres and other services.

Beneficiaries

Pursuant to the legislative provisions on care, beneficiaries are persons residing in the territory of the Polish Republic, including foreign nationals who reside and stay in said territory as authorised residents or refugees, as well as citizens of the European Union or the European Economic Area. Social care is provided to persons and families particularly for the following reasons: poverty; orphanhood; homelessness; maternity; unemployment; disability; family hardships, in particular in incomplete or large families; alcoholism or drug addiction; difficulties in reintegrating in society after periods of detention; natural or ecological disasters.
Social care is provided through various forms of benefits: from cash benefits to different forms of non-financial support such as social work, care services, (mainly legal and psychological) aid, training, etc.

The main groups of beneficiaries are:

- Assistance for migrants in the form of shelter, food and clothing;
- The unemployed (benefits in cash, reintegration activities);
- Disabled and dependent persons (care services, social welfare centres, benefits in cash);
- The poor (benefits in cash);
- Older people (care services, social welfare centres, benefits in cash);
- Families and children (benefits in cash, school canteens);
- Victims of natural and ecological disasters (purposive benefit).

The aim of social care is to facilitate the integration and social inclusion of the beneficiaries.

Financial beneficiaries

The Social Welfare Act of 12 March 2004 comprises three types of basic financial aid benefits:

- Permanent benefit;
- Periodic benefit;
- Purposive benefit, i.e. for a specific end.

According to this Act, financial benefits can be provided to persons and to families whose per capita income does not exceed limits set by this legislation.
The permanent benefit is granted to persons incapacitated owing to age or disability, on condition that their income does not exceed the stipulated limits. This benefit is integrated in their income as the difference between the income verification test and the personal income, but in any event no less than PLN 30 per person per month.
The provisional benefit may be granted to persons and families without sufficient income owing to illness, disability, unemployment or other circumstances; the law defines the requirement, scope and duration of this benefit.
The Social Welfare Act moreover provides measures to promote the integration of persons covered by international protection, such as refugees and foreign nationals in particular conditions.
The aid is provided under a specific integration programme agreed with the centre of the poviat for support to the family and foreign nationals, specifying the quantity, scope and form of aid, according to the specific conditions of such persons and their family. Aid is provided during a period that cannot exceed 12 months and assumes the form of benefits in cash, payment of contributions for health insurance and specialised counselling.

Who is it for

According to the Labour Market Act of 24 April 2004 and J.O. of 2008, no. 69, p. 414, a dependent person is a person who requests permanent aid because of his or her state of health or age, and who owing to family relationships or relations is close to the applicant or the person with whom he or she lives in a domestic community. It is a definition of the employment protection sector, but one that cannot be applied to long-term care for dependent persons because of their age, illness or other factors.
Polish legislation provides for long-term services through nursing personnel for rehabilitation in a sustained, continuous and professional manner, with pharmacological treatment, including at home, when hospitalisation is not required; it may moreover include training in the field for members of the family to provide better care to the sick. Long-term care is not planned for persons who require admission to social care centres or the terminally ill. There are various forms of organised long-term care depending on the needs.
The social policy for the elderly is implemented through numerous systems, such as the social security system, the health system, the rehabilitation system, etc.
According to the Act of 12 March 2004 (Dz.U. 04.64.593), social care centres provide persons who because of age, illness or other reasons require help from others, professional nursing services that include help with daily activities, hygienic care, treatment suggested by a doctor and, insofar as possible, contacts with those around them.
Long-term care in Poland is currently provided through two governmental departments: social welfare and social care.
It is based on reciprocal cooperation with institutions that provide health services and in the social care sector, as well as with non-governmental organisations.
The requirements and scope, as well as the rules and methods for the financing of the benefits are governed by the Health Care Benefits Act of 27 August 2004 and the money comes from public funds.

The Social Welfare Act of 12 March 2004 (Dz.U. 04.64.593, as amended) governs the services provided by the social welfare centres. Depending on the beneficiaries, the centres are divided into centres for older people, the chronically ill, the chronically mentally ill, and persons with physical and mental disabilities, whether adults, young people and children.

Organisation and financing

Although coordinated and arranged by the central administration, the actions are carried out by the local institutions under the general framework of social welfare.
The funding comes from the National Health Fund (NFZ), the state budget for medical care, and local organisations under the framework of social welfare.
The funding of care for dependent persons, however, is a very complicated issue that comprises and depends on many factors. By way of example, the financing of accommodation in a care facility is assumed by the National Health Fund (NFZ) for facilities that belong to the public health system and at the same time, entails the payment of a sum by the person concerned, his or her family or the municipality in other cases, depending on the status of the facility. The NFZ moreover covers a part of the expenses for the rehabilitation equipment; another part is assumed by the person concerned and, if the latter has a medical certificate of disability, by the National Fund for the Rehabilitation of the Disabled (PFRON).

The financing is provided to:

- The dependent person (allocation or benefit for care); if the beneficiary is staying in a facility that assumes the care, this benefit/allocation is not payable;
- The dependent person's family - the benefit for care is in such a case payable to the people who give up their job or other gainful employment to be able to take care of a child that has a certificate of disability (Family Allowances Act).

The social welfare centres pay the old-age and pension insurance contributions for the person who does not work to take care, directly and personally, of a chronically ill family member.
A care allowance is paid to the person who does not work and is not paid in any other way to take care of a child that has a certificate of disability. This benefit is payable also to make it possible to take care of a person who has a certificate of a high degree of disability.
Generally speaking, the family aid system cannot be said to meet the needs. The sums of the benefits for people who give up gainful employment to take care of a dependent family member are actually symbolic and the premises for their attribution are controversial. In the final analysis, it is still the family of the dependent person that is in charge of taking care of that person without any real support from the State.
Checks, the assessment of the overall efficacy of the system, and the inspections of long-term care are carried out by the Ministry of Health; the other checks are carried out by local organisations, especially in the districts.
An analysis and a verification of the regulations, results and organisation of the benefits and the provision of long-term services were carried out in 2007, as there were signals and information of irregularities. The analysis confirmed that the system was in urgent need of reform.
The current situation in the health system is causing and is affected by dispersions in access to healthcare services in certain areas and may concern in particular the social groups at the highest risk of social marginalisation, i.e. people living in poverty, persons with disabilities and the elderly. The reasons for this are to be found mainly in the methods for collecting and redistributing financial resources and in the mistakes made by the administration in the change implementation process. The adverse phenomena moreover stem from the low level of funding of the public health care system, which is particularly visible given the high growth rate of costs based on prices outside

the health system (prices for medicines, medical equipment, use of the facilities, labour), and the increase in the part concerned most strictly with health (generated through the development of training, advertising, demographic processes).
Since Poland's accession to the EU, the new phases of change have seemed to be more precise than in the past, and attention is focussed more and more on useful changes for the citizens.
The independent and autonomous trade union "SolidarnoĐĐ" is calling for a revision of the principles according to which the family allowances are allocated to people who give up gainful employment to care for dependent members of their family. The union demands that this benefit amount to at least a minimum wage, that the criterion linked to family income be eliminated, and that the base used to calculate the contributions for social insurance paid by the social welfare centre for a person who gives up gainful employment to take care of a dependent family member be at least equal to the minimum wage.

8.10. SOCIAL WELFARE IN THE NETHERLANDS

The municipalities are responsible for social assistance benefits: a monthly benefit of €650 (for a single person) to €1300 (family). The municipalities moreover provide social service and homecare.
According to the Work and Social Assistance Act (WWB), those who have insufficient income and limited capital are eligible for social welfare benefits. The beneficiaries are required to try and get back on their feet as promptly as possible.
Young people under 27 cannot apply for a WWB benefit. They are required to work or to go to school; otherwise they receive the equivalent of a WWB benefit.
The legal framework is national: the municipalities receive a budget for implementing the WWB and the Social Support Act (WMO).
WWB: for dependent persons. In specific cases, the benefit may be in kind or may be paid directly.
There have been certain attempts to assess the efficacy of assistance for those who are seeking employment, but such efficacy has often proven wanting.
The municipalities are generally reluctant to check what is happening to people that are maintained by the social welfare system.
The FNV has levelled criticism both at the legislation and at the implementation thereof at local level. One of the instruments in the past has been the work of the FNV, a biennial assessment of municipal social policies that have induced considerable changes in social policy. Data are currently being collected for the 2010 edition which is to be published in March. As a result of the introduction of the WMO, the municipalities are responsible for homecare measures and there are attempts to subcontract such services.
The FNV and the affiliated trade unions have attempted (also with success) to oppose legislation that tried to reduce the use of specialised personnel in care management.

9. Conclusive considerations

The preceding pages have tried to outline the current scenarios and the developments of actions to tackle dependency in the EU Member States.
This endeavour is not easy and certainly not complete. Countries with different political and social contexts, rules and regulations, organisations and structures, are not easy to compare.
The very absence of a common definition of dependency attests to this difficulty, without underestimating the importance of historical events for the situations of the populations, and for the decisions and sensitivity of the governments.
On the other hand, the stated aim of this comparative study is certainly not to draw up lists and rankings, but rather to rely on the contribution of all (the country sheets are valuable in this sense because in addition to providing essential information, they make it possible to gauge the "perception" of efficacy of actions to tackle dependency) to arrive at shared hypotheses for reform to be proposed and claimed in the individual countries as well as at EU level.
As reforms are intended for the future, it is worth reflecting on the foreseeable scenarios so as to decide on the actions that are needed and on those that are possible, by raising a number of indispensable questions:

WHAT IS THE BOUNDARY OF PUBLIC INTERVENTION?

It is necessary first of all to consider the methods for financing public spending on dependency. The study we have conducted has shown a constant and continuous change in the expenditure components to deal with emerging risks. At a time of shrinking resources, covering one risk may unfortunately mean leaving another problem uncovered.
This has immediate repercussions on the population which finances directly public investment in social protection through taxation in certain countries or employee's contributions in others. So much so, that in certain countries the idea is gaining ground that private individuals will have to contribute as well to cover the dependency risks. It is an ever topical issue that requires immediate answers to avoid having to find remedies when it will be too late.

WHAT IS THE RIGHT MIX OF SERVICES AND INTERVENTIONS?

The sheets show that the "right" mix is that which favours the point of view of the dependent person and not of the facilities and organisations. All interventions must be undertaken with the prime aim of meeting the needs of the person with disabilities. A graduated approach used in many countries should depend on the seriousness of the problem afflicting the persons in question from time to time. It will therefore be vital to implement (residential and home-care) service structures capable of meeting such needs in short periods of time, by calibrating the intervention in relation to the dependent person and to his or her needs and expectations.

HOW TO NETWORK SERVICES ON THE TERRITORY?

Based on previous experience, the requests and proposals are geared to providing as much service as possible to users without abandoning coordination, thereby capitalising on all the opportunities, including those with a high-tech content. Against such a background, various means of intervention must be devised that take due account of the infrastructural difficulties of a territory, the presence (or lack thereof) of professional components, and volunteer networks.

GIVE WHAT TO WHOM?

How to distribute resources – a delicate and crucial issue more than ever before at this time of crisis – should be decided by, in addition to institutional entities, the social forces and the interest groups such as volunteer organisations and associations representing persons with disabilities.

HOW TO BRIDGE TERRITORIAL DIFFERENCES?

This is certainly a problem that cannot be solved in the short term. It suffices to consider that there are still profound differences between the supply and utilisation of many services in individual countries. It must nonetheless be set as an objective and pursued consistently and coherently. The national authorities are looking into different ways to tackle the problem of the foreseeable growth in the demand for long-term care services brought about by the drop in the number of men and women of working age capable of providing informal care as the number of dependent older people increases. Furthermore, the trend of fewer nuclear families and more single-parent families is bound to aggravate territorial differences from country to country and from territory to territory.

WHAT SHOULD BE THE ROLE OF THE EUROPEAN UNION?

The differences encountered in the ways of dealing with the traditional and emerging risks show that greater and more incisive European coordination would be needed with all the means at the EU's disposal: WTO, objectives and incentives. The EU institutions shall assume the task of "advising" national governments to approve, as promptly as possible, specific legislation to provide protection against dependency. For it seems impossible that countries with spending on social protection in line with the European average (Italy is a blatant case in point) have no organic legislation to tackle the phenomenon.
Ad hoc work groups should then be created to reflect on and propose common approaches to solving the specific problems of a constantly growing segment of the population. As we have been able to gauge personally, the data available on the phenomenon reflect a situation with a considerable lag, which may mislead the EU legislator. Decision makers should therefore be provided with stable and comparable data on the dependency phenomenon, as well as precise information on the impact thereof on the elderly population, so that appropriate policies can be charted. The collection of data on services for dependent persons is just as vital. More specifically, there is a need for better quality data on the administrative systems that can be compared in time between different states and territories and different health and welfare programmes. In other words, the ageing of the population in Europe, with the increased levels of disability linked to the extended life expectancy, raises the need for valid cross-sectional and comparable data on health, among young and old, in order to create an ample empirical base and use it to conduct analyses and plan development policies and strategies. Once the data gathering procedures have been defined, and the consistency therefore assessed in time, it will be necessary, as indicated nearly unanimously by all those who replied to the questionnaire, whilst waiting to define common policies to tackle the problem, for Europe to start investing in policies to train personnel specialising in care (including homecare) for dependent older people. These policies, of ample scope and necessarily shared, must be capable of:

- Institutionalising assistance for the most vulnerable members of society, including through the recognition of a professional career for those who look after dependent persons. This is not the case today, especially in southern and eastern European countries, as can be gauged from the low wage levels and unfavourable working conditions in such occupations. It is moreover no coincidence that women are over-represented in care occupations;

- Taking into consideration the rise in qualifications and training for healthcare personnel; and thus subsequently raise the level of recognition for this occupational role;
- Ensuring the quality of care provided – an element clearly correlated with the two afore-exposed elements, including as regards financing. Cuts in state funding and the growing recourse to private health workers and the tertiary (volunteer) sector have inevitably led to a drop in the quality of services available. Furthermore, the first cases of companies organised to provide services are appearing in various countries;
- Guaranteeing effective opposition to the possible rationalisation of social health services which, owing to the lack of available resources, could entail a high number of older people being exposed to a high risk of exclusion;
- Bringing about a high degree of coordination between the social and health components inside the countries. In certain countries, the two components of the system actually operate without being aware of the programmes and methods of intervention of the other, with a real risk of duplicating efforts and squandering public funds that could be used more effectively.

The constant monitoring of what is being done to tackle dependency at national level deserves separate attention. If, as FERPA hopes, a decision is taken to intervene at both the EU and the national level, the measurable efficacy of the proposed actions would assume fundamental importance. It is therefore becoming necessary to establish and to use standard indicators at all levels that make it possible to compare the results of such monitoring. In this respect, it is worth underscoring the value of a Commission project entitled "Quality Care for Quality Aging: European Indicators for Home Health Care (HHC)" intended to establish quality indicators for assessing actions for dependent people who receive homecare in Europe.

The ratification of the UN Convention on the Rights of Persons with Disabilities by the Council of the European Union last November 26th should certainly be seen as an important step.[12]

This ratification constitutes an unprecedented case, in fact, as it is the first treaty on human rights ratified by the European Union. As a result of the ratification, all the EU institutions will have to take into consideration the values of the Convention in all policies under their purview, including those relating to cooperation for development. Furthermore, all the EU Member States will be bound to revise national legislation and programmes to bring them in line with said Convention.

It is hoped that this will be the first in a series of steps towards a concrete commitment on the part of the EU institutions on the matter.

[12] In Europe, the Convention has been ratified by the following countries: Italy, Austria, Belgium, Croatia, Denmark, Germany, the United Kingdom, Portugal, Czech Republic, San Marino, Serbia, Slovenia, Spain, Sweden and Hungary.

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