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A Comparative Study of Older People's Care in Europe

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Social Exclusion and Social Care

Tim Blackman

So far in this book we have explored how older people are cared for in six European countries, discussing similarities and differences at the level of both care systems and individuals. Each of the countries presents a different national context. Formal care services are interventions in these different contexts: in Ireland, Italy and Greece, interventions are quite rare – usually to avoid, or in response to, a crisis arising from inadequacies in family care, income or insurance which leave an older person at risk. In these countries, the vast majority of older people depend on the context of family and community life for their care. Day care in Greek KAPIs is perhaps an exception because it is open access and aims to improve the general quality of life for older people, but its success owes much to the way KAPIs are part of their communities, drawing on substantial voluntary help. In other countries, notably Denmark and Norway, services are likely to be provided to any older person needing assistance, rather than being provided as a last resort. In the UK, services aim to provide assistance beyond a basic level of responding only to crises, but they are frequently criticized for being inadequate and means tested (Royal Commission on Long Term Care, 1999a).

This chapter takes the analysis a step further by using the concept of social exclusion as a means of evaluating the adequacy of arrangements in each country, especially the quality of care in different care settings. The idea of 'welfare culture' is introduced to take account of national differences in the role of the family, and the chapter considers whether social exclusion can be applied as an evaluative concept across different welfare cultures. This is done by focusing on issues of *access* and *entitlement*, including variations in the provision of services, the roles of assessment and discretion, and the balance between informal

family care and formal, organized services. The chapter ends with some observations about where particular weaknesses lie in the different care systems.

Ageing and social exclusion

Social exclusion has different meanings in different national discourses. Rene Lenoir has been credited with inventing the term in the early 1970s, and it gained in popularity in France during the 1980s, spreading through European Commission channels to be introduced into other national debates (Haan, 1997). In the UK, until recently, more attention has been paid to poverty and its measurement than to social exclusion, which has been regarded as a broad concept that is difficult to measure. Inequality captures some of its meaning in operational terms, but not those aspects of social exclusion that relate to the solidarity and status of shared citizenship and common opportunities to participate in society. Tiemann (1993) comments that, 'Social exclusion can be seen, not just in levels of income, but also matters such as health, education, access to services, housing and debt' (quoted in Spicker, 1997, p. 134). A European Commission (1993, p. 43) commentary states:

> When we talk about social exclusion we are acknowledging that the problem is no longer simply one of inequity between the top and the bottom of the social scale (up/down) but also one of the distance within society between those who are active members and those who are forced towards the fringes (in/out). We are also highlighting the effects of the way society is developing and the concomitant risk of social disintegration and, finally, we are affirming that, for both the persons concerned and the society itself, this is a process of change and not a set of fixed and static situations.

The idea of social exclusion in France arose from the French concept of solidarity and the role of the state in furthering social integration. According to this view, social exclusion entails a rupturing of the social bond between an individual and his or her society, culturally and morally. It is a multifaceted idea and the policy responses have been equally multidimensional, although focusing on the concept of 'reinserting' individuals, families or groups. This is perhaps easier to understand in terms of reconnecting unemployed people with labour markets through training and job subsidies than with regard to older

people who cannot, or do not wish to, take up employment. Indeed, the integration of all people of working age into the labour market is now a dominant theme in social policy across Europe, both to reduce dependency on welfare spending and to promote economic growth (Cousins, 1999b). Levitas (1996, p. 5) argues that this has overshadowed other aspects of social exclusion as a policy issue:

> the concept of social exclusion ... has become embedded as a crucial element within a new hegemonic discourse. Within this discourse, terms such as social cohesion and solidarity abound, and social exclusion is contrasted not with inclusion but with integration, construed as integration into the labour market ... Within this discourse, the concept of social exclusion operates both to devalue unpaid work and to obscure the inequalities between paid workers.

Marginality in relation to the formal labour market, however, is a general feature of social exclusion, underlying its manifestation among diverse social groups (Corden and Duffy, 1998). This is because of the central importance of paid work as a distributional mechanism in market economies. But while being unemployed or unwaged is an important cause of social exclusion, the condition cannot be reduced to economic disadvantage. This is in part because social exclusion is multidimensional, but also because it is not a distributional concept (Room, 1996).

The main dimensions of social exclusion are relational. Corden and Duffy (1998) summarize these dimensions as discrimination in relation to rights; marginalization in relation to economic production; and a catastrophic break from the rest of society (Corden and Duffy, 1998). Older people – vulnerable to age discrimination and dependency on others, often regarded as 'non-productive', and often isolated from the rest of society by immobility and a decline in social networks – are clearly at risk of the multidimensional impact of social exclusion.

The difficulties of old age are conventionally attributed to biological ageing – the process by which the body's adaptive mechanisms are impaired, contributing to the increasing incidence and prevalence of most diseases and disabilities with age. The ageing process, however, is not purely a genetic process: it is a consequence of an interaction of genetic, environmental and social factors. Although the influences of extrinsic environmental factors, such as the design of buildings, neighbourhoods and household appliances increases with age, they are often modifiable or preventable. Old age is also socially constructed by wider

values and attitudes about ageing, and by economic exclusion such as compulsory retirement from the labour market, so that the experience of old age can have relatively little to do with biological ageing.

Those older people who have to cope with chronic illness or disability can find that their quality of life greatly depends on a wide range of these extrinsic environmental, economic and social factors. They include, for example, support from family members and friends; environmental obstacles and availability of public transport; income and the ability to pay for services; and the availability, accessibility and quality of organized social care services. Older people with chronic illnesses or disabilities are dependent on suitably adapted environments, practical help with activities of daily living, and appropriate medical, nursing and personal care. But they occupy different positions of power in relation to these resources (Gibson, 1998).

The extent to which an older person is empowered in relation to the resources needed for their care has ideological as well as material dimensions. Ideologically, disempowerment can occur because older people are not regarded as having legitimate needs as individual citizens because they are unproductive and at the end of their lives. The 'burden of ageing' still dominates both popular and policy discourses. For example, an OECD Policy Brief published in 1998 states:

> Population ageing in OECD countries over the coming decades could threaten future growth in prosperity ... Countries could finance future social spending obligations by raising payroll taxes to whatever level was necessary, but these would be so high as to discourage work effort and would cut deeply into working people's living standards. These considerations point to the overriding importance of curbing the growth of spending on public pensions, health and long-term care. (OECD, 1998b, pp. 1–2)

This view is contested by other economists and the argument is essentially political rather than economic: it is about the allocation of resources rather than the sustainability of expenditure (Atkinson, 1995). In ageing societies, assuring the living standards of all those in retirement while protecting the quality of life of those with particular health and social care needs does call for debate about the balance between private and public income and expenditure, and the targeting of public resources. However, the continuing currency of the 'burden of ageing' in these debates contrasts with the relative success of the disability rights movement which has made much progress in reframing

disability as a social and political issue, concerning discrimination and the distribution of resources, rather than a personal issue of individual functioning and burden (Oliver, 1998). The idea of ageing as a burden on society stigmatizes older people as well as the services they receive, both of which become devalued and associated with negative dependency (Spicker, 1984).

While physical and mental disabilities are causes of dependency, most older people are not disabled. The major cause of dependency for older people as a group is low income arising from compulsory retirement. Although many older people in Europe enjoy a relatively comfortable retirement, many do not and the extent of inequality both within and between countries is a growing issue. The trend in many countries is towards income polarization as older people divide between pension-poor and pension-rich groups depending on whether they have a good second pension, especially an occupational pension. Among the six countries discussed in this book, only Denmark is seeing a trend towards greater equality in pensioner incomes (Ministry of Finance, 1999). There is little evidence that many older people want to remain dependent on waged employment, and where early retirement pay has been relatively generous, as in Denmark, it has been a very popular option and much more so than partial retirement schemes (Platz and Freiberg Petersen, 1992). The issue is instead one of securing adequate living standards for older people in retirement, including enabling older people's continuing involvement in productive activities.

Because formal health and social care can be very costly for those who need it, no income support scheme can incorporate these needs, and special arrangements for funding care services are necessary. As noted in Chapter 1, arrangements for securing access to health care through universal health insurance or service coverage are reasonably comprehensive across Europe, although the level of public expenditure on health varies greatly. In 1995, spending per capita ranged from about €1600 in Denmark and Norway; to about €700–800 in the UK, Italy and Ireland; to only €350 in Greece – although Greece increased its spending eight-fold between 1975 and 1995, compared with increases of about five times among the other five countries (OECD, 1999). This range in spending per capita, however, is smaller in terms of purchasing power parity – from €545 in Greece to around €1300 in Norway and Denmark (OECD, 1999).

These differences are much more pronounced with regard to social care, largely because there is no policy commitment to universal coverage in Greece, Ireland or Italy. The southern Europe, family-based

welfare regimes are characterized by a preference for direct monetary benefits rather than services. In Italy, children are legally obliged to provide financial support to their parents, including paying for care, so older people may be placed in a position of negative dependency on their children. Mirabile (1999, pp. 112–13) comments that:

> this arrangement penalizes older people because they are forced to look for care services on the market. These services are costly and often older people cannot afford them, in spite of 'high' pensions. From this point of view, the wide variations in the economic and social circumstances of older people in Italy should be mentioned ... within this spectrum, there is a particular predominance of women receiving social pensions (about 80 per cent of total beneficiaries). This kind of benefit is so low that it is often an indication of poverty or hardship.

Pension policy is often considered in terms of the prevention of poverty. Greece, the UK and Italy fare badly in this respect, with 20–30 per cent of their older people (65 years plus) classified as poor in terms of incomes at or below minimum social security standards (Tsakloglou and Panopoulou, 1998; Walker and Maltby, 1997). Poverty is a particular issue in Ireland among a significant minority of older women who never married and lack sufficient contributions to obtain a full pension. In Greece, all employees and their dependants are obliged by law to join a contributory social insurance scheme which provides health care, holiday and pension benefits; unemployed people receive a state retirement pension and free medical services (see Chapter 8). But Stathopoulos and Amera (1992, p. 184) observe that although insurance coverage for medical needs and retirement benefits is effectively universal, 'there are great differences in both benefits and contributions, and there are some pensioners who have 10 or 20 times the amount of the minimum pension'. There is a marked lack of trust in the social insurance system and inadequate benefits, leading those who can to opt for 'top-up' private insurance. In the UK, the poorest 20 per cent of single pensioners in 1996/97 received an average income some three times lower than the richest fifth (Department of Social Security, 1998). The state pension is below the minimum social security threshold, with the result that pensioners with no other source of income must claim a means tested benefit, Income Support, to bring their income up to this threshold. It is estimated that about one million eligible pensioners in the UK do not claim this entitlement (Pension Provision Group, 1998).

In understanding the effect of low income on quality of life, it is inequality rather than poverty alone which is important because in unequal societies low income excludes people from a wider general prosperity (Atkinson, 1995). Thus, the European Commission defines people who face exclusion as those who have an income below 50 per cent of median household income after tax (European Commission, 1993). Exclusion defined in this way is least prevalent in the citizenship-based welfare states of Scandinavia, but not absent. In Norway, although no more than 1 per cent of older people have to resort to means tested social assistance payments, in 1990 7.9 per cent of people aged 67 or older were poor by the EC definition (Koren and Aslaksen, 1997). Surveys have also revealed a gender difference. Fifteen per cent of women and 6 per cent of men aged 67 or older reported that they would have problems paying an unforeseen bill of NOK 2000 (about €255), while 5 per cent of men and 3 per cent of women aged between 67 and 79 reported problems managing current expenses (Daatland, 1997a; Dahl and Vogt, 1995).

In both Denmark and Norway, state pensions are a right of citizenship. They are universal and set at a level that secures the participation of older people in the country's general prosperity. Norway's state pension is structured rather differently from Denmark's and is not as egalitarian (Daatland, 1997a). The level of pensions in both countries is such that family members will normally not feel any obligation to give financial support and in Norway surveys indicate that older people often support their children with financial help (Gulbrandsen and Langsether, 1999). Social inclusion is a general principle in these welfare systems and extends beyond pensions to universal social care coverage and the extensive provision of disabled access housing. While all is certainly not perfect, the social policy debate in Denmark and Norway is framed by a particular welfare culture in which social inclusion is a public issue and state responsibility (Chamberlayne *et al.*, 1999). Romøren (1996, p. 70) comments that despite experiments with private provision

> the principle of equal access for every citizen to almost total public financing of formal care has not changed. Today it is reasonable to consider this model more as a cultural pattern in the small and homogeneous Scandinavian populations than as a view held by one or other political wing.

The welfare culture of southern Europe is quite different. Social inclusion is not evident as a strong public policy objective. But as a set of

norms and values the concept is manifest in these societies, although in the private realm of family responsibility. The Greek family has been described as a type of 'clearing house' for the provision and receipt of financial and social support, mediating between individuals and the country's fragmented employment and income maintenance structures. Without this clearing house role, these structures would fail to provide security and welfare for many individual Greeks. Papadopoulos (1998, pp. 54–5) states that

> One could argue that the Greek nuclear family functions internally as a cooperative while competing with other families in a society dominated by the idea of social mobility. Solidarity remains firmly within the private sphere, as an inter-generational responsibility towards the family unit. In this context, the development of notions of social responsibility or social solidarity, essential for the creation and functioning of a civil society, encounter enormous obstacles. Thus, the possibility of creating a sustainable ideological base for expanding the residual welfare state in Greece is limited.

Although the inclusion of older people within families in countries such as Greece appears to be high, the perception of older people themselves may be different. Giarchi's (1996) description quoted in Chapter 1 of older Italians living within a type of closed institutional care within the family questions any necessary connection between family care and social inclusion. Karantinos, Ioannou and Cavounidis (1992, p. 82) comment about the Greek situation that

> the fact that recourse to family networks is often if not usually a matter of necessity for elderly people rather than a matter of choice means that older people are often forced to compromise their dignity and become dependent on their kin. Tensions and strain in relations with kin are often the result, and while the necessary economic or physical aid may be forthcoming, it is often at the cost of satisfactory emotional relationships ... (T)he burdens placed on members of informal networks, whether kin, friends, or neighbours, are numerous and severe. Among these burdens are the strain on economic resources, and the time and effort that must be devoted to care of the elderly. There are particularly serious implications for women, as it is they who bear the brunt of the latter burden.

Hugman (1994) reports recent studies that have found high levels of self-reported loneliness among older people in Greece and Poland,

both countries with an apparently high degree of family centredness (see also Chapter 2). He suggests that this is due to the greater expectations that older people have in these cultures about the range and frequency of contacts they should have, compared with the more individualistic Anglo-Saxon world.

Just as familism is not synonymous with inclusion, individualism does not imply that older people are excluded in terms of their family relationships. There is plenty of evidence from the UK, Denmark and Norway that older people generally prefer to live apart from their adult children, but that close kin remain important in their lives through 'intimacy at a distance' (McRae, 1999; Jakobsson, 1998). There is no necessary relationship between the apparent 'closeness' of family relationships and the social inclusion of older people. Indeed, Platz (1989) found in Denmark that while it is single older people in particular who feel lonely, frequent contact with children and others does not compensate for this feeling.

McRae (1999, p. 23) comments that in Britain co-residence of older people with their children was more common in the past because of necessity rather than choice:

> What we are seeing in Britain today are increased opportunities for older people to realize their wish to live independently: they are healthier and live longer, so there are more close friends with whom to socialize; there is better state support and more facilities (both state and private) to support independent living; and there is a significantly larger housing stock, so older people have somewhere to live. Had these conditions existed fifty or sixty years ago, it seems likely that many more older people would have chosen to live apart from their adult children.

Does the extent of familism in some countries reflect economic underdevelopment rather than cultural preference? Within Italy, 60 per cent of disabled older people in the less-developed south of the country live with their children, compared with 20 per cent in the more developed north, suggesting a relationship between the level of development and opportunities for independent living (Cioni, 1999). The cultural distinctiveness of southern Europe has been used as a basis for identifying a separate type of welfare regime. However, Katrougalos (1996) contests this, arguing that in the case of the Greek welfare state it is essentially a less developed version of a Continental 'state-corporate' welfare regime like Germany or France, a model not represented among the six countries in the present book (Esping-Andersen, 1990). It is less developed because of economic underdevelopment.

The type of care dependent older people receive is likely to reflect wider social attitudes towards old age, a point made at the conclusion of Chapter 1. Kitwood (1997) develops the idea of 'personhood' as a relational term in the care of people with dementia, using it to describe a type of interaction with older people that validates and empathizes with the experiences of ageing, rather than regarding these experiences as undesirable, either denying them or treating them as problems to be managed. Kitwood (1997, p. 12) makes a connection between the micro level of how older people are cared for, and the macro level of social norms and policies. Writing from a UK perspective, he describes the 'psychodynamics of exclusion' in the following terms: 'Many societies, including our own, are permeated by an ageism which categorizes older people as incompetent, ugly and burdensome, and which discriminates against them at both a personal and structural level.'

The care setting itself can exclude rather than promote the inclusion of older people; Kitwood (1997, p. 116) criticizes the 'warehousing' of older people with dementia, but notes that smaller, more homely residential units are still no guarantee against isolation:

> Huge benefits are to be gained when the doors of formal care settings are opened, giving access in both directions. The clients can maintain their links with the community, and more readily maintain a sense of their own history: doing some shopping, going to the pub, to the theatre, to church, taking a walk in the local park. People from the community – not merely relatives and close friends – can become regular visitors. In some instances a local school has established a strong contact with a day centre or residential home. Some organizations are making provision for people to become fully-fledged volunteer helpers, providing the necessary preparation and training ... When volunteers are fully drawn into dementia care there is even the possibility of having 'staff' to client rations of 1:1.

If social exclusion is to be used as an evaluative concept for comparing arrangements for the social care of older people across different countries, it is necessary to take account of both cultural and socio-economic differences. For example, what may seem to be a high degree of segregation of many older people living alone in small apartments in, say, Copenhagen, actually reflects the extent to which suitable housing is available to enable older people to make this choice to live

independently. What may seem to be the impressive integration of older people in their families and communities in Athens exists alongside quite the opposite degree of opportunity. Similarly, an apparently stigmatizing process of assessing and means testing older people in need of help from care services in the UK may appear to a Greek or Italian older person as an extensive procedural right to assessment and a gateway to care services targeted at those who really need them.

A definition of social exclusion is needed which takes account of cross-national diversity. Taking into account the above discussion of family care, retirement and formal services, the following seems to meet this criterion, defining social exclusion as 'a process of interaction of the dynamics of the family and personal networks, the labour market and the welfare state that results in a chronic and structured inability by individuals and groups to participate in social life' (Duffy, 1996, p. 13). This definition captures the dimensions of family and personal relationships, the unwaged ex-worker role and dependency on the welfare state that are so important to the experience of old age. The extent to which each dimension is significant depends on the welfare regime in each country. The prime focus of this book is on the role of organized social care services that support older people's activities of daily living. Exclusion occurs when an older person does not control the resources he or she needs in order to undertake everyday activities with the degree of autonomy most other people would take for granted. This is partly a question of whether the necessary care resources exist and can be drawn on, but it is also about how care is provided and by whom. An absence of rights, marginalization from economic and political power, and isolation from the mainstream of society tend to compound each other for the most vulnerable older people.

Welfare culture and social exclusion

It is difficult to avoid the significance of the level of economic development in explaining cross-national variation in the provision of formal care services. Even the link between women's labour market participation and publicly funded services for older people noted in Chapter 1 reflects the higher demand for labour in the stronger economies of northern Europe. Referring back to Table 1.1, there is indeed a relationship between the gross domestic product of each country and the level of publicly funded social care services for older people. There is, though, also evidence pointing the other way – towards the significance of welfare cultures. For example, from Table 1.1 it seems that Italy and

Ireland should be able to afford a level of social care provision closer to that of the UK than Greece, but there is little evidence of this being a significant policy priority for their governments, even in Ireland where GDP growth has been the highest of all OECD countries during the 1990s. Given its low GDP, it is perhaps surprising that Greece even achieves the low level of social care provision which it does. It seems plausible that it is lack of funds rather than familism which holds back provision in this country although, as suggested by Katrougalos, this may not be evidence that welfare culture is of little importance in explaining cross-national differences because the basic welfare principles of the Greek system are closer to the Continental 'state-corporate' regime than to the more Catholic-influenced southern European model.

The Nordic countries provide an interesting test of the influence of welfare culture. Eydal (1999) discusses the anomalous position of Iceland among these countries with regard to the state provision of child care. Despite having the highest level of female labour market participation of all the Nordic countries, Iceland has the lowest level of day care provision. Eydal suggests that Iceland's particular history and culture have created an attitude that problems such as reconciling paid work and child care should be solved privately, reinforced by a common view that too much adult supervision of children is undesirable. Among the Nordic countries, Iceland also has the highest proportion of older people living with their children – about 20 per cent, compared with 5 per cent in Denmark. Iceland's public expenditure on older and disabled people is also lower at 8 per cent of GDP compared with 15 to 20 per cent in the other Nordic countries, and it has the highest proportion of older people in institutions (Jakobsson, 1998).

Returning to the Greek welfare state, however, Cousins (1999a) questions whether its distinctiveness can just be explained in terms of economic underdevelopment. There are similarities with the Continental state-corporate welfare regime because of the high degree of fragmentation in social insurance arrangements along occupational lines and an emphasis on cash benefits rather than welfare services. But Greece differs from countries such as Germany and France in fundamental ways, notably the extent of clientelism and patronage in its welfare state, and the gulf between workers in core sectors of the labour market who have good social protection and others in weak labour market positions who have meagre or no benefits. As already noted, even with economic growth the role of the family in this wider context militates against political demands for a more developed welfare state because the family

is already meeting many needs, a situation also applying in Italy and generally in southern Europe.

> The family meets a whole range of needs of members, for example, provision of housing and financial support for those who are unemployed or in precarious jobs, education expenses, as well as caring for ill, disabled, and elderly people and for young children... The family therefore takes much of the strain of high unemployment, precarious work or inadequate social protection. (Cousins, 1999a, pp. 17–18)

Echoing Papadopoulos (1998) on the Greek family, Trifiletti (1999) describes the Italian family strategy as a 'synthesis of breadcrumbs', involving the pooling of a range of partial incomes from different sources such as agriculture, self-employment and benefits. The duty to care falls mainly on women in the absence of extended formal provision for child or elderly care, but Cousins (1999a) observes that support among women across generations means that the lack of formal services is not the constraint on women's participation in paid work which it is in northern Europe, as carers can still be found within the family.

Welfare culture is clearly important in determining whether needs become expressed as political demands on the State. High employment levels have been a product not just of strong economies in Scandinavia but also of deliberate policy measures (although increasingly challenged by globalization and competitive market pressures). State intervention is an independent factor, with effects on society separate from wider economic forces, and either reinforcing or moderating their influence, especially with regard to the distribution of income and services (Musterd and Ostendorf, 1998). The extent and nature of such intervention is greatly influenced by the value systems prevalent in a given welfare culture, especially the centrality of social exclusion in political debate. Social exclusion exists because access to a resource – including both material and social resources – is prevented by economic, political or social barriers. These barriers are constructed by mechanisms of exclusion controlled by people with more power than those who are excluded. Exclusion for some is created by the actions, words and beliefs of others, and although economic power is a key factor, exclusion is also created ideologically through the social construction of marginality and vulnerability in both political and everyday discourses.

As considered above, social exclusion is a wider concept than income inequality. It focuses analysis on 'exclusion mechanisms': the structures and processes which marginalize older people and their needs within a given welfare culture. It might appear that the welfare cultures of Norway and Denmark are more successful than those of the other countries in achieving the social inclusion of older people because of the existence of well-funded welfare states. But in other countries social inclusion is achieved in different ways, such as the provision of care and sharing of resources within families in which older people occupy a position of relative power. Although there is evidence of loneliness in familist welfare cultures, there is also evidence of dissatisfaction with services in well-funded welfare states where older people may feel less empowered because of professional dominance. Even bringing the situation of the family carer into consideration, it is not necessarily the case that familist care systems exclude women from wider opportunities because of their 'duty' to care. There is evidence of women taking up new opportunities for education and employment because of cross-generational support within their families, and extensive volunteering in familist welfare cultures gives many older people a productive role in their societies. This is not to deny the extent of burden that can exist for female carers and the loss of dignity that can be involved when, for example, a son has to attend to the intimate personal care needs of his mother, but it is to argue that whole systems of care cannot be rejected as exclusionary because they do not conform to, say, the traditional Scandinavian welfare model. All systems have strengths and weaknesses, and the possibilities for reform lie in building on the strengths and tackling the weaknesses.

Social exclusion therefore involves looking at the overall situation: it is perhaps most extreme in the economically depressed and depopulated rural areas of Greece or Italy where there are few informal or formal supports, but it can also exist in much more developed care systems. For instance, the well-being of many older women is bound up with their sense of self as competent adults able to maintain socially acceptable standards such as a clean house. In the UK, Norway and Denmark, the withdrawal of housework from the services provided by a local authority for older people, because funding and providing personal care is a higher priority than help with 'non-essential' practical tasks, has been criticized for impairing this sense of competency and undermining the person's motivation and ability to stay independent (Clark, Dyer and Horwood, 1998). Even in Denmark, the rising cost of care services for an increasing number of ageing older people has seen

a tightening of eligibility criteria for services. Some local authorities, for example, no longer offer help with shopping and cleaning unless the older person has mental health problems. The number of home care users has increased but services are more sharply targeted. There has been a reduction in hours per user, largely due to less help with housework and other practical tasks, and a focus on personal care and security. Sixty-five per cent of Danish home help users receive less than three hours help per week (Leeson, 1997). The same trend is evident in the UK, although the situation is not comparable given that about 20 per cent of older people receive some sort of local authority help in their homes in Denmark, compared with about 10 per cent in the UK.

Social exclusion is about how older people feel as well as structures and processes that deny material resources to older people in the interests of other more powerful groups in a society. The issue of how accessing the services that are available is experienced is crucial in this respect; in particular, the effects on an older person's dignity which follow from the experience of referral and assessment. 'Gatekeeping' is an inevitable feature of resource allocation, but this can take place either within a framework of rights or within a culture of disempowerment and discretion. Variations – or inequalities – between countries in the care services available for older people raise difficult political issues about the large-scale cross-national transfers of resources which would be needed to reduce them. However, there are also aspects of practice and policy within each care system which involve unnecessary exclusionary mechanisms that create inequities and stigma within the system. Variations in the allocation of resources and decisions about access and entitlement are particularly problematic issues in this regard.

Allocation of resources

None of the six countries provides substantive rights to social care services for older citizens, although the insurance-based system in Greece defines certain rights to financial assistance towards hiring care if a person is assessed as more than 67 per cent disabled. Generally, social security systems tend to define legal rights to cash benefits, but rights to social care *services* are not defined in law. While legal rights to care could be regarded to be an ideal situation, this would be likely to encourage a mechanistic approach, removing the capacity of assessors to make sensitive judgements about complex individual circumstances because of fixed rules about entitlement (Blackman, 1998).

Norway, Denmark and the UK have legislation requiring all local authorities to provide social care services. Types and levels of provision are not prescribed in Norway and the UK, but are for home help and community nursing services in Denmark, including one or both of these services being available round the clock. These three countries also have a procedural right to assessment whereby an older person who appears to be having difficulty with his or her care must be professionally assessed. These rights extend to the older person being informed about the reasons behind the subsequent decision whether to provide services, which is *guided* by eligibility criteria. As described in earlier chapters, however, older people may not understand what their rights are, and practitioners may not apply them as rigorously as they should, often due to workload and budgetary pressures.

The selective and discretionary nature of social care provision is evident to different extents in all six counties. This should in theory be moderated in Denmark, Norway and the UK by the routine use of standard assessment and eligibility criteria, which are publicly available and guide decisions on the basis of consistency and proportionality in the treatment of different cases depending on their needs. But even if selectivity is undertaken systematically according to objective criteria, there is still plenty of room for professional discretion. This was investigated in detail by research in the UK which used case study exercises in assessment and care planning to explore the consistency with which social care professionals responded to each case (Blackman, Durbin and Robb, 1998). The study was undertaken in two local authority areas, involving 160 practitioners. Marked variation was found in the number of hours of home care allocated to the same case, especially for older people with low or moderate needs. For one case with a low level of need as suggested by the local authority's own eligibility criteria, just under half of the 160 practitioners allocated no home care, about 40 per cent allocated up to four hours per week, just under 20 per cent allocated four to ten hours per week, and a few allocated ten or more hours per week. Another case with a high level of need revealed more consistency, probably because there are fewer options at this level and a greater focus would be expected. Over two-thirds of practitioners allocated this case ten or more hours per week, although over 10 per cent opted instead for long-term institutional care. About 10 per cent allocated between five and ten hours of home care per week, and a few allocated less than five hours.

Variations are also evident across local authorities in the UK in levels of service provision. It is difficult to make like-with-like comparisons

because of social and geographical differences between local authority areas, which influence the level of central government grant paid towards funding local services. But taking the 'big city' metropolitan district councils in England, in 1998/99 the proportion of people aged 65 or older receiving social care services in their own home ranged from 5.5 to 17.1 per cent, with 80 per cent of authorities within the range 5.7 to 12.4 per cent (Department of Health, 1999). The proportion of older people receiving an intensive domiciliary package of ten or more hours of home care per week varied from 0.3 to 3.4 per cent, with 80 per cent of authorities within the range 0.5 to 1.9 per cent. The number of publicly funded admissions to a residential or nursing home as a proportion of all older people varied from 0.9 to 5.5 per cent, with 80 per cent of authorities in the range of 1.1 to 2.2 per cent. There was no relationship between the level of home care services provided and the level of residential and nursing home care.

Similar variations are apparent with regard to the 'shire' county councils in England. The proportion of older people receiving social care services in their own home ranged from 2.2 to 14.4 per cent, with 80 per cent of authorities within the range 4.1 to 8.6 per cent. The proportion of older people receiving an intensive domiciliary package varied from 0.2 to 2.8 per cent, with 80 per cent of authorities within the range 0.3 to 1.1 per cent. The proportion of older people admitted with public funding to a residential or nursing home varied from 0.2 to 3.4 per cent, with 80 per cent of authorities in the range of 0.8 to 1.8 per cent. There was also no relationship between the level of home care services provided and residential and nursing home care provision.

There is also evidence of geographical variation in Norway, as discussed in Chapter 4. Næss and Wærness (1996) report variations in receipt of home care services across local authorities from a high of 22.9 per cent to a low of 17.6 per cent of people aged 67 plus – not a considerable difference. Home help visits ranged from an average of 140 minutes to an average of 126 minutes. More marked were differences in the number of institutional beds for people aged 80 or older, which varied from 16 to 39 per 100 people in this age group. These local variations reflect the different care profiles of local authorities in Norway: some have 'traditional' profiles with a relatively large number of institutional beds and moderate provision of home care services catering for people with more modest needs. Others have a low number of institutional beds and more generous provision of home care services, with more frequent visits and longer hours.

In Denmark, receipt of home help services has been found to vary from 40 per cent below the national average in the local authority with the lowest coverage to 40 per cent above in the authority with the highest coverage (see Chapter 3). These variations cannot be explained by either geographical or demographic factors. While the size of the local authority is the key factor with regard to differences in levels of provision, other differences reflect local decisions about the service mix. In the quarter of local authorities with the lowest coverage of nursing homes, 9 per cent of older people receive evening help and 4.7 per cent night-time help, compared with 5.7 per cent and 2.1 per cent respectively in the quarter of municipalities with the highest coverage of nursing homes. Fewer nursing homes places are thus compensated to a degree by more home care services. In both Norway and Denmark, there is an inverse relationship between the number of older people in a local authority area and the number of nursing home places and care workers, so that the volume of services in smaller local authorities is proportionately higher than in the large local authorities. Thus, the State having a responsibility for the social care of older people is not the same as people having substantive rights to services that are equitably allocated.

However, it is in those countries where the State has little responsibility for the general population of older people who need social care that inequities are most evident due to patchy provision and no formal allocation criteria. Italy has very marked geographical variations in provision, with the southern regions having significantly lower standards of living, and scarcer and poorer quality social and health care services (Giarchi, 1996). In all regions there are also significant local variations, with extensive decentralization following the principle of subsidiarity leading to a coverage of services that is determined by local political factors rather than by any national framework or needs-led allocation of resources. Levels of provision reflect the political make-up of municipalities, with left-wing administrations of north and central Italy far more likely than those on the political right to have developed social care services. Extensive bureaucratization is also a feature of Italy's care system.

Greece is attempting to develop its social care services beyond a traditional residual focus on the destitute and seriously ill to achieve a broader coverage of the older population. Older people with very low incomes who are chronically disabled receive cash help with the cost of care through the social security system. For other older people, Greece is seeking cost-effective ways of providing services, such as the open-access KAPI centres which now form a key part of the country's health and

social services provision for older people, combining public sector and voluntary resources (see Chapter 8). A significant expansion of home help programmes operated by local authorities is underway. Services provided by religious and non-governmental organizations and the private sector contribute to the patchy and uneven coverage of services rather than help to improve equity of access. The Church and large charities such as the Red Cross work autonomously. A range of private-sector organizations meet gaps in provision such as residential homes, nursing, home help and befriending, but only for those who can afford to pay.

In Ireland, the formal social care services that are provided are absorbed within a health service run by large area health boards and are often fragmented, with poor co-ordination between health and social care planning and delivery. In the largest of these, the Eastern Health Board, services for older people were, until recently, grouped together with acute hospital services. A relatively large voluntary sector, including many organizations associated with the Catholic Church, provides services that vary substantially in geographical coverage and the types of assistance they provide (see Chapter 6). The recent expansion of short-term services by health boards is not addressing Ireland's lack of universal long-term care provision.

Assessment

The right to a formal assessment of need is not a feature of care services in Italy, Ireland or Greece, where there is no legal duty on local authorities to provide social care services. Assessments in these countries are *ad hoc* and decisions about responding to need are discretionary, unregulated and strongly influenced by whether a local authority or, in particular, a voluntary organization happens to be providing a service in the locality. In Italy, Giarchi (1996) reports that discretion about what help is provided entails judgements about an older person's health and disability and whether they live alone. Provision of services is often limited to people with incomes below the official poverty line – about one-fifth of older people in Italy – with others expected to make their own arrangements privately. There are also long waiting lists for assessment.

In Ireland, the assessment of an older person's needs can be made by a community nurse who will also provide limited help with organizing services such as home help and meals-on-wheels. An older person may also receive assessments by particular service providers in the voluntary sector which each have their own criteria for eligibility, and these assessments are often informal and judgemental. General practitioners can take a lead role in assessment and organizing services, as can hospital social workers with discharge cases.

The formality of the assessment process in the UK, Norway and Denmark is important because it represents a single access point to services and is linked to decisions about eligibility, and these have become increasingly explicit and standardized. It is also linked to the practice of care management, with one professional taking responsibility for organizing services for an individual older person. This system of formal assessment and care management makes older people very dependent on professional power, but efforts are made to include users and carers in decisions. Unlike Greece, Italy and Ireland, the system can in theory make professionals accountable for their decisions because of the existence of bureaucratic guidelines. For example, many local authorities in Norway use a dependency scale as part of the individual needs assessment, both as a check-list and as a means of making decisions transparent. The need assessment is provided in writing to the user, but it is very general. It is recognized that there must be room for frontline staff to make informal judgements and adjustments with time, especially as it is not always possible to obtain a clear picture of needs at the beginning. Needs, however, are formally reassessed every six months. In Denmark, a similar type of written statement is used, but it is more tightly worded. A home helper must sign after each visit to the effect that she or he has provided the help defined in the statement. While protecting both the care worker and the user, the system discourages flexibility about what is done for the user from day to day.

There is a difficult balance to strike between formally defined entitlements and day-to-day flexibility, especially as a user's condition and social context may change over short periods of time. Without formal entitlements, however, discretion may occur on subjective grounds that cannot be justified objectively and remain hidden: for example, discriminating between 'deserving' and 'undeserving' older people on grounds other than need, such as personality, apparent material circumstances or family context. There is a growing number of examples of successful legal action to establish rights to social care. In the UK these have concerned mainly procedural rather than substantive rights, with the important exception of a recent case that established a right to free nursing care (see Chapter 5). In Norway legal action has established a right to care services in an older person's own home rather than their transfering to a residential or nursing home. But it is much more difficult to establish rights to particular amounts of help or, frequently, the type of help provided.

A significant issue with access which exists in the UK is that the procedural right to an assessment of need is combined with a financial assessment in the form of a means test. This is different from the systems of co-payment which exist for some services in Norway, including visits to family doctors, which are quite low and do not generate significant income for the local authority. In some UK local authorities, means testing can involve even older people on a very low income having to contribute something to the cost of their services, while users on middle or high incomes have to contribute a substantial proportion of the cost of any services they receive.

Intrusive means testing and judgements about ability to pay increase the stigma many older people feel about publicly funded services. In Greece and Italy, the older person's children are included in assessments of ability to pay, reflecting their wider duty to care. In Ireland, this was also the case until 1999 for private nursing home grants but was abandoned because of difficulty with enforcement. In the UK, means testing is restricted to members of the person's immediate household, although there is no provision in law to *demand* a contribution towards the cost of services from a liable relative (Schwehr, 1999). The means test is normally undertaken by a social worker, who will require the older person to provide evidence about their income and savings. Liability to pay towards the cost of a placement in a residential or nursing home is also assessed against the value of the person's original home, unless it cannot be sold because a partner continues to live there (although from April 2001 no sale will be required for the first three months of such a placement, and the alternative of a new loan system is to be introduced). In Ireland, where property has greater legal protection, the State does not have a claim on the value of a home vacated by a person who moves into subsidized nursing home care. Private nursing home beds are helping to free up hospital beds, although the cost of this strategy is escalating.

Older people in Ireland who hold medical cards are eligible for, although not entitled to, services such as home help, day centres and meals-on-wheels. This is normally for a small charge and although both home help and meals-on-wheels exist almost everywhere, their availability may be limited. With social care services in the community predominantly provided by voluntary organizations, means testing can be rough and ready. Even if someone refuses to pay, a service is unlikely to be denied if a doctor or public health nurse considers it is needed. Some 25 per cent of older people do not have medical cards, of whom two-thirds have health insurance; others are faced with the full cost of buying health or social care services. An older person without a medical card would normally not expect free services and would be likely to pay for private services in an increasingly buoyant private care market. Access to public funding for nursing home care is means tested and requires a medical assessment of dependency, but the grant provided, added to the older person's pension, can often be less than the fees charged. Families are therefore under pressure to pay the difference. In very exceptional cases, where the person is very dependent and has no family, the health board will pay the full cost. The escalating cost of Ireland's private nursing home subvention system has led to a major national review being undertaken at the time of writing, including exploring non-residential care options.

Charging is least prevalent in Denmark. Charges for home care for more affluent users were introduced in 1992 but later removed. Users of residential and nursing home care must pay for their board and lodgings, but this is not a particular financial burden given the relatively generous level of Denmark's universal and earnings-linked state pensions. Charging is more extensive in Norway, but it avoids some of the worst features of the UK's approach and is largely aimed at limiting 'unnecessary' demand while ensuring that low income and high-intensity users are not excluded from services. Charges for home care are low and cover only 5 per cent of the service's budget; local authorities have direct access to tax records which enables the financial assessment to be done without a personal means test. As in Denmark, there is a flat-rate, cost-price charge for meals-on-wheels, and nursing home care is directly subsidized so that users pay 75–85 per cent of their pensions in charges. These arrangements in Norway and Denmark reflect their relatively high pensions and avoid confronting older people with the full cost of their care and then requiring a means test before a decision is made about providing services.

In Italy social workers explore in detail why an older person cannot afford to buy the services they need and only provide publicly funded services if it is clear the person has no alternative. Older Italians are therefore very dependent on their pensions to buy care. With state provision being cut back in many localities, the private sector and – for poorer older Italians – the voluntary sector are increasing their role. Social co-operatives have grown substantially in importance, originating from grassroots action but often contracting with the local authority to provide services.

In the UK, a 'mixed economy' of publicly funded care services was introduced during the 1990s to extend choice of provider and contain

costs through competition. Privatization is most extensive in the residential and nursing homes sector where a huge growth in the number of private homes during the 1980s was a largely unplanned consequence of demand-led funding of places through the social security system (see Chapter 2). Particular criticism was made of the lack of flexibility of local authority services, such as few 24-hour services and little multitasking, as well as their cost of unionized workforces. While the UK has gone much further down the privatization route than Norway or Denmark, there are trends in the same direction in these two countries. Some Norwegian local authorities have contracted out the provision of care services and separated the need assessment function from service provision – reforms which have been budget driven. Such pressures have stirred up debate in Denmark about whether there should be a charge for help with domestic tasks. Local authorities increasingly contract out the delivery of domestic help to private and non-profit organizations, and some give the option to older people of a cash payment to purchase their own services rather than use local authority domestic services – a practice that is likely to become more common and includes the possibility of employing a family member. The absence of any significant private care market in Denmark, however, makes users dependent on local authority gate keeping because the only access to services is through a local authority assessment. In contrast to the UK and Ireland, where it is quite common for better-off older people to purchase a place in a residential or nursing home without any local authority involvement, in Denmark and Norway a state monopoly means that access is via a professional assessment of need, with the possibility of a long wait or that access will be denied if need is not established.

Care settings

Although developments are taking place that are extending formal social care services in the familist social care systems of Ireland, Greece and Italy, there is as yet no national coverage equivalent in philosophy or scope to Denmark, Norway or the UK. Greece has recently established a National Organization for Social Care equivalent to the National Health System, but services are still very limited in availability. The formal sector in these countries still consists largely of services provided by private or voluntary organizations, and access depends on ability to pay in cash or through insurance schemes or, for a minority, on charitable benevolence. The nature of social care provision in the

UK is much closer to that of Denmark and Norway than to these three other countries. This is because there is a universal entitlement to assessment, a national system of funding local authorities to provide social care services for older people, and a legal duty that they make appropriate provision for their areas. Crucial issues, however, are the equity of these arrangements and the adequacy of their funding. All three countries have now moved towards national 'frameworks' which set out general standards regarding what should be available in all localities, a development that is new for the UK but is in fact a shift away from earlier and stricter national norms and standards in Scandinavia (Jakobsson, 1998). The expansion of devolved budgets and devolved policy implementation is creating variation in patterns of services within municipalities as well as between them. The question of how national norms can be reconciled with local discretion remains unresolved; it is a particular concern in the UK where local decision making in the NHS is already unaccountable to local government (there are, however, proposals for this to change, with elected local authorities having the right to carry out formal scrutinies of local NHS services and refer major planned changes to central government (Secretary of State for Health, 2000)).

All the countries are entering the twenty-first century from different situations. Norway has high levels of both institutional and home care provision while Denmark, with a higher overall level of spending, has had a stronger policy of home care and 'ageing in place'. Thus Denmark has only 4 per cent of older people living in residential and nursing homes compared with over 7 per cent in Norway (Leeson, 1997; Daatland, 1997a). However, Denmark has been an important influence on the ideology of the Norwegian long-term care system, which is shifting its emphasis from a traditional medical orientation towards a social model, including a rebalancing of resources towards community care and supported housing. Denmark's number of nursing homes has fallen and access is more selective, with the result that their residents are severely disabled, often with dementia, and older. Indeed, it is also the case that most residents in Norwegian nursing homes – some 70 per cent – are people with dementia. Overall, about 16 per cent of those aged 80-plus live in nursing homes in Denmark, compared with Norway's figure for this age group of 23 per cent. Even special housing for older people in Denmark is now largely confined to older people who are very disabled or ill. Small communal schemes for older people with dementia have been built since 1988, justified by their contribution to the quality of life of people with dementia and the protection

of neighbours from disruptive behaviour (Platz and Petersen, 1992). Dementia is one of the last challenges to the philosophy of deinstitutionalized care for older people.

The UK's social care services are as deinstitutionalized as those of Denmark, with 4 per cent of older people living in residential and nursing homes. During the 1980s there was a rapid expansion of private homes funded by demand-led social security payments but reforms implemented in 1993 capped expenditure on social care and transferred responsibility for managing budgets and rationing provision to local authorities. This budget-driven scenario continues to encourage diverting older people from care in residential and nursing homes. In recent years the number of older and physically disabled people living in residential care settings has fallen and this is projected to continue (Hirst, 1999). Largely as a result of this, domiciliary services such as home care are being concentrated on relatively fewer, more dependent older people. Residential care is increasingly reserved for older people with dementia.

In Denmark, Norway and the UK, the role of residential and nursing homes is largely an issue of how to achieve a high quality of life for very dependent older people in these type of settings. In contrast to the UK, both Denmark and Norway have come to see residential homes as compromising the quality of life of older people. In Denmark, there are no residential homes and nursing homes have a much smaller role than in the past, and in Norway most residential homes have become nursing homes, with improved staffing and equipment, or have been converted into supported housing with independent small flats. In Italy, Greece and Ireland, however, the issue is still one of underprovision of affordable institutional care outside the hospital. Italy has relatively few nursing or residential homes, the tradition having been for the family to care for very frail older people within their household. In recent years this lack of provision has been recognized as a national shortage of suitable care, and attempts are being made to increase the number of homes. In Ireland, until recently, there was heavy reliance on non-acute hospital care of older people when family caring arrangements were either inadequate or broke down altogether. However, in the last decade there has been a huge increase in the number of older people going into private nursing homes, some health boards have developed purpose-built residential units based on a nursing model, and there has been an increase in respite and day care services. Nevertheless, there is a severe shortage of places in statutory residential units where the cost for the resident is low and limited to their pension minus a 'comfort allowance'.

Supported housing in the community remains a very underdeveloped type of provision in Ireland, Italy and Greece. In Ireland, 'welfare homes' were set up in the 1970s for fairly mobile older people who could no longer stay at home, with a view to residents moving on when they became more dependent. The closure of long-term hospital wards, however, has meant that there is often nowhere to move on to. The homes, either run directly by health boards or by voluntary organizations, and financed mostly by health boards, now accommodate very dependent populations, needing more support than originally intended. Sheltered housing schemes for older people provided by local authorities or voluntary organizations are relatively scarce and often lack the resources necessary to provide in-house social care services.

Greece has the lowest level of provision of residential care, with less than one per cent of older people living in residential or nursing homes (Stathopoulos and Amera, 1992). This represents a very substantial underprovision and those few homes that do exist – run by voluntary groups, religious orders or sometimes local authorities – usually have long waiting lists. Sometimes an older person needing nursing care receives this in a series of consecutive stays in 'short-term' clinics. Residential and nursing homes are very expensive to build and staff, but attempts are being made to expand this type of care so that each prefecture has at least one home, also offering day care services. However, it is not unusual for family members to provide the nursing care themselves for an older relative who is in a home.

In all six countries an important policy priority is to find the most cost-effective care setting for older people with care needs. With the exception of Denmark, there is a general trend towards developing services that support and complement family care in the hope that gravitation towards more expensive care settings can be prevented or delayed. In the UK, as noted above, it is relatively common for residential homes to be used by local authorities as a cheaper option than a domiciliary package of support for very dependent older people. The responsibility of the NHS for paying for nursing care in a nursing home, rather than this cost being met as part of a means tested local authority 'social care' placement, has been ill-defined; the recent Government decision that all nursing care in nursing homes will be free of charge should help to resolve this although activities defined as social care will remain means tested (see Chapter 5). In Norway, supported housing is a cheaper option than nursing home care for local authorities. While local authorities fund both types of provision, residents in supported housing must pay rent and, because this is sometimes

Table 10.1 In-patient hospital care: beds and length of stay

	Beds per 1000 of population		Average length of stay in days	
	1986	1996	1986	1996
Denmark	6.9	4.9	10.2	7.3
Norway	16.1	15.0	11.3	9.9
Greece	5.3	5.0	12.0	8.2
Ireland	8.0	4.9	8.0	7.2
Italy	8.1	6.2	12.1	9.8
UK	7.2	4.7	15.2	9.9

Source: OECD (1998c).

quite high, many residents receive a housing allowance which is paid by central government.

There is a marked trend towards shorter stays in expensive hospital settings, enabling the number of hospital beds to be reduced, although to a lesser extent in Italy (see Table 10.1). While this has, in part, been a welcome move away from a medical orientation that tended to construct older people with social care needs in a dependent sick role, it has given rise to concerns about the adequacy of services in the community, both health and social care. Italy and Ireland have lagged behind northern European countries in shifting from hospital care to community support, although in Italy polyclinics have been successful in providing local access to health care for older people (Giarchi, 1996). Denmark has the strongest commitment to reducing unnecessary hospitalization among older people but, even with its generous provision of community care services, delays in hospital discharge can occur because of a shortage of services and suitable housing in the community. This situation shows marked variation between local authorities but overall has improved in recent years, although many municipalities believe that counties discharge hospital patients too early – the situation reflecting an organizational and financial divide between community and hospital services (Platz and Freiberg Petersen, 1992). This issue is also evident in Norway, and among attempts at solving it in both countries is the power of hospital authorities to charge local authorities for the cost of each day that discharge is delayed by lack of community provision.

Despite their established publicly funded social care services, defined quality standards are a recent innovation in the UK, Norway and Denmark. The UK adopted quality standards for nursing and residential homes in 2000, backed up by regional inspection arrangements

(Department of Health, 1998a). Denmark's local authorities started introducing standards in 1998, but progress has been slow. In Norway, by 2000 all local authorities are expected to have established comprehensive quality control systems based on professional standards. Ireland, Italy and Greece are well behind in setting and regulating quality standards. In Ireland the lack of mandatory quality control over a growing private care sector – with a trend towards building large private nursing homes of 100 beds or more in some cases – is currently causing concern. Grants towards the cost of private nursing home care are only available if the home is registered by the health board, requiring conformity with minimum health and safety standards but not quality of care standards. In Greece conditions within the small number of public nursing homes are poor and 'such that many of those admitted soon lose the self-serving capacities they had upon entry ... Evidence suggests that approximately 30–50 per cent of the residents of these homes become bed-ridden within a few years of entry' (Karantinos, Ioannou and Cavounidis, 1992, pp. 89–90).

Conclusion

Social care in Europe sits uneasily between the policy priorities of governments seeking to contain public expenditure and the needs and rights of growing numbers of older people. Older people and their carers want practical help and other support when and where it is needed. The low coverage of publicly funded provision to address these needs in Greece, Italy and Ireland does not necessarily mean that older people are less likely to have these needs met at some level, but that responsibility falls on the family. In the UK, Norway and Denmark it is the State that has a legal responsibility to ensure that social care needs are met when there is no alternative, but services are subject to increasing rationing and targeting of 'legitimate' needs only. This is most marked in the UK, where there is a marked trend towards more intensive services for fewer, more frail, older people. The result is that older people with needs for less intensive support are often failing to receive any services because provision is being skewed towards higher levels of need: for example, between 1993 and 1997 the number of users who received one home care visit of less than two hours fell from 37 per cent to 23 per cent (*Community Care*, 1999). Even in Norway's relatively generously funded system, Vabø (1998) found that family members may be undertaking care work out of a feeling that public services are inadequate, although not intimate personal care.

This chapter has sought to bring together the range of material from earlier chapters and discuss its different aspects from the perspective of a concern with social exclusion. The results are multifaceted, from issues of variations in coverage of services to the effects on older people of assessment and care practices. The next chapter concludes the book by discussing some of the positive lessons that can be drawn from this analysis.

11
Conclusion: Issues and Solutions

Tim Blackman

This concluding chapter reviews a number of issues that arise from the material presented and discussed in previous chapters. It points to some possible solutions to the problems encountered with the social care of older people, identifying the various strengths that exist in both policy and practice, especially where these help to prevent the types of exclusion discussed in Chapter 10.

The chapter first considers the extent to which it is possible to generalize about welfare regimes and care systems, and whether such generalization helps us to understand why countries have different approaches to the social care of older people. This is followed by a short discussion of Denmark as a possible exemplar of social care provision, and a wider discussion about cross-national policy transfer. Issues and solutions are then explored, drawing on the experiences of all six countries considered in the book and, where appropriate, other research evidence. This starts with the decentralization and integration of social and health care services, and then moves on to the assessment of need, supporting informal care, the relevance of a social model, and the empowerment of older people. A final section draws together the main themes and conclusions.

Welfare regimes, care systems and cross-national policy transfer

We opened the book by asking whether the values and structures of Europe's diverse welfare regimes predispose countries towards particular configurations of social care provision for older people. We asked whether welfare regimes, and the systems of care that exist within them, determine particular patterns of responsibility, provision, access