Services for the elderly in Europe

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1990

1990-66.

2 ex

Faculteit der Economische Wetenschappen en Econometrie

ET

Serie Research Memoranda

Services for the Elderly in Europe: A Cross-National Comparative Analysis

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Research Memorandum 1990-66
December 1990

vrije Universiteit *amsterdam*

Abstract

This paper condenses the findings of a study on the provision of services for the elderly in Europe. The study, initiated by the Commission of the European Communities, includes the twelve countries of the current European Community (EC) and aims to identify the core public policy issues for the elderly arising from European integration. Apart from describing invariable developments within the EC relevant to public policymaking on aging the paper provides an overview of the residential and community services available to the current elderly of the EC. In order to safeguard appropriate usage and upgrading of these services, thereby promoting a dignified old age for all Europeans involved, we specify a new task that Brussels may need to take on.

Services for the Elderly in Europe: A Cross-National Comparative Analysis

A recent demographic development in the countries of the European Community - notably the unprecedented increase of that part of the population aged over 65 years - is likely to have far-reaching consequences. This article is one of the first attempts to depict the most important policy consequences and presents similarities and differences throughout the EC in the quality and quantity of services provided. The focus of this article is on the available residential and community services for the European elderly as well as on the social policy forces that propel them. It was found that the quantity and quality of the provision of services for the elderly differs considerably among the twelve countries studied. Furthermore, national policies oriented towards the supply of these services evolve in different directions and, besides some similarities, show great differences in scope, orientation, financing, institutional organization and coverage (see also Nijkamp, Vollering, Wilderom & Pacolet, 1991; and Nijkamp, et al., 1990). For a very long time information on these issues was so scattered among the widely different sources that the lack of comparable information precluded mutual learning within the EC about services and services planning. This situation prompted the Commission of the European Communities to launch a cross-national project in 1989 for the twelve EC countries with the following aim:

To analyze the field of established services that support the aged population in the European Community and to sketch future developments and bottlenecks in the field.

This aim was fairly broad and left open many degrees of freedom. But it was felt that this flexibility was necessary given the exploratory nature of the project and the uncertain data situation in each of the countries:
especially since this is the first integrative study on this policy area of the

EC. Two operational goals were pursued in our study: (1) a description of policy responses to care for the aged in all twelve EC countries, including an indication of the various available services; and (2) an inventory of available data on services for the aged in the EC, including identification of missing data. We placed special emphasis on the economic aspects to be measured - via observable indicators and on public policy data - that have an impact on residential and community services for the elderly.

Method

Given the range of focal points in the provision of service for the elderly, and the uncertainty regarding reliable information on demographic evolution and services for the aged in the EC member countries, it was decided not to collect primary data, but to make an inventory of available data in each of the twelve countries. For this purpose a so-called national contributor was selected in each of the twelve EC countries: a policy and/or research expert in services planning for the elderly. This national contributor acted as a liaison between the central research team in Amsterdam/Leuven and the various data sources in each individual country. These national contributors were of critical importance to the success of our study.

The primary means of data collection was a structured questionnaire, developed by the central team. A first draft of a questionnaire was sent out to all national contributors for comments regarding its response feasibility, completeness and clarity. After some revisions, which were necessary to cover the specific data situations in various countries, the final questionnaire was sent to each national contributor with the request to fill it out accurately.

The questionnaire has three main parts. The first concerns general information on the elderly population (e.g. regarding income level, degree of disability, and living arrangements). The second part of the questionnaire deals

with macro aspects of service provision for the elderly (e.g., changes in the supply of services, their causes, existing bottlenecks in services, etc.). The last part treats organizational aspects of the existing European services (conventional vs. innovative and temporary vs. permanent residential and community services, including old people's homes, home-care, day-care, etc.).

All data from the completed questionnaires were screened for comprehensiveness and comparability. Then, based on this survey as well as on complementary data sources (such as national, EC and OECD statistics, various reports or publications on demand and supply for services for the elderly in each country), the members of the central research team wrote twelve individual country reports. These reports were subsequently returned to all national contributors with a request to screen for completeness, validity and accuracy. All these preliminary results were discussed also at a meeting comprising the central research team and all national contributors, held in the fall of 1989 at "Europlan" in Sophia Antipolis, France. After a final round of revisions the twelve country reports may be considered as reliable and representative inventories of the state of the art in services for the elderly in the European Community (see Nijkamp et al., 1990). This paper draws especially on data from these twelve country reports. Before discussing the various residential and community services for the elderly in the twelve countries we will briefly review various demographic and socio-economic developments in Western-Europe.

Demographic Trends

According to a publication of Eurolink Age (1989), there are now nearly 100 million people older than 50 years in the European Community (out of a total EC population of 321 million).

Insert Figure 1 about here

Figure 1 shows that in the period 1980-2040 the elderly population of Europe-12 is projected to grow from 13.7 percent to over 23 percent. In comparison, the share of elderly in Japan is expected to grow from 9.1 to almost 23 percent, and in the USA from 11.3 to nearly 20 percent. This means that in the year 2040 almost one out of every four Europeans will be a part of the "silver" generation. This relatively rapid growth of the number of aged people in Europe is affected by two major societal developments such as an increase in life expectancy and a decrease in the birth rate (the so-called 'double aging' process). In the long run this leads to two structural demographic shifts: an increase in the number of older people and an increase in the average age of older people. These demographic developments are in general a result of two forces: a) changes in social attitudes (acceptance of contraception, couples without children, postponement of child birth, etc.), leading to a decline in population growth; and, b) improvements in health and nutrition; the average life expectancy for men and women in the EC has risen from 63.6 and 67.6 years in 1950 to 71.3 and 77.1 years in 1980/85, respectively. Note, furthermore, that the number of people (especially women) surviving into old age (85 years and over) is increasing in all EC Countries.

It should be added that in various countries (e.g. in Luxembourg and Germany) the expected decline in population size is partly offset by a high immigration rate. This means that drastic demographic shifts in Europe may be leveled out by migration flows, a situation which is likely to become even more important and clear after 1992. How migration flows resulting from the currently

changing political structures in East-Europe may affect the European policies on aging care is not yet known.

In sum, despite alarming reports by the media, there is no sign of most countries undergoing a declining population size in the foreseeable future. In some countries (e.g., in Spain and Ireland) a significant population rise is even expected. So at the EC level a considerable reduction in population does not seem plausible. However, all countries expect a rise in the number of aged people. Thus the most significant structural shifts in demography are of a qualitative nature. With a stabilizing or less rapidly growing population (i.e., with lower numbers of people in the lower age cohorts) the problem of the aging society of course becomes more pronounced, as a (relatively and absolutely) smaller number of younger people will have to carry the burden of the increasing numbers of the elderly. All EC countries are facing a similar pattern in this respect: a lower fertility rate and a higher life expectancy.

Social Indicators

It appears from the income figures that the European elderly belong to relatively lower income groups, but the variance is much greater than in the general population; Only in some EC countries do very old people belong to the lowest income classes (e.g., in Ireland and in Greece). However, income figures from different countries are very difficult to compare due to definitional problems, differences in tax schemes, etc. Another problem concerns the unit of measurement. The household income of the elderly may be relatively low, but - due to the small household size - the income per capita of aged people may be more favourable. This is clearly shown in the French and Spanish figures.

One indication of the income level of the European elderly can be found in the pension rates. Again, it is difficult to compare state pension levels accurately between the different EC member states, as such pensions do not

constitute the only factor in a retired person's income. In some countries, e.g., health care is free, while in others it must be paid for out of the basic pension.

In terms of living arrangements there is considerable variation among EC countries. In some countries the number of elderly people using residential services for the elderly is relatively low (e.g., in Belgium, Greece, Luxembourg, Portugal and in Spain), whilst in other countries (e.g., in the Netherlands) this is far higher. In most EC countries, however, family care and informal networks are still quite important.

Finally, regarding the degree of disability of the aged people it is evident that disability increases with age in all countries. In contrast to common opinion, it appears that a large proportion of elderly people is able to take care of itself. Due to a lack of consensus on the precise definition of (semi-)(dis)abled, the figures show much variation. For instance, Belgium and Germany report that more than 80% of their elderly is fully able, Denmark and Ireland report less than 50%.

Economic Consequences of the Aging Population

The described double aging pattern will lead to a decline in the numbers of the working population in the total population. This is also reflected in the projected elderly dependency ratio (i.e., the share of the population in the age group 65 and over with respect to the population between the ages 15 and 64) in various OECD countries. This ratio is expected to double: from 18 percent in most countries in 1980 to approximately 34 percent in 2040.

Assuming the age segment of 65+ is no longer economically active, it is evident that the elderly dependency ratio will be a financial burden on the economy as a whole. Clearly, one should take into account that a considerable part of the extra expenses of the aged population (e.g., medical care, assistance

in housekeeping, etc.) will be covered by their own savings. Nevertheless, a considerable part of the social costs of an aged society would have to be borne by those making up the active labour force (see also Bos & von Weizsacker, 1989; Butler, 1986; Houben, 1986; Knapp, 1986; and O'Shea & Corcoran, 1989).

In general the public social expenditures related to an aging society will rise, which is mainly caused by a rapid growth in social security (e.g., state pensions), welfare (or social) services and health care. Of course, this rise will be partly offset by lower per capita outlays for education, unemployment benefits, etc. Interesting information on these issues in various countries - also outside the EC - is contained in Table 1.

Insert Table 1 about here

In all EC countries the estimated public outlays for pensions in the future are expected to increase. Moreover, the share of pensions in Gross Domestic Product is rising in all EC countries. Drastic increases have already been observed, amongst others, in Spain, although this may also be a partly delayed response effect caused by growth towards a welfare state. But also other countries, such as the UK, expect a considerable rise in this area.

Contemporary public policy measures on specialized services for the elderly now seem to depend far more on developments in the total government budget. In order to circumnavigate severe frictions from strict budget limitations, policymakers have sought innovative strategies that guarantee the same service level for the elderly, but at a relatively lower cost. A popular tool for achieving this is the strategy of decentralization of responsibilities in the planning process of specialized services for the elderly.

The decentralization strategy - often a part of a broader deregulation policy - can take many shapes. Responsibilities in the field of legislation,

finance and administration can be decentralised and/or privatized. Decentralization demands more problem-solving involvement of the most directly concerned participants in solving problems. It is often argued that these participants will benefit from finding their own optimal solutions, and this in itself is often regarded as one of the main advantages of decentralization. However, such decentralized involvement in public policy-making may have serious drawbacks when the optimal solution for a group of clients does not match the optimal solution for society as a whole. This is likely to happen when participants - in order to protect their own rights or achievements - have competing interests, for example, by interpreting the needs of the elderly differently.

It is interesting to observe that in both the USA and in Europe the trend towards more decentralization and local responsibility runs parallel to the deregulation trend. Of course, this is partly caused by the public budgetary problems of the 1980s in most countries, but it is also related to the awareness that efficient management of social welfare programmes requires decentralized responsibilities. This holds true especially for planning services for the elderly, and hence it is no surprise that many countries show a trend toward decentralized planning and management schemes of service provision for its old people.

Residential and Community Services for the European Elderly

Services for the elderly appear to be offered in different forms and under different conditions in all EC countries (see Tables 2 and 3). In view of limited budgets and the increasing demand for services, the whole field of service provision is in motion, whilst at the same time the institutional and managerial structures are permanently changing. Our study is focussed on residential and community services, being the kind of services for the aged which, from an EC

policy perspective, requires most research effort.

Residential services include old people's homes, service flats, sheltered housing, flats for pensioners, flats for the disabled, rehabilitation homes and geriatric units. For residential services, which in many countries form a considerable share, the personnel costs are a relatively important cost component, which is likely to increase with an aging European population.

The entry conditions for residential services are different among various EC countries; some countries (e.g. Greece) have no entry conditions, whereas others (like Denmark and the Netherlands) impose conditions in terms of the need for help. Various countries stimulate the provision of residential services, whilst others (e.g. Germany and Greece) discourage such a policy.

Despite the emerging decentralization and deregulation trend, in almost all EC countries the government plays an active (financial, legislative and organisational) role in the provision of residential services. Most of these services are provided on a non-profit basis, although in various countries (e.g., in the Netherlands, Spain and in the UK), there is a tendency towards privatisation.

Community services for the elderly refer mainly to district nursing, home help services, social work, mental health advisory services, and general medical care. Also in the area of community services almost all EC countries show significant increases in public outlay, although as with residential services reliable information on services is very scarce. In most countries, the conditions for enjoying the benefits of community services for the elderly are fairly flexible. Furthermore, health care tends to rise on a structural basis in almost all EC countries (and also in all OECD countries). Great increases were reported in Spain and Portugal amongst others. Other countries (e.g. Ireland), however, exhibit a considerable decline in the outlay for public health care.

Insert Table 2 about here

Insert Table 3 about here

Examples of Innovative Residential and Community Services for the EC Aged

Most EC countries report on innovative residential and community services for the elderly. Again we observe much variation among all twelve countries. Some examples are:

-Belgium:	institutionalized cooperation initiatives between all service personnel; short-stay care for elderly people in special homes
-Denmark:	special flats for elderly with minor and major disabilities
-France:	transformation of hotels, residences and family pensions into real service institutions for the elderly; hospital-based home care; tele-alarm systems
-Germany:	family placement by using the personal care of a substitute family; living communities for the elderly with home help; institutionalized social commissions for the coordination of assistance to the elderly
-Greece:	the system of 'open protection' for the elderly
-Ireland:	community nursing units; day hospitals for the elderly; voluntary housing, sheltered housing and boarding out
-Italy:	subsidy to a family which shelters an old person in the family instead of using institutionalized care; community lodgings for self-sufficient elderly
-Luxembourg:	day care centres
-Netherlands:	attached institutions to a nursing home; special service buses; tele-alarm systems; new forms of (semi-)residential services (e.g., meals on wheels)
-Portugal:	day centres for elderly with a low income
-Spain:	old age tourism; sheltered housing
-UK:	sitting services; support groups for care-givers; tele-alarm systems; family placement

Changes in the Supply of Services for the European Aged

The high costs of residential services, especially of intramural care

provisions have, in many countries, caused a shift towards community services (e.g., day care centres, meals on wheels). Furthermore, in various countries (e.g. in Belgium, Germany, Italy, and the UK) partial financial contributions have to be paid by the elderly themselves in order to enjoy the benefits of these services. In various countries there is also a shortage of nursing staff, as a consequence of low remuneration, lack of training, etc., whilst informal service networks are gaining importance (e.g., in Germany, Ireland and the Netherlands). In order to reduce costs, some countries (e.g., Denmark, France and the Netherlands) have made a stricter division between housing and service functions. Furthermore, de-institutionalisation and decentralisation have become important organizational principles in the supply of services for the elderly (e.g., in Germany, Ireland, Italy and the UK).

Driving Forces in Changes in the Supply of Services for the European Aged

It is clear from observations in all EC countries that an important reason for the recent changes in the supply structure of services for the elderly is the demographic evolution leading to a higher share of the aged population. The traditional supply of domestic or informal care has declined during the same period, mainly because of an increased female labour force, the decreasing family size, etc. (e.g. in France, Germany, Italy, Spain). Government policy is another obvious stimulus for the changes in the supply structure. In the recent past, however, a severe conflict has arisen between rising needs and decreasing budgets, which has led public policy to encourage different types of informal, i.e., cheaper care (e.g. in Belgium, Italy, and the UK). Furthermore, the organized field of the elderly themselves, including the emerging professional organizations in this field, have exerted much influence in many countries (e.g. in Germany, Luxembourg and the Netherlands). Additionally, the changes in spatial organization are reported to be of decisive importance in many countries

for the emergence of new forms of services for the elderly: for instance, when children and older parents live apart (e.g. in Denmark, France, Ireland and Portugal).

Public Policy Principles on Elderly Care in EC Countries

Below we provide an overview of the most striking public policy issues to date which are relevant to the field of aging in Europe.

First, the (financial, legislative and administrative) responsibility for the care of the European elderly does not rest solely with the national governments, but also with local governments (e.g. in France, Germany and the Netherlands). In most countries a fairly complicated and multi-level institutionalized planning structure has emerged (e.g. in Belgium, Italy, the Netherlands and the UK).

Secondly, it has become an accepted guiding principle in most EC countries that aged people should remain as long as possible in their own homes, mainly in order to stay within the strict financial budgets of the government. In this perspective, complementary services (e.g., home help services) have been established (e.g. in Denmark, France, Ireland, Luxembourg, Portugal and Spain).

Third, in various countries there are strict conditions for entry in to a rest or nursing home (e.g. in France, Luxembourg, the Netherlands, the UK), whilst in various cases financial support is expected from the elderly themselves.

In conclusion, we can claim that public policies vis-a-vis the aged in all EC countries are at least in motion, in which the control of costs, decentralisation (or devolution) of planning, and more private initiatives have become focal points for their discussion.

EC Roles in Elderly Care

Any discussion on the role of the European Community in providing care for the elderly should recognize the fact that Europe of the Twelve is a pluralistic society in which each member state has its own specific intrinsic social and cultural value system and its specific financial constraints. From this multinational perspective, a European interest in care for the elderly may seem to be alien to the EC. Especially in our era of deregulated national policies and emerging informal and/or private initiatives the responsibility for care for the elderly is likely to be considered a matter for local or regional governments only. This seems particularly plausible now that the elderly are no longer regarded as passive patients or clients, but as potentially active members of our society; they are not second-class citizens, but 'normal human beings' who are often able to shape their own living conditions and to organize themselves in a proper way.

Despite the devolution of centralized elderly care planning within Europe, there remain important activities in aging care to be undertaken by the European Community. They pertain largely to information on care for its aged constituency. The human and economic costs of a completely passive role of the EC concerning elderly care would, in the long run, be very high. EC work in elderly care would not want to be of a 'top-down' or controlling type, but rather of a stimulating or enabling nature: so that an appropriate high quantity and quality of decentralized care will indeed be effectuated. Here follows our specification of this additional EC task:

1. The EC should be instrumental in setting up a central data bank for the exchange of relevant information between organizations in charge of care for the elderly (e.g., regarding innovative services); this continuous research activity ought to include the area of services management. Cross-national information exchanges on social, economic, institutional and physical planning of services

delivery to the aged population, based on comparable definitions of all concepts used, would benefit the quality and quantity of care rendered to our aging population.

2. The EG should design an efficient system for the transfer of knowledge onbest practices and successful management schemes in the various systems of care for the elderly.

3. The EC should actively encourage and coordinate research and planning experiments of services for the aged. For instance, much more attention should be given to the relationships between formal and informal care (including self-help) and the differences therein between various countries as well as to preventive actions and new planning systems for the provision of sufficient and satisfactory care for the elderly.

Very recently (on April 24, 1990) a proposal of the Commission of the European Communities for Community Actions for the Elderly was published (Commission of the European Communities, 1990, p. 11) which states: "The Community cannot substitute for measures taken in Member States at the appropriate level. In extending a limited number of actions already undertaken, the Community should limit its role to encouraging the exchange of information and experience as well as the transfer of knowledge and innovative initiatives on topics of common interest." The Commission proposes that the actions should be grouped around the following themes (Commission of the European Communities, 1990, pp. 13-15): 1. Studies and knowledge transfer; 2. Organisation of events and exchange of information; and 3. Preparation for networking of innovative experiences. These themes match quite closely the kinds of additional work our study formulated (see above).

One final observation should be made concerning the short-term 1992 development. The completion of the internal market may have implications for the elderly since it grants them the right of free residence in any EC country. Such

mobility may be hampered by uncoordinated and different social and health care standards.

Conclusion and Evaluation

This project on the provision of services for the European elderly has led to a number of important conclusions.

1. The data situation on services for the elderly, e.g., on financial aspects and on the actual use of services is - in contrast to demographic information - extremely poor. There is a wide variety of service provisions for the elderly. They tend to appear under different names and in different forms. Information exchange on these activities is lacking and every country in the EC seems to go its own way without systematically taking into consideration potentially important experiences of other EC countries. An EC-wide effort would have to be undertaken to improve this situation by providing precise operational definitions on core concepts and by offering guidelines to member countries for the measurement and monitoring of care of its elderly constituency.

2. There is a striking similarity in terms of planning for services for the elderly: almost all EC countries - as a result of both the double aging process and the tightness of national budgets - exhibit some form of devolution of service planning, characterized by decentralisation and sometimes privatisation (or combined private-public initiatives). Evaluation studies (e.g., on the cost-effectiveness of centralized vs. decentralized services and of residential vs. community services), carried out at the EC level, seem needed. However, in most countries informal networks and systems of voluntary service provision (e.g., meals on wheels, tele-alarm-systems, home help service) are in a state of flux. EC countries may improve the quality of services by exchanging information on the successes and failures of such experiments or experiences. The same holds true for data on the creation of new, innovative

forms of elderly care. Also in this context the role of national health boards could be stimulated by the EC: to promote or safeguard good-quality care for the aged.

3. The quality, efficiency and scope of residential and community care in Europe can be improved through the specification of service delivery standards, the stimulation of upgrading professional staff skills and by including more elderly people in services planning processes.

4. There is a wide spectrum of possible roles for the European Community in elderly care. Care roles are of an informational and stimulating nature.

Currently Brussels employs only two full-time staff members with explicit responsibility for "Aging Policy in Europe." They work under the Directorate Generale Five, i.e., the Directorate of Social Affairs. The intention is to increase this small number. However, the economic integration of 1992 as well as the new options in East-West Europe relations are so complex and absorbing that many aspects, including the formation of comprehensive EC Aging Policy, may take longer to implement than is perhaps desirable. Demographic and other (e.g. economic) developments require fast decision-making on the extent of its involvement in aging caring for the aged.

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TABLE 1: GROWTH OF PUBLIC SOCIAL EXPENDITURES IMPLIED BY PROJECTED DEMOGRAPHIC CHANGE, 1980-2040, (1980 = 100)

	Education	Family Benefits	Health	Pensions	Total Social Expenditure	Total Population	Population 65+
Australia	128	126	240	288	207	168	346
Belgium	71	74	99	134	102	92	139
Canada	103	110	218	304	187	146	345
Denmark	58	61	95	124	88	77	131
France	80	83	119	172	128	104	170
Germany	53	60	90	126	97	74	131
Italy	62	64	108	134	107	85	152
Japan	79	77	146	229	140	102	255
Netherlands	70	69	137	160	121	98	210
Sweden	83	84	117	123	109	95	126
United Kingdom	85	86	121	130	110	103	141
United States	102	114	178	215	165	136	238

a) Cumulative growth rates assuming constant real per capita expenditure by age within each programme.

b) Including education, health, pensions, family benefits, unemployment compensation and, in the case of Australia and the Netherlands, other cash benefits and welfare services.

Source: OECD (1988), Table 19, p. 36

PERMANENT	B	DK	D	E	F	G
1 Housing for pensioners	Bejaardenwoningen (Flanders: 9.969)	Kommunale pensionistboliger (=flats for pensioners) (30.000)				
2 Housing for the disabled		Aeldreegnede boliger i Almennyttigt byggeri (=flats for disabled) (25.000)				
3 Service flats	Service flats & Woningcomplexen met dienstverlening (Flanders: 7.165)	Lette kollektivboliger (3.800)	Altenwohnheim (69.000)			
4 Sheltered housing		Beskyttede boliger (6.800)			Logements-foyer (120.928)	
5 Centres de logement et d'accueil						
6 Old age homes	Bejaardentehuizen Rusthuizen Rustoorden (99.304)		Altenheim (128.000)	Residencias de tercera edao (89.799)	Private: Maisons de retraites privées (112.000) Public: Maisons de retraites publiques et hospices (144.476)	Gyrokomia (5.000)
7 Multilevel homes for the elderly			Mehrgliedrige einrichtungen (203.000)			
8 Nursing homes	Rust en verzorgingstehuizen (22.780)	Plejehjem (47.500)	Altenpflegeheim/Altenkrankerheim (39.000)		Section de cure medicale (48.000)	
9 Geriatric hospitals			Gerontopsychiatrisches Krankenheim			
10 Mental hospitals						Therapeuteria chronion patheseon (=chronic disease institution) (2.000)

Table 2a. Permanent Conventional Residential Services for the Elderly in Europe; types and capacity (to be continued)

ERMANENT	IRL	I	L	NL	P	UK
Housing for pensioners		'Case albergo' (='Hotel-houses') 'Case di soggiorno' (='Health-resort houses')				
Housing for the disabled						
Service flats				Service flats	Residenciais para idosos (167)	
Sheltered housing		Strutture protette	Sheltered housing	Sheltered housing		
Centres de logement et d'accueil			Centres de logement et d'accueil (636)			
Old age homes	Healthboard welfare homes (1.506)	Case di riposo	Maisons de retraite (2.353)	Bejaarden-oorden/verzorgingshuizen (140.000)	Lares para idosos (19.794)	Residential care homes (269.000)
Multilevel homes for the elderly						
Nursing homes	Longstay district hospitals (1.533) Approved nursing homes (3.197) Non-approved nursing homes (3.091)		Maisons de soins (713)	Verpleeghuizen (50.000)		Nursing homes (53.206)
Geriatric hospitals	Health board geriatric hospitals/homes (7.275)					Geriatric hospitals
Mental hospitals				Psychiatrische instellingen (24.667)	Hospitals psiquiatricos	Psychiatric hospitals

Table 2a. (continued)

TEMPORARY	B	DK	D	E	F	G
1 Rehabilitation homes		Genoptraenings-institution (500)				
2 Short run nursing homes		Short run nursing homes	Kurzzeit Pflegeheim			
3 General hospitals		General hospitals				Genika nosokomea
4 Geriatric units in general hospitals	Exclusief geriatrische diensten (5.185)	Langtidsmedi-cinske afde-linger (1.000)	Geriatrische Abteilung in Sonder-krankenhaus	Unidades Geriatrices		
5 Geriatric hospitals						
6 Medium stay wards in gene-ral hospitals					Section d'hôpital de moyen séjour (43.000)	
7 Long stay wards in general hospitals	V-diensten (4.540)				Section d'hôpital de long séjour (59.670)	
8 Psychiatric wards in gene-ral hospitals	Psycho-geriatrie (817)	Psychiatric wards in gene-ral hospitals				
9 Rest and nursing wards in general hospitals	Rest and nursing wards in general hospitals					
10 Rest and nursing wards in old age homes	Rest and nursing wards in old age homes					
11 Psycho-geriatric wards in mental hospitals	Psycho-geriatric wards in mental hospitals (949)	Psycho-geriatric wards in mental hospitals				

Table 2b. Temporary Conventional Residential Services for the Elderly in Europe; types and capacity (to be continued)

TEMPORARY	IRL	I	L	NL	P	UK
1 Rehabilitation homes			Convalescence homes (357)			
2 Short run nursing homes						
3 General hospitals				Ziekenhuizen (67.404)		
4 Geriatric units in general hospitals						
5 Geriatic hospitals						Geriatric hospitals (74.000)
6 Medium stay wards in general hospitals						
7 Long stay wards in general hospitals						
8 Psycho-geriatric wards in general hospitals						
9 Rest and nursing wards in general hospitals						
10 Rest and nursing wards in old age homes						
11 Psycho-geriatric wards in mental hospitals						

Table 2b. (continued)

		B	DK	D	E	F	G
1	Home improvements		Boligaendringer (20.000 flats per year)			Amelioration du confort des logements	Improvements on housing accommodation
2	Social work		Dagcentre (25.000)				Social work
3	Social centres for the elderly	Dienstencentra		Altentagesstaetten/Altenbegegnungsstaetten (90.646)	Clubs de tercera edad (1.900.000)	Clubs des personnes agees	Education/recreation
4	Home help services	Gezins- en bejaardenhulp (personnel:3.649)	Hjemmehjaelp (26% of elderly 70+)	Haus- und Familienpflegestationen Gemeinde-, Kranken- und Altenpflegedienste	Ayuda a domicilio (24.000)	Aide menagere	Home help services
5	Cleaning services	Poetsdiensten (Flanders: 41.069)					
6	Odd job services	Klusjesdiensten					
7	Transport services	Treinreducties	Transport services	Mobile Soziale Hilfsdienste	Free urban transport		
8	Meal distribution	Maaltijden aan huis (Flanders: 2 mio)	Maaltidsbringning (5% of the elderly)			Meal distribution	Meal distribution
9	Foyer restaurant					Foyer restaurant	
10	Domestic help						KAPI (=Centres for the Open Protection of the elderly) (135.000)
11	Health advisory services						Health advisory services
12	Mental health advisory services						
13	Paramedical care						Action therapy/ physiotherapy
14	Day care		Daghjemog dagcentre (2.400)	Tagespflegeheime/ Tageshelme (744) Geriatische Tages- oder Nachtkliniken			
15	District nursing	District nursing (personnel: 32.512)	Hjemmesygepleje (4% of the elderly households)	Sozialstationen		Soins infirmiers a domicile (28.228)	District nursing

Table 3. Conventional Community Services for the Elderly in Europe; types and capacity (to be continued)

	IRL	I	L	NL	P	UK
Home improvements				Woningverbetering/ -renovatie		Improvement in housing conditions
Social work		Social work		Maatschappelijk werk	Social work	Social work
Social centres for the elderly		Centri diurni per anziani		Dienstencentra	Centros de Dia	
Home help services	Home help services (12021 : 9515 > 65Y)	Assistenza domiciliaire	Home help services	Gezinsverzorging (280.000)		Home help
Cleaning services				Schoonmaakdiensten		
Odd job services						
Transport services						
Meal distribution	Meal distribution	Meal at home		Maaltijdverstrekking	Meal distribution	Meal distribution
Foyer restaurant						
Domestic help					Ajuda Domiciliaria (4.240)	
Health advisory services				Gezondheidsadviesdiensten		Health visiting
Mental health advisory services		Psychological/ relational help		RIAGG (=Mental health advisory services) (176.654)		Community psychiatric nursing
(Para)Medical care	Paramedical care			Huisartsenhulp		
Day care	Day care			Dagbehandeling Dagverzorging		Day care
District nursing	District public health nursing	Nursing services	Home nursing	Kruiswerk (1.400.000)	Nursing services	District nursing (16.455.000)

Table 3. Conventional Community Services for the Elderly in Europe; types and capacity (continued)

Figure 1

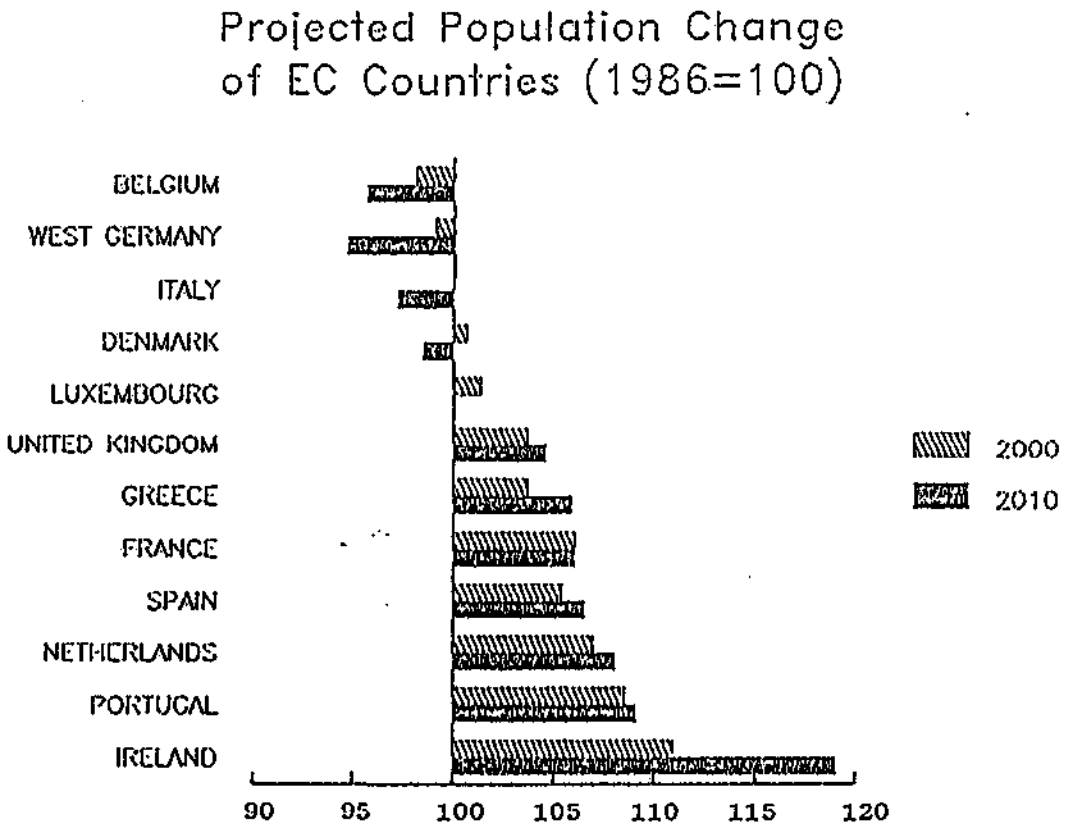
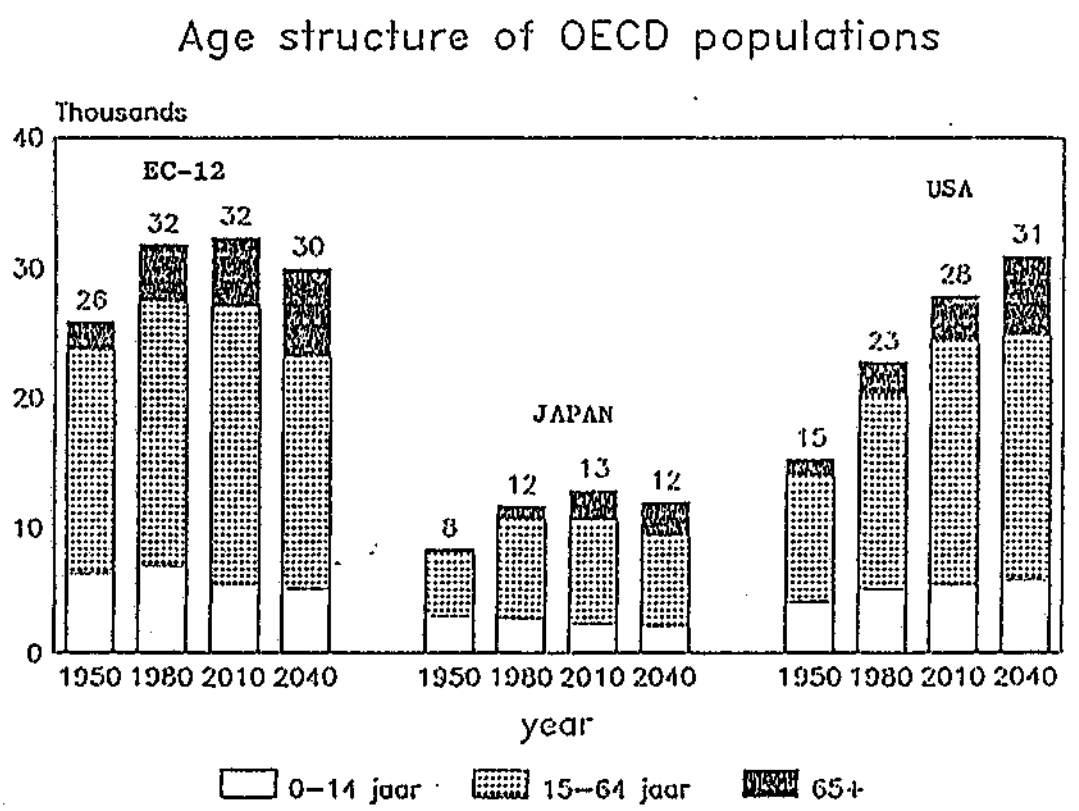

Projected Population Change
of EC Countries (1986=100)
BELGIUM
WEST GERMANY
ITALY
DENMARK
LUXEMBOURG
UNITED KINGDOM
GREECE
FRANCE
SPAIN
NETHERLANDS
PORTUGAL
IRELAND
90
95
100
105
110
115
120
2000
2010

Figure 2


Age structure of OECD populations
Thousands
40
30
20
10
0
EC-12
26
32
32
30
JAPAN
8
12
13
12
USA
15
23
28
31
1950 1980 2010 2040
1950 1980 2010 2040
1950 1980 2010 2040
year
0-14 jaar
15-64 jaar
65+

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