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Supporting carers of older people in Europe: a comparative report on six European countries*

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1. Introduction

Over the past few decades, the needs of family members caring for a disabled elderly relative have been analysed by a substantial body of literature. Most studies have concentrated on the burden and difficulties they experience, while only a minority of them has thoroughly taken into account the satisfaction that they might gain from the caregiving role (Warnes 1993: 325-328; Borgemans et al. 1998: 10). Despite the central role played by informal carers in providing support to frail elderly, however, their problems seem not to have received enough attention to produce a systematic approach to the implementation and reorganisation of the elderly care services across Europe. The provision of specific public diagnostic, therapeutic as well as respite service to support the families providing care to their frail elderly components is not always adequate, since it is too often based on economic and financial constraints, rather than on the evidence coming from an in-depth analysis of the needs and acceptance of their potential users.

In order to provide useful suggestion for the implementation of appropriate support measures for caregivers, this paper describes the situation in six European countries - France, Greece, Italy, Poland, Sweden and the United Kingdom - which have been involved in the "Carers Of Older People in Europe" (C.O.P.E.) Project, funded by the European Union within the Fourth Framework Programme for the years 1998-2001 under the coordination of the University of Sheffield, Institute

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for Studies on Ageing (Nolan and Philp 1999). After a short overview of the main features, resources and legislation characterising the health and social care systems in these countries, common problems and potential solutions with regard to the needs of informal caregivers will be pointed out, in order to formulate concrete suggestions for the implementation of a support policy on a European level.

It should be finally mentioned that a major innovation of the COPE project has been to address issues which go beyond the concept of burden of care, to identify also positive aspects connected with this activity. This approach is necessary, on the one hand, in order to better comprehend why so many families are committed to caring for their elderly relatives, given the weight of the physical, psychological and material hardship they often have to endure. On the other hand, this can also be helpful for the improvement of existing assessment instruments for carers within the network of primary care services. To this purpose, a new measure of the stresses and benefits of caring has been devised and piloted in the form of a "COPE Index", an instrument which has undergone cross-cultural and psychometric validation through field trials carried out in all of the countries involved in the project. The findings regarding this research, which go beyond the purpose of this presentation, are going to be published in the next future (McKee et al. 2001).

2. Demographic and socio-economic trends

Europe is an ageing continent. As we enter the twenty-first century, almost one sixth of its population is aged over 65, and it is estimated that this proportion will have risen in some West European countries up to one in five people by the year 2025 (U.S. Census 2000). As a matter of fact some of them, such as for instance Italy, Greece and Sweden, are today among those with the oldest populations in the world (United Nations 1999), due also to the fact that life expectancy at birth reaches an average of 75 years for their male population, and exceeds 80 in the female one (Table 1). Although in most East European countries life expectancies remain lower by comparison

Table 1: Life expectancy and evolution of the population aged 65 and above in the COPE project countries

	Life expectancy at birth		Percentage of total population aged 65 and above			
Country	**Males**	**Females**	**1960**	**1980**	**2000**	**2025**
EU-15	*74,6*	*80,9*	*10,6*	*13,9*	*16,3*	*23,8*
France	74,6	82,2	11,6	14,1	16,0	22,3
Greece	75,5	80,8	9,4	13,2	17,3	23,5
Italy	74,9	81,3	9,2	13,1	18,1	25,4
Poland	68,9	77,3	5,9	10,0	12,3	20,7
Sweden	76,7	81,8	11,6	16,2	17,3	23,8
United Kingdom	74,6	79,6	11,7	14,9	15,7	21,2

Sources: - life expectancy: Eurostat 1999;
- elderly population: 1960-1980: - all countries except Poland: Eurostat 1999;
- Poland: Country Background Report
2000-2025: own calculations based on data from U.S. Census 2000

- in some countries, such as for instance the former Soviet Union, even showing a dramatic decrease over the past decade (Shkolnikov, Cornia, Leon, and Mesle 1998) - the percentage of elderly people is expected to record in the near future a sharp increase in Poland, too, where by 2025 the elderly will reach over one fifth of the total population.

These trends towards an ageing population are likely to continue, and are expected to be particularly remarkable in the over 80 year old age groups. As a result, the demand of health and social care services is likely to increase, since age is the single most important factor demonstrating the strongest link with use of health and social services, due to its correlation with higher levels of disability (Walker and Maltby, 1997). Whilst the majority of people over the age of 65 are generally fit and healthy and does not need assistance in their daily lives, it has indeed to be acknowledged that the proportion of persons needing full-time care increases from less than 5% in the population aged 65-69 to about 30% among those over the age of 80 (Walker & Maltby 1997: 92). According to these data, it can be estimated that in most West European countries the overall need for care – including both full-time and part-time care - affects over 6% of the total population; lower, as expected is the quota recorded for Poland (Table 2).

Table 2: Estimated percentage of population needing full-time or part-time care in the COPE countries (1999)

	Estimated percentage of total population needing:								
	full time care age group:			***Sub-total***	part time care age group:			***Sub-total***	**Total**
Country	65-69	70-79	80+		65-69	70-79	80+		
EU-15	0,2	0,7	1,1	***2,1***	0,5	1,5	2,2	***4,2***	**6,3**
France	0,2	0,7	1,1	***2,1***	0,5	1,4	2,2	***4,1***	**6,2**
Greece	0,3	0,7	1,1	***2,1***	0,6	1,5	2,1	***4,1***	**6,2**
Italy	0,3	0,8	1,2	***2,3***	0,5	1,6	2,4	***4,5***	**6,8**
Poland	0,2	0,5	0,6	***1,4***	0,4	1,1	1,2	***2,7***	**4,1**
Sweden	0,2	0,8	1,4	***2,5***	0,4	1,6	2,9	***5,0***	**7,4**
United Kingdom	0,2	0,7	1,2	***2,2***	0,4	1,5	2,4	***4,3***	**6,5**

Data have been estimated according to following assumptions:
- the elderly population needing full time care is equivalent to the percentage of severely disabled elderly, which on turn is estimated to be 5% for the 65-69 year-old age group, 10% for the 70-79 age group, and 30% for the 80 and over age group (Walker and Maltby, 1997: 92);
- the elderly population needing part-time care is twice as numerous as the one in need of full time care (usually a higher ratio of two and half is reported, Eurolink Age 2000);
- there are no differences between countries (while recent findings show a decline in the percentage of severely disabled elderly in most developed countries, as a consequence of better health and living conditions: WHO 1999).

While the demand for elderly care is increasing, several demographic and socio-economic trends give rise to an potential reduction in the overall availability of family caregivers. A first reason for this can be identified in the decline in the mean number of children per woman (Table 3), which represents a definite contraction of the support network which parents can count upon.

Table 3: Mean number of children for a generation with completed fertility in the COPE countries

Country	Generation's year of birth 1930	1940	1950	1960	1963
EU-15	*2,42*	*2,23*	*1,97*	*1,81*	*1,70*
France	2,64	2,41	2,11	2,10	2,02
Greece	2,21	2,01	2,07	1,94	1,78
Italy	2,29	2,14	1,89	1,64	1,51
Poland	-	-	2,21	2,18	2,10
Sweden	2,11	2,05	2,00	2,04	1,98
United Kingdom	2,35	2,36	2,03	1,96	1,89

Source: EUROSTAT 1999: 104-105, 220-221

This demographic trend - which will show its effects mostly on the long term, but has already reduced the support ratio of several European countries to the lowest levels in the world (Table 4) – might in the short-mid term be reinforced by a second phenomenon, observed in many (but not all) European countries, according to which an increasing number of elderly tends to live alone or without children (Table 5). This change in living arrangements patterns - which could actually reflect the fact that a larger number of elderly stay healthy longer - could indeed make the provision of care by off-springs more difficult and complicated, thus contributing to a reduction in their overall availability as caregivers (although it has been pointed out that not only cohabitation with but also proximity to relatives should be taken into account when considering potential caregivers, Grundy 2000).

Table 4: Countries with the lowest potential support ratio* in 1999 and 2050

1999		2050	
Country	***Potential support ratio (*)***	***Country***	***Potential support ratio (*)***
1. Sweden	3.7	1. Spain	1.4
2. Italy	3.8	2. Italy	1.5
3. Greece	3.8	3. Greece	1.6
4. Belgium	4.0	4. China	1.6
5. United Kingdom	4.1	5. Czech Republic	1.6
6. Spain	4.1	6. Japan	1.7
7. Japan	4.1	7. Slovenia	1.7
8. France	4.1	8. Portugal	1.8
9. Norway	4.2	9. Romania	1.9
10. Germany	4.2	10. Austria	1.9
Average (world)	9.2	Average (world)	3.9

*: Average number of persons aged 15-64 for each person aged 65 or older

Source: United Nations 1999

Table 5: Percentage of over 65 year old persons living with their off-springs in some COPE countries

Country	1950-60	1970-75	1980-85	1990-95
France		24	20	17
Italy			35	28*
Sweden	27	9	5	
United Kingdom	33		16	

*: 1998

Source: OECD 1999: 26-27; Jacobzone 1999: 8; Presidenza del Consiglio dei Ministri 2000 (for Italy 1998)

A third reason for a potential reduction in the overall availability of family caregivers can be found in the increased participation of women in the labour market (see Table 6).

Table 6: Female activity rate and labour force participation in the COPE project countries (1980-1998)

Country	Female activity rate (1998)	Female % of labour force		
		1980	1998	Change 1980-98
France	61,6	40,1	44,8	+ 4,7
Greece	48,5	27,9	37,4	+ 9,5
Italy	44,2	32,9	38,2	+ 5,3
Poland	50,0*	45,3	46,2	+ 0,9
Sweden	72,2	43,8	47,9	+ 4,1
United Kingdom	66,9	38,9	43,7	+ 4,8

*: percentage of full employed women in the age class 15-59 year old

Source: - female activity rate: Country Background Reports
- female % of labour force: World Bank 2000:46-49

The latter trend is strengthened by a further phenomenon, which is the tendency, in a number of European countries, to raise the statutory retirement age (Table 7). As a consequence, the number of people in their 50s and 60s still working, especially women, is expected to increase in the next future (Naegele 1999: 7-10), after decades during which early retirement strategies had driven many mature workers out of the labour market (Walker 1997: 19-23). The effect for the future is that potential caregivers in this age group are less likely to be retired and more likely to be working, thus having less time to devote to caregiving. It should be mentioned, however, that decreasing participation rates of men to the labour market might have a counterbalancing effect, although there is so far no evidence that this phenomenon has been really taking place.

Table 7: Legal retirement age for statutory pensions in the COPE project countries

Country	Men	Women	Notes
France	60	60	
Greece	65	60	65 for women insured after 1993
Italy	64	59	65/60 from 2000 (new system: 57-65 flexible)
Poland	65	60	
Sweden	65	65	
United Kingdom	65	60	Women's to raise gradually to 65 (2010-2020)

Source: - Poland: Bastian 1999:499;
- other countries: *MISSOC (Mutual Information System on Social Protection in the EU)* 1998

As a consequence of the above mentioned trends, the pressure exerted on family caregivers of elderly disabled persons is likely to increase markedly in the future, unless suitable support policies are developed to provide appropriate care and respite services. The current situation in relation to such services in the COPE project countries is described in next section.

3. Overview of health and social care policy for the elderly

Providing an overview of health and social care policies in European countries is no easy task, for several reasons. One of these is for instance the different "terminology" used in each national context to indicate similar services or measures; in other cases there are "real" differences in policies and interventions, due to the peculiar historical, political and social background which characterise each country; a further reason is also the lack of comparable statistical information. Nevertheless, an attempt is made here in order to provide at least a rough comparative picture of healthcare for older people in the COPE project countries.

All of the countries involved in the COPE project, with the exception of France, have some form of national health service. After the Second World War the public sector assumed responsibility for social services and health care in many European countries, though in Greece the transformation occurred later, in 1983, and was initially implemented mainly at the secondary health care level. Health services are under the direct control of the central government via the Minister of Health, and are funded by a combination of national taxation (e.g. Italy and Greece and, up until 1999, also Poland) and contributions to national health insurance schemes (e.g. U.K., and since January 1999, Poland). France has an insurance based health system covering both acute and continuing care which is funded from contributions rather than general taxation.

A clear distinction is made in most countries between health services and social services, although a range of different approaches can be observed, with France maintaining perhaps the strictest boundaries between the two. Control of social services has, in most cases, been devolved to local authorities through various reforms which have taken place over the last 25 years. This trend towards the separation of health and social care which were formerly the responsibility of one ministry has occurred in recent years in countries such as the U.K. Italy and Poland – but not in Sweden, where there is a single Ministry for Health and Social Services - and is rooted in policies determined to defray the ever increasing costs of responding to the needs of, amongst others, an ageing population. The separation of health and social care is intended to shift the provision of social needs such as housing and domestic care onto families, whose access to services will depend

on the provisions and priorities set by local authorities, whilst leaving access to medical care free at the point of delivery. Provision of social services on the other hand is frequently means tested. This policy of separating health and social services has led to serious problems of co-ordination in countries such as Italy and Poland, where the decentralisation of responsibility for services has brought with it fragmentation and risks of discontinuity in service provision, which need to be adequately tackled, if effective case management is to be ensured[1]. Sweden has responded to these problems by setting up a government agency known as the National Board of Health and Welfare with responsibility for the supervision, evaluation and monitoring of social services, health care and medical services. The Board's aim is to promote good health, social welfare and high quality care on equal terms for the entire population, and much of its work is therefore concerned with improving the co-ordination of services.

In all European countries, allocation of resources has been the main factor in determining the level and extent to which services for older people are effectively provided. In Sweden successive governments have prioritised the care of older people and a favourable economic situation facilitated the training of well qualified staff to provide good standards of care, albeit with a relatively high level of institutionalisation. Most countries, however, did not set any priorities on health and social care until pressures began to squeeze existing services. Demographic predictions did little to force these services to provide for the rapid increases in the elderly population. In the United Kingdom, for example, the last decade has seen a dramatic increase in the service provision for older people, but this came as a response to an increasingly critical situation, rather than having been adequately planned in advance. At other times, older people have simply benefited (or otherwise) from the introduction of general reforms aimed at a process of rationalisation, mainly on economic grounds, of health and social care. During the 1960s and 70s a number of countries first attempted to reorganise their services, though not always with the idea of prioritising care for older people.

Some countries, such as Greece, Italy and Poland have continued to rely on the traditional provision of informal care by the family, a situation which is strongly determined not only by economic but also by socio-cultural factors. Greece has fewer than 1% of over 65 year olds in residential homes, mainly in the private sector, while a just little higher percentage is recorded in Italy, with figures which are among the lowest in Europe. Also due the lack of adequate residential services, in both countries the rapid ageing of the population has precipitated a crisis in family caregiving so that, increasingly, families with some economic means are turning for support to foreign migrant workers. These are mainly middle aged women, both legally registered and non-documented, in most case coming from Central and Eastern Europe (but in Italy also from much farther countries like the Philippines or Peru), willing to undertake the main burden of caring for a highly dependent older family member at home, receiving in turn a modest payment as well as, in many cases, board and lodging. A recent report for the Ministry of Health and Social Welfare in Greece (Sissouras et al., 1999) showed however a growing awareness of the situation of older people, and the start of home care services provided by the local authorities with initial support from the European Union also marks a move towards the development of services for the dependent elderly.

In Italy, up until the early 1970s the care of older people was the responsibility of central government. Services were organised through the provincial branch offices of the Ministry of the Interior as well as through numerous public charitable institutions working at either local or national level (Istituto per la Ricerca Sociale 1984: 11-37). The 1970s brought an attempt to rationalise these services, by abolishing most of the charitable institutions, decentralising social care to the 20 Italian

[1] Some European countries, such as Denmark and the Netherlands, have addressed these problems by merging services to overcome conflicts in professional roles between social workers and nurses as well as by taking a more flexible approach to case management (Walker and Maltby, 1997).

Regions and over 8,000 Communes, and devolving the delivery of health care to the Local Health Units (Unità Sanitarie Locali: USL), which constitute the Italian National Health System. These reforms worked successfully in the health care sector, as they integrated under the care of the Health Ministry the previously fragmented services provided by different ministries and institutions. Similar attempts to reorganise social care legislation have been less successful[2], thus contributing to a high level of uncertainty and territorial variability with regard to recognition of competent authorities and modalities of intervention. (Di Pasqua 1995). As a result, since the 70s the Italian Welfare State has experienced a lack of integration between health and social services, especially in some southern regions of the country, the consequences of which were inevitably borne by older people and their families, not only in financial terms but also in terms of the quality of care they received (Dogliotti et al 1994: 67-72).

In France, the debate on provision of care for the elderly, centering mainly around the perceived burdens of caring for an ageing population, also first emerged in the 1960s. Up until then most older people lived with their families, but several charitable associations began a system of aid for geographically isolated older people which consisted of providing some medical care at home and help with domestic tasks. The costs of these initiatives were borne by the social aid fund of the relevant government department (Aide Sociale Departementale) and later by primary government health insurance funds (CPAMs). In 1960 the French Prime Minister created a "Commission for the study of the problems of old age" (Commission d'Etude des Problemes de la Vieillesse), which focused its work on providing a new concept of old age, by emphasising autonomy and participation in everyday social life, with the goal of keeping older people active in society. This strategy was innovative in its aims to prevent the social exclusion of the elderly, caused by placement in institutions, and recognised the need for support services such as the provision of better help at home, help in maintaining social activities, campaigns for better conditions in the home, development of leisure activities and services, providing help with domestic tasks and care for physically handicapped people. The Commission's report (known as the Laroque Report, published in 1962) has formed the basis of all advances made in policies concerning the care of the elderly in France over the last 35 years. The first ten years after its publication saw several advances in the provision of home care, improvement in the home environment and the development of contracts between the state and a municipality or association which provided the basis for the implementation of multi-dimensional, co-ordinated actions for "community" or home care. However, despite these innovative ideas, a review of provisions developed over this ten year period showed that, as in Italy, in the absence of a global, properly co-ordinated policy, the development of services was hampered and had only developed to any notable degree in the area of services for household assistance. Other services which depended on the sustained goodwill of local communities and social security funding had, as in Italy, developed unequally across different geographic regions.

In Sweden too, a series of legislative changes were effected, whose aim was to provide older people with equity of access to services (Health and Medical Services Act, 1983) and help them to maintain their autonomy. These included the Social Services Act of 1982, which emphasised the individual's right to receive social services "if the needs cannot be met in any other way" and instituted case management as the means by which decisions were to be co-ordinated. In 1992 the "Adel reform" devolved responsibility for the health and social care of older people to the local authority level of the municipalities. The aim was to create a better organisational structure for services, thus making it possible to use resources more efficiently and thereby to implement parliamentary decisions relating to the care of the elderly more effectively. The municipalities received a great deal of financial autonomy and were made responsible for the care of older people whose medical treatment

[2] A recent, apparently promising “Law for the realisation of an integrated system of social interventions and services” (law n. 328/2000) has been launched by the Italian government in October 2000, but it is still too early to report on its effects.

had been completed. This created a strong incentive for them to expand their own housing and care facilities for older people. They were also expected to make provision for quality assurance in the delivery of care. The reforms were very far reaching, in that they allowed municipalities to take over all home nursing care, if the county council which is responsible for health care agreed, and pilot programmes were even introduced to allow them to operate the entire primary health care system locally. However, the experience of these organisational changes has been very varied. A recent law has finally established that, since 1998, municipalities have to provide support for informal caregivers and make relief and respite care available. This step represents an important integration of existing interventions, since it provides for the first time a systematic involvement of caregivers as service co-recipients, although it is still too early too make an overall evaluation of the impact exerted by this recent measure.

In terms of health care policy for the elderly, Greece and Poland share some similarities, such as the absence of specialist geriatric services (although in Greece some specialised additional geriatric nurse training is beginning to emerge), and the fact that older people have the same access to healthcare provisions as the rest of the population. As a matter of fact, in these countries the fear that the development of separate services for older people could create a two-tier system, in which care of the elderly would be given lower priority - thus leading to poorer services rather than facilitating access to a wider choice of services - has prevented a diversity of primary and secondary care services being established to support the elderly (Triantafillou and Mestheneos, 1995; Pędich, personal communication). The experiences of those countries, where such services have become established, might provide a helpful model of good practice to allay some of these fears. Moreover, geriatric medicine has only relatively recently been recognised as a specialism in many European countries (Walker and Maltby, 1997), having only the U.K. and Italy a long established medical specialisation in this field[3].

A particular position, within the COPE project countries, characterises Poland where, despite the fact that a specialism in geriatrics exists for over 20 years, the role of the geriatrician in the healthcare of the elderly has not been yet established satisfactorily, and the number of practising specialists - about 200 in a country with a population of 39 million – remains relatively small (Bien and Pedich 1998). Furthermore, the health service reforms introduced in 1999 did not specifically address the situation of older people. With respect to this it needs to be underlined that, as a former communist country, since 1990 Poland is undergoing a process of major political, economic and social transformation. Although the struggle to restore economic stability - an essential condition for improving the effectiveness of health care and social policies - is gradually gaining ground (Poland hopes to become a member of the European Union in 2003), the country is still facing profound economic difficulties when compared to the other COPE countries, as Poland's gross domestic product (GDP) in 1998 was 1/6 of that of Sweden and the U.K., 1/5 of the GDP for Italy and almost 1/3 of that for Greece (GUS, 1999)[4].

This short overview can be concluded by mentioning that, although in most European countries older people are guaranteed the same rights to health care as are available to other people – often by constitutional norms (e.g. in Italy and Poland), in other cases by legislation (e.g. in the United Kingdom and in Sweden) - a debate is emerging about whether access to health care is indeed equally available to all, irrespective of age. These fears about discriminatory practices based on age, which seem to be confirmed by recent studies (King's Fund 2000), need to be verified and tackled appropriately on a European level - like for instance it is already happening in other fields such as employment (Eurolink Age 2000a) - in order to prevent and combat the rise and diffusion of barriers

[3] This tradition can be found since the 60's in Sweden, too, but with great variations from area to area, so that in part of the country geriatric care is the norm, while in other parts elderly care is taken over by primary care.
[4] GUS: Statistical Yearbook of the Republic of Poland. Warsaw 1999; 707

to access to care services by elderly people, may they be due to insufficient attention to their peculiar needs or, even worse, to ageist attitudes.

4. Health and Social Care for Older People: Structures and Functions

The aim of the following discussion is to provide an overview of the health and social care provisions available to older people in the COPE project countries, and which constitute the resources upon which they and their carers may draw. The areas of health and social care will be treated separately in order to facilitate the presentation in an area of great complexity, but also because a distinction is made between health and social services in the majority of the analysed countries.

4.1 Health Care

4.1.1. General structure and organisation

All of the COPE countries have a health system based on a primary care model, where patients select a general practitioner (or "*family doctor*") who is institutionally responsible for supplying free and continuous primary care to patients irrespective of age and who acts as the "gatekeeper" to secondary care services. Although specific details of this arrangement vary from country to country, the idea is that the general practitioner should be responsible for the family's health care "from the cradle to the grave" and so build up lasting and trusting relationships with his/her patients. Major variation to this general scheme can however be found in Greece and Poland. In Greece, the general practice model, introduced over the past 15 years, has really only become established in the last five years and is relatively unpopular with patients and their families, who still tend to have a "consumer" approach to healthcare, "shopping around" for specialist services as they perceive them to be necessary. Thus most people attending a primary health care centre, without access to a family doctor, continue to be attended by specialists. Although it is too early to report on definitive results of recent reforms, the situation in Poland would appear to be similar, in that patients perceive the move to a family doctor system as one which restricts their access to health care and, in particular, to specialist advice. A further complication is that it will take time to train practitioners in general practice and, as in Greece, the majority of family doctors are former specialists in internal or general medicine and paediatrics.

As far as the other elder care services are concerned, it has to be acknowledge that each country has responded in a variety of ways to the diverse needs of older people, by developing a range of services and institutions both private and public, national and local, non-profit and private, health related and social, in different composition and according to variable models of intervention. Comparisons across countries are therefore difficult to be carried out, owing to the wide range of developments offered within these main categories of care, but are worthwhile in order to better understand how problems have been tackled in different contexts, thus providing examples of good practice which might be suitably transferred to other countries.

4.1.2 Hospital Care

Admission to hospital in the U.K. and Poland as well as, but to a much lesser extent, in Italy and Sweden is controlled by the General Practitioner, whereas in Greece such a proposal is currently under discussion for adoption in the legal reform of primary health care in the National Health system. Older people account for a high percentage of hospitalisations in most European countries:

in Poland the occupancy of beds by older people overcomes 50% in the majority of acute general medical wards, but in France this figure reaches often 70% and in Sweden even 80% (a percentage which is likely to be reached in Italy, too). Where specialist geriatric assessment services do not exist other services such as internal medicine, cardiology, and psychiatry are placed under considerable pressure, because older people require longer than average periods of hospitalisation. It is now widely recognised that this is sometimes not related to the patient's acute medical condition, but to the need for rehabilitation or for social reasons, such as the lack of family support at home or difficult access to specialist continuing care facilities. Hospitalisation is in these cases therefore seen as both inappropriate and costly.

Faced with problems of this kind, countries have responded in a variety of ways. France has developed policies to shift older people from acute care beds to the long term care sector, while in Italy nursing homes for dependent elderly people have been set up in addition to existing, traditional old age homes, though the policy has only been implemented partially. A similar solution is currently being introduced in Poland through the creation of short-stay nursing homes and rehabilitation facilities. There are also plans to restructure some hospitals, by converting acute to continuing care beds, thus easing the pressure on acute facilities. Lack of support and limited resources in terms of the availability of alternative care provisions sometimes leads to older people being "abandoned" in hospital, as a Council of Europe report (1992) shows with regard to a survey carried out in Athens. By contrast, in Sweden on-going support for community care has enabled the municipalities to take over responsibility for patients whose medical treatment has been completed.

In view of these considerations, a major imperative for all countries has been to lower the costs of care provision, but this has brought concerns about the quality of care delivered. In France, concerns about quality have lead to improved conditions in medical residential establishments and at the same time they have proved a strong driving force in aiming at reducing the number of long-stay hospital beds for older people. In the U.K., for example, up to one-third of health authorities have attempted to abolish their long-stay beds (Age Concern 1991), a tendency for which the NHS has been criticised, since it effects the replacement of free NHS care by private care or care in social services establishments, for which older people and their families would have to pay part or all of the cost (Henwood 1992). Another inquiry by the Health Advisory Service reports the persistence of negative attitudes towards older people and inadequacies in care provided to them on some general acute wards (HAS 2000). Those countries which have introduced health care reforms based on principles of managed competition and market economy, such as for instance Italy, have experienced the desired drop in the occupancy of beds in general hospitals by older people (Vineis and Paci 1995); in this country, however, hospitals have proved to be increasingly reluctant to accept elderly patients who are more "expensive" in terms of DRG (Diagnostic Related Group, the case-mix classification measure used as a reimbursement method), because of the longer periods of hospitalisation they require (Lucchetti and Lamura, 1998). Equally, over the first year of health service reforms in Poland, there has been a notable drop in bed occupancy as a result of family doctors being less likely to refer older people for costly in-patient treatment.

4.1.3. Hospices

Care for terminally ill or dying patients is provided by hospices in all of the COPE project countries with the exception of Greece, though the availability of these services varies greatly from country to country. Hospices admit patients irrespective of age, though the majority of beds are occupied by people over the age of 65. Some are run in conjunction with charitable trusts or other non-governmental organisations. Charging practices are varied, ranging from there being no charge at the point of contact, so that hospices are funded within a national health service provision as in the U.K. to charging policies as for social services homes, which is the position in Poland.

Hospice teams also often provide home care offering free medical and care services to people in their own homes. In France, in keeping with the hospital laws of 1970 and 1975, hospices have been transformed into long-stay health care units or medical retirement homes (nursing homes). By contrast, in Sweden there has been increasing pressure in recent years to enable terminally ill or seriously disabled people to remain at home. This has been made possible through the development of both hospital-based home care for terminally-ill patients and hospital-based home-rehabilitation services for those who need help with rehabilitation at home, and has provided a means of vacating beds in institutions. This, combined with the municipalities' responsibility for people whose medical treatment has been completed, has led to an evident decline in the number of older people occupying hospital beds. Although this has been balanced by providing additional care for people living at home, especially during the evenings, nights and weekends, with evident benefits in both human and financial terms, there is now a fear that the financial incentives of such changes may be forcing these developments to happen too quickly and extensively, with the resultant costs in terms of well-being being borne by family carers.

4.1.4. Interim Health Care Facilities

Medium-term or temporary residential facilities for sick people exist in a variety of forms in the analysed countries. In France they are intended to provide medical care over a critical period of illness after which it is intended that the person will readopt an independent lifestyle. They come within the realm of health care provision and so are funded publicly. In Poland, recuperation or rehabilitation centres, known as *sanatoria*, have functioned since before the Second World War, though with the introduction of a free national health service they became widely accessible, referrals being adjudicated by local committees of medical specialists. The *sanatoria* specialised in offering rehabilitation and physiotherapy for specific conditions such as cardiac problems, asthma, rheumatoid illnesses etc. and were spread throughout the country, often in attractive mountain or seaside locations, offering a combination of physical care with relaxing holiday-like surroundings. Since the market reforms in Poland, however, they have been very hard hit in financial terms as central funding has been restricted and they have been forced to restructure themselves, partly functioning as care providers within a newly emerging private sector. Inevitably, the number of NHS referrals has declined, as regional fund holders are unable to meet the costs of these services to the same extent as in the past. In Greece a scheme similar to the Polish system exists, but it is funded through social insurance schemes, and it is mainly used by older people to take spa holidays.

4.1.5. Community care

The official, current aim of elder care in all of the COPE project countries is to keep older people within their own homes and social environments for as long as possible, maintaining a satisfactory quality of life and avoid entry to institutional care. This policy, known also as “ageing in place”, often appears however to be invoked for quite different reasons. In the wealthier countries, such as the U.K., Sweden and France, current community care policies – whose diffusion represents partly a reversal of previous trends to a more widespread long-term institutionalisation - are implemented as a response to the desires of older people and their families of receiving/providing care at home, supported by a variety of domiciliary services. In Poland and Mediterranean countries, such as Greece and the south of Italy, it is rather a combination of cultural and socio-economic reasons which might explain why the overwhelming majority of dependent elderly is cared for at home. This phenomenon reflects indeed, on the one hand, the still broad availability of traditionally strong family support but, on the other hand, also the high percentage of elderly people who have to struggle under economic difficulties; therefore, such choices are doubtless determined by societal

values which, to some extent, mould care patterns as well as the fact that alternative care solutions (to be discussed below) still remain relatively scarce.

The way community care is implemented and co-operation between health and social services is carried out is quite different from country to country. Sweden has perhaps been strongest in retreating from institutionalised forms of care for elderly people, aiming to provide people with a full range and complexity of health care and social services in their own homes, including terminal care. In this country, 92% of older people live at home, and this figure is undoubtedly sustained by the high quality of community services. Countries such as the U.K., France and, to some extent, Italy are in a more intermediate position, based on a clear tendency to move towards community care, though with various forms of institutional care still forming an essential and integral part of the care offered to older people. In support of these policies a recent innovation within the Italian National Health System provides that G.P.s offer a so-called Scheduled Home Care Service, consisting of one to four monthly home visits to those patients, (mostly elderly), who are not able to leave their homes for health reasons.

Nonetheless, although government policy in the U.K. is aimed at providing adequate levels of community care, the last decade has seen the fastest growing rise in the residential care sector, because of politically motivated incentives for older people on income support benefits to enter private homes (Walker and Maltby, 1997). As a result, policy makers face a dilemma with regard to the rapidly developing private sector of residential and nursing homes, which the government has not been able to reverse in favour of the kind of community care pursued in Sweden. In comparison to these countries, Greece and Poland have very few community based facilities in the form of medical and psychiatric multidisciplinary community teams, which have a range of day care and respite care facilities available to them, thus hospital care is often the only real temporary alternative to family care at home.

4.2. Social care

Generally speaking, personal social services have, in most countries, been organised at two levels, residential and home care, with an intermediate one, represented by day care services, which is growing in importance, although it is still remains less developed. Among the COPE countries, Sweden provides the most widespread service network, while Poland and Greece (and, to a certain extent, Italy) show a less diffuse supply (Table 8).

Table 8: Use of residential and home care services

Country	**Estimated % of elderly (on total population aged 65 and over):**	
	living in institutions	receiving formal help at home
France	6,5	6,1
Greece	1,0	n.a.
Italy	3,9	2,8
Poland	0,7	1,0
Sweden	8,7	11,2
United Kingdom	5,1	5,5

Source: - all countries except Greece and Poland: Jacobzone 1999: 28
- Greece and Poland: Country Background Reports

4.2.1. Domiciliary services

The bulk of domiciliary support is usually provided by home help or home care services. In most COPE countries help is offered with personal and domestic tasks such as washing, dressing, cleaning, laundry, shopping, preparing meals and managing medication. There are, however, considerable differences between countries in the way in which these services are organized. Greece is the exception here, for there are no statutory services for providing home support to older people, so that not much has changed since Mestheneos and Triantafillou reported in 1992 that neither community nursing services nor home help support existed in Greece as public services. However, in 1998 new legislation allowed the setting up and implementation of a network of “Help at Home” services on a pilot basis through the local authorities and often working closely with the so called KAPI centres (see next paragraph), although with separate personnel and using volunteer services. A first evaluation of this pilot project has identified a number of problems, not least of which is the uneven implementation of the home care services, especially in rural areas where the need is often the greatest (Sissouras, 1999).

In all other countries involved in the COPE study, these services are the responsibility of the local social services departments. Italian home help services differ in that sometimes, especially in the North and Central part of the country, they are integrated with medical, nursing and rehabilitation care supplied by health providers, with access to the service granted via referral through so called Geriatric Assessment Units. In Poland, the referral route to social services is via the community health team, consisting of a doctor, community nurse and social worker, or it may be instigated by family carers, neighbours or friends. The splitting of health and social services has led to difficulties in team co-ordination at the primary care level, not least in determining budgetary responsibilities for different aspects of care. Furthermore, even after extensive assessment by social workers, older peoples' needs may not be met owing to the dearth of home care facilities (eg. there are no home care workers). In France, in keeping with the clear distinction made between health and social care, domiciliary services are divided into two main categories: those consisting of household assistance and home health-care services. The former, known as "aide menagere", is one of the oldest services in the country provided for the elderly, created over forty years ago, and consists mainly of domestic tasks such as domestic cleaning, shopping, help with administrative tasks and, in a minority of cases, cooking and personal care (hygiene). Home health care services, on the other hand, are aimed at providing assistance in the home for older people who are sick or dependent and need medical care and help with the activities of daily living, such as personal hygiene, moving, eating etc.

Funding practices for the provision of social services also vary. In the U.K. these services account for over a third of the total local authority domiciliary care budget. In Sweden fees are charged which vary from one municipality to another. The charges are dependent on the number of hours of help required and are means tested, but charges are capped so that older people are able to retain approximately one-third of their income. Similarly, Poland has a system of means tested eligibility for fees, services being provided free of charge in cases where the per capita income of family members does not exceed the minimum state pension. In France the costs are covered either by health insurance or public funding in the form of departmental medical aid, while in Italy financial assistance is available, up to a limited amount, from the communal social services for those clients whose economic condition makes it difficult for them to pay the total cost of the used service. Wide variations in the ways in which taxes are levied to fund social services mean that even within a particular country services may vary considerably. For example, the proportion of home helps per 1000 people aged 65 and over varies by a factor of four between different authorities in the U.K.

Allocation of domiciliary services is determined according to need, though comparisons in this area are likely to be misleading, owing to the enormity of the difference in service provision both in terms of the flexibility of options offered and the number of people that they reach in different countries. In France, for instance, almost 500,000 people were receiving household assistance in 1990 - with an average number of hours of about 16 hours per month - 97% of the beneficiaries being older people living alone (Alzon, 1997). As far as home healthcare services are concerned, in 1991 it was estimated that around 0.5% of people over the age of 65 living at home or in sheltered accommodation received this kind of service (Joel, 1997). Sweden appears to be the exception in making domiciliary care available during the evening, at night and at weekends. Most Swedish municipalities also provide night patrols which include both nursing and home help staff. In this country, over the last decade, attempts to rationalise services and provide them only to those in greatest need have resulted in the total number of recipients of home help services falling overall, but the number of hours of care provided have risen. 20% of older people aged 80 and over, living at home, were in receipt of social services/home nursing services in 1995. Most of them were living alone (60%), 30% had help every evening or night. These high figures reflect the success of a community care policy, allowing a large number of people with high levels of need to continue living at home.

Other domiciliary services – such as meals on wheels, disability equipment and adaptations to homes, transport, respite care and social work - are not equally available to older people in the different countries. In Greece, as has already been mentioned, no statutory support services of this kind exist (Mestheneos and Triantafillou, 1992). In Poland, older people are entitled to apply for statutory services in the form of the (state) Fund for the Rehabilitation of Disabled People, which extend to providing a limited range of disability equipment and adaptations to the home. The person is required to make a contribution to the cost of these services. Other services, such as the provision of meals etc., exist on a more ad hoc basis, via the assistance of formal carers, such as Red Cross nurses who may purchase and deliver a meal to an older person's home, by individual arrangement.

4.2.2. Day Care Services

Day care centres often provide a bridge between domiciliary and residential care. They exist, in one form or another in all the COPE countries, although the extent to which they are able to meet the needs of older people varies widely, even within countries; for example, there may be provision for forms of hospital day care, or day centres may exist alongside residential homes in the community. Alternatively, day centres may be run by social services in the community. Specialist forms of day centres are also provided, especially for older people suffering from dementia. In most cases, they provide elderly people with a hot meal during the day and, apart from the social functions, offer opportunities for rehabilitation in both physical and psychological functioning, as well as fundamental respite services to the caregivers.

In all countries, social support for the elderly is available in the form of senior citizen's clubs and places providing community meals and entertainment. These vary from groups organised by older people themselves, through ex-combatants' organisations to more structured activities provided by charities and self-help groups. These exist, even in countries with a paucity of more formal services for older people. For example, in Greece the KAPI (Open Care Community Centres for Older People), which began originally as pilot centres by volunteer groups using public funding, were incorporated into government policy in 1982 and developed to form the present extensive network of centres under the auspices of local authorities throughout rural and urban Greece. Similar initiatives occurred in Poland as part of the Cultural Centres that were provided under the communist system on housing estates throughout urban areas and even in small rural communities. Although they were designed to provide a cultural focus for all members of the community and

were supported by state funding, as with the Greek KAPI centres, they played an important role in helping to maintain older people as active and participating members of their local communities. The services offered by both the Greek KAPI and the Polish cultural centres are primarily recreational in nature, though the Greek KAPIS from their inception included the services of a full-time social worker, with some medical services provided by a full-time health visitor, a part-time doctor and, in some cases a physiotherapist, the emphasis being on preventive health care. The medical services provided are not integrated within the national health system, but co-operation with insurance schemes means that prescriptions for drugs, for instance, are covered. This appears to be an excellent model of good practice that could well be adopted in other countries with similar conditions.

4.2.3. Residential Care

Despite policies of community care, the number of residential establishments for older people expanded in most European countries for a long time, before a reversed tendency towards de-institutionalisation has taken place, more recently, in most North European countries (Jacobzone 1999). As already mentioned, in Poland, Greece and, but to a lesser extent, Italy, the quota of elderly people taking advantage of residential care has instead traditionally remained quite low, so that, due to the lack of adequate community support services for a large number of dependent elderly and of their family carers, the latter represent in most cases their main support and thus carry, often alone, the burden of caring for their relatives. In this sector, too, there are widely ranging differences in definition but, broadly speaking, three main types of residential accommodation can be identified in the COPE countries: nursing homes, residential homes for the elderly and sheltered accommodation.

Nursing homes

Nursing homes offer the most intensive and extended forms of care outside a hospital setting, with funding mechanisms which varies considerably between countries. In countries such as the U.K., for example, which has the largest number of private residential and nursing homes, these are strictly regulated and expected to meet certain standards such as employing qualified nursing staff 24 hours a day. In Italy, although there are no set minimal requirements in order to qualify for nursing home status, it is generally required that a doctor should be on site (Ministero della Sanita 1995:78; Banchero 1998:324). This is quite important since the reduction in hospital beds for the elderly, brought about by recent reforms to the Italian National Health Service (Vineis and Paci, 1995) has resulted in nursing homes having to admit an increasing number of very old, seriously disabled older people, with complex health and care needs requiring the intervention of qualified personnel and high care standards (Mengani 1993:48). As a result, Italian nursing homes and those in the U.K. have moved closer together in recent years, in respect of the care that they provide, although in Italy the number of self-sufficient residents in these homes is still very high (33% -50%), compared to the U.K. (Mengani 1993:48) reflecting their original role, which was to provide homes for the poorest in society.

In France, nursing homes are often a step on from the care offered by mid-term or short stay centres, when the person's condition does not allow them to return home. Placement may also follow a period of hospitalisation, when acute medical care is no longer required, but the person cannot return to an independent life at home. In Poland, nursing homes are being created to provide care in similar situations, being intended to serve rehabilitation purposes and to be a medium-term solution, rather than as a form of continuing care. In some cases, owing to the lack of availability of specialised residential care places for older people, the frail elderly have been placed (or remained) in continuing care beds in psychiatric hospitals or non-acute medical beds. In Greece there are strict regulations on the staffing and facilities of private clinics, the equivalent of nursing homes. The

problem lies here in the number of residential homes which are effectively nursing homes, which are unregistered or licensed as cheap hotel facilities, so that in this country data on residential care provision are inaccurate and allow only rough estimates. On the whole, however, residential care is a much rarer solution to the health care needs of the elderly population in most Mediterranean countries compared to the countries of Northern Europe (Glendinning and McLaughlin, 1993:8); This is reflected for instance in the low admission rate to nursing homes in Italy – which host only 2-3% of those over the age of 65 (Facchini, 1997: 288) – and in Greece - where only about 1% of older people are in residential care (Triantafillou & Mestheneos 1994b) – but a similar situation can be found also in a post-communist country such as Poland.

Residential homes for the elderly

The second type of residential accommodation that is available throughout most COPE countries is a wide range of retirement homes, which broadly speaking are intended for non-disabled older people. They provide a range of services and often take into account the gradual loss of independence while facilitating the maintenance of an active social and personal lifestyle. They often offer, like for instance in France, the U.K. and Italy, a treatment component for those who are not able to carry out their daily activities alone or have a stabilised somatic or psychological condition not requiring intensive medical care. Access to health care in residential homes is provided as necessary through the General Practitioner.

Needless to say, the availability of places in residential facilities run by the social services in most countries is limited and the quality of care available is inevitably linked to the ability to pay. For example, residential fees for social services homes run by local authorities in Poland amount to twice the lowest state pension, though individuals are not required to pay more than 70% of their entire income for living there. Payment by individuals is thus on a sliding scale, with state funding automatically making up any differences in the costs. Thus some older people may be partially, or even totally exempt from payment. In other countries, older people are required to reach into their capital assets in order to pay for residential care (this is the case in Italy), although recent government proposals in the U.K. have made provision for this to be deferred until after the person dies, through loan provisions.

Sheltered accommodation

The third form of accommodation available is sheltered housing, according to which people without a need or a desire for extended care live in separate apartments, but share common facilities such as being able to call upon the services of a warden. Such accommodation is commonly available to older people in the U.K. and, as in France, has often been closely developed with community activists or charitable organisations involved in the care of the elderly. They cater essentially for older people in good health, capable of living independently, but who would like occasional assistance and reassurance from a warden who lives on-site. Some examples of such housing developments also exist in Poland and in Italy, both in the state and charitable sectors.

Innovative alternative housing solutions

A number of countries have developed a range of unique and interesting services for the support of older people, with the aim of allowing them to lead as independent lives as possible, within the community. The Italian model, for instance, show some examples of residential homes for self-sufficient or partially self-sufficient elderly people, such as community homes, hotel-houses and multi-functional collective homes. In France, older people may be placed with a "foster" family, a practice which was reorganised by law in 1989, allowing families to take one or two elderly people

into their own homes for a fee. A similar scheme has been operated since before the war, in the north-eastern region of Poland for psychiatric patients who no longer require active treatment in hospital, but for whom discharge into the community was not possible for reasons of not having a family or home. Such long-stay psychiatric patients, the majority of whom were, or have become elderly as a result of many years of hospitalisation, are given the choice of going to stay with a local family, usually in a rural area, and helping them on their small-holdings or of remaining in hospital. Families are paid a monthly fee for taking former patients into their homes. Although this scheme has lost a great deal of impetus over the last decade and now provides very few rehabilitation placements for psychiatric patients, it was an innovative and remarkable contribution to the care of psychiatric patients, for whom hospital would have been the only alternative.

5. The role of informal care

Despite the great and increasing variety of residential and community services, informal care (a term which include family, volunteer, neighbourhood and other forms of unpaid, non public support to the elderly) represents still today in almost all COPE countries the most continuous and pervasive form of care dependent people can count upon in case of need. A first, main feature of caregiving has been defined a “female task”, due to the fact that also in all COPE countries, as elsewhere (Estes 1993), women represent the overwhelming majority of carers. Another related, common factor is the primary role played in the provision of care by the spouse of the cared-for person, followed by that of the daughters (and, much less frequently, daughters-in-law and sons), who usually intervene in the absence of a spouse or when the spouse is unable to provide the necessary help her/himself. The burden of caring represents a further phenomenon which characterises the support activity provided by many carers in all countries, although truly comparative data which enable carers experiencing the highest or lowest levels of stress to be identified are still lacking. A situation common to all carers is furthermore the inadequate information most of them experience with regard to the existence of assistance and available support programmes (where the latter exist). However, differences among countries, sometimes striking ones, are also present, and the following paragraphs will concentrate on the presentation of these international variations.

5.1. Family care

The role played by the family in granting support to the disabled elderly in need varies from country to country, but still remains central in most of the investigated nations. Empirical findings from France, Italy and Poland let estimate the percentage of elderly receiving family care (on the total of elderly needing support) to be approximately between 80% and 90%; similar figures can be reasonably supposed to be true for Greece, too, while for Sweden and the U.K. lower percentages might rather be the case. It has to be underlined, once again, that good comparative international data on this issue are quite rare and that one should be cautious about the use of such figures, since they "hide" those older people not cared for at all, nor allow any relevant insight into the quality of caregiving (like for instance how many elderly, while nominally under family care, are actually inadequately cared for, or how many carers are managing badly with their role).

Legal aspects

From a legal point of view, in almost all COPE countries children are obliged to take care of their dependent elderly or, in other words, to “pay” for their care in case they have to be cared for by public services, eventually through residential solutions (see Table 9).

Table 9: Legal regulation of care in case of a dependent elderly

Country	Obligated persons
France	Children, children-in-law and other ascendants
Greece	Children
Italy	Spouse, children, children-in law, parents-in law, siblings
Poland	Children, grandchildren and other descendants
Sweden	None
United Kingdom	Spouse (in some cases, for refunding costs of institutionalisation)

Source: Country Background Reports

There are, however, national variations in the degree of such obligations. In Greece, for instance, it is the Constitution itself which makes the children of an older dependent person responsible for his/her welfare and support. Already this specification makes clear that caregiving responsibilities are devolved onto the family, with the proviso that the first responsibility be charged by the children. However, there is no legal or social mechanism to chase up children who do not care and could. Similarly to the Greek context, Polish legislation too ensures that children are obliged to support financially their elderly parents, if these find themselves in difficult economic circumstances. Even though this law is in practice very rarely invoked - although the newly introduced system of assessing social needs might determine a more frequent application of it in the future - the norm reflects the fundamental role which the family plays also in Poland in providing elderly care, being expected to fulfil all the basic care tasks with respect to its members. The maintenance obligation constitutes in France too the legal basis for the idea of solidarity within the family, being children obliged to provide maintenance to their parents (and parents-in-law) or other ascendants in need (Jani-Le Bris 1993). The evolving family structures, contexts and situations are however reducing the social consensus towards this traditional approach. As a matter of fact, this has been increasingly seen by many elderly as an "attack" of the State towards their children, since the State usually succeeds in collecting from other relatives an average of 40-45% of the financial support provided to older people in form of social aid. In the U.K., although various duties and responsibilities are imposed by statute upon professional or paid carers, informal carers are not legally obliged to either initiate or maintain their caring duties. This means, among other things, that family members are not legally implicated in covering the costs of a dependant's accommodation fees. In some cases, however, spouses (who, according to legislation, are liable to maintain each other) may be requested to refund part or all of the local authority's expenditure on the residential accommodation. The only country where this does not seem the case is Sweden.

The role of the family in the care of the dependent elderly

The traditionally well-developed Swedish welfare system had been till not long time ago able to ensure a quite comprehensive range of care services in both health and social sector, thus considerably reducing the necessity and the importance of non professional carers. One way to quantify, even though approximately, the relevance of the formal sector is provided by the estimates suggesting that in this country home help services cover almost half of the need existing in this

field, being the other half covered by informal work. This seems to reflect a deep cultural characteristic of the Swedish society, where four persons out of five state to prefer help from the society rather than from their own family (Jeppson Grassman 1993; Andersson & Johansson 1996) and most older people do not want to depend on help from their relatives under any circumstances (Möller 1996).

With regard to this aspect, the difference between the Swedish case and the Greek situation is quite striking, since the "Greek way" of providing elderly care is mainly based on the family, and much less on formal services. The indicators of this overwhelming role played by the family in this sector have to be inferred from secondary data, such as the low percentages of elderly hosted in residential homes (less than 1%) or receiving home care (a few hundred households concentrated in the few main cities) (Triantafillou & Mestheneos 1994b). The social and cultural reasons of this central role of the family lies in the traditional principle of reciprocity which rules the Greek society, according to which the adult generation "invests" during the life course in the younger generation by providing it with support in different forms, with the "unwritten" expectation that these gifts will be later on repaid in terms of care in old age. Under such circumstances, it is not surprising that the financial situation of both cared for and caring persons is often a decisive factor in determining the actual quality and quantity of informal care on which an elderly person can count upon, thus representing one main factor of inequality among elderly people in Greece (Tinios 1996).

In the U.K. one adult in eight (13%) is providing care, indicating that there are about 5.7 million carers overall in Great Britain, of which about three fourths caring for a partner (50%) or a parent or parent-in-law (24%). Data for this country indicate that the elderly between the ages of 45 and 74 are most likely to be cared for by a spouse/partner, those aged 75 to 84 are equally likely to be cared for by an adult son or daughter as a spouse/partner, while those aged 85 and over are much more likely to be cared for by an adult child.

In Poland, the closeness of family ties is expressed in different forms of mutual help, of which the most important experienced by the older generations are "receiving care during times of illness or disability", "psychological support" and "help with the performance of the activities of daily living", while financial or material assistance is much less frequent (Halicka, Pedich, 1997[10]). On the whole, a reasonable estimate is that 80% of all disabled elderly receive support from their own families.

In France, too, the majority of older people are able to spend their last years at home, thanks to the support provided by their families in integration to the system of formal care. The few available data provided by studies on informal caregivers of older people in this country suggest that up to 90% of all dependent elderly French living at home receive help from people around them (Renaut & Rozenkier 1995). A national survey conducted in 1992 revealed furthermore that 80% of children of the "pivot" generation (aged roughly 45-55) would be ready to provide regular support to their parents or parents in law, in case they needed it. Only 25% of them would however be available for housing the elderly, preferring the majority (56%) to provide care without housing them, alone (23%) or complemented by professional care (33%).

Similarly to other Mediterranean countries, Italy too shows a traditional approach to elderly care mainly based on the support provided by the family. Many Italian elderly, though not cohabiting with other family members, experience a so-called "intimacy at a distance" with them, as shown by the fact that 59% of elderly who live alone see their offspring once a day and 20% more than once a week (Istat 1995b: 110-111), confirming that Italian elderly, compared to their North-European peers, have more frequent family contacts (Ditch 1995: 120). Cautious estimates indicate that, similarly to what recorded for Poland, over 80% of elderly care is provided within the informal network of the enlarged family (Ditch 1995: 118; Pernigotti 1994; Dell'Orto Garzonio 1990: 81).

5.2. Voluntary organisations and other forms of informal care

The role of voluntary organisations in providing some form of support to carers seems to be greater in France, Sweden and the U.K., in an intermediate position in Italy and much less developed in Greece and Poland. In the last country, however, the ongoing transformation from a communist to a more market-oriented society shows to have triggered off a process of pluralisation of care providers partly based also on the contribution of a growing number of non-governmental organisations. This has been defined by some observer as a transition - although a very slow one - from a two-dimensional (State-family) welfare system to a three-dimensional one (State-family-market/voluntary sector). Evidence of this trend can be observed for instance in the fact that home care services, generally ensured by the local authorities by means of the community centres for social services, were in one third of cases provided through non governmental organisations (of which the most representative are the Polish Red Cross, Polish Committee for Social Services, Association of Friends of the Terminally Ill "Hospice") or private care agencies.

In all countries voluntary organisations provide hands-on care (this is the case in France, Poland and Italy), but in Sweden and the U.K. these organisations are also involved in lobby work (mainly, but not only, through the pensioners' organisation) and in supplying information and advice to both carers and decision makers. In Greece voluntary work has traditionally been practised on a religious or philanthropic basis. The Orthodox Church as well as the smaller denominations provide considerable support in the form of residential homes, meal services and parish support. The Hellenic Red Cross piloted projects of home care services in the main Greek cities with joint public funding. More recently, an organisation for the support of family carers of people with Alzheimer's disease has been formed, under the auspices of the Hellenic Association for Gerontology.

As far as France is concerned, several organisations are involved in the provision of support programmes not only for the elderly in need, but also for their carers. Among the most engaged in this field are the *Fondation de France* (active since 1988), the Association of Rural Families (in co-operation with the Complementary Fund for Agricultural Workers since 1993), the National Federation of Schools for Parents and Educators as well as the "Green Door" Listening-Counselling-Orientation Programme.

In the U.K. there are several voluntary organisations involved in health care that operate at a variety of levels. Organisations that work at a national level - such as for instance Age Concern, Help the Aged and the Centre for Policy on Ageing - often play an important policy development role in campaigning for health and social issues related to older people. A similar lobbying role is undertaken on behalf of carers by voluntary organisations such as the Carers National Association. The smaller, more locally based, voluntary organisations provide important health and social care services. Services provided by such organisations may substitute, complement or support those offered by the statutory sector. These may include hospice care, self-help groups, information services, advice centres and health research facilities.

In Italy, the work of volunteers - who in 1996 amounted to 70,000 person in 1,280 organisations working in the elderly care sector - is mainly concentrated in institutes and hospitals of urban areas, where they are sometimes integrated by conscientious objectors, young men performing their call-up service within the care departments of Municipalities and Health Authorities. In this country, collaboration from neighbours – mostly in terms of errands, company to the old person, or "respite" support aimed at providing a short break to the family carer - is a reality which concerns a minority of the elderly population, in most cases living in small towns or rural areas. On the whole, however,

these non-familial support sources tend to be quite sporadic, thus often ending up as a very bland kind of support.

A particularity of the Greek and Italian situation can be found in the fact that a relative large and still increasing number of well-off families turns to the services of foreign migrant care workers, mainly women, in order to provide care in the home of the older person. This solution is often preferred when the carers cannot provide themselves continuous supervision, and because it remains still less expensive - being in most cases undertaken through non registered labour - than paying the fee of a residential or nursing home, which would also mean moving the elderly person out of his/her home. A further reason lies in the fact that, in these countries, informal support coming from sources other than one's own family is quite rare, but due to both demographic, and socio-economic reasons the enlarged network of relatives, active above all in rural communities, can less and less frequently represent a simultaneous care support for the elderly and a physical-psychological help to the caregiver. While the presence of foreign immigrants in the home care of the elderly is documented also in Sweden and the U.K., no data are available on this issue for Poland.

6. Support measures to family and informal caregivers

The role played by the State in providing support to caregivers varies greatly from country to country. Lately, however, the involvement of some national governments in terms of formal support programmes and relief measures for caregivers has been more explicitly pursued by countries like Sweden and the U.K., while the issue has still difficulty to reach the national political agenda in countries like France, Poland, Greece and Italy. In the latter it is sometimes the local level which plays a major and innovative role in providing support measures and innovative intervention in favour of caregivers. A synoptic overview of the supports made available to carers in the different countries can be found in Table 10.

Table 10: Support measures available to caregivers

Country	At a national level			At a local level
	Care allowances	Pension benefits	Fiscal measures	
France	Yes (to cared for)	-	Yes	Yes
Greece	-	-	Yes	-
Italy	Yes (to cared-for)	-	Yes	Yes
Poland	Yes (to cared-for)	-	Yes	Yes
Sweden	Yes (to carer)			Yes
United Kingdom	Yes (to carer)	planned	planned	Yes

Source: Country Background Reports

6.1. National level

General legislation

In Greece there are no statutory payments made directly to family carers for the services they perform in looking after their older dependent relatives. Some incidental support is provided by the Hellenic Red Cross home care services, in association with the Greek Ministry of Health and Welfare, through counselling services and training programmes for carers in home nursing techniques (Triantafillou & Mestheneos 1994b). However, these interventions are limited to the three main cities of the country. Similarly to the Greek case, in Poland too no national support measure is formally available, but some support might be found on a local level (see next paragraph). Both the Greek and the Polish tax systems provide furthermore a certain limited tax relief on expenses involved in the care of a dependent relative. In Poland this is however limited to those cases in which the cared for person has got the legal confirmation of disability.

As far as France is concerned, it can be stated that in this country no real "system" of support for the family caregivers exists, with the exception of some tax exemptions and of limited allowances, services and/or programmes for people caring for family members in certain geographic areas scattered throughout the country. As a matter of fact, the diversity of public finance sources and the lack of co-ordination among existing services contribute to make the "French way" of providing support to carers a quite uneven (and for many carers therefore often unknown) ensemble of variegated measures.

The Italian State provides to the disabled elderly, besides a disability allowance, a so-called "care allowance", aimed at paying (part of) the costs faced by the cared-for person for the help provided by third parties. This kind of support, which currently amounts to circa 400 Euro per month, is therefore not a right of the carer, but of the cared-for person, who is actually free to use it as he/she wants. No other kind of supports are available at a national level, but financial help and care services at a local level are increasing (see next paragraph). The Italian legislation allows furthermore that all expenses incurred as a direct consequence of sustaining a disability, whether by the person themselves or by other family members, are tax-deductible up to a sum of 5% of the person's income.

In the U.K. informal carers are eligible, providing they are under retirement age and caring for more than 35 hours a week, for the Invalid Care Allowance of £38.70 per week, which is currently received by 373,000 recipients. Although this figure may appear large, for those caring for 20 hours a week this works out at under £2 an hour - considerably less than the minimum wage. Furthermore, a great many carers must forsake a full-time career to allow time and energy for their caring roles, and as such suffer a major loss of earnings, thus the Invalid Care Allowance clearly offers only a very limited contribution towards the costs of informal caring.

The Swedish legislation provides that relatives who take care of their older family members can receive payment from the municipality in terms of financial support or employment for carrying out the caring activity (see next paragraph). Furthermore, if a person has to take care of a seriously ill family member, there is the possibility for the carer to take time off work (care leave), with compensation from the social insurance system, for up to a total of 60 days per person.

Supports for a particular group of caregivers: the working carers

Due to the increased participation of women in the labour market and the concomitant tendency to raise the statutory retirement age, a group of carers who are increasingly put under pressure is the

one of the professionally active caregivers. Although some kinds of relief measures are already available (see Table 11), only a few countries have adopted a deliberate approach in support of the specific needs of this growing segment of population.

Table 11: Support measures for working caregivers

	paid leave	**unpaid leave**	**part - time**
France	Few days per year	possible	Promoted and widespread
Greece	-	6 days per year (10 in case of two cared-for persons)	Possible and rare
Italy	25 days per year (up to 24 months during the working career)	up to two years (without pension benefits)	Promoted but rare
Poland	14 days per year	possible	promoted but rare
Sweden	Up to 60 days per year	possible	possible but fairly rare
UK	Short term breaks	possible	promoted and widespread

Source: Country Background Reports

One of these countries is for instance Sweden, where working carers can take time off work, with compensation from the social insurance system, up to 60 days per year. This opportunity, furthermore, can be taken advantage of not only in favour of an older family member but also for taking care of a close friend. Much less generous is in comparison the Greek legislation, which allows only for an unpaid leave of 6 days per year, extendable to 10 days in case the carer has to provide support to more than one cared-for person (until recently, however, female workers in the public sector with young children and over 15 years of employment service were entitled to early retirement with a lower level of pension).

Flexible working patterns and leave provisions are two ways through which the U.K. government is trying to encourage and enable caregivers to remain in work. Since most of existing provisions aimed at allowing individuals to meet both work and family responsibilities have been originally targeted at parents, there are official plans of extending them explicitly to encompass carers. Furthermore, the government's *National Strategy for Carers* is planning more flexible support services as well as schemes aimed at helping carers to return to work when caring comes to an end. Improvements in financial support for working carers and in the entitlement to pension benefits in connection to a caregiving activity are also included in the official steps to be undertaken in the next future.

Among the different alternatives available to the Italian employee who has to look after an elderly (or any other disabled person), one is the recourse to part-time, which is though relatively easy to obtain only for public employees, while many private employers are still very reluctant to grant it. To the employee who has to look after an elderly on a full-time basis - and cannot therefore profit by working part-time – paid leave is available, but only if the dependent family member co-habits with the older person and, perhaps the greatest restriction of this measure, only up to a maximum of 25 days per year and 24 months in the whole working life. For those who have to dedicate themselves to periods of continuous full-time caregiving - and this is the burden the family usually faces when having to care for a totally disabled elderly person - the only alternative presently available is to quit working for a period of "unpaid leave", recently prolonged to a maximum of two years. This opportunity is again available in practice only to civil servants, as in the private sector the recourse to it is much less realistic, and often represents an "easy way to lose one's job". The increasing difficulties which working caregivers are currently facing, despite recent improvement within the Italian legislation can at best be illustrated on the basis of a recent survey on over 400 carers carried out by I.N.R.C.A. (the Italian National Research Institute on Ageing, run on behalf of the Italian Ministry of Health). Preliminary results show that, *among the caregivers who are still working*, over one fourth complains of problems of excessive inflexibility at work - in terms of time schedules, leave of absence and holidays - as well as of lost career opportunities. *Among the non-working caregivers,* problems are due to early retirement (for pensioners) and to the impossibility to work (for housewives).

6.2. Local level

The involvement of Greek local authorities in caregiving support programmes is quite recent, and still at an embryo stage. Since 1995 Greek municipalities are however responsible for the running of the KAPIs (Open Care Community Centres for Older People), originally organised by the Ministry of Health and Welfare based on pilot volunteers projects. Since 1998 an EU funded 2 year pilot project provides the necessary resources for implementing home care services for dependent older people in 140 municipalities. However, neither the KAPI centres which cater primarily for the well elderly, nor the new home services are designed to support family carers, even if in practice many do so.

Although in Poland no specific support programmes are organised to provide help to caregivers of disabled elderly, carers are entitled to apply for social support like any other citizen, as long as they can prove to find themselves in a condition of low income and of not being able to manage the caring situation by themselves. As a matter of fact, since 1993 the provision of care services falls within the competence of local authorities, which are responsible for ensuring an as wide as possible range of services to the population.

In the U.K. several local Social Services Departments provide relief measures for carers of older persons. These can be found in form of relief periods, day care centres or short-stay care. Day care centres, in particular, are attended at present by approximately 5% of the elderly population around the country, thus fulfilling the role of providing a break from their caring duties to a large amount of carers. Short-stay care services organised by local authorities allow instead older people to stay for a limited period, either on a one-off or a rotational basis, in a residential home. This provides the older person with a holiday/rehabilitative break – and it is often employed to aid in emergency situations or to prepare/assess an older person for entry into long-term care – but one of the primary purposes of short-stay care is also to provide relief for carers.

As far as Italy is concerned, in the last few years local forms of contribution have been provided by several regional and municipal authorities, aimed at financially support families who care for non self sufficient elderly in their own home (Credendino 1997: 70). These contributions - which usually add up to amounts between 300 and 500 Euros per month - are mostly meant to be used to cover expenses for home help and, unlike the state care allowance, are means-tested. The provision of health and social care services is otherwise very seldom explicitly organised with the aim of providing relief and/or help to the caregivers, although the growing number of (generally means-tested) home care programmes for disabled persons certainly does contribute to provide some relief to their carers, too. It is worthwhile to mention that, in some municipalities, a new form of "elderly fosterage" has been recently experimented, according to which non relatives (such as friends or neighbours) are stimulated to provide care to disabled elderly - either by hosting them in their home or taking care of them in the latter's home – receiving for this task a "foster allowance" of 300-500 Euros.

In Sweden, despite the legislative provision according to which caregivers can receive from the municipality financial support or an allowance for carrying out the caring activity, very few carers are today beneficiaries of such measures (in 1997 6.000 received financial support and 3.300 were employed under this kind of programme in the whole country). Furthermore, just a few municipalities provide a systematic way of supporting informal caregivers. While only 5% of the municipalities have already an official plan for carers and 15% distribute written information about the help provided, in 40% of them the development of support measures for informal caregivers is still in progress and 45% have selected a responsible for this work; so far, no effort has been made to try to evaluate the quality of what has been done (National Board of Health and Welfare 1998).

6.3. Assessment

The burden and isolation from which many carers suffer, to the extent of having to be considered a group at risk, is reported in all considered countries, so as the need for respite and relief care, eventually combined with information and educational programmes. This has been identified as true especially for caregivers of demented elderly. The experience of positive feelings in connection with the caring activity is much rarer, but not totally absent, and mostly connected with emotional aspects, too often neglected by existing support programmes. Despite the evidence of such widespread and consistent needs, only in very few cases a formal assessment of the exigencies of caregivers is carried out, although the relevance of such instruments has already been widely recognised by most national authorities.

In Sweden, for instance, 75% of municipalities uses standardised processes in order to identify people with needs, but due to the high autonomy enjoyed by these bodies, the assessment tools can vary greatly from municipality to municipality. In Greece, the only assessment of the carer's needs is informally provided by the Red Cross Home Care services, as part of the global evaluation performed regarding the older person whom the home care service is actually supplied to. No formal assessment instruments are used to this scope.

No systematic or structured assessment instruments are used in practice in order to evaluate the possible specific needs of care coming from caregivers living in Poland. However, since 1997 the social workers of the Community Centres for Social Services are obliged to use an extensive questionnaire whenever someone applies for public help. This instrument - which is actually used to assess the financial circumstances of the client and of his/her whole family, in order to evaluate if and to which extent public resources can be granted to ease his/her case - allows to identify also the main family carer, and possible needs from his/her part.

The use of a standardised assessment technology seems to be a little bit more widespread in France, where several quantitative tools are available for measuring the psychological consequences of care for the carer, including instruments for the evaluation of burden. The latter instruments – and in particular Zarit’s *Burden Inventory* - have been used in several areas to synthesise physical, psychological and social dimensions of carers' situations. Despite this great availability of assessment tools, however, their use by existing support programmes carried out throughout the country seems to be quite limited. As a recent national survey has in fact clearly shown, most of these programmes do no give priority to evaluation, and often go by intuition in maintaining that their actions are useful and necessary.

In Italy, the assessment of the health and social status of the caregivers and of the effectiveness of the interventions adopted to improve it, has traditionally made little use of standardised instruments, also due to the lack of clear legislation. Although in the last few years there have been signs of a cultural change, this has rarely been reflected in routine assessment measures of caregivers’ condition, and mostly used in primary health care only by those practitioners who, apart from their clinical activity, also carry out research and scientific writing. Among the most used instruments, Greene’s *Relative’s Stress Scale* is no doubt the most commonly used assessment instrument, given its extreme rapidity of administration, and it is used not only in hospitals or outpatient settings, but also for field research. The need for more refined and gender-sensitive instruments of diagnosis and evaluation in this field is however generally felt and affirmed by several authors and supported by research.

Already in 1995 the U.K. government devised a *Carers (Recognition and Services) Act,* whose main feature was to commission social services departments with a statutory duty to assess carer’s ability to care and their needs. This provision, however, has been not sufficiently enforced, since evidence suggests that, despite existing legislation, in this country many carers are not being offered an assessment nor do they know that they have a right to ask for one. This is probably due to the fact that assessment eligibility criteria are unclear, assessment itself remains strongly focused on the cared-for (with carer’s needs being marginalised) and, finally, no demand is made for the utilisation of a standardised assessment tool. In addition, assessments are likely to focus on the objective components of caring, such as physical demands, which reveals relatively little about the degree of stress that a carer is experiencing, and all too often assessments focus on the negative aspects of informal caregiving to the detriment of the neglected positive dimensions of caring, as it can be noticed for the most widespread tools, such as the Zarit’s Burden Interview, Robinson’s Caregiver Strain Instrument, Lawton’s Caregiver Appraisal Measure and Kinney’s and Stephens’ Caregiver Hassles Scale. The deficits of the Carers Act are recognised by the recent *Carers National Strategy*, which however, despite the provision that carers are entitled to expect at least an annual discussion of their needs, nothing says about the manner in which this information should to be collected.

6.5. A synoptic scheme of public support available in a practical case

In order to provide a practical example of which supports are available in the COPE countries when a family member is facing a difficult caregiving task, like for instance in case of an incontinent, severely demented elderly with disruptive behaviour, table 12 synthesises which public supports are available to dependent elderly and their caregivers under such circumstances.

Table 12: Public support available in case of an incontinent, severely demented elderly with disruptive behaviour

Country	Assessment of		Care allowances*		Day care centre	Pension benefits	Fiscal measures	Local support	
	cared for	carer	Cared for	carer				Home care	Allowances*
France	Yes	rare	yes	no	rare	no	yes	in main towns	in some regions only
Greece	Yes, hospital	no	yes	no	no	no	yes	not for those with family carers	Limited, discretionary and low
Italy	Yes	occa-sional	yes	no	rare	no	yes	in most towns (means tested)	only in some regions / towns
Poland	Yes	rare	for 75+	no	rare	no	yes	in most towns (means tested)	Means tested
Sweden	Yes	yes	no	various	rather rare	no	no	Yes	Various
United Kingdom	Yes	social services only	yes	yes	rare	not yet	not yet	mainly in towns	In some regions only

Source: Country Background Reports

7. Summary and final remarks

In response to the ageing of their populations, many European countries have introduced changes to their health and social care legislation, aimed at providing an adequate response to the needs of an increasing number of elderly users. In most cases, the restructuring in the provision of services has been driven by the objective of helping older people to lead as independent lives as possible within the community, despite their disabilities. Equally however, it has been increasingly recognised that the burden for family members who care for a sick or disabled relative can be considerable, sometimes even intolerable, leading in certain cases to a sudden and terminal breakdown in care. Some countries such as Sweden and the U.K have responded to this situation by introducing legislation aimed at supporting carers, whilst others, such as Italy, Greece, Poland and, to a certain extent, also France, are only just beginning to develop legislation in this area.

Current problems

In Sweden the recent cuts operated, due to financial constraints, especially in the number of hospital beds for long-term care as well as in the resources provided by municipalities for carers' support programmes have increased the pressure on the family, which is today expected to intervene in help of its weaker members to a much greater extent than in the past. This is confirmed by the fact that today, despite the above mentioned generalised desire of not having to rely on relatives, only 35% of people with needs living at home can count on professional carers in addition to help provided by the family. Among these professionals, however, a growing lack of involvement as well as of co-ordination between services is reported. Quite recently a new programme in support of informal caregivers has been started by the National Board of Health and Welfare, which since 1998 is accompanied also by a new legislation that imposes on municipalities the task of improving the system of relief and respite care services for informal caregivers, thanks to ad hoc funding for the

period 1999-2001, aimed at stimulating support projects for informal caregivers and to bring about improvements to co-ordinate all the different resources in this sector.

The traditional centrality of the Greek family in elder care is under growing pressure, due to trends such as the fall in the birth rate, the increasing participation of women into the paid labour market and a stronger tendency to individualism and consumerism. These phenomena are already causing a greater strain on the family which, due to the lack of valid alternatives in terms of community care, may lead to improper use of hospital facilities for "respite" admissions. However, compared to other European (and especially North-European) countries, the idea that caring represents an inevitable element of family life and constitute a duty of a family member, may explain why still today many Greeks, especially women, tolerate the difficulties connected with caring, often sustained also by the realisation of the fallibility of medicine and of health care in general, which many Greeks seem to share.

The lack of data and appropriate research does not allow definitive inferences on the issue with respect to Poland, where the marginality of the caregivers' support topic within the national political agenda is reflected by the fact that no new measures have been adopted in the last two years in this field. However, the gradual disintegration of multi-generational family life observed recently in this country can be expected to produce a negative effect on the conditions under which family caregivers provide help to their elderly relatives, increasing their burden and worsening the quality of care provided, thus producing a greater pressure on policy makers to reconsider with greater attention the issue.

The French social security and social aid systems have recently faced growing financial difficulties due to high (although now declining) unemployment rates, increasing quota of older population as well as growing health and pension costs. The strategies which have been implemented by the State in order to respond to this financial crisis, have been mainly consisting in reducing existing benefits, limiting access to certain services and decentralising their management and privatisation measures. These have however had the effect of shifting part of the responsibilities towards the family and the community, looking at these social institutions as more economic and efficient solutions when used in conjunction with the formal public systems of care. Therefore, over the past decade, the role of informal care has been regarded as increasingly important, even to the detriment of formal care. In many cases, however, the impact of this decline in government assistance has been negative for the family, which has been often pushed to the limits of its capacities.

As far as Italy is concerned, the traditional lack of home care services and of support measures aimed at the elderly and their caregivers seems currently to be improving. A first sign in this direction came from the Italian National Health Plan 1998-2000, where within the section devoted to the elderly the objective was set up "to adopt policies of support to families with elderly people in need of home care (also with a view to safeguarding the health of women who are, in most cases, the main responsible for the assistance)". A second trend is the establishment - especially in the North of the country - of "special units" for demented elderly within existing residential structures (nursing homes and long-term care centres), as well as of daily care centres and outdoor areas (the so called "Alzheimer gardens") for patients affected by wandering behaviour. A recent law has introduced a series of norms to favour a better co-ordination between work and family life, through the rationalisation of existing laws in terms of unpaid leave from work, financial support and incentives to part-time work for caring reason. On the whole, however, these proposals appear to be still too cautious and modest for a health system which allocates two thirds of financial resources to hospital care, leaving to prevention, rehabilitation and primary care a very marginal role, and in a time in which, following financial cuts due to economic constraints, elderly people affected by chronic pathologies are more and more "expelled" from the system of health care, thus increasing

the difficulties the sector of social assistance but also in the burden of assistance to be borne by the families.

Also in the U.K., although both the National Health Service and the Department of Social Services have been designated a key role in supporting carers, there is a distinct lack of co-ordination and co-operation between the two. Indeed, each agency works as a separate body and only has limited interaction with the other. The carer and the cared-for, however, present with a rich conglomeration of health and social needs, that would be best met by a comprehensive interdisciplinary team. Related to the issue of inequality, particularly salient are the variations between support available to those living in rural areas as compared to those living in urban regions, so that still all too often "support depends on where carers live and who they are in contact with in social services than on what they need".

In order to provide an analytical framework for the comprehension of the different carers' support systems existing in the COPE countries, table 10 contains an overview of their main features. These are in particular referred to following aspects, showing whether the system characterising each country:

- is prevalently based on a division of tasks between health and social care (*specialised)*, or on an integrated co-ordination between the two sectors (*integrated*);
- relies more on monetary transfers or rather on the provision of real services;
- is mainly made up of measures and interventions initiated at a national level or rather promoted by local administrations;
- can be considered at an initial stage of implementation of support measures for carers, or rather advanced, this meaning that such interventions are offered since a relatively long time and in an articulated way
- all in all, is improving or deteriorating in the general task of providing relief and support to carers.

Table 13: Overall characteristics of the support system for carers in the COPE project countries

Country	Integrated vs. specialised	Monetary transfers vs. care services	National vs. local support (uniformity vs. differentiation)	Stage of system (initial vs. mature)	Overall trend (improving vs. worsening)
France	Specialised	Mixed	mixed	Initial/medium	Slightly improving
Greece	integrated	tax support	local support	initial	Very slight improvement
Italy	specialised	Monetary transfers	mixed	initial/medium	slightly improving
Poland	specialised	Monetary transfers	mixed	initial	slightly improving
Sweden	integrated	care services	national decisions but local discretionality	medium	Improving
United Kingdom	specialised	care services	mixed	medium	Improving

Source: Country Background Reports

Future perspectives

Due to the deep differences existing among the various national health and social care systems, elderly care seems today a field where still much needs to be known and to be done on an European level, where in particular it can be recommended to encourage policy actions aimed at improving active involvement of caregivers, especially if of older age (EurolinkAge 1999). This is particularly important in order to promote healthy ageing by reducing social isolation and negative effects on mental health such as anxiety and depression, who on turn are important contributing factors to frailty and loss of function in later life. At a national level, the implementation of support policies to informal caregivers needs in some countries a more decisive impulse, since these are universally recognised as the real "motor" of the elderly care systems at work in the different countries, but very seldom officially rewarded for the tasks they daily provide, in most of cases without any formal support. On the basis of the most recent trends observed with regard to this aspect, some major challenges to be urgently tackle in the next future can be identified in the COPE countries.

In Italy a better allocation of public resources, especially within the health care sector, could contribute, on the one hand, to an improvement of the still lacking home care services and, on the other hand, to the diffusion of day-care centres and "special residential units" for demented elderly people, both very important means for providing relief to caregivers. It is furthermore urgent that a better co-ordination between health and social care takes place, in order to reach more synergies among services provided by the two sectors, and more benefits for the dependent elderly and their families.

The U.K. government is currently consulting on proposals which, according to the *National Strategy for Carers*, could mean that, by 2050, carers receive an extra £50 a week for the Invalid Care Allowance in today's terms. In addition, a Carers Special Grant of £140 million is being made available over the next three years to allow carers to take breaks from their caring duties. This is certainly a step in the right direction for carers, many of whom consider short-term breaks to be one of their key priorities. A major problem which needs to be tackled urgently is the limitations existing in the current assessment procedures for both carers and older people receiving care who, despite personal issues and individual needs, also form a 'caring team'. Steps need to be taken to clearly define eligibility criteria and exact contents of assessments for carers and their dependants, in order to introduce standardised and culturally sensitive assessment tools.

The co-ordination of all existing resources from public and informal care seems to represent a main challenge in Sweden, too. Taken for granted that a good quality level of existing care services will be maintained in the next future, a more individually tailored provision of the care programmes according to the specific needs of each patient, as well as of the support measures for each informal caregiver, is probably the next goals which the elder care policies of this countries will try to achieve.

As far as France is concerned, while the range and quality of provisions for frail elderly people has undoubtedly improved enormously in the past - especially in the fields of residential and of home care (OECD 1996; Hutten and Dikstra 1996) - the development of policies and services in response to the needs of family caregivers has been lacking, and needs in the future a stronger impulse towards a practical implementation. One major problem which needs to be urgently overcome is also the fragmentation of responsibilities concerning the organisation and funding of the health care system, which prevents the provision of co-ordinated, multidisciplinary support services. This is partly due to cultural factors, such as for instance the phenomenon of the medicalisation of the

problems of older people with chronic diseases and of their caregivers, which has contributed to the lack of interdisciplinary solutions to the "dependency" of older people in need of integrated, multiple services, and not just of medical care.

In Greece a major problem lies in the income related inequalities in private solutions for the support of the dependent elderly available to family carers, and in the absence of adequate public provision. The existence of traditional family expectations comes into conflict with the fact that many women are forced into the labour market to maximise family income, and their own changing expectations. The middle class, which in most countries is a major force for achieving better public provision, is here finding temporary solutions through foreign home carers and residential homes. What will happen when these forms of cheap domestic labour are no longer available? Will there be enough local people willing to work in organised domestic and home care support services for the elderly? Private services have hardly begun to develop in Greece, a situation that contrasts with the UK where many such services have developed.

Poland is the country that is facing, within the COPE countries, the most intensive transformation, rebuilding and developing its economic potential for improving the effectiveness of its medical and social policy. Health and social policies are not enough formally and in practice integrated. Social and health policy for the elderly still does not exist. An implemented health reforms do favour neither the older people nor geriatricians. The future challenges should apply to education in gerontology at both under- and postgraduate level. The next challenge is to bring about an improvement in team co-operation between medical and social practitioners in the field of primary care in the area of recognising and helping to solve the complex problems and needs of the older person in his/him life environment. An essential condition for this kind of co-operation is the mutual exchange of information, based on objective and standardised instruments for the assessment of functional, psychological and social status. The development of pluralism in care provision, as well as providing support for family carers, might be a way of reducing the need for services from malfunctioning public sources, and at the same time help to improve quality of life for older people. Finally, a further important challenge for health and social policy in Poland is to develop a widely accessible geriatric rehabilitation, also for people housebound.

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