The Geneva Papers on Risk and Insurance Vol. 26 No. 4 (October 2001) 667–683

Long-term Health and Social Care for the Elderly: An International Perspective*

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This paper describes how industrialized countries have taken different paths towards meeting the needs of their dependent elderly. Dependency-related needs come under the heading of social protection, since they involve general home help and medical care, even if homecare is essentially provided by members of the person's family. Thus, the diversity of medical care and social protection systems, their level, their "Bismarckian" or "Beveridgian" nature, has an impact on long-term care systems. We can therefore distinguish three main groups of countries that differ from an institutional point of view. In the future, because of demographic and sociological changes, it seems unlikely that family care could continue to play such an important spontaneous role, especially in the southern European countries.

1. Introduction

The most common consequence of population ageing is to destabilize the financing of pension schemes and healthcare systems. At the same time the rise in the proportion of very elderly persons leads naturally to a rise in the proportion of individuals who are likely to find themselves in a state of dependency. Clearly the notion of dependency,[1] which relates to the notion of need for healthcare and also for home help, is intimately related to age.[2]

This survey is based on the 15 Member States of the European Union, although it occasionally refers to the situation in the United States, Canada and Japan. The major issues relating to dependency coverage are analysed after a brief review of population ageing. Then we examine dependency coverage from an institutional point of view before presenting the various forms of coverage. In the last part we attempt to reply to questions relating to the various types of long-term care benefits.

2. Population ageing

One of the prime indicators for measuring the potential pressure that the increasingly ageing population brings to bear on care systems for the elderly is the rise in the proportion of

* This article is partly based on a working paper written together with Pierre Ralle (see References), to whom the author extends her warmest thanks for the time he devoted to this survey and for all the advice he gave. Thanks are also due to Christel Lolin, Mireille Elbaum, Marie-Eve Joël, Nicole Kerschen and Ronan Mahieu for their useful comments on the earlier versions of this paper.

** At the time of preparation of this article, the author was an economist of the Ministry of Social Affairs, DREES.

[1] The notion of "dependency" is very often used in France. In other countries, the concept is rather one of "long-term care". This article uses both terms.

[2] Frequency of dependency rises sharply with age, with a break between the ages of 80 and 85 (Badeyan and Colin, 1999). But the notion of dependency is not necessarily related to age. In most countries (except for France where the official political view is that dependent persons aged under 60 are handicapped), dependency is seen as a risk that could arise at any age.

persons aged 80 and over in the population as a whole. In the 18 countries in this survey the proportion of over-80s has increased over the last 40 years or so. In 1960 the proportion of over-80s in the relevant countries was between 0.7 and 2 per cent of the population, whereas in 1997 it ranged from 2.5 to 4.8 per cent. However, the pattern of changes in the ageing population has varied from country to country.

If we use the ratio of over-80s to over-65s as an indicator we can eliminate the effects of "downward ageing" due to a sharp fall in the birth rate (as in Italy). In Figure 1, which shows the proportion of over-65s in the population as a whole along the bottom line, we can see that there are five groups of countries:

- Young countries (Ireland and Canada), with 11 to 12 per cent of the population aged 65 and over and about a fifth of the population aged over 80;
- Relatively young countries (United States, Netherlands, Luxembourg and Finland), with the proportion of over-65s ranging between 12.7 per cent in the U.S. and 14.5 per cent in Finland;
- Spain, Portugal, Greece and Japan where there is already a high proportion of the population aged 65 and over (between 15 and 16 per cent) but where the ratio of over-80s to over-65s remains relatively low. These countries have slightly different patterns of ageing from the European countries;
- The remainder of the European countries, where the proportion of over-65s ranges from 15 per cent (Denmark) to 17.1 per cent (Italy), but where the proportion of over-80s is higher than in the southern European countries or in Japan (between 23 per cent for Belgium and 26 per cent for Denmark);
- Sweden, where 17.4 per cent of the population are over 65 and nearly 28 per cent of the over-65s are over 80, is the "oldest" country in the world.

According to the Eurostat predictions (1997), if we consider the proportion of over-80s

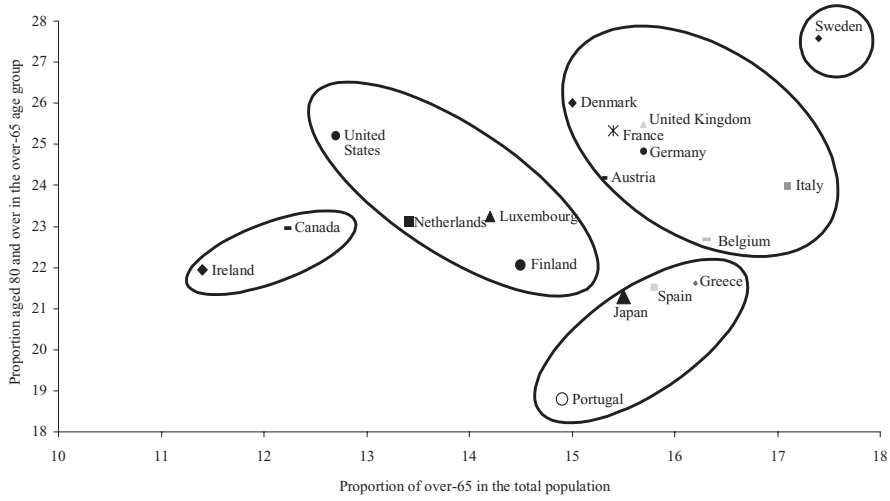

Figure 1: Ratio of very elderly in the population aged 65 and over to older persons in the total population
Source: Eurostat, DREES calculation.

in the population as a whole by the year 2020, this analysis will change significantly. Two southern countries, Italy and Greece, will become the "oldest", with respectively 6.8 and 6.3 per cent of their population aged over 80. The other countries with a score above the European average, which at that date is projected to be 5.6 per cent, will be Germany, France and Belgium, which will keep their relative positions. Spain will be very close to the European average, just above Sweden, where 5 per cent of the population as a whole will be over 80. Ireland, Denmark and Portugal will be the countries with the lowest proportion of over-80s (3.3 per cent in Ireland, 4.3 per cent in Denmark and Portugal). Thus we can see that generally speaking it will be the countries in southern Europe that become "old", while the countries in the north will have a proportion of the very elderly much below the average. In Japan there will be a spectacular rise in the elderly population: in 2020, according to the forecast by the Japanese ministry of health, the population aged 75 and over will form 12.5 per cent of the population as a whole, which will place Japan far ahead of the other countries.

This increase, past, present and future, in the number of the very elderly is therefore putting pressure on the care systems in all the European countries, with distinct patterns in each group of countries: the southern European countries and Japan have to face a spectacularly ageing population; France, Germany and Belgium are in a similar situation, though it is slightly less severe.

3. The main problems of dependency coverage

Dependent persons need help both with the routine of their daily lives and for medical reasons. These needs come generally under the umbrella of social protection, i.e. the social services and the health services, and are not unconnected. Thus provision for long-term care goes hand in hand with the provision of medical care. It is therefore not always easy to draw the line between what concerns health insurance and what comes under the systems specifically concerned with dependency. There are two consequences of this: firstly, the orientations of the various countries with regard to long-term care coverage are generally linked to their existing health system (and more generally to social protection) (summary no. 1). Secondly, because of the multiplicity of the social actors concerned and their diversity from one country to another, it is difficult to quantify the financial amounts devoted to financing dependency.

In virtually all of the countries in the survey medical care is covered by the health insurance system when individuals lose their mobility. Where insurance cover for long-term care exists, its general purpose is to reimburse the expenses that arise from calling on the services of a third person to assist with the essential day-to-day routine. In the countries where there is only a system of social welfare, the local authority bears the cost of caring for those below a certain income level. With regard to the accommodation of dependent persons, it is possible for the local authority or the pension funds to carry part of the costs that arise from adapting the home to their needs. By contrast, the long-term care services do not generally carry the costs related to accommodation, which, if they arise, come under complementary social assistance.

We may distinguish three main groups of countries from the point of view of their institutional systems (Table 1). In the Beveridge-type countries long-term care is generally provided by the local authorities who organize home-based services. In some of the Bismarck-type countries, dependency is recognized as a new risk. In southern Europe the main system is one of social welfare. Apart from these differences, the main areas of concern with regard to dependency provision are the following: Is there a sufficiently large market of

Table 1:
The main types of institutional system for dependency provision

Beveridge-type responses	Dependency: a new risk (date when the new system was introduced)	Approach based primarily on social welfare
Denmark	Germany (1995)	Belgium
Sweden	Austria (1993)	France
Finland	Luxembourg (1998)	Greece
Netherlands[3]	Japan (01/04/2000)	Spain
United Kingdom		Portugal
Ireland		Italy

the dependent elderly? Does the existing provision tend to favour informal care? And finally, what is the level of dependency benefits? – a level which logically should increase as the level of family involvement decreases.

Summary no. 1

Healthcare and social protection systems

In Europe (and in Japan), the social protection systems are based on two models:

- The *Bismarck* model, which is still in use in Germany. This system of social protection is designed to cover the worker and his family against social risks that deprive him temporarily or permanently of his job and of his income. Using a system of income-based *contributions*, this form of social protection guarantees the worker's previous standard of living by paying him a replacement income. This type of insurance scheme is described by Esping-Andersen (1993) as "*conservative-corporate*".
- The *Beveridge* model. This system of social protection aims to cover the whole population against social risks. It implements direct rights called *universal rights*, awarded to all the residents of a country, uniform for all and financed by the *taxpayer*. The Scandinavian model should be seen separately from the English and Irish models. According to Esping-Andersen's typology, the *social-democratic* Scandinavian systems are based on a universal principle: their aim is to ensure social cohesion and improve living conditions. The so-called "*liberal*" systems in the U.K. and Ireland are less generous: they are exposed to market forces and a major part of social policy is directed towards the poorest sections of society (rather low levels of benefits are available subject to means-testing).

[3] In the Netherlands, a special fund for exceptional health costs (AWBZ), introduced in 1968 and financed by the taxpayer, is available to all residents whatever their level of income and covers long-term care where the cost is considered too high to be borne by the individual or adequately covered by a private insurance. At first the AWBZ bore the whole cost of residential care. Since the early 1980s the financial contribution on the part of the user has been increasing.

The European countries have therefore progressively moved away from the standard models and the differences between the systems of social protection have generally become blurred. In fact there is more of a tendency for the systems of most of these countries to converge, adopting as they do more and more frequently elements that derive both from the Beveridge and the Bismarck models. Currently the European Union has three main categories of health system (Table 2): the national health services of northern Europe, the continental systems based on health insurance schemes supported by the state and the mixed systems of southern Europe, very similar to the continental countries, but with their own characteristics (major institutional fragmentation of the income maintenance systems; but on the other hand universal health systems).

Table 2:
The main types of health system

National health systems in northern Europe	Systems based on insurance health schemes	Mixed systems in southern Europe
Denmark	Germany	Spain
Finland	Austria	Italy
Sweden	Belgium	Greece
United Kingdom	France	Portugal
Ireland	Japan	
	Luxembourg	
	Netherlands	

3.1. Complementarity between the various types of coverage

Given the complexity of the systems that cover long-term care it is difficult to evaluate the global sums that are allocated to this area, each type of institutional system having its own method of measurement. A recent OECD report nevertheless estimates the total cost of covering long-term care for the elderly as between 1 per cent and 3 per cent of the GDP (Jacobzone, 1999). According to this report, the levels of expenditure are lower in southern Europe (between 0.2 per cent of the GDP in Greece and 0.6 per cent in Italy) than in northern Europe (2.7 per cent in Sweden and Netherlands, 1.3 per cent in the United Kingdom).

The level of agreed expenditure therefore remains rather restrained and in any event considerably below the amount allocated to pensions or healthcare. Older people usually receive long-term care benefits in complementarity to a pension.[4] Dependency benefits must therefore be viewed together with the retirement pension rate, with the levels of provision offered by the social protection system and with healthcare coverage. It is therefore entirely likely that some countries where the health and retirement schemes offer a relatively high level of social protection have felt less than others the need to implement a system of provision for long-term care, the elderly people in question being able to finance this risk out of their

[4] By contrast with handicapped persons unable to work (before the age of retirement) who are in need of an additional benefit, besides the basic income necessary to be able to take on the cost of their dependency.

own resources. Looked at the other way round, we may suppose that if dependency led to high levels of coverage, expenditure on pensions would be lower, as the elderly would have less need to protect themselves against this potential risk by saving or by taking out private insurance.

3.2. Co-ordination between the social services and the health services

In most of the countries in the survey, the social services and the health services are separate structures, and so they often operate in a rather disjointed fashion in relation to each other. To deal with the problems that arise in this situation, most reforms concentrate on better co-ordination or integration between the health and the social services. Frequently medical care works out as more costly for the taxpayer but is often free to the user, whereas the social services generally require a contribution – sometimes significant – from those who use them, but they are less heavy on the public purse. This situation may result in economic inefficiency, as individuals will naturally opt for the solution that is the cheapest for them; this may, however, turn out to be the most expensive for the taxpayer or for the local authority as a whole.

Thus, for example, the Spanish social services, by contrast with the health services, require a contribution from the individual towards the cost of residential care, so the dependent elderly who turn to the health services get completely free treatment and those who turn to the social services are deprived of three-quarters of their pension. This system, together with the lack of co-ordination with the social services, has resulted in older persons taking excessive advantage of hospital stays. Similarly, in the United Kingdom families often put pressure on the use of the free hospital structures in preference to the social services. This problem is nevertheless regulated by the number of hospital beds available for the dependent elderly.

In Germany, long-term care insurance is a separate legal entity from health insurance even though all the applications for benefits go through the same health insurance scheme. The decision to introduce a separate social insurance scheme to cover long-term care has not, however, solved the problem of distinguishing between dependency and illness: the dividing line between them remains just as blurred. Moreover the health insurance schemes are reluctant to cover prevention and re-education, as then the dependency insurance schemes would be the ones to reap any benefits of these treatments. So setting up dependency insurance schemes in Germany has not resolved all the problems to do with co-ordination. With separate budgets and roles that are not always sufficiently well defined, what happens is that the insurance schemes try to pass on responsibility, and the costs, to each other.

4. Three main types of institutional system

4.1. The Beveridge-type schemes: an uneven level of protection in the Scandinavian countries and a rather less generous system in the United Kingdom

In the 1960s one of the special features of the Scandinavian welfare state systems was to view the right to enter an institution to receive care as a basic citizen's right, which resulted in the development of services of a very high standard, financed by the taxpayer. In the 1970s these countries started to question the justification of giving this priority to institutional care, both from an economic and a humane point of view, and homecare for the elderly became much more widespread. Since then, in spite of the serious economic crisis suffered by Sweden

and Finland, the Scandinavian countries have tried to improve their care offer by making it more flexible in order to enable dependent elderly people to stay at home.

Today the high level of social protection and the extent of homecare services available to the elderly in the Scandinavian countries are practically unrivalled. These Beveridge-style countries have progressively reorganized their health and social services to respond to the needs of the dependent elderly. They long ago integrated long-term care into the existing public health and social services provision.

In the domain of services to the individual, Denmark has acquired the reputation of being the leader amongst the Nordic countries, both because of the early date at which it adopted the concept of support within the community and because of the generosity of the services. In Denmark the distinction between institutional accommodation and homecare was abolished by legislation in 1987. The new notion is that of a "habitat adapted to an advanced age" combined with services provided according to the needs of the elderly person regardless of their place of residence. These services are gradually replacing residential establishments. The financial contribution of the users is minimal even if the person is in residential care: since 1995 dependent people pay 15 per cent of their pension towards their rent and a fixed sum for accommodation and electricity. District nursing and medical appliances are supplied free of charge to the user. Denmark is the only country where some home help is supplied to the elderly.

In the United Kingdom, the National Health Service (NHS) offers the over-60s completely free access to the medical services, but the system of long-term care and medical treatment turns out to be much less generous. State support for the dependent elderly is limited to those with assets worth less than £16,000. In general, people with assets of over £16,000 pay all of the costs until their income is reduced to this level ("*spending down*"), those with an income of less than £10,000 *per annum* pay nothing, and the rest pay part of the costs. If the dependent person has an income of over £16,000 but has only a small pension, the local authority generally grants a full allowance, which is then recovered by selling the person's home after the owner dies. A general review of long-term care and medical treatment is currently being carried out in the United Kingdom. The Royal Commission on Long Term Care made some proposals in 1999 to which the government replied in 2000.[5] Amongst other things, the Royal Commission suggested abolishing the means test for granting dependency benefits, but the government did not agree to do this; on the other hand, from 1 April 2001 the income threshold was raised to £18,000 and the value of a person's main place of residence is not taken into account in calculating his or her financial contribution to the first three months of residential care.

4.2. The Bismark model of the welfare state: dependency is recognized as a new risk

Most of the welfare states based on the Bismarck model have entered into or concluded the debate on the creation of an insurance system specifically to provide for long-term care. Recently, because they consider that the social provision is inadequate in the face of a situation whose cost far exceeds the normal income of an individual, Germany, Luxembourg and Japan have been looking at mechanisms that would provide funding for the demand.

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[5] These reports are available on the internet: the report of the Royal Commission is at http://*www.open.gov.uk/royal-commission-elderly/* and the government's reply is at http://*www.nhs.uk/nationalplan/ltcreport.htm*

The form they have chosen is that of dependency insurance as a new branch of social insurance. But it must be said that these countries have decided, primarily for budgetary reasons, to take on only persons in the most dependent category and to set, in contrast to the normal health insurance benefits, a maximum figure for benefits. Thus the German dependency insurance scheme, in contrast to health insurance, does not provide total cover; dependency is only covered beyond a certain threshold of "high-level needs" and for a stated amount.

In Germany, the law on dependency insurance which was introduced in 1995 guarantees all the contributors to a state insurance scheme specific cover for long-term care regardless of their financial means or their age. Benefits are available to persons who require a "substantial" degree of assistance to carry out their normal daily activities over a period of at least six months. The law defines three levels of dependency (need for assistance is defined as substantial, serious or very serious) and also includes social coverage for family members who care for a dependent relative.[6] The cause of the dependency must be illness or physical, psychological or mental handicap. In this way Germany is trying to link up dependency with the health policy in the areas of prevention and re-education. The state insurance scheme for long-term care is financed by a contribution of 1.7 per cent of gross salary up to the social security ceiling, shared equally between the employer and the employee for those in work. Pensioners share the contribution payments in equal measure with their pension organization. Government concern over the funding is shown by the exclusion of any federal responsibility for any insurance deficit that might arise.

In the German system, workers whose income is below the social security level automatically come under the state insurance scheme, both for sickness and for long-term care (the benefits apply equally to all the beneficiaries). The rest have a choice between contributing to a state insurance scheme or taking out private insurance: 10 per cent of the population are in the private insurance sector (once a person has decided to leave the state insurance system she or he cannot return). The terms of private insurance for long-term care are extremely well-defined: the schemes are obliged to offer benefits at least equivalent to those of the state schemes and the ceiling of the premium is set at the level of the maximum contribution to the state schemes.

In Japan, the law on long-term care, which was adopted in 1997 and came into force on 1 April 2000, clearly marks a new departure with regard to dependency coverage. The law was introduced to establish a new insurance scheme. In this system all residents aged 40 and over are insured and pay contributions. The over-65s are covered if they need long-term care whatever the cause of their dependence. Beneficiaries under the age of 65, however, are only covered by this system if the cause of their dependency is related to a geriatric disorder.

4.3. The situation in France and in the southern European countries: hitherto mainly a pattern of social welfare[7]

Although some countries have opted to set up a specific contribution scheme to cover the costs of long-term care, most developed countries (including France, the United States and the

[6] In 1998, 550,000 carers, of whom 90 per cent were women, were covered by this mechanismn.

[7] Social welfare provides benefits and services to persons with too low an income to cope with needs generally related to handicap, sickness, old age or social difficulties.

southern European countries) have so far steered away from treating dependency as a new risk supported by national solidarity.

Dependency coverage in France at the present time is predominantly characterized by a social welfare structure and also by a wide diversity of actors and sources of financing. After years of testing various schemes in the domain of allowances to the dependent elderly, in 1997 France introduced a specific benefit called the *Prestation spécifique dépendance*, or PSD. This scheme is on the point of being revised. The PSD, set up to gradually replace the third-party benefit scheme (*Allocation compensatrice pour tierce personne*, or ACTP) for persons aged 60 and over, is a service in kind paid for by the French departments and defined as part of an individual welfare plan. This benefit, which is subject to a means test, is intended for the most severely dependent persons: currently 135,000 persons receive this allowance (and 40,000 continue to benefit from the ACTP), although the number of elderly persons who have lost their mobility is around 800,000 (Kerjosse, 2001; Colin, 2000).

The funds devoted to the PSD represent just a small part of the public effort to help elderly persons who have lost their mobility. At the national level, the cost of medical care for dependent persons is covered by the national health insurance scheme; and the social action of the retirement schemes finances a major part of homecare by supplying home help. At the departmental level, the local authorities (*Conseils généraux*), who since decentralization have taken over the responsibility for social welfare, have become the main decision-makers according to PSD legislation (see summary no. 2). A whole system of fixed arrangements also contributes to the financing of dependency coverage: persons receiving the PSD or ACTP are completely exempt from the employers' contributions related to the employment of a third person. In addition, there are tax rebates known as "*emplois familiaux*" which allow taxpayers to deduct 50 per cent of the sum they commit to paying a home help up to the figure of FF45,000. This ceiling is doubled if the taxpayer or one of the members of his fiscal household is the holder of a disabled card for at least 80 per cent disability. The costs of long-term residential care or relating to a medical cure also entitle the beneficiary to a tax rebate of up to FF15,000 per person.

The law to create an individual mobility allowance (*allocation personnalisée à l'autonomie,* or APA) (which was voted in June 2001 and will come into force on 1 January 2002) is a reply to the main criticisms levelled against the PSD: that the latter is awarded to too few beneficiaries (because the access conditions are too restrictive and because it excludes persons of average dependency) and presents too much disparity between one department and another.

The APA, which is to be paid to persons who have lost their mobility, regardless of income, is to be of a standard amount throughout the country to pay for assistance received. But only the lowest income brackets will be exonerated from paying the patient's contribution; at the highest levels these may amount to 80 per cent of the benefits. This new scheme is to be financed by the departments and by the attribution of one point of a general social contribution (*contribution sociale generalisée* or CSG). This project may mark the first stage in France of recognition of a new life risk, even though for the time being this plan, which has borrowed elements from other systems, is difficult to characterize.

In the Mediterranean countries, the debate around the necessity for long-term care insurance has had much less encouragement, no doubt because of an attachment to the family models of informal aid or because the constraints on public funding are too great. In these countries, as in France, benefits are awarded both within a contributory protection system (such as those covering sickness, disability, accidents at work and old-age pensions) and within the system of social welfare. Thus benefits to the dependent elderly are mainly awarded

on the grounds of handicap or old age, and in the case of the latter in the form of an increased pension or tax deductions. In Spain, for example, families who have living with them a parent aged 70 or over, and whose income is below a certain level, may claim exemption from part of their income tax. This exemption is more than three times higher if the person is handicapped.

Spain is currently implementing an "Action Plan 2000–2005" for the elderly which includes some ambitious actions to modernize their system of dependency coverage. This is characterized by far-reaching decentralization of the services and by involving the users in the definition of the programme. Greece and Italy also have some special programmes which are administered at the local level (which leads to considerable disparities).

Summary no. 2

The maintenance obligation:
a perspective on the situation in France

Civil-law countries differ from common-law countries with regard to the relationship between individuals, the family and the state. Common-law countries, with their individualist philosophy, refuse to let the government interfere in their private lives (Martin, 1997). There is therefore virtually no rule of law that orders family relationships. By contrast, the civil-law countries have always been concerned to guarantee a principle of mutual solidarity and legal obligations between the members of the same family.

The main countries that uphold a system of compulsory support by the younger generation towards the senior members of their family are France, Germany, Austria and Spain. French civil law theoretically upholds a wide-ranging maintenance obligation, particularly of children towards their parents and grandparents and even their great-grandparents. In France the family is particularly called on to pay the cost of residential care for a dependent elderly person. In Germany, there is a filial obligation, subject to a means test, of children towards their parents. In Austria, in all the provinces, with the exception of Vienna where filial obligations have been abolished, there is a strict maintenance obligation which is nevertheless subject to a means test (Jensen, 1999). In Spain, there is the possibility of participation by the family in the cost of covering dependency under the maintenance obligation, but this possibility remains theoretical as very little is done to implement it. In Sweden, the legislation concerning "filial duty" was annulled in 1956, the government deciding that it had become "obsolete and pointless". Denmark for its part has never had any legislation of this type; Norway kept its version rather longer (Sundström, 1999).

Death duties: legislation that leads to unequal treatment

In France, in the case of the PSD, the maintenance obligation is not immediate but deferred: members of the family are not required to contribute during the lifetime of the dependent person; on the other hand, the cost of care to the local authority may be deducted later from the beneficiary's personal assets. The possibility of recovering the cost of social care when a person's main place of residence is sold after the death of the owner also exists in Great Britain and in the United States. In the United States, if the persons benefiting from the "Medicaid" social welfare programme in an institution

are married, their spouse may keep part of their income and assets, but after the death of the beneficiary, the federal state may recover the cost of social care from the fixed assets of the deceased.

In France until the end of 2001, if a dependent person uses the PSD, the payments may be deducted from their assets above the level FF300,000 before the remainder is redistributed to all the successors. In order to guarantee this possibility of recovery from the descendants, the administration may take out a charge on the property of the beneficiary. Recovery can also be made from donations made by the recipient of the care benefit after his/her application for care in the ten years preceding this request. The notion of a death duty, whatever the threshold figure above which it takes effect, raises very real psychological resistance, which explains why so many cases are abandoned during the procedure, or why an application for PSD is not taken out (Sueur Report, 2000).

These days application of the maintenance obligation is on the way out. In France for example, some departments have decided never to appeal to the relatives who would have a maintenance obligation towards an elderly person or, to give another situation, to approach their grandchildren. In any case, recovery of the sums paid out for social welfare is far from systematic: a decision is made by the access committee for social welfare on each individual case according to circumstances, a system which can easily lead to unequal treatment.

5. Various modes of dependency coverage

5.1. The essential role of the family and a predictable diminution in the scope of family care

Although one may note a fall in the number of elderly persons living with their children, the family is the first natural support for dependent elderly persons. In most countries, most of the caring is done within the family. This form of assistance, which is said to cost the social services less than formal care, generally corresponds well with the expectations of the elderly person. But it can be very varied, depending on whether the elderly person lives alone or with other members of his or her family. From this point of view, the family configurations vary considerably from one country to another.

If we define "simple" households as those where the elderly persons live alone or with a partner, and "complex" households as those where they live with their children or in some other configuration, very roughly, the northern European countries have a different pattern from those in the south.[8] In southern Europe, the proportion of complex households is quite high. In Spain in 1994, 54 per cent of the population aged 80 and over still at home lived in a complex household. The same population accounted for 42 per cent in Portugal, 35 per cent in Greece and 34 per cent in Italy. Other countries with similar patterns are Ireland, Austria and Luxembourg. In the northern European countries on the other hand, there are very few over-80-year-olds living in a complex household (2 per cent in Denmark, 5 per cent in Netherlands). In France (where the figure is 18 per cent), Germany, Belgium and the United Kingdom, the situation is somewhere between the two.

Even if we accept that the role of the family is primordial in supporting elderly dependent persons, demographic changes are bringing about a diminution in the practical facilities for

[8] The analysis that follows is based on the community family panel (DREES calculation).

caring for the dependent elderly. Thus the ratio between the number of women aged between 45 and 69 (who are the principal carers) and persons aged 80 and over has diminished by about a third in the OECD countries over the last 30 years. The present average is 3.8 in the European Union and is expected to drop to 3.1 in 2020 according to the population forecasts of Eurostat. In five countries this ratio will remain stable (Sweden, Denmark, the United Kingdom, Austria, Ireland). In the others it will go down. The countries where this diminution will be the most significant are Greece, Finland, Portugal, Germany and Italy. So in the future there will no doubt be a considerable diminution in homecare capacity in the southern European countries.

Moreover in the industrialized countries there is a significant rise in the activity rate of women of working age. This general phenomenon, which has not yet affected all the countries to the same degree, will of necessity reduce the "care potential" that might be supplied by more mature women by limiting the time they have available for unpaid domestic duties. At the present time the activity rate for women aged 45 to 59 is much lower in southern than in northern Europe. Nevertheless it is probable that in the future the rate in the south will approach that in the north, reducing even further the future potential for care within the family.

Over and above these particular national contexts, which may be explained by demographic and sociological differences, there are sometimes obligations of a cultural or legal nature that lead to other divergences in the role of the family. In Japan, the role of the family is preponderant. Although the figure is falling, the proportion of elderly persons living with their children is over 50 per cent. This ratio, which is much higher than the average in the other developed countries, reflects a particular form of family care: it is generally the son who takes in his elderly parents and the daughter-in-law who looks after them (Ribault, 1999). In Germany, the official downward view of the family organization presupposes, in the absence of evidence to the contrary, that the family is in a position to provide the necessary support. In France, support within the family has always had a central place in social policies.

5.2. Arrangements for encouraging informal aid

In spite of the undeniable advantages that are universally recognized it is unlikely that informal aid, particularly in the southern countries, can continue to play such a large spontaneous role. In this respect a number of countries have already decided on the usefulness of giving financial support to intra-family solidarity by offering economic incentives.

Thus in the last few years Germany, Austria, Luxembourg, Sweden, Finland, the United Kingdom and Ireland have set up benefit schemes aimed at persons who look after their elderly parents, or cash allowances to elderly persons who have lost their mobility which can then be used to "pay" the person who is looking after them in an informal situation. In addition, in some countries these benefits are not limited to the immediate payments: in Finland, as in Austria, Germany and Luxembourg, persons providing care for a relative can contribute to a pension scheme and have access to other social advantages. In Japan, the hours devoted to giving voluntary care provide the right to hours of free assistance later on, following a principle known as "capitalization of the time devoted to mutual assistance".

Another form of assistance awarded to carers is in the area of "relief" care, which recognizes the need of carers to be able to free themselves from the heavy burden of looking after a dependent person. Several countries have programmes of relief services (including Germany and Luxembourg), but Finland has gone the furthest down this line, demanding that local authorities provide one weekend of leave per month. These measures that are gradually

being set up, even though in a limited way at first, are a first step in the process of institutional recognition of informal care.

5.3. The number of residential care places and the availability of homecare services are generally interrelated

The fact that the family is the first potential assistant to a dependent elderly person is not in contradiction with the development of a more formal care structure. An elderly person may live at home and still have recourse to homecare services; she or he may also live in an institution. The expansion of places in institutions nevertheless came to an end in the 1980s. The rate of institutionalization has dropped in nearly all countries. Now the solution that is generally put forward by governments is for home support, made easier by the development of new home services.

It is however important to distinguish between the nature of the institutional system of dependency coverage and the existence of a sufficiently large market, private or public, for services to the dependent elderly (at home or in an institution). In fact, except in the Scandinavian countries and Netherlands, who are very advanced in this domain, the need is generally felt to develop the extent and the quality of the available services and often to favour the creation of a market of private service providers.

With regard to the number of beds and the services available, international comparisons are made difficult by the absence of uniform data and because similar labels can refer to different situations. The heading "institutional care", may cover various different situations, from accommodation offering simple hostel services through highly specialized medical care to long-term hospitalization. The growing databank deriving from various sources (Jacobzone, 1999; OCDE, 1996; etc.) makes it possible to distinguish three main types of situation (Table 3). Denmark, Sweden, Finland and the Netherlands have a high proportion of their elderly population living in institutions (about a quarter of the over-85s in the Scandinavian countries and more than 8 per cent of the over-65s in Denmark, Sweden and Netherlands) and in these countries more than 10 per cent of persons aged 65 and over receive home help. In the southern European countries, as well as in Ireland and Japan, fewer than 5 per cent of the over-65s live in institutions (0.5 per cent in Greece and 5 per cent in Ireland); similarly, fewer than 5 per cent of this population receive home help. In France, 7 per cent of the over-65s and 2 per cent of over-85-year-olds are accommodated in institutions.

Table 3:
Level of development of long-term care establishments and of formal homecare

High percentage of persons in long-term care establishments/ more than 10 per cent of older persons receive home help	**Intermediate**	**Low percentage of persons in long-term care establishments/ fewer than 5 per cent of older persons receive home help**
Denmark	France	Ireland
Sweden	Belgium	Japan
Finland	The United Kingdom	Greece
Netherlands	Germany	Spain
	Austria	Portugal
	Luxembourg	Italy

This analysis shows that the demand for a place in an institution does not rise until after the age of 80. On the other hand, the countries that prefer to accommodate the elderly in institutions are also those where most of the elderly population receive assistance at home. So homecare is not a compensation for a shortage of residential accommodation.

Furthermore, and contrary to what one might expect, the typology that emerges from these various data bears no relation to the composition by age of the elderly population, or to put it another way, with the proportion of very elderly persons in the group of persons aged 65 and over. In fact, the group of countries where there is a high rate of use of institutional accommodation includes the Netherlands, which is still a relatively "young" country, whereas the group of countries where the rate of institutionalization is low includes Italy, which has a relatively old population (see Figure 1). This distribution would therefore seem to reflect the orientations of long-term social policies in each country and the changing patterns of family life rather than the demographic situation.

6. What types of dependency benefits?

6.1. Benefits in kind or cash benefits?

Traditionally, the Bismarck model of social protection attaches more importance to cash benefits than the Beveridge model, which favours benefits in kind (offering direct services).

However with regard to long-term care the European countries and Japan seem to have a declared preference for assistance in kind. This is so that the sums that are paid out are not used for some purpose other than their prime objective, or simply hoarded; and also because most governments are generally in need of improving their offer of services. Thus, in Japan the notion of offering cash payments to family carers was rejected, mainly because it does not contribute to the development of the professional services (Ribault, 1999). Other countries, such as Austria, opted for cash benefits to cope with the diversity in the lifestyles of dependent elderly persons, as cash benefits can be awarded in a flexible manner by different services or paid to a relative, thereby favouring informal aid. Austria, which since 1993 has offered a universal "care allowance" to dependent persons who need to be cared for at home, an allowance which is not part of the social security system, is nevertheless the only European country to offer only cash benefits.

6.2. Means-testing

In most European countries the benefits are subject to means testing. In the countries where dependency benefits are allocated within the framework of social welfare, the ceiling is generally low (even though, as is currently the case in France for PSD, it may be higher than for other social welfare benefits).

This type of thinking goes against the recognition of dependency as a normal life risk (which may concern everybody and sometimes necessitate care for a long period of time). In reality, means-tested benefits were originally intended as a safety net for the exceptional cases of victims more deprived than the average, or in the case of relatively rare temporary distress (Kessler, 1997). In addition, applying a means test implies little participation in the system by persons whose income is above the ceiling, and this might lead to debatable distinctions between beneficiaries and non-beneficiaries (stigmatization of the beneficiaries of social welfare). In Germany, the main justification given to explain the implementation of long-term care insurance was that "it is not politically admissible for an elderly person to have to spend

the whole of their retirement pension on financing dependency services or to have to be obliged to ask for social assistance in the case of dependency" (Igl, 1997).

The decision to provide means-tested coverage probably derives from the fact that a policy of uniform benefits with no means test costs more for each benefit awarded than a service directed at only a limited section of the population. In addition, in the case of benefits that have a high practical value (domestic help, for example), a policy of uniform benefits could be open to criticism on ethical grounds. Why, for example, pay for all the domestic services supplied to a well-off person as soon as that person becomes dependent?

Note that in the case of medical care these criticisms are less pertinent inasmuch as the services supplied do not have intrinsic consumer value. On the contrary, state coverage of healthcare, with conditions determined only by the needs of the elderly person, agrees with the principle of equality for all in matters of medical care (Breuil-Genier, 1996). But could this principle not be applied to dependency coverage in its entirety?

6.3. Is private insurance adapted to the problem of dependency?

Until now there have been few indicators of a massive implication of the private sector in dependency insurance. Even in the United States private insurance only offers (limited) cover to less than 10 per cent of the elderly population (Wiener *et al*., 2000). In France at the end of 1999, 18 insurance companies offered savings schemes or dependency insurance. The number of contracts sold in France at the end of 2000 was 1 million.[9]

There are several reasons for the small part that private insurance has played in covering dependency risks. Firstly, surveys carried out in the United States show that most people underestimate the risk of becoming dependent. Also, for the time being it seems that the premiums required in dependency insurance policies are too high to appeal to a very wide public – either the elderly person cannot pay them or at that price the loss due to the immediate expense is not compensated for by the hypothetical future benefits, especially when they are policies with sinking funds (as opposed to life annuity policies). This slow development of the private insurance market can no doubt be explained by the fact that in addition to the usual insurance problems – anti-selection (over-representation of high risks in the population ensured), moral hazard (over-consumption encouraged by the insurance), and the fact that insurers try to exclude bad risks (Bocognano *et al*., 1999) – there are difficulties in the case of dependency in covering a chronic risk in a shifting demographic, economic and health environment.

The dependency risk is in fact chronic and, according to Breuil-Genier (1996), "the only way to insure this risk is to introduce providence mechanisms, involving contributions or premiums spread out over part of the lifecycle, whereas the benefits themselves tend to be concentrated at the end of life." Just as with a retirement pension, there is a marked time dimension to the dependency risk. If, for example, we take the case of a private dependency policy, the contract cannot be based only on the calculation of annual premiums reflecting the anticipated expenditure for the current year. Policies have to be designed to provide a balance across the whole lifecycle of the policy-holders.

Pricing for dependency insurance products is therefore likely to be subject to wide variations. There are several difficult unknown factors since the advent of dependency, the

[9] For further details see Assous and Mahieu: "L'assural bilité de la dépendance et sa prise en charge par le secteur privé: une mise en perspective internationale", forthcoming.

length of life in this condition, the change in life expectancy and in life expectancy without handicaps are particularly difficult to anticipate. In addition it is unclear what the average future cost of dependency coverage might be. This could be increased by the possible addition of medical costs to the liability. Routine home help, based on acts that are not specially skilled but that are very costly in time and often unrewarding, is also a service for which it is difficult to calculate a future rate. Thus, whereas in a standard insurance policy the uncertainty factor affects the difference between the expenditure of an individual and the average expenditure, in dependency insurance the uncertainty factor essentially relates to the average level of expenditure in the future.

As the problems of dependency and how to finance it seem similar to those of retirement schemes – all the expenses are concentrated at the end of the lifecycle (obviously over a shorter period for dependency than for retirement) – opting to build up reserves that may be used to finance the future cost of dependency coverage could be a good solution from an economic point of view. Finally, a policy of actively preventing the dependency of elderly persons, where one attempts to reduce the gravity of increasing dependency by developing re-education programmes, might lead to a diminution in the financial burden over the long term.

7. Conclusion

The Scandinavian countries and Netherlands are amongst the countries where dependency coverage is very highly professionalized, with very few elderly persons living with their children and a significant proportion in residential care or receiving home help. These countries are not expected to experience major difficulties in the coming years as their demographic situation seems fairly stable and population ageing well anticipated. The situation in the U.K. provides a greater contrast.

The southern European countries for their part tend to favour family care for a dependent person. Formal care, in an institution or at home, remains very limited. With the exception of Portugal, these countries are expected to experience more rapid and more pronounced ageing than the European average, which is likely to result in a sharp rise in the demand for long-term care. Up to the present in these countries the family has played a crucial role, with social welfare sometimes complementing this traditional pattern. However it is probable that this model will not survive. The number of working women is increasing and the number of potential carers is diminishing, as is the habit of living with one's parents, and the number of dependent persons is showing a rising trend. So these countries will most likely veer towards a more formal system of dependency coverage.

The countries that have a Bismarck-type system, with the exception of Japan (which is fast becoming the "oldest" country), are generally in a mid-way situation between the north and the south of Europe. In these countries the demographic and sociological changes are less marked than in southern Europe. They seem nevertheless inescapable and the authorities are probably not sufficiently conscious of the combined consequences of future population ageing and the predictable diminution in informal care.

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