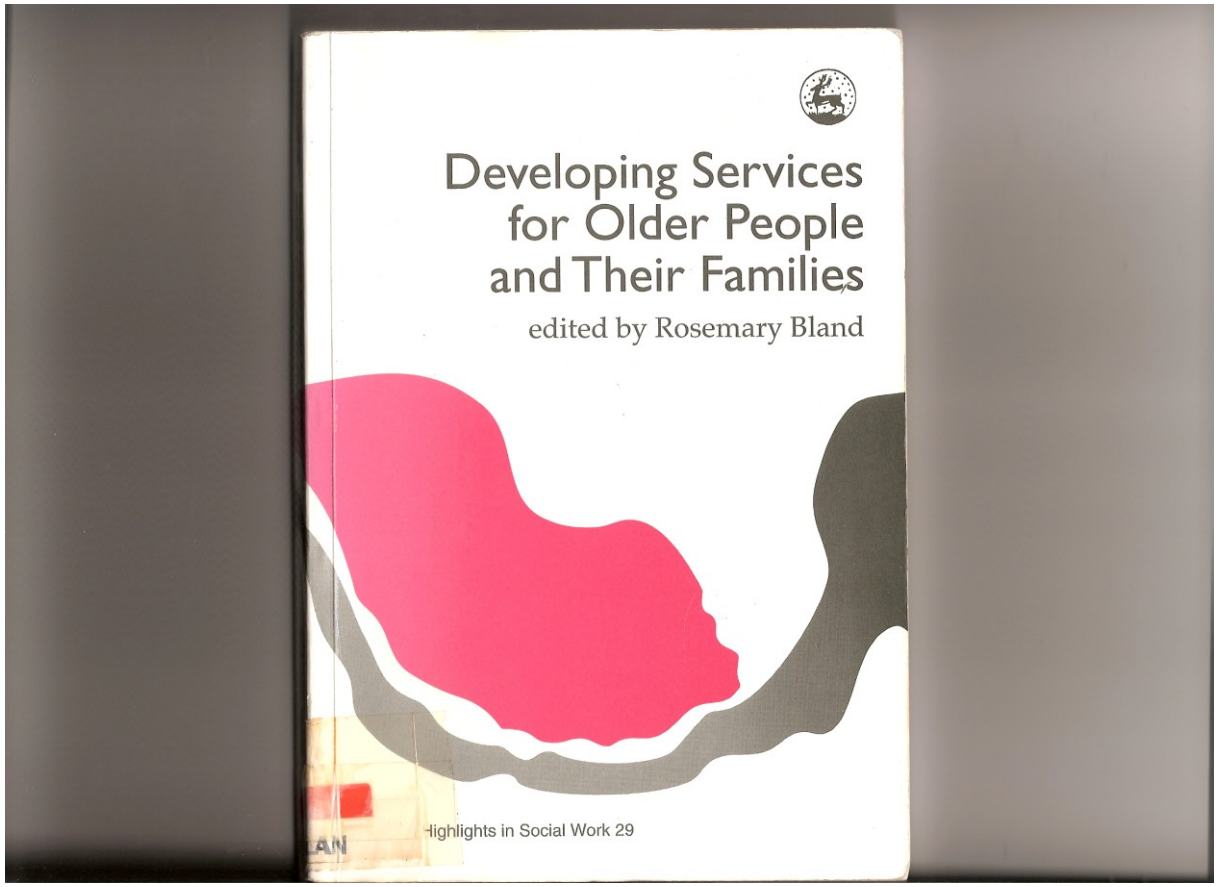
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Chapter 4

Social Services for Older People in Europe

Alan Walker

Introduction

Social services are in transition throughout the European Union. The recent combination of various pressures – socio-demographic, fiscal, ideological, grassroots – has begun to produce reforms, or proposals for reform, in all EU countries. Reforms include the creation of more mixed economies of welfare, the separation of provider and funding roles, care-packaging, case management and the tailoring of services to users (Friedmann, Gilbert and Sherer 1987, Evers 1991), though the extent and pace of change in social services is by no means uniform across member states. In the interests of promoting the development of more effective and better quality systems of care for older people, it is important to understand the scope of the reforms and to build on the most progressive features of them, even though in some cases the ideological engine driving them may be antithetical to this goal (Walker 1989).

The aims of this chapter are two-fold. The first is to examine the degree of convergence between member states of the EU in their policies and practices towards the care of older people; and, second, to outline the challenges facing social services over the next decade or so. This analysis inevitably raises the issue of the EU's competence in this field and, specifically, how far the development of its social policies will generate convergence among the fifteen national social services systems, and I will return to this matter by way of a conclusion. As a starting point, here is a very brief summary of the main organisational features of social services in EU countries focussing on domiciliary care.

Organisation of home care services in the EU

There is considerable institutional variation between member states, including a range of different funding arrangements, so caution is necessary in making international comparisons. Also, until recently, there was very little comparative information on personal social service provision in the EU. That deficiency has been rectified to a considerable extent by a series of cross-national research projects on the care of older people in EU countries, most of which were sponsored by the European Commission. These include the joint Leuven-Amsterdam comparative study of services in the twelve countries of the European Community (Nijkamp *et al.* 1991); the Age Care Research Europe project covering nine countries (Jamieson and Illsley 1990, Jamieson 1991); the European Centre's study of service innovations in The Netherlands, Sweden and England and Wales (Kraan *et al.* 1991); the Hoger Institute's research (Pacolet, Versieck and Bouten 1994); and the early stages of the comparative research of the EU's own Observatory on Ageing and Older People (Walker, Guillemard and Alber 1991, Walker, Alber and Guillemard 1993).

The most common approach to the organisation of domiciliary care in the EU is for these social services to be clearly differentiated from medical services and under the control of local authorities. Home care services in the EU are at varying stages of development and three broad groups of countries may be distinguished: those with fully developed services in terms of scope and coverage, those with partially developed domiciliary service infrastructure; and those where services are underdeveloped. (As will be seen later in this chapter, even in those countries with fully developed home care services by no means all domiciliary care needs are being met, and regional disparities in provision are common).

Looking first at those countries with fully developed home care services, in *Belgium*, services have been organised on a regional basis under the control of local authorities and non-profit voluntary associations since 1982 (while health care is centralised). The main domiciliary services are home helps and cleaning services, district nursing, meals on wheels and day centres. *Denmark* has the most fully developed system of domiciliary care services in the EU. The main services provided are home helps, district nursing, meals on wheels and social work. All services are co-ordinated and administered by local authorities and financed from taxation. The home help service covers house-

hold management tasks, such as cleaning, and personal care including hairdressing, assistance with eating and dressing. In most municipalities the home help service is available on a 24-hour basis and is combined with district nursing in the same organisational unit. The development of home care services in *France* may be split into two periods, pre- and post-1983. Since 1983 these services have been increasingly regionalised under the control of local branches of national government. Home helps are financed from social assistance and pension insurance. In *Luxembourg* home help and home nursing have been long established as the main domiciliary services and they are run almost wholly by private and non-profit organisations. The Family Ministry co-ordinates and partly pays for services going to low-income families. The major providers of home nursing services are religious orders, the Red Cross and two municipalities. Meals on wheels have been introduced recently but day centres are scarce and emergency telephones are found only in the capital. Until recently the bulk of social services expenditure in the *Netherlands* went to residential care but increasing amounts of home care are being provided to substitute for residential care. Domiciliary care is supplied by local non-profit associations and financed (up to a limit) by an exceptional medical expenses scheme with private cost-sharing. The *United Kingdom* would also be classified as a country with a fully developed social services system, as would the new EU members, Austria, Finland and Sweden.

Turning to those countries with partially developed systems, in *Germany* (former FDR) home helps are financed by means-tested social assistance and provided by the voluntary sector with public subsidies. *Italy* is still in transition from institutional to community care. Domiciliary services are organised by local health units, financed from regional funds. Provision is patchy and inadequate in many places, especially in the south. Community care policy towards older people in *Spain* developed in three stages: prior to 1972 there were no social policies for older people, between 1973 and 1979 policy concentrated on residential homes, and from 1979 local personal social services have been created, including home helps and day centres. Domiciliary services are organised by local authorities and voluntary associations and financed by municipalities for low-income users.

Finally, there are two countries with underdeveloped domiciliary services. The last decade in *Greece* has seen the development of community services around the KAPI system (i.e. decentralised community

centres and informal care) supplemented by district nurses, home helps, meals on wheels and physiotherapy, but provision is minimal. *Portugal* has placed increased emphasis on day centres for older people (there are 530 such centres) but domiciliary services are in very short supply. Where these services exist they are financed partly from social security and partly from private charges.

Care of older people in the EU: current trends

Despite considerable institutional variations between EU countries, particularly on the north/south axis, it is possible to identify five major common trends and themes in the current development of policies towards the care of older people.

The State preference for community care

Not only are at least some community care services for older people available in all EU countries, but all governments are expressing a preference for this form of care as opposed to residential or hospital care. In some cases this preference has been a long-term one. The various reasons for this policy are outlined below but, for the moment, it is important to recognise that because the motivations behind this policy vary between countries, the nature, the pace and scale of the changes underway, or being contemplated, differ significantly between countries. Thus, among the long-established institutional welfare states of the Northern part of the EU, we may contrast the market-orientated thrust of the British government's community care policy – privatisation, the creation of quasi-markets in social care and the withdrawal of local government from the direct provision of services – with the careful attempts to reform the state agencies themselves in Denmark.

These sorts of variations derive from fundamental differences in ideologies between the governments in power in member states rather than from any intrinsic features of their social services. But, in addition, as shown above there is considerable variation between EU countries in the organisation and level of development of social services. For example, in administrative terms, the home help/home care services in Greece and Portugal are combined with district nursing and, in Belgium and the Netherlands, there are additional cleaning services. There are also some variations in the classification of home care tasks

as being either primarily nursing or domestic in nature. The dominant model of care in the EU appears to be the conventional home help role consisting of, on the one hand, practical care and tending, primarily in household management and domestic tasks and assistance with other activities of daily living; and on the other, emotional support – being concerned, befriending, acting as adviser or confidant (Warren 1990). Moreover, in the majority of EU countries home care provision is either public or predominantly public; at the present time there are very few for-profit agencies. The Swedish model of home care appears to be more flexible, covering housekeeping and personal care as well as some straightforward medical tasks.

The clear preference on the part of EU governments for the community-based care of older people is also shared by EU citizens. In the recent Eurobarometer survey in all 12 member states a large majority of the general public (four out of five) thought that older people should be helped to remain in their own homes (Walker 1993a, p.29). The only countries wherein more than one-fifth of the general public preferred residential accommodation to community care were Denmark and Portugal.

Shortages of community care personnel

While there is a clear convergence in political rhetoric concerning community care, there are wide variations in provision between EU countries. The range stretches from more than one home help for every five households headed by a person aged 65 and over in Denmark, to 1 in 10 in France, 3 in 100 in Ireland, 1 in 100 in Spain, to 1 in 200 in Portugal. Denmark and the Netherlands and, to a lesser extent, the UK seem to be the countries with the most extensive infrastructure of services among the Northern EU countries. For example, Denmark has 27,000 people employed in home care services (35 per 1000 people aged 65 and over). Whereas in Germany there are only 22,000 full-time equivalents or 2.4 per 1000 people aged 65 and over. The proportion of older people in receipt of services is smaller than these figures suggest because the home care jam is not spread uniformly across the older population in any country. Swedish home care provision is closer to the Danish levels than those of other EU countries (Kraan *et al.* 1991).

Thus, even in some of the major EU countries, the levels of domiciliary care services are not sufficient to keep pace with the rising need created by socio-demographic change. In other words, there is a 'care gap' between the need for care among older people and the supply of both informal and formal carers (Walker 1985, Qureshi and Walker 1989). It has both demand side and supply side components (Nijkamp *et al.* 1991, p.270). This care gap is a feature of the majority of EU countries, all of whom except Denmark and Luxembourg report excess demand, and there are growing concerns about the lack of specialist services for older people with dementia. Surprisingly, there are also signs of a care gap in Sweden (Kraan *et al.* 1991, p.190).

The continuing failure to provide sufficient community care services obviously means that some frail older people and their family carers are put under intolerable strains which, in turn, threaten the viability of their caring relationships. It means too that the social services cannot realise their full potential in the prevention of dependency but, instead, are forced to act in a reactive or casualty mode – a point I return to later.

Territorial inequalities

There are considerable territorial variations in the coverage of social care services *within* EU countries. In some cases these regional disparities appear to be of the same magnitude as some of those between the north and south of the EU. For example, in Italy there is not a full home care service in all of the country's 21 regions, and in France and the UK there are wide differences in provision between different areas. Geographical isolation is a factor in such territorial inequalities but it is not the major one. For example, in the UK there is wide variation in home help numbers between local authorities, depending on their political complexion: within London some boroughs provide three times as many home helps per 1000 older people as others. Even in Denmark and Sweden there are regional variations in home care provision, partly resulting from their highly decentralised systems.

Fragmentation of community care

In most EU countries there is fragmentation of community care policies: public, private and voluntary agencies, and, as a consequence, lack of co-ordination between domiciliary care and other services. Most important of all there is the separation between health and social services. Whereas health services are financed from social insurance or general taxation, social services are usually administered and financed

either by local government or by various voluntary organisations or a combination of both.

So the necessity of integrating the services is impeded by the organisational separation of responsibilities for funding and management. Most countries report problems of co-ordination between health and social services and these appear to be particularly acute in Belgium, Germany, the Netherlands and the UK. The main exception is Ireland, where health and social services are managed by the same department at local level.

The problem of lack of co-ordination in the face of ever-increasing demand has led to adaptations being made to services in some countries. For example, in Italy some social workers are acting as social network organisers. In Belgium co-operation initiatives between GPs, home help services and district nursing have been introduced. In France there are regional coordinators, in Luxembourg the integration of all services in regional centres for older people is intended to enhance co-operation and in the Netherlands there are neighbourhood health centres.

Service innovations

What is, perhaps, most striking about the comparative EU research is that despite, or rather because of, shortages of funding, the social services are in a state of purposive development. Examples include:

- service buses – Ireland, the Netherlands;
- the spread of alarm systems – in Belgium, France, Luxembourg, the Netherlands, Spain, Sweden and the UK;
- hospital at home/terminal care schemes – the Netherlands;
- hospital discharge schemes – the UK;
- the increasing recognition of and support for informal carers including self-help groups in Belgium and Sweden; carers' support groups in Belgium, the Netherlands, Sweden and the UK; family placements/boarding out in Germany, Greece, Ireland and Italy and the UK; respite care in Belgium, the Netherlands, Sweden and the UK; sitting services in Belgium and the UK;
- short-term or supplementary home care – the Netherlands;

- new community resources in support of home care, such as day centres in Belgium, France, Ireland, Luxembourg, the Netherlands, Portugal, Sweden and the KAPI in Greece;
- housing improvements – Denmark, the Netherlands and the UK;
- new forms of service integration and co-ordination in Belgium, France, Ireland, the Netherlands and the UK;
- new training regimes to improve the quality of home care services in Denmark and Luxembourg.

While there is plenty of evidence of considerable innovatory zeal throughout the Community it is important to guard against the danger of over-emphasising the impact of service innovations. Despite the existence of high profile innovations throughout the EU (and beyond) the dominant model of social care remains that of the traditional home help. In other words, the experience of the majority of older people who are fortunate enough to be receiving social services amounts to one or two hours per week of home help. Change is taking place even within the social services, for example, the enhanced home care/community support worker role in the UK and Denmark, but the 'spotlight effect' of innovations should not mislead us into imagining that they are universal.

So, it is necessary to be cautious in concluding that evidence of innovation means that the majority of older people in the EU are receiving an adequate home care service – this is very far from being the case, even in the long-established welfare state societies.

Pressures for change in social services

This brief review of current trends in the provision of domiciliary care reveals both convergence and divergence: there is a remarkable degree of similarity between member states in the sort of traditional services available to older people but considerable disparities in the level of such services. With the exception of Denmark, the Netherlands and the UK (together with Austria, Finland and Sweden) the northern EU states are characterised by minimal home care provision (with a wide variation in the definition of 'minimal'); while the southern states and Ireland suffer from underdevelopment in all social services. Nonetheless, it is possible to discern similar trends and service developments within the Community as a whole. This is not surprising perhaps

because some of the pressures for change facing member states are common ones. There are three main sources of pressure:

Socio-demographic pressures

The European Union is ageing rapidly. At present there are 48 million people aged 65 and over in the EC, 20 million of whom are aged 75 or over. By the year 2000 they will represent more than one-fifth of the population and by 2020 they will comprise more than one-quarter. All EU countries face similar demographic patterns: lower fertility rates coupled with higher life expectancy – though they have different starting points. There is considerable convergence between member states in the proportion of their populations aged 65 and over.

The facts of the demographic revolution are well known so I will not labour the point, but it is important to guard against the tendency to regard population ageing automatically as a problem (Henwood and Wicks 1984, Phillipson and Walker 1986). Ageing populations are a sign of success – mainly on the part of national health services and especially public health measures – in overcoming many of the causes of premature death that cut short people's lives in the last century. Moreover, even among the very elderly it is still only a minority that require care (one-third of those aged 80 and over in Germany and the UK).

But population ageing does present a challenge to the social services, partly because of the association between disability (including dementia) and advanced old age, and partly because this change is coupled with other socio-demographic changes.

Most importantly there is the fertility trend towards smaller family size. This means that by far the main source of care for older people in need – their own families – are having more and more to face the prospect of caring for older relatives for longer and with fewer potential family members to help. Moreover, since women are the main source of care within the family, smaller families mean that more and more women are being forced to shoulder both the labour and the responsibility for caring, on their own (Qureshi and Walker 1989). This development is of profound importance for both families and the providers of home care and other services.

It means that family members are entering new inter-generational caring relationships – new in terms of both their intensity and duration – with both sides having to bear the strains these relationships can generate (Walker 1993b). The inevitable result is that these caring

relationships will break down with increasing frequency, due to carer fatigue. Alternatively, given this prognosis fewer and fewer women will be prepared to enter such long-term caring relationships. Either way, the result is increased demand for service provision (often residential). There are very few examples of care systems having fully adjusted to the implications of the demographic revolution that we are experiencing currently.

The trend towards increased female participation in the labour market (often in roles, such as home care, that mirror their domestic one) puts additional burdens on the female-dominated informal care sector. Although there is no widespread evidence at present that women are giving up family care for the labour market, the case of Denmark gives some indication of the potential conflict between full time paid employment and unpaid domestic labour. In 1960 one quarter of women aged 25–34 were employed. By 1986 this had risen to 89 per cent (Dooghe 1991). At the same time Denmark is the one EU country to report relatively low 'family' participation in care (Walker, Guillemard and Alber 1991). The example of Denmark gives some flavour of the distaste of Scandinavian women for the full-time housewife role (Waerness 1990) and, therefore, the enlargement of the EU is likely to emphasise further the social distance between north and south. The growth in divorce and family break-ups is also important because there is evidence that divorced children give less help to older relatives than those in stable marriages. As well as providing less direct personal care they are less likely to have social contact with their older relatives (Cicirelli 1983).

There is one further point of importance in this socio-demographic matrix. In all EU countries an increasing proportion of older people are living alone. This is partly a function of demographic change and geographical mobility, but it also appears to reflect a desire for separate dwelling places on the part of both older and younger people. The variation in the EU is from a low of 17.5 per cent of people aged 65 and over living alone in Ireland to a high of 49.3 per cent in Denmark. Again, it is necessary to be cautious about this trend. There has been a great deal of speculation about the break-up of the family which is simply not borne out by the evidence. What the research shows is that, although they may live in separate households, older people and their adult children are still in close contact – they prefer 'intimacy at a

distance' (Qureshi and Walker 1989, Walker, Guillemard and Alber 1991).

So caution is necessary, but the widespread trend towards living alone has service implications: older people living alone are likely to be poorer than couples and in some countries, such as the UK, social services have traditionally been targetted on (or rationed to) those living alone.

Political/economic pressures

In all EU countries economic concern about the cost implications of population ageing – in terms of pensions, health and social services – is coupled with political worries about the fiscal implications of increased welfare spending. In some countries this has led to a high level of pessimism about the so-called 'burden' of societal ageing (Walker 1990). In general, economic concerns about the cost implications of population ageing are universal – however, the more extreme forms of pessimism are associated primarily with those governments that, for ideological reasons, have adopted an anti-welfare state posture.

The service implications of these political/economic pressures are, as far as the mild form found in most EU countries is concerned, a cost-effectiveness imperative that, for example, establishes the principle that older people should stay in their own homes for as long as possible and promotes a search for cheaper forms of care. In the extreme pessimistic form of these pressures there is a desire to place even greater responsibilities on family members and to encourage the growth of the private and voluntary sectors in substitution for the public sector. Scandinavian countries are not immune to these pressures but, so far at least, they have taken the relatively mild forms of action with regard to social care (Waerness 1990, Kraan *et al.* 1991).

Within the EU the specific service implications of these political/economic pressures include: strict financial limits on care (Belgium, France, Greece, Ireland, Italy, the Netherlands and the UK); a shift or a planned shift from residential to community care (all countries but most radical in the Netherlands because the proportion of older people in residential care has been, on average, twice as much as other countries); deinstitutionalisation (Ireland, Germany, the Netherlands and the UK); increased expectation of financial contributions (Belgium, Germany, Italy and the UK); decentralisation (Germany, Ireland, Italy, the Netherlands and the UK); encouragement of family and informal service networks (Germany, Ireland, the Netherlands); failure to improve training and pay for home care staff, which reinforces staff shortages (most countries); local experimentation with cheaper forms of care (most countries); encouragement of the private sector (Italy, Luxembourg, the Netherlands, Portugal and the UK).

Thus, although they are not the only factors underlying the new agenda in services for older people, political and economic pressures are key inspirations behind innovation and experimentation. In other words, if necessity is the mother of invention, then the primary necessity in EU countries is shortage of funds.

Grassroots pressures

In the Northern EU states with long-established social services systems a certain disillusionment with these services has set in recently, particularly with regard to monolithic public services. These services, including traditional home care services, have been subjected to four sorts of criticism.

USERS

First, more and more users of the social services have been complaining about their bureaucratic organisation, complexity and lack of responsiveness to felt needs. In fact, there is a long series of research studies pointing to the divergence between the perceptions of need held by users and professional providers in the social services (Mayer and Timms 1970, Sainsbury 1980, Fisher 1989). Some groups of users – such as people with disabilities – have formed self-advocacy movements to press their case for greater influence over their own lives and the services they use. At the present time groups of older people are not at the forefront of pressure for change in the social services, but the recent emergence of grey political parties and the strengthening of EU wide organisations of older people suggests that this may change in the future.

WOMEN

Second, there is the distinct feminist critique of the gendered nature of care which has developed, since the late 1970s, into a devastating indictment of both informal and formal care. Feminists have been primarily responsible for demonstrating that community care is, in fact, mainly care by female kin and also that care consists of two dimensions: labour and love (Land 1978, Finch and Groves 1980, Walker 1981). This

has led to a demand for alternative approaches that do not exploit women (Dalley 1983, Finch 1984, Waerness 1986). Of course, this criticism is of direct relevance to traditional home care services because they are modelled largely on the female domestic or housewife role and are staffed mainly by women. Furthermore, many innovations in social care rely on the unpaid or low paid services of women and, therefore, they may be subjected to the same feminist critique as traditional social services.

CARERS

Third, out of this feminist critique has come a specific case mounted by those people responsible for providing informal care. During the 1980s, in Britain and the Netherlands, carers began to form self-help and pressure groups to support themselves and represent their views. Together with researchers they have shown, for example in the UK, that community care policies have paid very little attention to the needs of carers and the state has done very little to support the activities of the 6 million carers (Oliver 1983, Wright 1986). The EU is likely to see the emergence of more politically active informal carers as more women enter the labour market and more men take on caring roles. Their pursuit of their own and their relatives' interests will inevitably put further pressure on services.

Informal (unpaid) carers are part of the 'taken-for-granted' context within which services are provided (Twigg, Atkin and Perring 1990). For example, the provision of home care is based to some extent on assumptions about the availability of informal carers and their domestic duties towards the person in need of care. Thus the scope of home care is determined frequently by the activities performed, or assumed to be performed, by a caring relative. If home care services are targetted on those living alone and without relatives living nearby, then those carers often under the greatest strain (those living with a frail older person) will not receive the support they need (Levin, Sinclair and Gorbach 1985).

BLACK AND ETHNIC MINORITIES

Fourth, users and carers from ethnic minority groups have begun to criticise the social services in general and the home care services in particular for failing to recognise their specific needs and the extent to which their cultural background and their experience of racism should be reflected in service provision (Atkin 1991).

These four criticisms are contributing to a disillusionment with social services, including traditional home care services, and, in combination with the demographic, political and economic factors, have created significant pressures for change in the organisation and delivery of services. They have set a new agenda for the care of older people and other groups (Evers 1991). Some changes are already underway, for example:

- standard, off-the-peg, services are being replaced by more flexible, 'tailor-made' and co-ordinated care services;
- the role of the informal sector is becoming more explicit and attempts are being made to integrate better the formal and informal, rather than seeing them as substitutes for each other;
- in some cases the service user as a passive recipient is being replaced by the idea of an active co-producer of welfare;
- symbolically the term 'client' is being replaced by 'user'.

These are, of course, desirable changes because they mean that services can begin to reflect better the needs of users and informal carers.

But the progress of change across the EU is patchy and still the majority of older people who are fortunate enough to receive services will not be aware of any new agenda. This raises questions about the prospects for the emergence of an EU wide convergence in policies on the care of older people.

Towards a European policy on the care of older people?

The goal of extending domiciliary care for older people is explicit throughout the EU. But, at the same time, we have seen that home care services are in short supply in virtually all EU countries and only in Denmark and Sweden is there a widespread 24-hour service. Thus, there is a continuing care gap and many home care services are still stuck in a traditional mould. At the same time most older people in need of care have very little choice, if any at all, about the service they receive (both in terms of the type of service and its intensity). The signs of overburdening can be seen in the incidence of physical and mental ill-health among informal carers (and in sickness rates and absenteeism among paid home carers).

How should EU countries respond to the pressures I have outlined? What is the role of the Commission itself in encouraging convergence

towards best practice in the social care of older people? It must be recognised that the primary motivations behind change in the social services are political and economic rather than grassroots. Thus, one of the most important and difficult challenges facing policy makers and service providers is how to create a more equal and effective partnership with the citizens they serve. Of course the answer to this challenge has profound implications for the meaning of citizenship to older people and their carers and, in particular, how much power and autonomy they are able to exercise in making decisions about their own needs and the sorts of services they require. In other words, how far can the political and economic pressures for change be steered in the positive direction of empowering service users and carers, or are these elements of the new agenda entirely incompatible?

It is possible to envisage forms of care provision in which older users and their carers are involved at every level of service planning and delivery (Croft and Beresford 1990, Walker 1992). However, there is substantial institutional inertia standing in the way of this user involvement and empowerment. In addition there are even more formidable political and ideological barriers confronting the introduction of users' rights and empowerment. If the primary motives behind the promotion of community care are political and economic, then the added encumbrance of more costly user-representation and advocacy machinery is not likely to be favoured by national governments. Also, user empowerment fits uneasily with the two extremes of current welfare state governance in Europe. On the one hand there is the paternalistic tradition of the Nordic Welfare states and, on the other, there is neo-liberalism, found in its extreme form in Britain but in watered-down versions elsewhere, which deprecates welfare rights and is opposed to the further development of public services. However, it must be said that rights are (or have been) more commonly associated with Scandinavian welfare states than with other forms of welfare state.

What hope is there that the EU itself will act as a major source of pressure towards convergence in user-orientated social services? The main difficulty is that the Commission has no legislative competence in this field. Indeed, until very recently it had taken hardly any action at all with regard to older people. In discussions concerning the Internal Market of 1992 older people have been largely invisible and the Social Charter or Chapter is primarily concerned with those in employment.

Moreover, the agreement on EU social policy at Maastricht shifted the emphasis in social security from harmonisation to convergence. Thus the principle of subsidiarity is likely to rule out the granting of any powers to the Commission with regard to the care of older people. But this does not mean that the Commission has no role to play, far from it. The Maastricht Treaty gave the Commission some competence in the field of public health and the second programme on ageing (due to be ratified in June 1995) includes specific mention of good practice with regard to the care of disabled older people. Thus the Commission has a vital task to perform in publicising examples of good practice – in service provision, training and so on – and encouraging the standardisation of vocational qualifications, in order to facilitate the convergence of social services towards a model that enhances the status of older people in the EU by ensuring that they are treated with respect and dignity. The Commission also has an important contribution to make in research and monitoring and the encouragement of knowledge transfer. The sharing of knowledge North/South and South/North is particularly important in order to ensure convergence within the EU, in so far as convergence is possible in the context of very different cultures.

Conclusion

Considerable convergence has already taken place in the social services of member states towards an increased emphasis on community care. This will undoubtedly lead to improvements in care for some older people but provision in most countries is likely to remain minimal. There is little realistic hope of a massive and widespread growth in home care, for example, to harmonise with Danish, Dutch or Swedish levels of provision. There is even less chance of the voluntary sponsorship of user empowerment by national governments, or in the medium term, by the EU Commission. The best that we can hope for in the short-term is to build on good practice in service innovations, while in the long-term the growing political confidence of older people's organisations in Europe may well bear fruit. Their campaign for equal EU citizenship, perhaps in combination with domiciliary care providers and their organisations, could produce a radical new agenda in the care of older people: one based on users' rights rather than providers' discretion.

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Part II

Adopting a User- and Carer-Led Approach to Services