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PRIMARY HEALTH CARE FOR ELDERLY PEOPLE IN EUROPE: A DESCRIPTION OF ITS STRUCTURE AND FUNCTION IN SEVEN EUROPEAN COUNTRIES

Jack B.F. Hutten, Herman J. Sixma

PRIMARY HEALTH CARE FOR THE ELDERLY IN SEVEN EUROPEAN COUNTRIES: INTRODUCTION AND SUMMARY OF FINDINGS

This chapter will provide the reader with an introduction to the main subject of this background report: a detailed description of the structure and function of primary health care for elderly people. We will briefly discuss the background of the study, the methods used, and the countries which were selected for a cross-national comparison. Secondly, the chapter will summarise some of the main results from the individual country reports by comparing them with the results from the other participating countries. In doing so, we hope to disentangle some of the more common trends in the structure and functioning of primary health care services for the elderly.

INTRODUCTION

Nowadays most European countries are being confronted with a steady increase of the proportion of elderly people in their populations. In particular, the proportion of people over 80 is increasing rapidly (Statistik Sentralbyrå, 1990; OECD, 1990). In combination with increasing role of informal carers such as family members and friends, as part of the trend towards smaller families and more women being employed on the labour market, these developments lead to a rise in the demand for professional care for elderly people on Europe. A growing demand not only for hospital care and nursing homes, but also for the primary health care sector; a sector which in most countries is not only responsible for home care services but in which general practitioners play important roles as gate keepers for the use of secondary health care services such as hospital care. One might say that these demographic changes at a European level mean a significant challenge to health care institutions, services and resources to provide health care for

alone. Another similarity that can be witnessed in all seven countries is that, for financial reasons, governments are trying to control the continuous increase of the health care expenditures. With home care being considerably less expensive than institutionalised care, policy programmes within the seven countries aim to maintain older people as long as possible in their own homes or social environment. To reach this goal, most countries rely on (combinations of) four instruments. These instruments are:

Patient centredness or focusing on the own resources of the elderly. A shift is seen from providing total care (mostly carried out by public (state or local) organisations) to self-care and self-responsibility. The availability of services is not the starting point, but the patients or elderly people and their needs and expectations. The introduction of so called personal budgets or Attendance Allowance in countries like the UK, the Netherlands and Germany can be seen as an operationalisation of this trend towards patient centredness.

Reduction of institutional care. In the previous century care for the elderly was, in many countries, strongly situated in specific institutions. Since the end of the 1980s there is a shift from institutional care to community care. In Denmark, for instance, there is an official end to the building of traditional institutions for the elderly like nursing homes, service flats and pensioners' flats since 1988, while the existing nursing homes are being converted into sheltered housing, housing collectives and adapted flats. The leading principle is that all kinds of care must be available for all groups of elderly people, irrespective of the place where they are living and that elderly persons do not have to move when his/her needs for care change. In Finland and Belgium more attention is given to the creation of new forms of short-term or part-time living facilities instead if permanent residential care. However, Spain is still increasing the number of places for elderly people in residential services because there was a sufficient lack of these kinds of facilities compared to the other SCOPE countries.

Improvement of community services and home care. A reduction of institutional care is only possible when non-institutionalised services at the community level improve and take over specific tasks and functions. This is what is happening in most of the seven SCOPE countries. Important developments in this area are an increase in the co-operation, integration and co-ordination of health care services and social services, improvements in the educational process of home helps in particular, and the introduction of new facilities such as day care centres.

Stimulating informal care. A fourth, and last, instrument which is commonly used in the seven SCOPE countries is the strengthening of the position of informal care givers and

stimulating informal care, by introducing special allowances for informal carers and better legal regulation for caring leaves. However, the scope of this instrument is limited by the fact that it is conflicting with trends towards more individualisation in society. Also, there are large differences between countries in the percentage of elderly people are living alone. These percentages vary from more than 50% in Denmark to less than 20% in Spain.

THE ROLE OF THE GENERAL PRACTITIONER

A good definition of what is meant by 'primary care for the elderly' very much depends on the country one is describing. It could include different types of care such as formal and informal care, community care and institutional care, public and private care, and social services and health care. Despite these differences, there are also some common features to be noticed, especially in the way national health care systems are organised and financed. Denmark, Finland, Spain and the U.K. are all having a kind of national Health Service, funded by taxes and with public organisations being responsible for the delivery of services. In countries like Belgium, Germany and the Netherlands services are mainly provided by (non-profit) private organisations and funded by private organisations or social health insurance.

The role of the general practitioner (GP) in the health care system also differs from country to country. A first distinction can be made between gatekeepers and non-gatekeepers. In countries like Denmark, the Netherlands, Spain and the UK, there is no direct access to specialist care (except for emergency care and, in Denmark, for ophthalmology and E.N.T). All patients first have to visit their GP who decides whether they need a referral. GPs in these countries mostly have fixed lists which means that patients are registered at one practice or GP and that that GP is more or less responsible for his/her defined patient population. He acts as a co-ordinator in the whole package of care which is received by a patient and as a guide in 'health care land'. Belgium and Germany operate a more liberal primary health care system: free choice for patients is a very important feature of these systems. There is no fixed list system: every person can, within limitations, choose to contact the physician he or she prefers at a particular moment. Therefore, primary health is not necessarily the domain of GPs like in the other countries. This situation leads, together with a high physician density and a fee-for-service remuneration, to competition between physicians. As a result Belgian GPs are famous for the large number of

home visits (medical specialists who work in primary health care do not make home visits) and the number of consultations per week are the highest in Germany.

Three types of practice setting can be distinguished which are related to the level of co-operation. In Belgium and Germany most GPs work in single handed practices, although the number of group practice and partnerships are recently increasing. The latter are more frequently seen in the Netherlands and Denmark, but also in these countries a lot of GPs work in single handed practices. The Finnish and Spanish system is organised with multidisciplinary health care centres in which GPs work together with a lot of other primary care providers such as community nurses, physiotherapists, social workers and so on. These centres cover the whole country. In Finland, these centres also have a limited number of beds in health centre hospitals which are often used for the treatment of long-term elderly patients. However, also in other countries, like the Netherlands, Belgium and Denmark, GPs are sometimes involved in the care for elderly living in institutions. Table 1 summarises the different ways general practitioners are operating within each of the seven countries.

Table 1 Main characteristics of how general practice is organised in the seven SCOPE countries

	BEL	DEN	FIN	GER	NET	SPA	UK
GPs as gatekeepers	NO	YES		NO	NO	YES	YES	YES
Fixed lists	NO	YES		i.d*	NO	YES	YES	YES
Main practice type**	S	S/G		H	S	S/G	H	G

* in development
**(S=single handed, G=group practice/partnership, H=health centre)

Do these differences in how GPs are organised result in differences in their task profiles with respect to health care services for elderly people? To answer this question we have used data from the task profile study (Boerma, 1996) which are related to health care problems presented by elderly people. With respect to the question to what extent patients would contact their GP first, there were hardly any differences between the countries for four out of five problems. A large majority of GPs consider themselves as doctor of first contact in case of (1) Woman aged

60 with polyuria, (2) Woman aged 60 with acute symptoms of paralysis/paresis, (3) Man aged 70 with joint pain, and (4) Woman aged 75 with moderate memory problems.

Figure 1 GP as first point of contact for four different health problems in the seven SCOPE countries

As can be seen in figure 1, in all four cases Finnish GPs score the lowest percentage, while for the Netherlands and the United Kingdom for all four cases the percentage is almost 100% So, even in countries where people have free access to almost all available physicians, GPs consider themselves as doctor of first contact in most of the conditions mentioned.

An exception is the fifth case, namely a woman aged 60 whose vision is getting worse. Figure 2 illustrates that in countries without a gatekeeping GP, people will go directly to the specialist. In countries where the GP holds a much stronger position with respect to gate-keeping (the Netherlands, Spain, UK) the respondents indicate that usually such persons would see them first instead of going directly to a medical specialist. In Denmark people can directly contact an ophthalmologist.

Figure 2 GP as first point of contact for a 'Woman (60) with deteriorating vision' in the seven SCOPE countries

With respect to disease management, it was asked to what extent GPs were involved in the treatment and follow-up of patients with specific diagnosis especially relevant for elderly people. As can be seen in figure 3, a majority of GPs is involved in the treatment and follow-up of congestive heart failure. To a lesser extent they are involved in Acute cerebrovascular accident and myocardial infraction. There is hardly any relationship between the level of disease management and type of health care system in which GPs work.

Figure 3 GP's involvement in treatment and follow-up of cerebrovascular accidents, myocardial infractions and congestive heart failures, in seven SCOPE countries.

Similar conclusions - hardly any relationship between national health care system characteristics and a high performance level of general practitioners - can be drawn with regards to Uncomplicated diabetes type II.

Although one has to keep in mind that the results from the task profile study refer to self reports from GPs in each of the participating countries, it is obvious that in all the seven SCOPE countries the GP is playing an important role with respect to specific health problems presented by elderly people. With respect to the relationship between the type of health care system and the performance level of general practitioners, for most diseases such relationship is missing. Apart from a few exceptions, patients and GPs do not have different roles in care and treatment of elderly patients under different organisational and/or structural circumstances.

THE ORGANISATION AND FUNCTIONING OF HOME CARE

The improvement of home care is seen as an important tool to maintain older people in their own social environment or house. An important problem in home care in many countries is the fragmentation and discontinuity of care caused by the large number of caregivers which can be involved and because home care is a mixture of social services and health services. In this general review we will limit ourselves to one of the central points of interest, the integration of home nursing care and home help services.

With respect to the level of co-operation and integration of home nursing care and home help services the seven SCOPE countries can be divided into three groups. When it comes to the integration of both services, Denmark may serve as an example for the six other SCOPE countries. In Denmark both services are part of the same organisation, namely the local authorities themselves. In the light of the integration of both services, it is relevant to mention that a new education programme is created with a common ground for both home helps and assistant nurses. Since 1991 there is a combined education programme for assistant nurses. There is one year common both to future home helps and assistant nurses; after that year a further 1.5 year qualifies for assistant nurse.

The second group of countries consist of Finland, the Netherlands and Germany. In these countries the integration of both services is an ongoing process. Finland is in the middle of an integration process of health and social services in primary health care. The former sectoral service structure (separation of services) has been transformed into small-area-responsibility. This means that the 460 Finnish municipalities are responsible for a broad range of public services such as home care (home nursing care and home help services), housing, and environmental aspects in their regions. Until the beginning of the 1990s, home nursing care and

home help services were separately organised. Now, in most municipalities, the so called health and social care centres provided both services. This, however, does not necessarily mean that the actual provision of social and health services is integrated. Also in Germany a process of integrating home nursing and home help services is taking place. The number of these separate organisations for home nursing or home help services had decreased with about 30%. At the same time, the number of integrated organisations for home nursing and home help (*Sozialstationen*) had grown. In the Netherlands, in 1990 the two umbrella organisations for community nursing and home help services were merged into the National Association for Home Care. At this moment this integration is also taking place on the regional level. It is expected that this integration will result in more efficiency in home care and will help to avoid unnecessary overlap between home nursing and home help services.

The third and last group of countries consists of Belgium, Spain and the United Kingdom. In these three countries there are some organisations which provide both kinds of services, but the integration process has just been started or established in a only a few places. Generally, home nursing and home help services are separately organised in Belgium. Only a few organisations provide both kinds of home care. However, in the actual provision of care co-operation between home nurses and home helps is increasing. Home helps sometimes assist home nurses in the daily care of the patient (especially with hygienic tasks) and occasionally signal problems which they discuss together. Most professional and even informal home care-providers are now urged to participate in 'team meetings' on shared clients in the context of the 'co-operation initiatives' (*samenwerkingsinitiatieven*) which are co-operative structures for several home care organisations and GPs, organised both locally and regionally. These co-ordinating structures are partly subsidised by the Flemish government. They started since 1987 and now about 60 of them are functioning in Flanders.

Home care in Spain is still in its infancy. Domestic support is mainly the responsibility of informal carers such as family members and volunteers. The availability of formal professional home care differs highly between the regions in the country. For instance, the primary health care teams providing home care have as yet only been introduced in about 50% of Catalonia, and the nurses working in the teams devote little time to nursing patients at home. The main objective of INSALUD for 1994 was to increase the provision of home care services so that this type of assistance may cover 15% of the population over 65 years of age. In most of Spain, home nursing and home help services are provided by separate organisations. Home nursing

belongs to the health care sector provided by INSALUD or the Autonomous Communities, home help is part of the social services provided by INSERSO or Municipal Councils (the *Ayuntamientos*). Collaboration between the two types of services is being initiated on an experimental basis. In some regions, there are integrated home care organisations providing both home nursing and home help services. This is the case, for example, in Asturias. There, home nurses and home helps take part in the same team. In the integrated teams, nurses and home helps discuss mutual patients during regular meetings. The general trend in home care and home help services is towards *visita domiciliaria* (home visits) and *cuidados paliativos* (palliative treatment). Many educational programmes are directed to these kind of activities, and efforts are being made to develop these aspects.

Finally, in most parts of the UK, there are still separate organisations for home nursing care on the one hand and home help services on the other hand. Only in Northern Ireland and some parts of Scotland a longer tradition of integrated health and social services exists. However, one of the major conditions for the new approach in home care in the whole UK is an extended co-operation between home nursing and home help services. The new legislation requires e.g. consultation between social services and health agencies. Where more than one agency is involved in arranging for care to be delivered, the service delivery should be co-ordinated so that the users and carers experience a 'seamless' service. A new development is the introduction of the so called care manager to manage the care, from a variety of sources, for each individual. The care manager under the new legislation is supposed to co-ordinate the care. Evidence so far is that they have little influence over the supply of community nursing.

Apart from the trend towards integration of home nursing and home help services, another important development is the introduction of commercial home care agencies in many countries. The availability of commercial home care agencies varies considerably between the seven countries.

CONCLUSION

Firstly, one might say that care for the elderly is moving towards a more patient centred approach. This is most clearly demonstrated by the introduction of the so called 'personal budgets' in the United Kingdom, Germany and the Netherlands. Secondly, a common feature is that in the seven SCOPE countries institutional care is replaced by community care, in which

general practitioners and home help organisations play important roles. In combination with the more patient-centred approach and freedom of choice for patients, this shift will result in a new mixture in the services. More than in the past, services will be goal-oriented and will aim at leaving these elderly patients in their home situation.

These developments stress the need for evaluation instruments which also have to be patient-centred, outcome-related and will have to include questions about the economy, efficiency and effectiveness of care, as perceived by patients and the different authorities and health care services involved.

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PRIMARY HEALTH CARE FOR THE ELDERLY IN BELGIUM[1]

BACKGROUND

Policy and services for the elderly: a general overview

Over the past 20-30 years, Belgium has been developing into a federal state. An increasing number of tasks and responsibilities are delegated by the national government to the governments of the three communities: the Flemish, Walloon and Brussels communities. The central government is still involved in health insurance, planning of hospital care, professional education, and quality of care in general. As regards health care and social services, the communities are responsible for setting the minimum standards for health care provision, management of social services, care for the elderly, health education, and home care. Therefore the organisation and provision of services for the elderly can differ between the regions.

The Flemish and Walloon communities have issued a decree, concerning the recognition and subsidy of services for the elderly, in 1985 and 1984 respectively (Pacolet & Wilderom, 1991). Like in most of the European countries, the government stresses the importance of a higher degree of independence for the elderly allowing them to live in their own social environment as long as possible. This requires more qualified care provided in the community (Dooghe et al., 1988). Although professional home care has a high priority, the policy not only emphasises professional care but also encourages informal care provided by family members, neighbours or friends (Baro et al., 1991). However, for demographic reasons, the growth of the informal network is stagnating (Pacolet & Wilderom, 1991) and although there is a formal obligation for children to support their parents if indigent, a decreasing number of the elderly choose to live with their families (Dooghe et al., 1988). The encouragement of home care implies cutting down the costs of hospital care by bed reduction and reconversion of acute hospital beds o beds in rest and nursing homes (Pacolet & Wilderom, 1991).

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[1] **A significant part of this chapter is already published in:**
BOERMA, W.G.W., F.A.J.M DE JONG, P.H. MULDER. Health care and general practice across Europe. Utrecht: NIVEL, 1993.
HUTTEN, J.B.F., A. KERKSTRA. Home care in Europe: a country-specific guide to its organization and financing. Aldershot: Arena, 1996.

Generally, services for the elderly are relatively well developed in Belgium (Baro, et al. 1991; Nijkamp et al., 1991). The system is described as flexible and complex with a perfect balance between public (state/community) responsibility on the one hand and private and voluntary/Church organisations on the other hand (Giarchi, 1996). Most services for the elderly are organised at the local level. Each municipality should have its own PCSW (public centres for social welfare)[2] which is in charge of the social services and social security. The municipalities have the authority to control the budget of the centres. There are 589 PCSWs in Belgium: 308 in Flanders and 201 in the Walloon community (Lammertyn, 1990). These centres own hospitals, old people's homes, and alternative housing units. They organise home help services, cleaning services, job services, service centres and meal distribution. The social function with regard to the elderly is mainly to grant those with an insufficient income a benefit equal to the subsistence level and, if necessary, to contribute to the accommodation expenses in the institutions (Pacolet & Wilderom, 1991). About 30% of the elderly make use of 'meals-on-wheels' services (Nijkamp et al., 1991). Furthermore, one of every three municipalities has a 'service centre' (*dienstencentrum*) (Lammertyn, 1990). These centres provide hot meals, have bathing facilities and are very important meeting places for recreational activities. They are mainly subsidised by the government (Pacolet & Wilderom, 1991).

As mentioned services are well developed. An important problem is, however, the limited facilities for elderly people with dementia or other psychiatric problems (Nijkamp et al., 1991). There are few categorical services for these patients and they are spread over all general services (Van Audenhove & Lammertyn, 1995). Furthermore, there are differences regarding the availability of services between the communities. More services are available in Flanders than in the Walloon and Brussels communities. In the latter two there is a real shortage (Nijkamp et al., 1991).

SOCIAL SECURITY

The Belgian state pension, part of the social security system, covers all employees. There are different schemes for specific occupational groups such as civil servants and self-employed people. Premiums paid by employees and employers and state subsidy finance the pension

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2 **In Flemish: OCMW (Openbaar Centrum voor Maatschappelijk Welzijn); in French CPAS (Centre Public d'Aide Sociale).**

system. For employees and the self-employed, full pension (60% of the average earnings) is paid at the age of 65+ (for men) and 60+ (for women) to those people who have worked a full career (45 years for men and 40 years for women). There is a minimum as well as a maximum pension.

The system for civil servants is different. In general they receive a higher pension because it is based on the earnings of the previous five years instead of the total career which is the case for other employees or the self-employed.

For all people of respectively 60 and 65 years who do not have sufficient financial means to live, there is a so-called social safety-net. They receive the 'guaranteed income for elderly (*Gewaarborgd inkomen voor bejaarden*). Still, elderly belong to the lowest income class: 39% of the elderly living alone and 57% of the couples of 65+ have an income below the social minimum income level (Nijkamp et al., 1991).

Furthermore, elderly can receive additional allowances and special benefits for public transport, telephone, home improvements and adaptations, social and cultural activities. Furthermore, elderly who need assistance with activities of daily living because of a handicap and who have a low income receive a contribution for help to elderly people (*Tegemoetkoming voor hulp aan bejaarden*). The amount of the contribution depends on the level of help needed and the financial situation of the elderly person.

RESIDENTIAL SERVICES FOR THE ELDERLY

In 1991, about 5.4% of the Belgian population over 65 lived in residential homes (old people's homes (*rusthuizen*). More than 60% of the old people's homes are private organisations and about 25% work on a for-profit basis. It is estimated that about 70% of the total costs of old people's homes are paid by the elderly themselves, 16% are contributed by the PCSWs and 14% by the social health insurance (Nijkamp et al., 1991). About 30% of the residents receive a contribution from the PCSW. Traditionally, old peoples' homes (rest houses) only admitted independent elderly people in good health. Since the decree of 1985, they are no longer allowed to discriminate on the health status of the elderly. Only small homes (less than 25 inhabitants) may restrict themselves to elderly without health problems or handicaps.

Until the beginning of the 1980s there were no housing facilities for frail elderly who were in need of care which was not available at home. Therefore the introduction of so called rest- and

nursing homes (*RVT: rust- en verzorgingstehuizen*), in 1982, was an important step in the care for the elderly. The nursing part of the care that is provided in the RVTs is paid for by the Health Insurance Associations (mutualities). There are, however, important problems with regard to the financing of the other parts of the care, mainly the housing facilities. With regard to the future, it is expected that frail elderly will become the most important group of inhabitants of rest homes and that elderly in good health will stay at home as long as possible. RVTs and old people's homes will be integrated in one kind of facility. For elderly with mental problems and diseases, so called psychiatric rest- and nursing homes (*PVT: Psychiatrisch rust- en verzorgingstehuis*) have been created.

In Flanders especially, there is a tendency to increase the number of semi-residential services such as service flats, collective housing with services, day centres, and centres for night time relief. This policy is reflected in the planning standards for residential care. The former national planning standards of seven beds in old people's homes for 1,000 inhabitants are still used in the Walloon and Brussels communities, while the government of Flanders has replaced these standards by new ones: four beds in old people's homes per 100 elderly over 60 and three places in sheltered housing per 100 elderly over 60. A problem, however, with these living facilities is that they are more expensive and are therefore mostly occupied by richer elderly people.

In 1987, about one third of all hospital admissions involved people over 65. Hospitals also have special wards for elderly patients. Geriatric wards are meant especially for acute problems and specialised care. Special psycho-geriatric wards are available in general and psychiatric hospitals for the demented elderly. There is, however, an increasing shortage of beds in these kinds of wards.

Finally, there are long-stay wards in the hospitals: originally intended for continuous care and rehabilitation of the elderly with non-acute problems. However, these beds are more frequently used for the relief of the severely disabled elderly which increases the average length of stay and obstructs the circulation of patients. Consequently, the government intends to reduce these long-stay wards and encourages the replacement of the permanent care of the severely disabled elderly to rest and nursing homes associated with general hospitals or old people's homes.

ORGANISATION OF HEALTH CARE

Belgium has a highly privatised system of health care supply. With a large number of non-governmental organisations, the organisation is competitive in nature (Boerma et al., 1993). Direct government involvement is limited to general regulation and partial funding. The tasks of primary and secondary care are not well defined, which results in overlapping activities and competition among physicians (Boerma et al., 1993). This is enforced by the remuneration system (doctors are paid on a fee-for-service basis) and the large number of physicians in Belgium. There are. as many as 140 specialists in internal medicine in geriatrics which is the highest number in the whole of Europe (Giarchi, 1996).

Patients are free to choose any doctor they like; no referral is required for a visit to a medical specialist. People can also directly apply for hospital admission, the need for which will be judged by a hospital doctor.

52% of Belgian health care is financed from social insurance premiums, 27% from taxes, 21% from direct payments and only 2% from additional private insurance (Schneider, et al., 1992). There are two social health insurance schemes: one general scheme compulsory for all employees and their dependants and covering a broad range of risks and another scheme, also compulsory, covering only 'great risks' (mostly hospital care) for the self-employed. Nevertheless, about 70% of the self-employed take out a voluntary complementary health insurance covering ambulatory medical care, drugs, and prostheses.

A key position in the insurance scheme is taken by the six Health Insurance Associations (mutualities) supervised by the National Sickness and Disability Fund (RIZIV). These mutualities are umbrella associations with different religious and political backgrounds: the Christian and Socialist organisations are the largest with 4.5 and 2.6 million insured respectively (Schneider et al., 1992). Mutualities are more than just the accounts department of health care, they are also entitled to take the initiative in the provision of care. Despite the decentralised character, funds are centrally collected by the National Office of Social Security (ONSS/RSZ) and consist of premiums from employers, employees and self-employed as well as governmental subsidies for the benefit of the unemployed, the aged and the poor. Insurance premiums are income-related and set by negotiations between the medical profession and national social affairs authorities. The ONSS/RSZ is responsible for the distribution of these

funds via the National Sickness Insurance Institution (INAMI/RIZIV) to the six Health Insurance Associations.

The remuneration system is based on the principle of reimbursement. Patients pay the bills directly and get (a part of) their money back from the local Health Insurance office. Hospital bills are mostly directly paid by the office. A substantial part of health care costs is directly paid by the patients (co-payments: the so-called *ticket modérateur* or *remgeld*). The governments of the communities determine the amount of co-payment. For hospital admissions, patients have to pay a fee for the first day. Generally, patients have to pay 20-25% of the costs for primary care themselves. Widows, elderly people, handicapped and orphans have lower levels of co-payments. There is no maximum limit to the amount of co-payment for an individual patient.

Primary health care

Primary care is provided by numerous general practitioners (GPs) and by many specialists, in their private practice or in hospital out-patient departments. As mentioned the physician density in Belgium is very high. In 1990 there were 319 inhabitants per physician and 588 inhabitants per GP. There are no legal limitations regards accessibility, establishment of GPs or the number of patients served. Free choice of patients is a very important feature of the Belgium system. There is no fixed list system: every person can choose to contact the physician he or she prefers at a particular moment.

Most Belgian GPs work in single-handed practices and they are famous because of their large number of home visits. An international comparative study showed that almost half of their consultations were home visits compared to 24% in France, 19% in the Netherlands, and 15% in the UK (Fleming, 1993). Medical specialists who work in primary health care do not make home visits.

Secondary care

The number of hospitals and hospital beds is quite high. Most hospital beds are in private or semi private facilities: all function on a non-profit basis. They are run by organisations such as societies for mutual aid and religious communities. The public hospitals are mostly the responsibility of the PCSWs. The government has some influence on the hospital supply. Hospitals have to meet requirements for appropriate structural and organisational standards and

must be compatible with national and regional hospital plans (Boerma et al., 1993). In comparison with a lot of other European countries the hospitals in Belgium are rather small.

Health care figures (1993) (OECD, 1995)

Expenditure	
Total expenditure on health	
Absolute per head in ppp$	1601
Percentage of GDP	8.3
Public expenditure on health	
Absolute per head in ppp$	1423
Percentage of GDP	7.3
Manpower	
Physicians per 1000 pop.	3.7
GPs per 1000 pop.	1.5 (1992)
Qualified nurses per 1000 pop.	6.5 (1988)
Hospital care	
In-patient care	
Beds per 1000 pop.	7.7
Admissions per 100 pop.	19.7
Mean length of stay	12.0
Acute hospitals	
Beds per 1000 pop.	4.8
Admissions per 100 pop.	17.7
Mean length of stay	8.0
Nursing homes	
Beds per 1000 pop.	1.1

GENERAL PRACTICE

As mentioned, primary and secondary care are not strictly separated in Belgium. Therefore, formally, primary health care for the elderly is not necessarily restricted to general practitioners as in many other countries. But, there are hardly any figures available to quantify the role of GPs with regard to the elderly (Van den Audenhove & Lammertyn, 1995). The scarce information indicates that the elderly are over-represented in the patient population of Belgium GPs. Although elderly people can consult every specialist directly, they mostly visit their GP first who will refer them to the required specialist. Furthermore it must be mentioned that the

medical care of people living in old people's homes or rest- and nursing homes is mainly the responsibility of their own GP.

In 1993, NIVEL co-ordinated a large international comparative study of the task profiles of primary health care physicians/general practitioners in 32 European countries. This study also contains information of 511 Belgium doctors: two separate samples of 348 Flemish and 163 Walloon doctors. In this section we present the data related to care for the elderly. An important question concerns first contact to the health care when a person experiences a health problem. The respondents were asked to what extent patients would in first instance contact them for 27 health problems. Five problems concerned elderly people (see table).

Percentage of Belgium GPs who are almost(always) or usually the doctor of first contact for the following health problems[1].

	Flanders (n=348)	Wallonia (n=163)
Woman aged 60 with deteriorating vision	25.9 %	29.6 %
Woman aged 60 with polyuria	94.2	93.9
Woman aged 60 with acute symptoms of paralysis/paresis	87.5	89.4
Man aged 70 with joint pain	96.8	98.8
Woman aged 75 with moderate memory problems	96.8	98.8

[1] Source: Task profile study, NIVEL, 1993

Although, as mentioned in the former section, people have free access to almost all available physicians, the figures of the research show that most Belgium GPs consider themselves as doctor of first contact in most of the conditions mentioned. Like in most countries, deteriorating vision is not a part of the GPs' work but this condition is mostly firstly seen by an ophthalmologist. Acute symptoms of paralysis are, according to the GPs who answered the questionnaire, also the responsibility of neurology or the emergency department of the hospital. Furthermore, the table shows no relevant differences between the GPs in Flanders and Wallonia. The topic of another question was disease management. It was asked to what extent GPs or primary care physicians were involved in the treatment and follow-up of patients with specific diagnosis. Again we selected the conditions relevant for the care for the elderly.

Percentage of GPs involved in the treatment and follow-up of the following diagnoses[1]

	Flanders (n=348)	Wallonia (n=163)
Acute cerebro-vascular accident	69.0%	73.1%
Congestive heart failure	78.0	90.0
Myocardial infraction	60.2	70.3
Chronic bronchitis	99.1	100.0
Pneumonia	84.7	93.1
Parkinson's disease	61.9	73.0
Uncomplicated diabetes type II	96.8	99.4
Rheumatoid arthritis	77.7	77.2

[1] Source: Task profile study, NIVEL, 1993

In general, Walloon GPs seem to be a little more involved in the treatment and follow-up of the diseases than their Flemish colleagues.

The treatment and follow-up of acute CVA is mainly the domain of specialists in neurology and internal medicine. The neurologist also plays a relevant role in the treatment of Parkinson's disease. There are also rheumatologists.

HOME CARE

Generally, home nursing and home help services are separately organised in Belgium (Hutten, 1996). Only a few organisations provide both kinds of home care. However, in the actual provision of care co-operation between home nurses and home helps is increasing. Home helps sometimes assist home nurses in the daily care of the patient (especially with hygienic tasks) and occasionally signal problems which they discuss together. Most professional and even informal home care-providers are now urged to participate in 'team meetings' on shared clients in the context of the 'co-operation initiatives' (*samenwerkingsinitiatieven*) which are co-operative structures for several home care organisations and GPs, organised both locally and regionally. These co-ordinating structures are partly subsidised by the Flemish government. They started since 1987 and now about 60 of them are functioning in Flanders. In the Walloon community there is a parallel development ((Hutten, 1996).

Home nursing care

Home nursing services are mainly provided by private organisations which work on a non-profit basis and an increasing number of independent nurses working in private practices. In 1991, about 15,000 nurses were working in the Belgian home care: about 8,000 (53%) of them were working independently (Hutten, 1996). It is estimated that about 40% of the market are covered by independent nurses.

The largest professional organisation is the White/Yellow Cross which covers the whole country and performs about 50% of all home nursing activities. Besides, there are a number of smaller organisations like Solidarity for the Family. This organisation provides both home nursing and home help services, mainly in Eastern Flanders. In the Walloon community, an equivalent organisation exists namely the C.S.D. (*Centre des Soins à Domicile*).

Three levels of nursing expertise can be distinguished in Belgium. *Graduate nurses* (*gegradueerd verpleegkundigen*) have had two years of basic training followed by one year's specialisation in hospital nursing, psychiatric nursing, paediatric nursing or two years in social nursing. *Brevetted nurses* (*gebrevetteerd verpleegkundingen*) are trained for three years with a higher emphasis on the practical part of the job. The admission requirements for this training are less strict. Graduate and brevetted nurses are authorised to perform the same kind of tasks. The third, marginal group in home nursing care are the *brevetted hospital assistants* (*gebrevetteerd ziekenhuisassistentes*) with two year's training in the hospital. In practice, they can do the same tasks as other nurses, but must always be supervised by a graduate or brevetted nurse.

Home nursing care is mainly provided to elderly people: about 80% of the patients are above 60 (Hutten, 1996). Two out of three patients are women and the percentage of patients over 80 of age is increasing fast: to almost 36% in 1993. There are no waiting lists for home nursing in Belgium. Patients can immediately be helped because of the availability of a large supply of independent working nurses and an adequate planned nursing staff for home nursing organisations.

Home nursing is mainly funded by the health insurances. Patients have to pay a membership fee to the White/Yellow Cross, which varies between BEF 500 and 1,000 per family per year. The actual costs of home nursing activities are paid directly by the Health Insurance funds to the home nursing organisations or the independent nurses. By law only well-defined nursing tasks can be reimbursed by the health insurance funds. Reimbursement requires a formal prescription from a doctor, except for ADL help. The remuneration is fee-for-service based. Technical

nursing care, such as injections, are paid per item of service (nomenclature). Other activities are paid per diem depending on the level of care dependency of the patient. To assess this level of dependency, a nurse from the home nursing organisation will visit the patient. A standardised screening form (*De aangepaste KATZ-schaal*) is used which includes six questions about activities of daily living and five additional items about mental problems and social circumstances. The ADL-items are derived from the original Katz-scale and include the degree of impairment with regard to bathing, dressing, moving, continence, going to the toilet, and nutrition. Orientation in time and place, restlessness, the living situation, availability of informal care, and living conditions (bathroom, hot water supply) are the other five aspects which are taken into account. The score of an individual patient determines the remuneration of the nursing services and the amount, type and duration of the home nursing activities needed. Three patient categories are distinguished:

1. *Less dependent patients*: fee-for-service reimbursement according to a list, which contains technical nursing procedures only. Prevention, caring activities and psychosocial guiding are therefore not reimbursed for these patients.
2. *Moderately dependent patients*: low reimbursement per day of care, about BEF 500 a day.
3. *Highly dependent patients*: high reimbursement per day of care, about BEF 950 a day.

The reimbursements per day are all in. So, the technical nursing procedures are not reimbursed separately.

There are no special professionals for the assessment procedure: all nurses who provide home care are also able to fill out the screening forms. Accordingly, the assessment of needs, the actual provision of care and the evaluation of the care provided are mostly the responsibility of the same person.

The actual nursing care provided includes hygiene and other personal care, routine technical nursing procedures (injections, stoma care, bladder washouts), more complicated nursing activities (epidural anaesthesia, handling respirator, catherisation), patient education, and the encouragement of informal care. ADL-assistance, injections and wound dressing are the activities most frequently performed by the Belgian home nurses during home visits (Hutten, 1996).

Home help services

Home help services are mainly provided by private non-profit organisations, although some public organisations are active in this field. The public system is the responsibility of the already mentioned local PCSWs. Private home help organisations are still associated or linked with broader social organisations (e.g. the Christian Workers movement, Socialist movement) and organisations for more specific groups such as the Catholic Pensioners Union, other religious groups, and Health Insurance funds (mutualities). They are organised at a local level and their catchment area is restricted. Examples of these kinds of organisations are Family Help (*Familie-hulp*), Family Care (*Familiezorg*), and Solidarity for the Family (*Solidariteit voor het gezin*) (Lammertyn, 1990). These services have to be recognised officially by the PCSWs for reimbursement.

Home helps are mainly involved in housework (Baro et al., 1991). Since the end of 1970 long-term unemployed people (unemployed for least two years) were able to be employed in community jobs, e.g. in the so called cleaning services (*poetsdiensten*). The cleaners are attached to the home help organisations and can be considered as a separate type of home help which requires no specific qualifications.

Trained home helps, the so called family and elderly helps, are supposed to have an adequate level of education. Vocational training at upper secondary level is required, for instance training as a family social-worker, family and health worker, children's nurse or a training in an acknowledged training centre for home-help workers. The training must include moral, psychological, hygienic, social and domestic knowledge and include 500 hours of theoretical training and 150 hours of practical training in various health and social institutes. In addition to this, home helps must also participate in some in-service training every two years.

The client population of home help services is characterised as the most vulnerable category of elderly people, that is the oldest among the elderly living alone, without children, financially weak and with a multi-pathological state of health (Dooghe et al., 1988).

No formal referral is needed for home help services. Potential clients can contact the home help organisations themselves. The needs of the potential client are assessed through a so called social investigation performed by a social worker (or social nurse). Since 1994, the so called BEL-profile scale (*Basis Eerste Lijn*) is applied by all subsidised services. This scale consists of the same items as the Katz-scale completed by some specific items concerning household activities. The income of the client is also part of the social investigation not to determine the

needs of care but because it is used to calculate the level of co-payment by the client. The decision about the type of home help care to be provided and the period of care is made by the service managers or special committees of the organisations.

The work of cleaners is restricted to the cleaning of the house. Home helps provide a larger range of care, i.e. housework (preparing meals, washing dishes, washing and ironing, and cleaning), hygienic and other personal care (bathing, ADL-help), moral support (counselling and advice), general and family support (shopping, going for a walk, administrative support), and occasionally encouraging help from family members, neighbours or friends. In practice, the same organisations will provide cleaning as well as home help to the same client.

In contrast to the home nursing services, some of the new clients of home help services have to wait before they actually receive home help. About 10% of the potential clients are placed on a waiting list and the waiting time varies between one and six months. Shortage of personnel and the increasing number of applicants for home help services are the most important causes.

The largest part of the cost of home help services in Belgium is financed by general taxation. However, all clients have to pay co-payments depending on the net family income and the composition of household.

Home help organisations need to be authorised by the Ministry of Social Welfare and the Family to receive governmental funding. The subsidies consist of two parts. Firstly, organisations receive a fixed budget toward overhead costs such as administration, co-ordination costs, and wages of the social workers and managers. The level of the budget is based on the number of clients, home helps and cleaners. The second part is an allowance toward wages and operating costs of the actual work in the families at a certain rate per hour. To receive an allowance by the government, the organisations have to meet the following criteria:

- total working hours must not exceed the quota that can be subsidised;
- a social inquiry must be carried out to estimate the needs of the applicant before the help is actually granted;
- home help must be provided in the residence of the applicant.

An officially recognised organisation employs at least three full-time home helps and can be subsidised for the following staff members:

- one full-time social nurse for every 150 families who receive help;
- one extra half-time social nurse for every additional 75 families;
- one manager for every 150 home helps.

Since 1980, the number of hours that can be reimbursed has been fixed by the government. Each organisation has a certain quota of subsidised hours which is stated at the level of provision for 1979. In addition to budgetary considerations, this regulation was intended to force the organisations to be more selective with the provision of help. An extension of these hours is possible in the context of the IBF (Interdepartmental Budget Fund) and the operation which intended to support employment of long-term unemployed.

TECHNICAL AIDS

The delivery and payment of technical aids depend on the age of the person involved and the cause of the disability (e.g. occupational accident, illness or congenital defect). The health insurance funds, the RIZIV/INAMI and Community Funds can be involved (De Witte et al., 1994). In general, most technical aids for the elderly are paid by the health insurance funds. There are no national assessment procedure. When an elderly person needs a technical aid, he/she will contact a medical doctor, often a GP, who will decide whether or not it is necessary. With regard to aids for washing, bathing, showering and domestic activities, the elderly person can directly buy the aid in a so called ADL shop (mostly run by a health insurance), with a prescription of a physician. Afterwards the costs are reimbursed. In the case of wheelchairs, the doctor will send a prescription for approval to the organisation which reimburses the costs. With this approval the elderly person can buy the wheelchair in a ADL shop.

DAY CARE FOR THE ELDERLY

Especially to relieve the family during the day, day care centres (*dagcentra*) were established in the Flemish community: in 1988 there 15 of these centres mostly related to old people's homes (Nijkamp et al., 1991). These centres receive a subsidy from the Flemish government. The main goal of the centres is to activate the elderly by means of group- and leisure-activities. People can also make use of other services like bathing, pedicure and hairdressing. Only elderly people who have been multidisciplinarily screened are allowed in these day care centres.

CONCLUSION

In general, a broad range of services are available for the elderly in Belgium. Only with regards to the care of elderly with mental problems such as dementia some important shortcomings are reported. Also the availability of home help services is a point of concern.

In health care, primary and secondary care are not strictly separated. This leads to competition between physicians but it seems that GPs play an important role in the primary health care for the elderly. A lot of his/her work is provided within the home of the elderly given the high number of home visits.

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PRIMARY HEALTH CARE FOR THE ELDERLY IN DENMARK[3]

BACKGROUND

Policy and services for the elderly: a general overview

Denmark has created one of the most comprehensive service systems for the elderly in the world. By social law (The Social Security Act of 1973) each municipality (*kommune*) is obliged to offer or arrange adequate facilities for the elderly such as nursing homes, sheltered housing and home care. The exact amount of these services is the responsibility of the municipalities themselves. Danish policy towards the elderly can be summarised in three basic principals: continuity of care, self-determination, and optimal use of one's individual resources (Friediger, 1992). Official state policy is mainly oriented towards a shift from total care to self-care and to let elderly people stay as long as possible in their own social environment or in purpose designed housing facilities where they maintain their role as independent citizens who have become older.

Social legislation is focused on the development of community services and the restriction of institutionalised care. An important feature of the Danish policy in this respect is the split between housing/living facilities on the one hand and supporting and caring facilities on the other hand. This split will prevent the elderly having to move when their needs for care change (Van der Zee, 1996). The basic idea is that all kinds of care must be available for all elderly, irrespective of their living place. There is a collective belief among policy makers and health and social professionals that most types of services offered in a nursing home can easily be provided in the own home of the elderly (Cates, 1994). An important consequence of this principle is the decision, to stop building traditional institutions for the elderly (e.g. nursing homes, service flats and pensioners' flats), after 1988. Instead, nursing homes are converted to sheltered housing, and housing collectives and adapted flats are established.

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[3] **A significant part of this chapter is already published in:**
BOERMA, W.G.W., F.A.J.M DE JONG, P.H. MULDER. Health care and general practice across Europe. Utrecht: NIVEL, 1993.
HUTTEN, J.B.F., A. KERKSTRA. Home care in Europe: a country-specific guide to its organization and financing. Aldershot: Arena, 1996.

With the exception of acute hospital care, psychiatric institutions and general medical care (GPs), which are the county's responsibility, all remaining care for the elderly is organised by the municipality. This implies that a broad range of facilities can be offered, while, according to priorities determined at local level, the emphasis can be on residential services, home care or other facilities. However, as mentioned, absolute priority has been given to home care and sheltered housing. Next to home nursing and home help services, there are all sorts of additional community services for the elderly, such as meals-on-wheels, alarm systems, transport services, assistance with shopping, gardening and snow clearance. The elderly pay only a limited or symbolic contribution for these kinds of services. However, the availability of these types of services vary between municipalities due to the economical and political situation.

Care for the Danish elderly is mainly the responsibility of public services, the role of informal carers is less important in this respect. There is less potential for informal care because of a higher labour market participation of women and greater mobility which separates children form their aged parents (Giarchi, 1996). Informal care from children is mainly social in nature (Nijkamp et al., 1991). Therefore, older people still expect the state to provide all kinds of services for them without charge. However, according to Cates (Cates, 1994), 'in future it may become necessary to require the elderly to contribute or pay for services that they now do not pay. The government could raise taxes, but at the present time it is doubtful whether this is politically possible'.

SOCIAL SECURITY

According to an international comparative study, the incomes of most Danish elderly are relatively low (Nijkamp et al., 1991). However, there are special regulations in the taxation system and special allowances e.g. for transport, housing and heating to compensate this low income.

All residents aged 67 and over receive a universal flat-rate state pension, the so called *Folkepension*. Furthermore, for employees there is the so called employment-related occupational pension scheme (*arbejdsmarkedets tillaegspension*) and for those who are members of an employment insurance fund, there is the voluntary early retirement pay scheme

(*fortidspension*) for retirement at the age of 60 (Nijkamp et al., 1991). In addition to these main schemes, persons aged 60+ may reduce their working hours and receive state compensation.
An important problem in the near future is the growing discrepancy between elderly who only have a basic state pension and those with additional sources of income like private pensions, insurances and capital income. It is estimated that the former group earns about 40-50% of their former salary compared to 75-90% in the latter group (Abrahamson, 1991). Only one third of the employed have private pensions (Nijkamp et al., 1991).

RESIDENTIAL SERVICES FOR THE ELDERLY

During the last decade the percentage of elderly living permanently in institutions has dropped quickly due to the public housing policy for the elderly which de-emphasises the traditional types of residential and semi-residential care facilities to provide appropriate care through better housing conditions. Although there has been a building stop for traditional institutions for the elderly since 1988, there are still a number of traditional residential services such as nursing homes (*Plejehjem*) for the elderly impaired in need of extensive nursing care and personal and practical assistance, sheltered housing facilities (*Beskyttede boliger*) for the elderly needing less care, and collective service flats (*Lette kollektivboliger*) or pensioners flats (*Kommunale pensionistboliger*) reserved for the elderly and handicapped. Furthermore, adapted flats for the disabled and elderly in non-profit housing (*Aeldreegnede boliger i almenyttigt byggeri*) are still constructed and many of the old nursing homes have been or are going to be modernised and changed into these kind of flats. In 1995, 1.1% of the elderly between 60 and 66 lived in one of these kind of facilities: for the people between 67 and 80 this percentage raises to 3.8 and 20.4% of the people of 80 years and over lived there (Statistisk årbog, 1996). A comparison of 1994 and 1995 showed that the number of inhabitants of nursing homes and sheltered housing facilities dropped with more than 3%, while the number of inhabitants of adapted flats increased with 18% in the same period (Statistisk årbog, 1996).
The new housing facilities are owned by municipalities and non-profit housing associations. However, in both cases, the allocation decision is the responsibility of the municipalities.
Specially for mentally ill elderly there are four medium-sized hospital in the whole country (Giarchi, 1996). They are located near general hospitals and also serve out-patients.

Until 1989 elderly used to pay for nursing homes with their (state-)pensions in exchange for pocket money. As mentioned it is now possible to separate the housing and service function. This means that the elderly in traditional residential homes can choose whether they wish to make use of a particular kind of service. For housing the maximum contribution is 15% of income; in such cases, services are purchased according to need. The maximum contribution is 15% of income for service-flats and sheltered housing (Nijkamp et al., 1991).

ORGANISATION OF HEALTH CARE

Although the Ministry of Health is overall responsible for health care, the planning and management of health care facilities and staff are largely decentralised to the counties (*Amt*) and municipalities (*Kommunes*) (Boerma et al., 1993). They develop plans for health policy and development of health care services in their own territories on a regular basis. Besides, the planning and provision of social services have also been decentralised to the local level. Hospital care and a great deal of the out-patient care sector, including general practice, are within the competence of sixteen regions (the city of Copenhagen is one of them) each with 250,000 to 550,000 inhabitants. The remaining primary care facilities, like most of the preventive care, all sorts of adapted and sheltered housing facilities, nursing homes, community nursing and home help services, belong to the domain of the municipalities.

About 85% of the system are financed by taxation (mainly local and regional taxes); the remaining 15% are paid by the patients themselves (Boerma et al., 1993). The counties can levy a proportional income tax, and they are free to determine the rate. Municipalities also raise funds by taxing incomes, property and industrial estates. Health expenditure is a major part of the regional budgets; about two thirds of its total are spent on it. The central authorities apply a system of grants to equalise and supplement local resources. Regions with a lot of elderly persons, bad housing and other factors associated with increased health needs receive extra money from the state.

The health insurance system covers the whole population (Schneider et al., 1992). There are two different schemes which people can choose freely. Group one insured people, 98% of the population, have access, almost free of cost, to comprehensive health care including free medical care from the GP and free specialist care after referral. People in the other scheme,

group two insured, have the freedom to consult GPs or specialists of their choice without limitations but they are charged for 50% of the costs of out-patient care. Reimbursement rates for prescribed drugs are the same in both groups, namely 75% for essential drugs and 50% for others (with the exception of tranquillisers, sleeping tables and drugs with doubtful effect).

Primary health care

Primary health care in Denmark consists of a variety of services: general practice, home care, mother and child care, preventive services and school health care (Boerma et al., 1993). General Practitioners have a central role in the Danish health care system which can be compared with that of GPs in the Netherlands and the United Kingdom (Boerma et al., 1993). GPs are independent practitioners who have a national contract with the government which is administered by the counties. They all have a highly qualified vocational training in family medicine.

Most of the population (all group 1 insured) are listed with a particular general practice. For them, access to specialist or hospital care is only possible after a formal referral of a GP: except for emergency care, ophthalmology and E.N.T. In 1993, the average list size was 1400 inhabitants per GP (Boerma et al., 1993).

Although about 40% of the GPs still work in single handed practice, the number of partnerships and group practice is increasing: also in the rural areas. In contrast to e.g. Finland, there are only a few multidisciplinary health centres in Denmark. This might be related to the fact that general practice is the responsibility of the counties and have patients from different municipalities, while e.g. home care is mainly provided by community nurses and home helps employed by the municipality.

GPs are paid by the county through a mixed remuneration system, a capitation and fee-for-service part for each patient, which is aimed at keeping patients in primary care as long as possible (Boerma et al., 1993). The GP receives a capitation fee for all group 1 insured over 16 years of age. In addition each consultation is remunerated separately. Furthermore, the GPs is paid for special medical services within a consultation, e.g. urine test, taking a blood sample, removing warts and large wound treatment.

Secondary care

Secondary care is mostly provided by hospital-based salaried medical specialists. A limited number, mainly ophthalmologists and E.N.T. specialists, work as independent practitioners who have a contract with the county like the GPs. GPs refer patients to the admissions department of a hospital that will allocate the patient to a specific ward. So, in contrast to many other countries, Danish GPs do not refer directly to an individual specialist in the hospital.

In 1990, there were 106 hospitals with 30,145 beds in the country. There were 6 highly specialised hospitals which performed special high-tech medical services on a national scale. Furthermore there were 20 specialised regional hospital. The majority of the beds were in local hospitals.

Most of the hospitals are public organisations; a few are in the hands of patient unions and only two were privately owned (Boerma et al., 1993).

Health care figures (1993) (OECD, 1995)

Expenditure		
Total expenditure on health		
Absolute per head in ppp$	1296	
Percentage of GDP	6.7	
Public expenditure on health		
Absolute per head in ppp$	1070	
Percentage of GDP	5.5	
Manpower		
Physicians per 1000 pop.	2.8	(1992)
GPs per 1000 pop.	0.7	(1992)
Qualified nurses per 1000 pop.	6.7	(1991)
Hospital care		
In-patient care		
Beds per 1000 pop.	5.0	
Admissions per 100 pop.	20.5	
Mean length of stay	7.6	
Acute hospitals		
Beds per 1000 pop.	4.1	
Admissions per 100 pop.	19.8	
Mean length of stay	6.3	
Long-term care		
Beds per 1000 pop.	N.a.	

GENERAL PRACTICE

As mentioned the general practitioners have a central position in primary health care in general, so also for the elderly population. The are responsible for the care for the elderly patients on their lists. Even long-term residential care institutes now have the policy that their inhabitants have their own GP. According to a publication of 1982, one fourth of the GP services in Denmark are utilised by people of 65 and over (Krasnik et al., 1982). Furthermore GPs provide the most extensive surveillance of the elderly, since 85% of the elderly have at least one contact with the GP in a year (Holstein et al., 1989).

In 1993, NIVEL co-ordinated a large international comparative study of the task profiles of primary health care physicians/general practitioners in 32 European countries. This study also contains information of 198 Danish GPs. In this section we present the data related to care for the elderly. An important question concerns first contact to the health care when a person experiences a health problem. The respondents were asked to what extent patients would in first instance contact them for 27 health problems. Five problems concerned elderly people (see table).

Percentage of Danish GPs who are almost(always) or usually the doctor of first contact for the following health problems (N=198)[1].

Woman aged 60 with deteriorating vision	55.2%		
Woman aged 60 with polyuria			94.9
Woman aged 60 with acute symptoms of paralysis/paresis	88.7		
Man aged 70 with joint pain			100.0
Woman aged 75 with moderate memory problems	100.0		

[1] Source: Task profile study, NIVEL, 1993

Most of the health problems are firstly seen by the GPs. Only with regard to vision-problems their role as doctor of first contact is less strong. The problem of deteriorating vision mostly firstly seen by an ophthalmologist which can be consulted directly by a patient.

The topic of another question was disease management. It was asked to what extent GPs or primary care physicians were involved in the treatment and follow-up of patients with specific diagnosis. Again we have selected the conditions relevant for the care for the elderly.

Percentage of GPs involved in the treatment and follow-up of the following diagnoses[1]

Acute cerebro-vascular accident	56.1%
Congestive heart failure	93.4
Myocardial infraction	51.8
Chronic bronchitis	99.0
Pneumonia	99.0
Parkinson's disease	62.4
Uncomplicated diabetes type II	97.5
Rheumatoid arthritis	72.6

[1] Source: Task profile study, NIVEL, 1993

Danish GPs are relatively less involved in the treatment and follow-up of CVA, myocardial infraction, Parkinson's disease, and Rheumatoid arthritis. According to the respondents, these diseases are often the domain of specialist care such as internal medicine, hospital emergency department, neurology, and rheumatology. But probably many of the patients with these health problems are cared for by the GP and the specialist together.

HOME CARE

Unlike most other European countries home nursing (*Hjemmesygepleje*) and home help (*Hjemmehjaelp*) are two of a kind; they are part of the same organisation and their activities are employed complementarily (Van der Zee, 1996). As the elderly and chronically ill have a high preference for one single help, home helps provide quite a range of services to this group. Nurses usually are in charge of need-assessment and allocation of a broad range of services. In the light of the integration of both services, it is relevant to mention that a new education programme has been created with a common ground for both home helps and assistant nurses. Since 1991 there is a combined education programme for assistant nurses. There is one year common both to future home helps and assistant nurses; after that year a further 1.5 year qualifies for assistant nurse.

As already mentioned, home help and home nursing are organised by the local authorities. Local and national taxation form the funding sources. In general, both services are free of charge (these are specific exceptions). Denmark in the only country in the European Union where no co-payment from the elderly is required for home help services. Their is some varying

co-payment for acute home help of non-permanent character (usually for younger persons after accidents or illnesses) and for additional services like gardening.

Home nursing care

Home nursing services are provided by home nurses and assistant nurses. Nurses receive four years of post-high school education. Community nursing organisations provide extra schooling for these nurses, provided they have at least two years of practical experience in hospital nursing. In general the typical functions of home nurses include the usual activities like giving drugs and injections, wound care and giving health advice.

There is a trend towards a strong increase of nurses working in Danish home care: from one nurse per 345 elderly people in 1977 to one nurse per 114 of the elderly in 1992 (Van der Zee, 1996).

In 1991, 7.3% of the population over 65 were patients of the home nursing scheme.

An official authorisation by a physician (GP or hospital doctor) is required in case of a medical treatment such as injections, medication or wound treatment. No such medical referral is needed for social, caring and preventive activities. The assessment procedures of home nursing needs can differ between the municipalities.

Although supply of home nursing was almost doubled since 1988, the year Denmark stopped building nursing homes, obligations have increased too. Twenty-four-hour service is a possible option now in most municipalities, although no extra budget is available for that service from the state or the county; extension of it will be at the expense of services of the municipality (Van der Zee, 1996).

Home help services

Home help services are part of an even wider range of services namely neighbourhood work (*Omsorgs-arbejde*) that includes e.g. services like gardening, snow clearance, meals-on-wheels and public transport. In the Social Security Act of 1972 the following home help activities have been described officially (Van der Zee, 1996):

- housework such as cleaning, cooking, bed making, washing and ironing;
- personal assistance such as going to the toilet, dressing, washing, bathing, hair combing and other aspects of personal hygiene;

- shopping and -outdoor walks.

Like the number of home nurses, there has clearly been a considerable increase of the number of home helps in the last 20 years. In 1972, there was one home help available for 43 elderly; in 1984, one home help for 29 elderly; and in 1992 there was one home help per 21 elderly (Van der Zee, 1996).

In 1992, 20.5% of the people over 67 received home help services in Denmark (Van der Zee, 1996).

Assessment of needs for home help services is mostly done in combination with that for home nursing care. The co-ordinating home nurse performs this combined evaluation.

Danish home help services involve substantially more than just cleaning the house. The home helps take care of a great deal of chronically ill patients. The helps provide a wide range of services compared to other countries. Personal (hygiene) care e.g. is assigned to assistant nurses in most countries; while accompanying a disabled or frail elderly person on outdoor walks and taking care of shopping is usually not included in home help activities in other countries that are more strictly limited to cleaning activities.

TECHNICAL AIDS

Like all other services for the Danish elderly, technical aids such as aids for washing, bathing and showering, wheelchairs, and special household equipment are available for the people who need these devices. They are financed through taxation.

The delivery system of technical aids have be decentralised: responsibility is shifted from the state to the counties and municipalities. They can easily co-ordinate the supply of technical aids with other social services such as housing adaptations, home nursing, and rehabilitation (De Witte, 1994).

Aids are provided free of charge, unless the cost of the aid is less than 300 DEK. All aids that can be re-used are owned by the municipality and loaned to the user.

In practice the local Social and Health Departments in the municipalities take care of the actual provision of technical aids for the elderly. They have the authority to decide about the financing of these aids and inform the users. The social or health worker (often occupational therapists, physiotherapists, nurses) makes the home visits, assesses the applicant's situation, selects the

appropriate aids and delivers it. There are a number of advisory boards or centres which can be consulted.

DAY CARE FOR THE ELDERLY

There are about 443 day centres (*Dagcentre*) which provide all kinds of social services e.g. educational programmes, clubs for pensioners, etc. (Cates, 1994). It is estimated that about 50.000 elderly use these facilities daily. Respite care is provided in special day centres (*Dagcentre og daghjem*). In an increasing number of municipalities 24-hour services are available. They had a capacity of 24.000 places (Nijkamp et al., 1991).

CONCLUSION

In many international comparative studies the service system in Denmark is mentioned as a good example. It is the most comprehensive system for the elderly in the world. The main principle of the system is that all the citizens have a right to receive all the social and health services they need. Services are generally free of charge and the financial situation of the individual is not taken into account because the system is funded by general taxation.

The municipalities are mainly responsible for the provision of whole wide range of services. Therefore, it is easier to integrate different services. A problem in this respect is, however, that in health care there is a split in responsibilities. E.g. in primary health care, GP services and physiotherapy are county's responsibilities, while home nursing and some parts of the rehabilitation are the responsibilities of the municipalities.

With regard to the future, the question rises whether this comprehensive and expensive system can be maintained. The increasing number of elderly will put pressure on the system and it is doubtful whether people are willing to pay extra taxes to finance the service system for the elderly.

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PRIMARY HEALTH CARE FOR THE ELDERLY IN FINLAND[4]

BACKGROUND

Policy and services for the elderly: a general overview

During the past few decades Finland has been developed as a social welfare state. Care for the elderly is mainly the responsibility of the national government and, more recently, of the local authorities (municipalities). The role of informal carers such as relatives, friends and neighbours is less important (Sipilä, 1993; Heikkinen, 1994). Services are mainly provided by public organisations.

Until the end of the 1980s the care system was strongly based on institutional services. For financial and social reasons more community oriented services have been developed recently. On the one hand, due to the economic recession, the public services and expenditures have to cut down drastically. On the other hand the demand for care is increasing. Since 1950, the proportion of the elderly in the Finnish population has been increasing rapidly (Heikkinen, 1994). In 1994, 14.2% were over 65 (OECD, 1995). This figure is expected to double in the first half of the next century. Furthermore, the proportion of elderly living alone is growing. In 1988, 38% of the people aged 65 or over, were living alone (Sundström, 1994). Besides, old people prefer to stay in their own home as long as possible.

To cope with these developments a new national program for care for the elderly was formulated in 1988. Home care needed to be stimulated and institutional care has to create short-term and part-time treatment. Opportunities for day care and treatment of clients for a maximum period of three months in a old people's home had to be increased. In 1993, a sort of day care service was available in 40% of the municipalities (Heikkinen, 1994). Besides home nursing and home help services, there are several supportive services developed for the elderly, such as meals-on-wheels, bathing services, and transport services.

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[4] **A significant part of this chapter was already published in:**
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HUTTEN, J.B.F., A. KERKSTRA. Home care in Europe: a country-specific guide to its organization and financing. Aldershot: Arena, 1996.

In general, it can be stated that Finnish old-age policy is focused on an increasing co-operation, integration and co-ordination of health care services on the one hand and social welfare services on the other hand.

SOCIAL SECURITY

The income of the elderly is guaranteed through several pension schemes (Giarchi, 1996). Firstly, there is a national flat-rate pension for all inhabitants of 65 years or older who have lived for at least five years in Finland. This national pension consists of a minimum basic income which represents the semi-official poverty line. Nowadays most elderly have additional earnings-related programmes. There are different programmes for e.g. employees, civil servants, and self-employed people. The payments depend on the number of years in employment, with a maximum of 60% to 66% of the previous salary level. A higher level of this earnings-related pension leads to a reduction of the state pension.

The elderly can also apply for special allowances, e.g. for housing and special technical aids. Furthermore, people who take care of elderly patients are eligible for a home care allowance; the actual amount of money varies between local authorities.

RESIDENTIAL SERVICES FOR THE ELDERLY

Institutional care of the elderly is provided mainly in old people's homes as part of the social services and in health centre hospitals which are part of the primary health care services. The number of long-term patients (more than 90 days in hospital) in general hospitals is rather small; they are mainly involved in acute care.

In 1991, about 5.5% of the elderly over 64 years were in long-term institutional care: 3.4% in old people's homes and 2.1% in health centre hospitals (Hutten, 1996). Very old people in particular were in permanent care: 1.3% of the people between 65 and 74, 7.4% of the people between 75-85, and 27.7% of the people 80 years or older lived permanently in institutional services.

Since the 1970s, the number of places in old people's homes decreased considerable. In 1992, 26,715 places were available, compared to 31,000 in the late 1970s (Giarchi, 1996). Taking into account the rapid growth of the elderly population, the proportional decrease is even larger.

The majority of the old people's homes are owned by municipalities; about 8.5% are run by private associations and non-profit organisations. These private homes are mostly occupied by elderly in relatively good health. Emphasis is on residential services and less on medical treatment. Municipalities contribute to the operating costs of private homes according to the number of places. The residents themselves have to pay the monthly fees. Elderly who cannot afford this can apply for housing allowances to the municipalities.

Old people's homes owned by the municipalities are mostly larger than the private services. They provide more medical services. The level of the fees for institutional care depends on the personal income of the elderly.

Furthermore, new experiments with forms of sheltered housing for the elderly are recently developed. These sheltered housing facilities are situated near service centres which provide social and health care, emergency call service, sauna, bathing and pedicure services, transport, laundry and educational or leisure programmes (Hutten, 1996).

ORGANISATION OF HEALTH CARE

Finland has a national health service. This means that health care is mainly provided by public organisations (mainly health care centres and hospitals) which are financed through general and local taxation. The entire Finnish population is covered by a public health insurance run by the National Social Insurance Institute (NSI). This compulsory scheme is funded by premiums paid by employers and employees on the one hand and subsidies from the state or local authorities on the other hand. This insurance scheme mainly covers drugs prescribed by a physician, examinations and treatment performed in the private sector, and dental care for young adults. Most of these services require some co-payment from the patients. As regards medicines, percentages can vary between 50 and 100% reimbursement, depending on the related diagnosis.

Until the beginning of the 1990s, the central government was mainly responsible, but since 1993, the central influence of the state has been reduced considerably. Municipalities can provide extra services not included in the national plan, without a state subsidy. Furthermore, state subsidies are no longer earmarked which gives the municipalities more autonomy in the allocation of this money between different policy areas. The level of the block grant is calculated taking into account the number of inhabitants, age distribution, morbidity rates, population density, geographic area, and the economic situation of the municipality.

Primary health care

Since 1972, primary health care has been a major priority in Finnish health policy. Primary care is provided by the 223 health care centres. Every municipality has a health centre, either of its own or shared with neighbouring municipalities. It is important to notice that the term health centre is not related to one specific building, but refers to an independent organisation supplying health care. These centres provide a full range of primary care services including dental care, physiotherapy, laboratory and X-ray facilities, an emergency unit, a maternity and child health unit, and a local hospital for acute and chronic patients. The average number of beds in health centre hospitals is 100. Most centres employ at least four general practitioners and several primary care nurses. The centres account for almost three-quarters of the patient contacts in primary care. The remaining is seen in private practice or by a hospital out-patient department in acute cases.

Until recently, there was no personal doctor system: all GPs in a centre had the collective responsibility for the patients. However, nowadays, the centres are being reorganised so that each GP has his/her own personal list of patients. In 1993, 36% of the Finnish population was listed at an individual GP.

Traditionally physicians, in hospitals as well as in primary care, work on a salary basis in the public system. They are, however, free to run a private practice in their spare time. In private practice, a fee-for-service system is used. For reasons of efficiency, a new remuneration system has been introduced recently. In primary care, an experimental contract has been developed dividing physician's remuneration into three components: basic salary (60%); a capitation fee for patients on the list with three or more visits in the previous year (20%) and fee-for-service payment for other patients (20%). This system is of course closely related to the development of the personal doctor system mentioned above.

Secondary care

Historically, hospital bed supply is fairly high in Finland. However, in the last decade, the number of beds (especially in psychiatric wards) has been diminished. Between 1984 and 1994, the number of acute beds per 1000 populations dropped from 4.8 to 4.3 (average annual reduction of 1.2%), and the number of psychiatric beds from 3.6 to 1.6 (average annual reduction of 7.6%) (OECD, 1995).

For in-patient medical treatment the country is divided into 21 'hospital regions'. Each region has a central hospital where the most common specialities are available. Highly specialised medicine is practised in the five University Hospitals. Furthermore, there are a large number of smaller district hospitals. No distinction is made between hospitals for acute patients and hospitals for chronic cases. Most chronic patients stay in health centre hospital, except for those who are in need of specialised medical care. Hospital out-patient departments are only accessible after patients have been referred by a health centre (except in case of emergency).

Health care figures (1993) (OECD, 1995)

Expenditure	
Total expenditure on health	
Absolute per head in ppp$	1363
Percentage of GDP	8.8
Public expenditure on health	
Absolute per head in ppp$	1080
Percentage of GDP	7.0
Manpower	
Physicians per 1000 pop.	2.6 (1992)
Gps per 1000 pop.	1.1
Qualified nurses per 1000 pop.	11.3
Hospital care	
In-patient care	
Beds per 1000 pop.	11.0 (1992)
Admissions per 100 pop.	24.4
Mean length of stay	14.8
Acute hospitals	
Beds per 1000 pop.	4.3
Admissions per 100 pop.	19.1
Mean length of stay	5.7
Long-term care	
Beds per 1000 pop.	9.7*

* 4.7 in old people's homes and 5.0 in health centre hospitals (Hutten, 1996)

GENERAL PRACTICE

As mentioned in the previous section, general practice is organised from the health care centres. The GPs are employed by these centres and are involved in services such as curative care, emergency care, rehabilitation, and care for the chronically ill (Boerma et al., 1993). The GPs only make home visits to elderly and chronically ill in 'home care'. All other home visits are

performed by a community nurse. The GPs also are in charge of the treatment of the long-term patients in the health centre hospitals.

As mentioned, the organisation of general practice is now developing into a personal doctor system where each GP will have the responsibility of his/her own patients. On average, there are about 1600 patients per GP (Boerma et al., 1993).

In 1993, NIVEL co-ordinated a large international comparative study of the task profiles of primary health care physicians/general practitioners in 32 European countries. This study also contains information from 239 Finnish doctors. In this section we present the data related to care for the elderly. An important question concerns first contact to the health care when a person experiences a health problem. The respondents were asked to what extent patients would in the first instance contact them for 27 health problems. Five problems concerned elderly people (see table).

Percentage of Finnish GPs who are almost(always) or usually the doctor of first contact for the following health problems (N=239)[1].

Woman aged 60 with deteriorating vision	44.8%
Woman aged 60 with polyuria	90.3
Woman aged 60 with acute symptoms of paralysis/paresis	72.3
Man aged 70 with joint pain	92.0
Woman aged 75 with moderate memory problems	89.0

[1] Source: Task profile study, NIVEL, 1993

Generally, these health problems are part of the responsibility of most of the GPs. Only with regard to the deteriorating vision ophthalmology was more often mentioned as a speciality of first contact.

The topic of another question was disease management. It was asked to what extent GPs or primary care physicians were involved in the treatment and follow-up of patients with specific diagnosis. Again we selected the conditions relevant for the care for the elderly.

Percentage of GPs involved in the treatment and follow-up of the following diagnoses[1]

Acute cerebro-vascular accident	45.8%
Congestive heart failure	89.0
Myocardial infraction	27.7
Chronic bronchitis	90.8
Pneumonia	96.2
Parkinson's disease	38.4
Uncomplicated diabetes type II	95.0
Rheumatoid arthritis	49.2

[1] Source: Task profile study, NIVEL, 1993

Finnish GPs are less involved in the treatment and follow-up of CVA, Myocardial infraction, Parkinson's disease, and Rheumatoid arthritis. According to the respondents, these diseases are mostly treated by specialists in internal medicine or neurology.

HOME CARE

Finland is in the middle of an integration process of health and social services in primary health care. The former sectoral service structure (separation of services) has been transformed into small-area-responsibility. This means that the 460 Finnish municipalities are responsible for a broad range of public services such as home care (home nursing care and home help services), housing, and environmental aspects in their regions. Until the beginning of the 1990s, home nursing care and home help services were separately organised. Now, in most municipalities, the so called health and social care centres provide both services. This, however, does not necessarily mean that the actual provision of social and health services is integrated. Therefore, home nursing care and home help services are separately discussed in the next two sections.

Home nursing care

As mentioned home nursing care is mostly organised by the municipal health centres, but some municipalities contract private organisations. The general tasks of home nursing services are formally described in three points:

- to give medical and nursing care at the patient's own home;
- to assist with all activities of daily living ;

- to plan and co-ordinate the care of the patient in co-operation with home help services to keep the patient living in his/her own home as long as possible.

Home nursing services are mainly used by the elderly: only 11 percent were below 65. The very old, 80 years and older, were the largest group (46.4% of the total).

There are three kinds of nurses working in Finnish home care. The majority are health visitors or public health nurses (*terveydenhoitajat*). Furthermore there are registered nurses (*sairaanhoitajat*) and practical nurses (*perushoitajat*). With the exception of more complicated nursing care, the three types of nurses are qualified to perform the same kind of tasks. However, in the daily practice there is differentiation. All three types are involved in routine technical nursing procedures such as injections and dressings. One of the main activities in this respect is the provision of medicines. Hygienic and other personal care (bathing, dressing, etc.) are mainly done by practical or registered nurses. The activities of health visitors and registered nurses extend towards more complicated technical nursing procedures (handling respirator, catheterisation), patient education, counselling (e.g. concerning psychological or social problems), and the evaluation of the care provided. However, it must be mentioned that complicated technical nursing procedures in home care are more restricted than in many other European countries: e.g. epidural anaesthesia at home is not allowed. Sometimes, practical or registered nurses are involved in housework, but this is mainly done by home helps (Hutten, 1996).

All inhabitants have access to home nursing care, but a formal referral by a physician is always required. In most of the cases, this will be the general practitioner who is attached to the health centres.

Home nurses operate from health (and social) care centres. They sometimes work alone, but often in teams of varying composition. On special occasions, e.g. difficult or special patients, a multi-professional team can be formed including physicians, nurses, home helps and social workers.

The public system does not completely cover the costs for home nursing activities. All patients have to pay additional fees themselves. The level of co-payment depends on monthly income and the size of the family.

Home help services

Home help services are part of the public social service system which is also the responsibility of the municipalities. Everyone has a right to apply for these services when needed. All clients have to pay a fee which is based on their income and the care and service plan.

About 90% of the services are provided by municipal organisations; 10% by private organisations which are contracted by the municipalities, such as the Central Union for the Welfare of the Aged, the Finnish Red Cross, National Association of the Disabled, and the Association for Old Aged and Neighbours Service.

A leading home maker or home service advisor is generally in charge of the municipal home help service. These services are involved in three main tasks:

- domiciliary care (provided by home makers and home helps);
- supporting services such as meals-on-wheels, transport services;
- payment of home care allowances to individuals for care of the elderly or disabled.

The actual work within the homes is done by two types of personnel: home makers (*kodinhoitaja*) and home helps (*kotiavustaja*). The tasks of home help and home makers do not differ largely. They are mainly involved in housework and assistance with personal hygiene. The first include e.g. cleaning, providing meals (including shopping), and care for clothes (washing, repairs, ironing). Assistance with all kinds of activities of daily living, bathing, dressing, help with the lavatory can be done by a home help or home maker, but also by someone with a nursing background. Moral support is also a part of the work of home helps and home makers. They are not allowed to do any simple technical nursing procedure like wound care or pressure sores and are not involved in the assessment and evaluation of the provided care.

In 1993 there was one home help per 1,483 inhabitants and one home maker per 819 inhabitants (Sundström, 1994). The age distribution of home help clients shows a deviant picture compared to many other countries. 35.5% of the clients were under 65 years of age; 16.3% between 65 and 74, and 48.2% were 75 years or older. It is interesting to notice that home help services in Finland are not exclusively used by the elderly. However, in the future the increasing demand for home help by the elderly will lead to a decrease in child care and assistance to young families.

In the daily practice, home makers and home helps operate from a home help service office or health (and social care) centres. They can work as soloists as well as in teams. Help is available for 24-hours, seven-days-a-week.

Nowadays, nurses and home helps/makers sometimes work in teams or discuss shared patients occasionally. This is mainly by telephone, informal meetings at the client's house, or through a note (message) book. But, the extension of integration in health and social services and the improvement of communication and exchange of information are still important goals in home care. The introduction of a new integrated basic qualification in social and health care is an important step forward.

TECHNICAL AIDS

Like most services for the Finnish elderly, the provision of technical aids such as aids for washing, bathing and showering, wheelchairs, and special household devices, is also the responsibility of the municipalities (de Witte et al., 1994). Most technical aids are free of charge for the user or given in loan. The delivery of aids is highly integrated in the whole system of home care services. For instance the home nursing department is often responsible for the instruction, maintenance and repair of most devices. Application and assessment procedures are also performed by home care personnel (nurses, home helps, physicians).

DAY CARE FOR THE ELDERLY

Day hospital care is arranged by municipal hospitals. About 1 per 1000 elderly aged 65 or over receive this kind of care. This figure raises with age: almost 3 per 1000 elderly of 75 or over are in day hospital care (Vaarama, 1995). Furthermore special day care facilities for demented people has been increasing in the last years. Some of it is arranged by municipal health (and social) care centres and some by private organisations such as the Association of Alzheimer's disease but they are often contracted by the municipalities which remain responsible.

CONCLUSION

The role of primary health care for the elderly in Finland has been increasing recently. The amount of institutional care has been decreasing. New forms of care are being developed. Policy is focused to create a comprehensive coherent system of care. The integration of home nursing care and home help services is an important step forward in this respect. Also the introduction of the principle of small-area responsibility, which will be implemented in all municipalities

before the end of 1996, is important. Because municipalities become responsible for the whole range of social and health services, they are able to meet the needs of the population.

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PRIMARY HEALTH CARE FOR THE ELDERLY IN GERMANY[5]

BACKGROUND

Policy and services for the elderly: a general overview

Germany is a federal state, consisting of sixteen *Länder*: eleven in the former Federal Republic of Germany (FRG) and five in the former German Democratic Republic (GDR). The sixteen *Länder* each have their own national legislation which might result in differences regarding the organisation of care for the elderly. After the reunification in 1990, there is still a big gap between social and health care facilities in the western and eastern part of the country. Furthermore there are important differences in the availability of services between urban and rural areas throughout the country.

The ageing of the population has taken place more rapidly in Germany than elsewhere in the European Union (Delnoij, 1996). Especially the percentage of people above 80 and the percentage of elderly women living alone without offspring have increased rapidly (Giarchi, 1996). This development is caused by the increased life expectancy on the one hand and decreased birth rates on the other hand. As a consequence the number of potential carers will drop in the future. This is an important problem in Germany because care for the elderly was to a large extent the responsibility of informal carers (mainly family members).

For a long time, the principle of subsidiarity is central in the German social system (Giarchi, 1996). This means that individuals or families are mainly responsible for their own well-being and have to manage themselves as long as they are able to do so. Public social services from the state are only considered as the last opportunity when all others have failed. The introduction of the so called *Pflegeversicherung* (nursing insurance) in 1995, which will be discussed in one of the next sections, increases the collective responsibility towards care for the elderly. It can be seen as social support to organise subsidiarity.

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[5] **A significant part of this chapter is already published in:**
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HUTTEN, J.B.F., A. KERKSTRA. Home care in Europe: a country-specific guide to its organization and financing. Aldershot: Arena, 1996.

In the former GDR special problems arise in the care for the elderly (Delnoij, 1996). For one thing, there has been a considerable amount of migration of people of working age from the old GDR to the former FRG. The average age of those remaining has increased markedly as a result of that process.

The state organises the financing of care and social services, but is not directly involved in the actual provision. The actual provision is the task of private for- and non-profit organisations (e.g. related to the churches or social-political movements). In the whole country there are about 6000 private organisation providing services to the elderly. The totality of all forms of social support on a non-statutory, non-profit making basis in Germany is called the *Freie Wohlfahrtspflege* (Delnoij, 1996). Within the *Freie Wohlfahrtspflege*, the welfare associations have combined to form six national umbrella organisations:

- the *Diakonisches Werk* (of Protestant denomination)
- the *Caritas* (of Catholic denomination)
- the *Arbeiterwohlfahrt*
- the *Zentralwohlfahrtsstelle der Juden in Deutschland* (of Jewish denomination)
- the *Deutsches Rotes Kreuz*
- the *Deutscher Paritätischer Wohlfahrtsverband*

These organisations provide both residential services (hospital beds, places in old people's homes and nursing homes) and community services (home nursing, home help, social activities).

In Germany, several types of organisation are involved in providing ambulatory care for the elderly. In general the *Ambulante Pflegedienste* can be divided in two types of organisations: the already mentioned *Freie Wohlfahrtspflege* and the private organisations. There are a lot of regional differences in this respect. In some areas, like Hamburg, more than 60% of the services are delivered by private for-profit organisations. In other areas ambulatory care for the elderly is mainly provided by e.g. *Gemeindekrankenpflegestationen*, *Haus- und Familienpflegestationen*, *Sozialstationen* and *Mobilen Sozialen Hilfsdienste*. The so-called *Sozialstationen* (Social Stations) are, in a number of areas, important community-based care-providing institutions (Delnoij, 1996). The first *Sozialstationen* were established in 1970 in Rheinland-Pfalz. The state of Berlin was one of the last to start a programme of *Sozialstationen* in 1982, though in the state of Bremen, for example, *Sozialstationen* do not yet exist. The services that are provided elsewhere by *Sozialstationen* are in Bremen delivered by *Dienstleistungszentren* (service

centres). In the former GDR home nursing was provided by *Gemeindekrankenschwestern*. In addition to that, many companies would take care of their pensioners, e.g. by providing meals from the canteen. Since 1990, *Sozialstationen* have been introduced in the former GDR.

An important starting point to organise care for the elderly legally was the introduction of the Federal Social Assistance Act of 1961. This act stresses three main aims regarding elderly, namely:

- to secure the integration of older people into society;
- to maintain independent living in an environment of their own choice as long as possible;
- to establish and support suitable facilities and institutions for those older people who are incapable of maintaining an independent household.

Although these formal principals regarding the care for the elderly were already formulated in 1961, services for the elderly such as home care are still an important point of concern, especially in the Eastern part of the country (Giarchi, 1996). Only Since the Health Reform Laws of 1989 and 1991 and the introduction of the *Pflegeversicherung* in 1995, more (insurance) money has become available for home nursing and home help services.

SOCIAL SECURITY

Social conditions for the elderly in the old Federal Republic have improved over the past decade, but, at the same time, the social inequality has risen because the pension is earnings-related. From the age of 65 people are entitled to a pension. Income after retirement is made up (in various proportions) by rebates from the statutory Federal Pension Insurance Scheme for workers and employees; of state, industrial or professional pension schemes; of social security benefits; and of income from personal means. The existing old-age and social welfare schemes can lead to an insufficient level of income for those who have always earned low wages (Evers & Svetlik, 1991). The most vulnerable group are unmarried women, divorcees as well as widows (Nijkamp et al., 1991).

In the former GDR the social circumstances of the elderly are worse than in the Western part of the country.

RESIDENTIAL SERVICES FOR THE ELDERLY

The availability of residential services for the elderly varies within the country: especially between the Eastern and Western part. In the latter, a distinction must be made between institutions for temporary and permanent residency (Nijkamp, 1991; Giarchi, 1996).

In general there are five types of services for permanent living. Firstly, there are the old people's homes (*Altenheim*) for elderly who can not live independently. These services provide housing, meals and health care. About 4% of the elderly, not necessarily in need of care, live in homes for the elderly (*Altenheim*) (Nijkamp, 1991; Delnoij, 1996). Secondly, service apartments attached to support services (*Altenwhohnheim*) can be mentioned. They provide the same kind of services as old people's homes but there is more privacy. These first two are becoming less important in the near future. Permanent residential care will be mainly provided in nursing homes (*Altenpflegeheim/Altenkrankenheim*) for elderly who need more intensive care (mainly medical), multilevel homes for the elderly (*Mehrgliedrige Einrichtungen*) which are complex institutions offering a combination of services and special nursing homes for demented elderly people (*Gerontopsychiatrisch Pflegeheim*) focusing on psychiatric treatments.

Also with regard to non-permanent residential services for the elderly five different types can be distinguished (Giarchi, 1996). Like in most other countries, general hospitals have specific Geriatric units (*Geriatrische Abteilung in Krankenhäusern*) for the temporary treatment of diseases. When a longer period of treatment is needed after a stay in a hospital people can be admitted to a geriatric day or night hospital (*Geriatrische Tages-oder Nachtkliniken*). Furthermore, day care nursing homes (*Tagespflegeheime/Tagesheime*) provide nursing home care during the day-time. There are also short-run nursing homes (*Kurzzeitpflegeheim*) where elderly people have a temporary room and receive meals and health care mainly when informal carers are temporarily absent and also after a long stay in a hospital. Finally, the communication centres for the elderly (*Altentagesstätten/Altenbegegnungsstätten*) can be mentioned. These meeting centres for elderly people are mainly active in leisure time activities.

In the former GDR residential services for the elderly were limited. There were only large residential institutes which were financed by the state. About 4.5 to 5% of the elderly in the former GDR live in old people's homes. The buildings in which these homes are located, are generally old (often pre-war) and as such, the constructions lack modern facilities and comfort.

ORGANISATION OF HEALTH CARE

The German health care system is a decentralised system with private practice physicians (for ambulatory care) and independent, mostly non-profit, hospitals (Boerma et al., 1993). A strong distinct division is created between institutional care (provided by salaried hospital doctors) and non-institutional, ambulatory care. Ambulatory care physicians can not treat hospitalised patients, and hospital physicians can not treat ambulatory patients. This also implies that hospitals do not have outpatient clinics for ambulatory care.

In 1993, most Germans (93%) obtained their health insurance through membership in one of 1,241 *gesetzliche Krankenkassen* (Statutory Health Insurance funds) (Boerma et al., 1993). All Germans with an income below a certain level (income ceiling) are obliged to join a *Krankenkasse*. The remaining 7% are privately insured. Furthermore, 8% of the population have *supplementary* private insurance. Health Insurance funds provide their members quarterly with a health insurance certificate, the so-called *Checkkarte*, with which patients may consult any physician who has a contract with the Health Insurance fund. Handing in the certificate ties patients to one specific provider for the period of three months.

According to national law, the Health Insurance funds are forced to provide a comprehensive benefits package, including ambulatory and hospital care; maternity, dental, and preventive care; physical therapy; drugs and family planning; rehabilitation; eyeglasses; medical appliances; short-term home nursing care (for a period of less than six months); fitness tests and work therapy (including spa visits). Apart from these service benefits, health insurance includes certain cash benefits for maternity leave, paid leave for care of a sick child, sick leave and burial allowances. Above a certain income ceiling there are co-payments for the cost of drugs, inpatient hospital care and dental care. Health insurance benefits do not include long-term nursing care. Long-term nursing care (for a period of at least 6 months) is covered by the new *Pflegeversicherung* which is introduced in 1995. This new insurance, which is administrated by the health insurances, is paid through earmarked premiums from employers and employees.

Those eligible are people who, due to physical or mental illness, are (partly) unable to attend to activities of daily living for at least (unexpected) six months. Three categories of need are distinguished:

- category I: *erheblich Pflegebedürftige*, people who need help with at least two activities of daily living once a day and who need home help services several times a week. For this category, as far as ambulatory care is concerned, benefits consist of service benefits (professional home care delivered in kind) up to a maximum of DEM 750 a month, or cash benefits, with which a patient can buy their own home care, up to a maximum of DEM 400 a month.
- category II: *Schwerpflegebedürftige*, people who need help with activities of daily living at least three times a day and who need home help services several times a week. For this category, service benefits may not exceed DEM 1,800 a month; cash benefits may not exceed DEM 800 a month.
- category III: *Schwerstpflegebedürftige*, people who need help with activities of daily living 24 hours a day and who need home help services several times a week. For this category, service benefits may not exceed DEM 2,800 a month; cash benefits may not exceed DEM 1,300 a month. For long-term care in nursing homes, service benefits may not exceed DEM 2,800 a month as well.

The assessment of patients in order to determine to which category they belong, will be the responsibility of the medical advisors of the Health Insurance funds (*Medizinische Dienst der Krankenversicherung*).

Primary health care

Within primary health or ambulatory care, provided by so-called *niedergelassene Ärzte*, no further division is made between GPs (*Hausartz*, *Algemeinartz*, *Praktische Artz*) and medical specialists. On average there are about 870 inhabitants per out-patient care doctor (Boerma et al., 1993).

Patients can freely choose a physician and are not obliged to be listed with a specific general practitioner. The physicians are controlled by the 'Kassenärztliche Vereinigungen' which are mainly responsible for providing primary health care. They are also responsible for the remuneration of the physicians who are paid on a fee-or-service basis. Most primary care

doctors work in single handed practices, although the number of partnerships and group practices has been increasing recently.

German GPs have the highest number of consultation per week throughout Europe. In a comparative study, they recorded an average of 220 consultations in a normal working week: in the Netherlands 142, Belgium 135, the UK 128, and in France 82 (Fleming, 1993).

Secondary care

The hospitals in Germany are partly publicly owned and partly private. In 1989 there were in total 3510 hospitals (3069 in the former GDR and 441 in the former FRG). There is, in general, one hospital physician per 718 inhabitants. In contrast to many other European countries, hospitals do not operate out-patient care. All hospital admissions are by referral, but people are free to choose which hospital they want to visit.

Health care figures (1993) (OECD, 1995)

Expenditure	
Total expenditure on health	
Absolute per head in ppp$	1815
Percentage of GDP	8.6
Public expenditure on health	
Absolute per head in ppp$	1274
Percentage of GDP	6.0
Manpower	
Physicians per 1000 pop.	3.2 (1992)
GPs per 1000 pop.	1.2 (1992)
Qualified nurses per 1000 pop.	5.2 (1989)
Hospital care	
In-patient care	
Beds per 1000 pop.	10.1
Admissions per 100 pop.	21.3
Mean length of stay	15.8
Acute hospitals	
Beds per 1000 pop.	7.2
Admissions per 100 pop.	18.5 (1990)
Mean length of stay	12.4
Nursing homes	
Beds per 1000 pop.	9.6 (1988)

GENERAL PRACTICE

As mentioned primary health care for the elderly is provided by GPs as well as by out-patient specialists, mainly specialists in internal medicine, neurology and psychiatry.

In 1993, NIVEL co-ordinated a large international comparative study of the task profiles of primary health care physicians/general practitioners in 32 European countries. This study also contains information from 168 German GPs. In this section we present the data related to care for the elderly. An important question concerns first contact with the health care when a person experiences a health problem. The respondents were asked to what extent patients would in the first instance contact them for 27 health problems. Five problems concerned elderly people (see table).

Percentage of German GPs who are almost(always) or usually the doctor of first contact for the following health problems (N=168)[1].

Woman aged 60 with deteriorating vision	33.1%	
Woman aged 60 with polyuria		93.4
Woman aged 60 with acute symptoms of paralysis/paresis	88.5	
Man aged 70 with joint pain		99.4
Woman aged 75 with moderate memory problems	98.2	

[1] Source: Task profile study, NIVEL, 1993

German GPs consider themselves as the doctor of first contact with regard to most of the conditions mentioned. Only women with deteriorating vision mainly visits an ophthalmologist first. The topic of another question was disease management. It was asked to what extent GPs or primary care physicians were involved in the treatment and follow-up of patients with a specific diagnosis. Again we selected the conditions relevant for the care for the elderly.

Percentage of GPs involved in the treatment and follow-up of the following diagnoses[1]

Acute cerebro-vascular accident	84.2%
Congestive heart failure	100.0
Myocardial infraction	74.7
Chronic bronchitis	100.0
Pneumonia	95.8
Parkinson's disease	75.4
Uncomplicated diabetes type II	99.4
Rheumatoid arthritis	94.6

[1] Source: Task profile study, NIVEL, 1993

The results of our study show that most of the selected conditions are part of the responsibility of German GPs.

HOME CARE

In this section a general outline of home nursing and home help services in Germany is presented. It should be noted that the details of the organisation of home care vary greatly between areas. The legal framework is determined by federal law, but since the implementation of legal guidelines is left to private initiative, the actual care provision can differ.

In Germany, like in most of the other European countries, a process of integrating home nursing and home help services is taking place. The number of these separate organisations for home nursing or home help services had decreased by about 30%. At the same time, the number of integrated organisations for home nursing and home help have grown (Delnoij, 1996).

Home nursing care

Home nursing is provided by private non-profit organisations such as the *Gemeindekrankenpflegestationen* (organisations for home nursing only) and the *Sozialstationen* (providing a broad range of ambulatory services, including home nursing and home help services). However, for the past few years, home nursing services are increasingly provided by for-profit private organisations. In 1993, there were 1,072 *Gemeindekrankenpflege- stationen* and 3,069 *Sozialstationen* in Germany as a whole (Delnoij, 1996). The size of the population that is served by a *Sozialstation* varies between 12,000 and 50,000. For-profit organisations have developed mainly in urban areas. E.g. in Hamburg, more than 60% of home nursing are delivered by for-profit providers.

Home care for the elderly is mainly provided by a *Krankenschwester/Krankenpfleger*, a nurse generalist with three years of education, *Altenpfleger(in)*, specialised in care for the elderly (two to three years of education) and *Krankenpflegehelfer(in)* and the auxiliary nurse (one year of education).

In the provision of services, a quite important legal distinction is made between *Grundpflege* (helping the patient with basic needs including ADL-activities) and *Behandlungspflege* (specialised, technical nursing procedures). The two types of care are generally carried out by

Krankenschwestern. Krankenschwesterhelferinnen and *Altenpflegerinnen* are only allowed to do the activities which are part of the *Grundpflege*.

Officially, a patient needs a referral for home nursing care from a physician.

Home help services

Home help services are provided by three types of organisations. "Traditional" home help services are provided by *Haus- und Familiepflegestationen* and by *Sozialstationen*. Clients of this form of home help services are families with children as well as elderly people. They are mainly focused on temporary care: basic nursing care, psychological care and homemaking activities. In the former GDR, domestic services, hot meals, and cultural activities used to be provided by a semi-governmental organisation called *Volkssolidarität* (People's Solidarity). Now, the five *Wohlfahrtsverbände* are engaged in providing home help services through their *Sozialstationen*.

Additional home help services mainly for elderly people are provided also by *Mobilen sozialen Hilfsdienste*. Although they do not provide traditional home help services, they are of vital importance in German home care: they provide services such as 'meals-on-wheels' and cleaning services, which enable the elderly (and chronically ill) to stay in their own homes, instead of being admitted to nursing homes or old people's homes.

Traditional home help services are provided by *Haus- und Familienpflegerin* (home and family helpers who have two year's training and provide care mainly in 'problem' families) and *Haus- und Familienpflegehelferin* (home and family help assistants), who usually have attended a variety of short training courses and provide care in families without further social problems. The *Mobilen sozialen Hilfsdienste* also employ a large number of volunteers and *Zivildienst-leistenden* (conscientious objectors to military service) that work in this particular area of ambulatory care.

Payment for home help services, as for home nursing, are based on the principle of subsidiarity. Clients have to pay for home help services themselves, and only if they or their children can not afford this, social welfare will take over the costs.

TECHNICAL AIDS

Technical aids for the elderly are part of the Health Insurance schemes or pension schemes (de Witte et al., 1994). The agencies are organised at local, regional and national level. The local agencies are mainly involved in the provision of technical aids. A prescription from a physician is always required. There is a large variety of aids available in Germany.

DAY CARE FOR THE ELDERLY

Like in most of the countries, day care facilities for the elderly are becoming more important in Germany. As mentioned there are day care nursing homes (*Tagespflegeheime/Tagesheime*) and the communication centres for the elderly (*Altentagesstätten/Altenbegegnungsstätten*). Furthermore, the number centres for geronto-psychiatric day care have been increasing.

CONCLUSION

There is a large variation in the organisation and role of primary health care for the elderly across Germany, but two important general developments can be mentioned.

Firstly, in the beginning of the 1990s some important changes of the care system for the elderly have been taken place in Germany. The financing of home care has been improved, especially with the introduction of the so called *Pflegeversicherung* in 1995. People can now decide themselves whether they prefer service benefits in kind or cash benefits which can be spent on informal and professional carers. Secondly, in large parts of the country, the delivery of services for the elderly is taken over by private for-profit organisations. Therefore, there are a large number of different kinds of organisations involved in care for the elderly and is it very difficult to get a clear picture of all services for the elderly.

Primary medical care is provided by GPs and specialists who are directly accessible for the patients. Empirical data, however, shows that the GPs have a prominent role in the treatment of elderly patients.

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PRIMARY HEALTH CARE FOR THE ELDERLY IN THE NETHERLANDS[6]

BACKGROUND

Policy and services for the elderly: a general overview

The elderly are an important group in Dutch society. Their number has, like in other Western countries, been increasing rapidly over the past years. Also the fact that, a few years ago, two political parties for the elderly have been elected in the parliament indicates that their significance in society is growing.

Care for the elderly in the Netherlands is mainly provided by private non-profit organisations and, to a lesser extent, by some public organisations. They operate within the legal and policy framework that is developed by the government. In 1970, the first White Paper on policy regarding the elderly was published (Pijl, 1991). The central policy objective was to facilitate the independence of the elderly. Special attention was given to the situation and the care of the frail elderly. Five years later (in the second White Paper) these general goals were transferred into specific policy tools mainly related to the volume of the available facilities: the number of old peoples' homes was limited and more money became available for sheltered housing and home help services. At the end of 1990 a new White Paper is published which stresses the importance of a national prevention programme for the elderly population, more coherence between housing facilities and caring facilities, improvement of care for the chronically ill elderly, and a so called re-evaluation of the elderly. It is stated that the integration and participation of elderly people in society is an important instrument for prevention and that it strengthens the policy to let elderly people live as long as possible in their own houses or social environment.

In 1994 the advisory commission on the modernisation of the care for the elderly (*Commissie Modernisering Ouderenzorg*) published their report *Ouderenzorg met toekomst* (Care for the elderly with future). Central points in this report are the problems with regard to the relation

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[6] **A significant part of this chapter is already published in:**
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HUTTEN, J.B.F., A. KERKSTRA. Home care in Europe: a country-specific guide to its organization and financing. Aldershot: Arena, 1996.

between living and care facilities and the necessity to cut back the costs of residential services for the elderly (mainly old people's homes). The commission lists the most important bottle necks in the care for the elderly. Firstly, although there are possibilities to reduce some expenditures, people have to be aware that, because of the increasing number of elderly in the Dutch population, an increase in the public expenditure for care is necessary. Secondly, there are severe problems and obstacles in maintaining elderly people as long as possible in their own houses or social environment: houses are often not adapted to the special needs of the elderly and there are some serious (financial) problems to provide the amount of home care that is required. Furthermore, the commission stresses that, though most elderly want to stay in their own home as long as possible, they will not do that at any price. At least a part of the elderly will, also in future, choose to live in an old people's home when necessary. It is predicted that the percentage of elderly in these living places will not change in the future. Finally, because of the large amount of care providers, care is fragmented which can affect the efficiency, quality and continuity of care.

The commission also formulates some important recommendations. The main solution for the problems is a better co-operation between care providers in a region. To decrease the fragmentation of care one central point or counter ('*Loket*') has to be created at a local level. There also must come one local independent assessment commission for the integrated and elderly-centred assessment of needs in all relevant areas such as social services, living facilities and (health) care. Another interesting option which is mentioned in the report is to stop building new nursing homes. In the future, this will lead to one type of permanent residential service, especially for frail elderly and there will no longer be a distinction between old people's homes and nursing homes.

Compared to a lot of other European countries, the availability of services for the elderly is rather complete and comprehensive (Vollering, 1991; Giarchi, 1996). There is a wide variety of residential services such as: nursing homes, old people's homes, sheltered housing, services flats and respite care provided by nursing homes. In the community, there are e.g. mental health advisory services (RIAGG), community nursing, home help services and meals-on-wheels. Community or social care is mainly the responsibility of the local authorities, but the actual provision of these kinds of services is mainly done by voluntary organisations. A lot of the social services are provided through neighbourhood centres (*wijk- en buurtcentra*) which are

mostly part of the general social and community work: e.g. providing meals and leisure activities. In some areas these services are provided by the old people's homes in so called '*huiskamer-projecten*' (living room-projects). Furthermore, there are organisations related to the church which are also active in providing services for the elderly. They are mainly financed through governmental subsidies and private contributions.

Most public money for care for the aged is spent on residential services (about 88%) and less on community services (Nijkamp et al., 1991; Vollering, 1991).

SOCIAL SECURITY

When the age of 65 is reached, all elderly receive a collective or state pension (the *AOW: Algemene Ouderdomswet*). This is a fixed amount of money which is paid monthly. The level of the allowance, based on the household composition, is related to the official social minimum level of income which is considered to be sufficient to enjoy the minimum standards for a decent life (Giarchi, 1996). People who are living alone receive 70% of the allowance for a two person household (Vollering, 1996). Premiums are paid by employees. So, the pension is financed by the present working population.

In addition to the state pension, an increasing number of people take out a 'personal' or private pension at one of the private insurance companies. This is often done in a collective contract e.g. for a whole enterprise. Some large enterprises, e.g. Philips and Dutch Railways, operate their own pension funds. Often participation in the private pension is compulsory, e.g. for civil servants. The allowances are income-related: in most cases a fixed percentage of final salary.

Although private or personal pensions become more important in the near future, a significant part of the elderly will only receive an allowance from the state pension (Commissie modernisering ouderenzorg, 1994).

As mentioned the state pension is related to the minimum costs of living. There are, however, special situations (e.g. chronic illness or disability) which increase these costs. To cover these extra costs one can apply for Special Benefits (*Bijzondere Bijstand*) which are administered by the local authorities.

RESIDENTIAL SERVICES FOR THE ELDERLY

Dutch residential services and institutional care are considered as one of the best in Europe (Giarchi, 1996). There is along tradition in these kinds of services and therefore, the number of elderly living in residential services is one of the highest in Europe. In 1991, it was estimated that about 7% of the population above 65 lived in old people's homes and about 2.5% in nursing homes (Vollering, 1991).

Nursing homes (*Verpleeghuizen*) play an important role in the health care system in the Netherlands (Ribbe, 1993). They provide long-term intensive care for somatic and psychogeriatric elderly with multiple pathology, disabilities and handicaps.

The capacity in beds and the number of nursing homes increased sharply from 1970 to the middle of the 1980s, mainly as a result of the encouragement of institutional psycho-geriatric care by the government (Tunissen & Knapen, 1991). Between 1988 to 1993 the number of nursing homes did not increase any further but the number of beds increased due to an increase of psycho-geriatric patients (van der Kwartel et al., 1994).

Nursing homes provide care in a clinical as well as an ambulatory setting. In 1993, 73% of the nursing homes also delivered day care (Kerkstra, 1996).

As mentioned before, the role of nursing homes is under discussion (Kerkstra, 1996). The issues at stake are considerations of costs, privacy, individualisation and social integration. Treatment and rehabilitation are being given more emphasis than nursing. The dilemma remains as to whether the focus should be more on medical treatment than on providing an adequate living environment. Although the number of places have stabilised, the range of provisions have become more differentiated. Relatively new provisions are night admissions, weekend and day treatment, respite care, crisis intervention and the consultative task of the nursing home doctor towards homes for the elderly and primary health care staff.

Old people's homes are mainly run by private foundations. Since 1977, a '7% norm' has been in effect for these homes, meaning that the total number of beds should correspond to 7% of the number of the elderly in a city or province. Nation-wide admission criteria and selection procedures were introduced to ensure that only the high-need elderly would be admitted (Tunissen & Knapen, 1991). As a consequence the number of actual places and the number of residents decreased during the last ten years.

In addition, many homes have special accommodation on the premises for self-reliant elderly people who need help occasionally (Kerkstra, 1996). The number of these so-called *aanleunwoningen* has increased markedly during the past decade. The elderly living in this type of sheltered housing run an independent household, but are able to use certain facilities and services provided by the old people's homes (Tunissen & Knapen, 1991). The original purpose of residential services was to offer an adequate living environment to those among the elderly who can only manage on their own with difficulty. Because of the stricter admission criteria, and also because of the fact that residents are becoming older and therefore require more intensive care, the difference between the populations of old people's homes and nursing homes is fading (Tunissen & Knapen, 1991; van der Kwartel et al., 1994).

ORGANISATION OF HEALTH CARE

In the Netherlands health care services are mainly provided by (non-profit) private organisations or independent professional care providers and funded by private or social Health insurances. The government is mainly responsible for legal framework which is necessary to guarantee quality of care, equality in accessibility of services, and determines the restrictions of the health care expenditures.

The provision of health services in the Netherlands has been structured in four layers (Boerma, 1993). Collective disease prevention, the basic echelon, includes immunisation, school health care, mother and child care, and health education. This is organised separately from primary health care (with the exception of mother and child care), also called the first echelon. Usually, patients need a referral from their GP to obtain specialist or (acute) hospital care (the second echelon). The third echelon consists of long term care in psychiatric hospitals, convalescent centres and nursing homes.

National policy making and overall financial supervision is the responsibility of the Minister of Health, Welfare and Sports (Boerma, 1993). Planning of hospitals and nursing homes, which are non-profit private initiatives, is a duty of the twelve provinces. The over 700 municipalities are in charge of public health (the basic echelon).

There are two health insurance systems: a public system, run by Health Insurance funds,

compulsory for people below a certain income level (about 60% of the Dutch population) and private insurance for the other 40% (Boerma, 1993). In addition there is a health scheme for the entire population. This last scheme, called the General Act on Exceptional Medical Expenses (AWBZ), covers psychiatric hospital care, out-patient mental health care, community nursing, home help services and nursing homes. It is financed by tax revenue.

Health insurance funds are non-governmental organisations. Premiums are deducted from salaries by the employers and paid on a fifty-fifty basis by both employees and employers. The private scheme is financed by commercial and non-commercial insurance companies. Premiums depend on age, choice of package, optional cost sharing conditions etc. In the past couple of years, more health insurance funds and private insurance companies have merged.

The need for cost containment and improvement of efficiency in health care has resulted in proposals for a new structure and financing system, where there is a shift from government planning to self regulation, relying on market principles. Some parts of the plans have been implemented while others have been postponed or cancelled.

Primary health care

There is a well developed system of primary health care. One of the main characteristics of the Dutch health care system is the strong central position of general practitioners. Almost all inhabitants are registered at a general practice , the so called list system, and general specialist or hospital care is only accessible after a referral by a GP. The position of the GPs can be compared with those in the UK and Denmark: gatekeeper, fixed lists, working in independent practice (no fixed salary). The average list size in the Netherlands is 2300.

For their publicly insured patients GPs have contracts with the sick funds which pay a yearly flat capitation fee. Privately insured patients pay their GP on a fee-for-service basis.

About half of the GPs work in single handed practices, 10% work in multidisciplinary health care centres and the remaining in partnerships or group practices. The number of GPs in single handed practice is expected to drop in the near future.

Home care organisations are also important providers of primary health care. At the end of 1996 all separate organisations for home nursing care and home help services in one specific area have to be merged into one organisation: the home care organisation. Some home care organisations already operate so called integrated teams which provide integrated care (health and social care) to avoid overlap between the services of community nurses and home helps.

Secondary care

As mentioned specialist and hospital care is, in most cases, not directly accessible. Formally patients need a referral from their GP. In the Dutch health care system specialist and hospital care are separated. Hospitals provide medical and caring facilities and accommodation. In general medical specialists work as free entrepreneurs who employ their own allied staff and have contracts for the use of hospital facilities and space. Most medical specialists are organised in independent partnerships which hire room in a hospital.

Until recently, medical specialists are paid on a fee for service as for publicly as well as privately insured patients. There is a lot of discussion about the remuneration of medical specialist at the moment and a number experiments for changes are being carried out.

Health care figures (1993) (OECD, 1995)

Expenditure	
Total expenditure on health	
Absolute per head in ppp$	1531
Percentage of GDP	8.7
Public expenditure on health	
Absolute per head in ppp$	1190
Percentage of GDP	6.8
Manpower	
Physicians per 1000 pop.	2.5 (1990)
GPs per 1000 pop.	0.5 (1990)
Qualified nurses per 1000 pop.	n.a.
Hospital care	
In-patient care	
Beds per 1000 pop.	11.3
Admissions per 100 pop.	11.0
Mean length of stay	33.3*
Acute hospitals	
Beds per 1000 pop.	4.1
Admissions per 100 pop.	10.3
Mean length of stay	10.4
Nursing homes	
Beds per 1000 pop.	3.5

* Includes long-term/permanent stays in nursing homes

GENERAL PRACTICE

As mentioned GPs have a central role in the Dutch health care system. Almost all inhabitants of the Netherlands are listed at a specific general practice or GP. Consequently, the general practitioner is the most important physician providing health care for the elderly in the Netherlands. The GP is responsible for the elderly who are living in their own houses as well as those in old people's homes. Only elderly in nursing homes (special homes for long-term residential treatment) are not the responsibility of the GP but of special nursing home doctors. This service is, however, not a part of primary health care.

Because patients have to be referred to specialist care by a GP, he or she can co-ordinate, guide and monitor the care for a specific patient. The Dutch Association of General Practitioners stresses the importance of the GP for the elderly. Common chronic conditions such as Diabetes type II have to be treated and monitored in general practice. The Dutch College of General Practitioners has developed a large number of standards of care. In these standards guidelines for good treatment and practice are formulated. There are standards which are especially relevant for elderly people. It is, however, very difficult to measure these standards in daily practice.

In 1993, NIVEL co-ordinated a large international comparative study of the task profiles of primary health care physicians/general practitioners in 32 European countries. This study also contains information from 209 Dutch GPs. In this section we present the data related to care for the elderly. An important question concerns first contact with the health care when a person experiences a health problem. The respondents were asked to what extent patients would in the first instance contact them for 27 health problems. Five problems concerned elderly people (see table).

Percentage of Dutch GPs who are almost(always) or usually the doctor of first contact for the following health problems (N=209)[1].

Woman aged 60 with deteriorating vision	88.5%
Woman aged 60 with polyuria	100.0
Woman aged 60 with acute symptoms of paralysis/paresis	99.0
Man aged 70 with joint pain	100.0
Woman aged 75 with moderate memory problems	100.0

[1] Source: Task profile study, NIVEL, 1993

These figures confirm the gate-keeping function of the Dutch GP. Almost every participating GP assumes that patients will almost always visit them first when these health problems occur.
The topic of another question was disease management. It was asked to what extent GPs or primary care physicians were involved in the treatment and follow-up of patients with specific diagnosis. Again we selected the conditions relevant for the care for the elderly.

Percentage of GPs involved in the treatment and follow-up of the following diagnoses (N=206)[1]

Acute cerebro-vascular accident	54.8%
Congestive heart failure	77.9
Myocardial infraction	32.4
Chronic bronchitis	98.1
Pneumonia	94.2
Parkinson's disease	42.5
Uncomplicated diabetes type II	99.5
Rheumatoid arthritis	62.9

[1] Source: Task profile study, NIVEL, 1993

Three conditions are treated by almost all GPs who have completed the questionnaire: chronic bronchitis, pneumonia and uncomplicated diabetes type II. There is more variation in the other diagnoses. GPs play a less central role in the treatment and follow-up of myocardial infraction, Parkinson's disease and Rheumatoid arthritis.

HOME CARE

Primary health care for the elderly is also provided by home care organisations. At the end of 1996 all separate organisations for home nursing care and home help services in one specific area have to be merged into one organisation: the home care organisation. Some home care organisations already operate so called integrated teams which provide integrated care (health and social care) to avoid overlap between the services of community nurses and home helps.
This process of integration is still going on at the moment. Therefore the relation and co-operation between home nursing and home help services can vary between regions.

In 1990 the two umbrella organisations for community nursing and home help services were merged into the National Association for Home Care (*LVT*). This association has four main duties (Kerkstra, 1996), namely: - policy making on the national level, - promotion of the interests of its members, i.e. the regional organisations, - engaging in collective bargaining with government and insurance companies, and - provision of services to the regional organisations. The actual delivery of services is the responsibility of the regional organisations.

Home nursing care

Legally all residents of the Netherlands are entitled to receive community nursing care. The regional cross associations and the home care organisations are the main providers of home nursing. These private non-profit organisations are financed by a system of public insurance based on the General Act on Exceptional Medical Expenses (AWBZ) which covers about 85% of the expenditure. The remaining 15% of the costs are mainly paid by members of the regional home care organisation or cross association. All patients have to be a member of the regional cross association in order to receive nursing care at home. The number of private for-profit agencies is limited and they mostly offer only a specific kind of (intensive) home care.

In some parts of the Netherlands the old situation still exists in which home nursing care is provided by the *Regional Cross Associations*. However, as mentioned, in most regions home nursing care is provided the integrated *Home Care Organisations*. The work of the nurses is organised in so called basic units which have an average catchment area of about 35.000 inhabitants (Kerkstra, 1996). Some organisations have basic units which only consists of a chief nursing officer (head nurse) and a team of nurses (community nurses as well as auxiliary nurses). In other organisations so called integrated teams have been established in which community nurses, auxiliary nurses and qualified home helps participate. Within this team each individual nurse, or a sub-team of a few nurses and an auxiliary nurse, is assigned to a specific sub-area.

Home nursing organisations in the Netherlands can be reached 24-hours-a-day and care can be elivered in the evenings, nights and weekends if necessary. Patients are entitled to a maximum ount of nursing care at home: 2.5 hours a day or three visits a day, for an unlimited period of . Patients who need more intensive home nursing for a limited period of time, mostly nal care or patients who are waiting for admission to a nursing home, can make an appeal

for additional home care. This additional home care is provided by private organisations or by foundations related to the home care organisations.

Three types of nurses work in home care (Kerkstra, 1996). Community nurses (*Wijkverpleegkundigen*) have had either four years of higher vocational training or 3.5 years in-service training in a hospital with another two years of intermediate vocational training. Nurses in the community (*Verpleegkundigen in de wijk*) have had 3.5 years in-service training in a hospital to become a registered nurse but did not have additional training in community nursing. And, finally, auxiliary community nurses (*Wijkziekenverzorgenden*) who either had two years in-service training in a hospital or nursing home and a six-month course in community nursing or three years intermediate vocational training in nursing. Community nurses are considered as first level nurses and nurses in the community and auxiliary community nurses as second level nurses. Community nurses can perform a wide range of tasks such as assessment of the need for care, hygienic and other personal care (e.g. bathing, help with lavatory, help with activities of daily living), routine technical nursing procedures (such as injections, dressings, stoma care, bladder washout), more complicated technical nursing (e.g. epidural anaesthesia, handling respirator, catheterisation), patient education, psychosocial activities, and involvement in the evaluation of care. Auxiliary nurses are also qualified to perform most of these tasks, except the assessment of the need for care, more complicated technical nursing procedures and the evaluation of care. In addition, auxiliaries more often provide hygiene care and give less often psychosocial support.

In general, patients do not have a choice as to which home nursing organisation they want to approach, because there is only one regional cross association or home care organisation in the region. In some places there are local private home nursing organisations patients can turn to. However, the insurance companies only remunerate the costs of supplementary home nursing under certain conditions and not the costs of regular nursing care at home provided by these private organisations. Consequently the patienst have to pay most of the cost themselves. Patients can contact the cross associations or home care organisations themselves because no referral is needed.

Traditionally, the assessment is carried out by a community nurse, who is also going to provide the nursing care or who delegates the care to a second level nurse. In the regional cross associations this is still the case. However, most integrated home care organisations intend to

combine the assessment of patient's need for home help and for nursing care. Most organisations have chosen a special assessment team consisting of a few people with a nursing background and a few people with experience in assessing needs for home help services (mostly social workers) (Kerkstra, 1996). The members of the team pay all the assessment visits and they are not involved in direct patient care. Sometimes the member of the assessment team also makes a nursing care plan, but in most organisations the care plan is made by the nurse who is going to provide the care. There is no standardised form that is being used in the whole country: each home care organisation can develop its own form. Recently new assessment forms have been developed suitable for assessing needs for home nursing as well as home help services (Verheij et al., 1993).

Home help services

The home help service is officially defined as help of a domestic and caring nature, occasionally supplemented by help of a personal and supporting nature, offered to all inhabitants of the Netherlands who need at least help of a domestic nature related to illness, recovery, old age, handicap, death, psychosocial, and personal problems that threaten the maintenance of the household. Its objectives are to support families and individuals in need and enable them to live as independently as possible (van den Heuvel & Gerritsen, 1991).

All inhabitants of the Netherlands are entitled to receive home help services which are also financed by a system of subsidies based on the General Act on Exceptional Medical Expenses (AWBZ) and co-payments by clients. However, because there are waiting lists for home help services the most desirable amount of care cannot always be provided and depending on the urgency of the needs most clients have to wait some weeks or even some months before they actually receive the assessed care.

Just as described in the case of home nursing are there are still two situations in the Netherlands. In some regions separate home help organisations still exist, while in other regions home help services are provided by the integrated home care organisations. As mentioned most of the home care organisations have integrated teams in which community nurses and auxiliary community nurses and qualified home helps work together. In addition they have separate teams of unqualified home helps, who only carry out household tasks. Traditionally in most home help organisations (qualified) home helps do not work in teams, they work as soloists.

The home help organisations and home care organisations are non-profit organisations. However, there are private for-profit organisations which, among others, provide home help.

The home help services are performed by home helps with a variety of qualifications (Kerkstra, 1996). Specialised home carers (*gespecialiseerde gezinsverzorgenden*) support households with multiple complex problems. Home carers (*gezinsverzorgdenden*) organise a household and provide also personal care as far as this can not be done by the members of the household. Qualified home helps (*gediplomeerd helpenden*) do the housekeeping and some personal caring tasks as far as they can not be done by the members of the household. Unqualified home helps (*ongediplomeerd helpenden*) are only allowed to do the housework. In addition, in 1973 'alpha-help'(*alpha-hulp*) was introduced as a way of providing cheaper help. This was achieved by allowing people to work as home helps for a maximum of twelve hours a week, which is the limit below which they do not have to pay social security contributions. Alpha-helps have the same tasks as the unqualified home helps, but formally the client is the direct employer of the alpha-help. Alpha-help is therefore formally organised outside the home help organisations. However, most of the organisations operate as an intermediary between the client and the alpha-help.

The work of the alpha-helps is limited to housework like cleaning the home, washing dishes, washing and ironing. Unqualified home helps are also only allowed to do the housekeeping. Qualified home helps do the housekeeping and some caring tasks as far as they can not be done by the members of the household, like bathing, help with lavatory, and providing general and family support like shopping, take for a walk, administrative support (filling in forms). Qualified home carers provide hygiene and personal care, some homekeeping activities, they organise the household and they support with psychosocial problems. Finally, specialised home carers support households with complex (psychosocial) problems.

In most regions of the Netherlands there is only one home help or home care organisation. Consequently, people formally do not have a choice when they need home help services. Of course, theoretically it is always possible to organise informal care by family members or friends, or to pay a private help for housekeeping, but the last alternative may be much more expensive. No formal referral is needed, so potential clients can contact the home help services themselves.

Traditionally, the assessment of needs is done by a home help organiser (*leidinggevende gezinsverzorging*): mostly someone with training in social work, who is not involved in direct

patient care. Within the home help organisations this is still the case. The situation in most of the integrated home care organisations is already described in the previous section.

All (former) home help organisations use one standardised assessment form the so-called LIER system (*Landelijk Indicatie en Registratie systeem*; National intake and documentary system). This system is used by the home help organisers to assess and allocate the quality and quantity of home help care. However, within the integrated home care organisations, new assessment forms are being developed suitable for assessing needs for home nursing as well as home help services.

DAY CARE FOR THE ELDERLY

Like in most of the other countries, day care facilities for the elderly in the Netherlands have increased recently. There are organisations or centres which are focused on leisure activities. Day care for frail elderly is provided in nursing homes, old people's homes and specific facilities e.g. for demented elderly.

CONCLUSION

The Dutch health and social system provides a broad range of services and facilities for the elderly. The main formal providers are independent providers and private non-profit organisations. As a consequence care for the elderly is often fragmented. One of the most important policy goals is, therefore, the improvement of the integration and co-ordination of services.

Although the Dutch system includes a lot of residential services, primary health care plays a very important role. The general practitioner is the most important provider of medical care. Home care, both home nursing and home help services, are mainly delivered by private non-profit organisations. In the near future, the provision of these two parts of home care are the responsibility of one integrated home care organisation in each region. This, however, does not mean that also the actual provision of these two services is integrated in the daily practice.

Furthermore private for-profit organisation are involved in home care, but their role is still marginal.

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PRIMARY HEALTH CARE FOR THE ELDERLY IN SPAIN[7]

BACKGROUND

Policy and services for the elderly: a general overview

Spain is a semi-federal state, consisting of seventeen communities that enjoy a considerable amount of autonomy. The national government (in particular the Ministry of Social Affairs) determines the basic legal and financial structure of the social service system (Giarchi, 1996). However the aim is that finally each of the Autonomous Communities (*Comunidades Autónomas*) will be responsible for all social services, including health care, in their area (Ministerio de Sanidad y Consumo, 1989). As yet, competences have been completely transferred to the so-called 'historic communities': the Basque Country, Catalonia, Andalusia, Galicia, Pais Valenciano, and the Balearic islands. These communities now control 35% of all non pension Government spending (Ministerio de Sanidad y Consumo, 1989). In the remaining parts of the country the central government is still mainly responsible for the social security system. There are three main national institutes involved (Delnoij, 1996):

- The National Institute of Social Security (INSS), responsible for financial services (e.g. supplementary benefit, support grants, pensions).
- The National Institute of Social Services (INSERSO), in charge of social services ancillary to those of the social security (e.g. home help services, and other services for the disabled, the aged).
- The National Institute of Health (INSALUD), in charge of running the social security health services.

In comparison to the other European countries, Spain has a relatively young population (Giarchi, 1996). Therefore care for the elderly became a policy issue later than in most other countries and services are still in a developmental stage. In 1973, a new social security law was passed, based on an ambitious plan to build old people's homes (Nijkamp et al., 1991; Delnoij, 1996). Currently, however, the emphasis is on increasing community services for the elderly.

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7 **A significant part of this chapter is already published in:**
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HUTTEN, J.B.F., A. KERKSTRA. Home care in Europe: a country-specific guide to its organization and financing. Aldershot: Arena, 1996.

The main problem in the care for the elderly is how to co-ordinate the different policies (developing community services and at the same time increase the capacity of old people's homes). Striving for co-ordination, the Ministry of Social Affairs has launched the so-called gerontological plan, in which it is outlined that in the year 2000 the total number of residential places should double, unless a growth of community services enables a less dramatic growth (Pacolet & Wilderom, 1991). At the local level policy concerning the elderly is mainly developed in big cities. Currently, town councils are the driving force behind the development of domestic services for the elderly as an alternative to institutionalisation. The two most common community services for the elderly are clubs (*hogares*) and the home help system (*ayuda a domicilio*) (Ministerio de Sanidad y Consumo, 1989). The former are very popular day centres with recreational, medical and integration facilities. The latter, the home help system, is in many aspects new in Spain. Home help services are provided mainly in big cities and they are mostly organised by public authorities.

In addition to the public social support system for the elderly, private voluntary organisations (mostly related to the church) are involved in the care for the elderly. For-profit organisations only play a marginal role (Giarchi, 1996). Though professional help is becoming increasingly important in the Spanish care for the elderly, still the family is the main carer for the elderly like in most of the other South European countries. But, also in Spain, this is changing rapidly due to general developments such as declining family sizes and mobility from rural to urban areas. Therefore it is important that new supporting services will be established.

SOCIAL SECURITY

In Spain, a state pension exists which is income-related. There is a compulsory scheme for employees and a voluntary scheme for the self-employed (Giarchi, 1996). The old age pensions are low, but to a certain extent they are compensated by other benefits, such as free travel, old age pensioners holidays during the low season (October to May), low price meals, and subsidised home care (Nijkamp et al., 1991).

RESIDENTIAL SERVICES FOR THE ELDERLY

Also residential services for the Spanish elderly are still in developmental stage. In contrast to most of the other European countries, Spain is increasing the number of places in residential

services for the elderly. As a result of this development, the institutionalisation of the elderly population has increased recently. At the beginning of the 1990s only 2.6% of the people over 65 lived in old people's homes. It was estimated that a very dependent 5% of the elderly require residential and nursing care (Giarchi, 1996). The lack of residential services is an important point of concern. The government finances old people's homes in the public sector (*residencias proprias*) and in the private sector. In 1989, almost 70% of the places in old people's homes were private, especially run by the Catholic Church (Nijkamp et al., 1991).

The establishment of sheltered houses (*pisos protegidos*) has only started since the end of the 1980s. Most elderly still live in unadapted houses. The hospitals have only recently developed new special units for severely handicapped elderly people (Giarchi, 1996). It is, however, already expected that it will be impossible to meet the demand for these facilities in the next decade.

ORGANISATION OF HEALTH CARE

Since 1986, when the General Health Law (*Ley General de Sanidad*) passed parliament, Spain has been in a process of establishing a National Health Service (*Sistema Nacional de la Salud*) (Boerma et al., 1993). The NHS practically covers the whole Spanish population (about 99%) with the exception of certain self-employed persons and the majority of civil servants, who are members of special private health insurance schemes.

As a NHS, the Spanish health care system is now largely financed through general taxation (approximately 80%) and specific social security contributions which are income-related and shared by employers and employees. The system covers primary health care, hospital care, provision of drugs, ambulance services, and dental extractions (Ministerio de Sanidad y Consumo, 1989). Public primary health care and hospital services are free of charge to the consumer. For drugs a co-insurance rate of 40% is in effect. However, for pensioners, drugs are free of charge (Boerma et al., 1993).

As mentioned, the six historic communities are already in charge of the health care provision in their areas. In the rest of the country the NHS is operated by INSALUD.

The 1986 General Health Law further decrees that within the Autonomous Communities, health services are planned around geographical units: the so-called Health Areas, catering for a population somewhere between 200,000 and 250,000. Each Health Area is subdivided into Basic Health Zones: territorial units for primary health care, in which the health centres are to

operate. In health centres, staff should be grouped in cross-disciplinary medical teams, denominated primary health care teams (Ministerio de Sanidad y Consumo, 1989). In parts of the country where health care is provided through INSALUD, public establishments are run by INSALUD itself, or INSALUD has contracted private physicians and non-profit hospitals (Boerma et al., 1993). Primary health care is usually provided in INSALUD practices, the so-called *consultorios* or *ambulatorios*, in which a minimum staff of a GP, a nurse and a paediatrician is employed. Many *ambulatorios* also employ specialists without hospital privileges (Schneider et al., 1993).

Next to the NHS, a significant private health care supply is developing. In 1989, some 24% of the total population had taken out additional private health insurance, covering the costs of private ambulatory and hospital care (Schneider et al., 1993). The percentage of people with private insurance differs across regions; it is the highest in Catalonia. Private insurance companies are free to fix prices and premiums, which are risk-based and individual (Delnoij, 1996).

Primary health care

The provision of primary health care is changing from an old pattern, in which GPs would work in clinics for two hours a day, to the new system of above mentioned primary health care teams. In these teams, GPs and nurses provide care for six hours a day (Delnoij, 1996).

GPs working in the new primary health care teams are usually salaried, GPs in the traditional *ambulatorios* are paid by capitation, based on the number of 'insurance'-cards held. The average number of cards held by GPs varies from 700 to 1,300. However, insurance coverage extends to financially dependent spouses, children under 26, brothers and sisters under 18, close relatives in an ascendant line and their spouses and, exceptionally, people adopted into the family (Schneider et al., 1993). As a result, as many as five or more members of a household or family may be 'attached' to one insurance card, so that the real population at risk per GP may well vary from 1,300 to 3,500 for the same income and nominal list (Hart, 1990).

In order to visit a specialist, a referral by a GP or paediatrician is required. In the *ambulatorios* a complex three-tier referral system exists: the specialists without hospital privileges, who work in the health centres, for the first line of referral for GPs. If patients should be seen by a hospital-based physician, they are referred a second time by the ambulatory care specialist (Hart, 1990).

Secondary care

Spanish hospital capacity is considered as insufficient. Although there is a network of smaller and larger hospitals in the country, supply is inadequate to meet the increasing demand. Large waiting lists exist: in big cities such as Madrid waiting-time can even exceed to one year (van Kemenade, 1993). Therefore patients with high incomes often consult specialists working in private hospitals.

About one third of the total bed capacity in Spain belong to INSALUD (Delnoij, 1996). The rest is privately owned. In general, the hospitals are funded through global budgets by local authorities or provinces. Hospital physicians are usually paid a fixed salary. As mentioned, a lot of medical specialists work in an ambulatory setting.

Health care figures (1993) (OECD, 1995)

Expenditure	
Total expenditure on health	
Absolute per head in ppp$	972
Percentage of GDP	7.3
Public expenditure on health	
Absolute per head in ppp$	763
Percentage of GDP	5.7
Manpower	
Physicians per 1000 pop.	4.1
GPs per 1000 pop.	n.a
Qualified nurses per 1000 pop.	4.3
Hospital care	
In-patient care	
Beds per 1000 pop.	4.2 (1991)
Admissions per 100 pop.	10.0
Mean length of stay	11.5
Acute hospitals	
Beds per 1000 pop.	3.4 (1991)
Admissions per 100 pop.	10.0
Mean length of stay	9.1
Long-term care	
Beds per 1000 pop.	0.9 (1991)

GENERAL PRACTICE

In the National Health Service general practice is embedded in the primary health care centres. They are mostly the first doctors confronted with health problems and are, in most cases, the gatekeepers of the other health care facilities. Because of the lack of specific community and residential services for the elderly, the GP is a very important carer for this group.

In 1993, NIVEL co-ordinated a large international comparative study of the task profiles of primary health care physicians/general practitioners in 32 European countries. This study also contains information from 577 Spanish doctors: 166 from Basque country, 187 from Andalusia and 224 from Catalonia. Because of the differences in the organisation of health care in the three parts of Spain the results are presented separately. In this section we present the data related to care for the elderly. An important question concerns the first contact with health care when a person experiences a health problems The respondents were asked to what extent patients would in the first instance contact them for 27 health problems. Five problems concerned elderly people (see table).

Percentage of Spanish GPs who are almost(always) or usually the doctor of first contact for the following health problems[1].

	Andalusia (n=187)	Catalonia (n=224)	Basque country (n=166)
Woman aged 60 with deteriorating vision	92.5%	78.0%	95.8%
Woman aged 60 with polyuria	97.9	94.6	98.8
Woman aged 60 with acute symptoms of paralysis/paresis	80.2	77.3	87.1
Man aged 70 with joint pain	99.5	98.2	100.0
Woman aged 75 with moderate memory problems	95.2	95.5	98.2

[1] Source: Task profile study, NIVEL, 1993

In the three Autonomous Communities most participating GPs consider themselves as the doctor of first contact regarding the health problems of the elderly. The GPs in Catalonia are a more likely to share this position with specialists in ophthalmology, internal medicine and neurology than in the Basque Country and Andalusia but, in general, the differences are rather small.

The topic of another question was disease management. It was asked to what extent GPs or primary care physicians were involved in the treatment and follow-up of patients with specific diagnosis. Again we selected conditions relevant to the care of the elderly.

Percentage of GPs involved in the treatment and follow-up of the following diagnoses[1]

	Andalusia (n=187)	Catalonia (n=224)	Basque country (n=166)
Acute cerebro-vascular accident	73.1%	66.8%	68.9%
Congestive heart failure	73.4	75.1	74.8
Myocardial infraction	49.7	40.1	38.9
Chronic bronchitis	98.8	95.9	98.2
Pneumonia	93.0	90.5	93.3
Parkinson's disease	57.9	46.8	38.9
Uncomplicated diabetes type II	96.3	91.3	98.2
Rheumatoid arthritis	74.2	51.1	56.2

[1] Source: Task profile study, NIVEL, 1993

The results show only marginal differences between the three communities. The GPs in Andalusia seem to have the strongest position in this respect because they have a higher percentage which is involved in the treatment and follow-up of the diseases which were selected.

HOME CARE

Home care in Spain is still in its infancy. Domestic support is mainly the responsibility of informal carers such as family members and volunteers. The availability of formal professional home care differs greatly between the regions in the country. For instance, the primary health care teams providing home care have as yet only been introduced in about 50% of Catalonia, and the nurses working in the teams devote little time to nursing patients at home (Delnoij, 1996). The main objective of INSALUD for 1994 was to increase the provision of home care services so that this type of assistance would cover 15% of the population over 65 years of age.
In most of Spain, home nursing and home help services are provided by separate organisations. Home nursing belongs to the health care sector provided by INSALUD or the Autonomous Communities, home help is part of the social services provided by INSERSO or Municipal

Councils (the *Ayuntamientos*). Collaboration between the two types of services is being initiated on an experimental basis. In some regions, there are integrated home care organisations providing both home nursing and home help services. This is the case, for example, in Asturias. There, home nursing and home help take part in the same team. In the integrated teams, nurses and home helps discuss mutual patients during regular meetings.

The general trend in home care and home help services is towards *visita domiciliaria* (home visits) and *cuidados paliativos* (palliative treatment). Many educational programmes are directed to these kind of activities, and efforts are being made to develop these aspects (Delnoij, 1996).

Home nursing care

Home nursing is provided within the new Spanish primary health care system, which now covers approximately 65% of the total Spanish population (Delnoij, 1996). The nurses mainly operate from the primary health centres. They work in the primary health care teams together with GPs, social workers and in some cases home helps. Different programmes for home nursing may coexist within the Autonomous Communities. For example, in Catalonia home nursing is delivered by the *Programa de Atención Domiciliària, Equipos de Soporto (PADES)* and by the primary health care teams, the so-called *Equipos de Atención Primaria (EAP)*. In general, in the Autonomous Communities home nursing is provided by the primary health care teams (EAP) and by home nursing organisations (APD/Zona).

Costs of home nursing care are part of the total budget of the health centres paid by either INSALUD or the Autonomous Communities. There are no co-payments and patients have free access to the service. Private insurance for home nursing does not exist.

No referral from a physician is needed, but patients need a specific document, which is signed by a physician, in order to receive special assistance or drug administration. In order to assess a patient's need for nursing care, standardised assessment forms are used. Assessment takes place during a first visit (a so-called *Visita domiciliaria de valoración*).

All nurses have received a three-year in-service training at a university, resulting in a bachelor's degree. There is no special training for work in primary care, therefore the difference between primary care nurses and hospital nurses is not well defined. It is important to notice that only a

small part of the working time of nurses in primary health care centres is spent on home care: most of their work is done within the centres.

Because of their university training, (primary care) nurses are qualified to perform a wide range of tasks including assessment of the need for care, hygiene and other personal care (e.g. bathing, help with lavatory), routine technical nursing procedures (such as injections, dressings, stoma care, bladder washout) and more complicated technical nursing (e.g. epidural anaesthesia, handling respirator, catheterisation), patient education and psychosocial activities, home making activities (e.g. preparing food and drinks, washing clothes, dishes, shopping etc), and the evaluation of care. In practice, however, not all of these tasks are regularly performed by nurses.

Home help services

Home help services are part of the Spanish social service system (Delnoij, 1996). These services are even more scarcely distributed over the country than home nursing care. On a national level, home help services are the responsibility of INSERSO. This national institution conducts necessary studies, it also co-operates with local authorities and occasionally with private organisations for the provision of home help services, it provides additional home help services in some provinces, processes individual complaints and monitors the activities of the providing organisations, especially in case they do not employ qualified personnel.

In the Autonomous Communities, the Councils of Social Well-being (*Consejerías de Bienestar Social*) are for home help services. Of the seventeen Autonomous Communities, ten still fall under the influence of INSERSO, while the other seven are themselves responsible for the home help services. Local authorities (the *Ayuntamientos, Mancomunidades* and *Diputaciones*) contract providers of home help services. Small municipalities contract individual home helps, whereas larger municipalities delegate the provision of services to private organisations. In some cases, home help is provided directly by employees of the public organisations.

When professional home help services are available in a municipality, there is only one organisation involved. No referral is need and the clients have free access to home help services. The assessment of a patient's needs is done by a social worker in the area. In the area of influence of INSERSO, a standardised form is used to assess the need for home help services. Standardised forms are used also in Autonomous Communities such as the Basque Country. The INSERSO form consists of four chapters: a client's self-reliance in activities of daily living, social and family situation, financial situation and other factors (including mental and physical

health status). On the basis of the number of points a patient has on the form, the number of home help hours is determined.

Two types of professionals work in home help services: social workers and home helps (Delnoij, 1996). Social workers have three-years of university training and hold a bachelor's degree. In order to be a home help only primary education is required. In general most of the Spanish professional home helps operate from a home help services building and work in teams co-ordinated by a social worker. Apart from co-ordination of the teams, *social workers* take care of assessing of the need for care, moral support (e.g. in the form of counselling and advice), encouraging help from family members, neighbours, friends etc., and the evaluation of the provided care. Home helps provide the actual home help services, such as homemaking activities (e.g. preparing meals, washing dishes, washing, ironing etc.), hygiene and other personal care (e.g. bathing, help with lavatory and activities of daily living) and general and family support (e.g. shopping, administrative support).

As a part of the social services in Spain, the costs of home help services are covered by public expenditure. In most municipalities clients have to pay a part of the costs themselves. Co-payments depend often on income. There are differences in this respect outside the zone of influence of INSERSO. In the zone of influence of INSERSO, home help organisations are 90% funded by social welfare administrations. The remaining 10% are financed by clients' out-of-pocket payments. In the seven 'historical communities' this may differ (Delnoij, 1996). Under INSERSO, the budget allocated to home help organisations is based on the number of hours of care delivered. Outside the zone of influence of INSERSO other arrangements may be in effect.

Due to budgetary limitations, the main problem of home help organisations is the existence of waiting lists. Practically all organisations for home help services have waiting lists, though there are no data on how many weeks clients have to wait. A second problem is the shortage of home helps mainly in rural areas. This shortage is caused by a general trend of young people migrating from rural to urban areas, a lower cultural level in rural areas, and the relatively low professional status of the occupation of home help (Delnoij, 1996).

TECHNICAL AIDS

The provision of technical aids for handicapped and elderly people have only recently begun. In some regions a system of renting or lending technical support devices has been developed. The most important problem is, however, that there are not sufficient financial resources available at this moment to meet all the demands.

Technical aids such as wheelchairs, aids for cooking, washing or bathing can be provided within the health care system and as part of the social services system (de Witte et al., 1994). Furthermore also private organisations finance and deliver these devices. Only the elderly with a special certification, showing that they have a kind of disability that justifies the use of the technical aid, can get a device. When it is prescribed in the National Health Service, the system is legally obliged to deliver and finance the device. For products provided in the social services system there is no such obligation: the actual delivery depends on the financial availability.

In the communities that already have full autonomy, the financing is less divided amongst organisations. This is done by appropriate councils and departments (de Witte et al., 1994).

DAY CARE FOR THE ELDERLY

An important facility for the elderly at a local level are the day care centres (*hogares*). They perform leisure, medical, social and cultural activities. About 30% of the elderly in Spain make use of these centres (Nijkamp et al., 1991). About half of these centres are run by public bodies (local authorities, provinces), the private centres are, to a large extent, part of the Catholic church or welfare activities of private companies.

CONCLUSION

Compared to many other countries of Europe, professional services for the Spanish elderly are still in their infancy. Important community services (e.g. home care) but also residential facilities need to be developed. Because of the lack of services, general practitioners (who work in the new primary health care teams) play a highly significant role in care for the elderly. He/she will probably be the most important professional support for all the informal carers (family members as well as volunteers) who still provide most of the help for the elderly.

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PRIMARY HEALTH CARE FOR THE ELDERLY IN THE UNITED KINGDOM[8]

BACKGROUND

Policy and services for the elderly: a general overview

The United Kingdom consists of three countries (England, Wales and Scotland) and a province (Northern Ireland) which have a considerable degree of autonomy in areas such as education, health, housing and social policy. As a consequence the policy and organisation of services for the elderly may differ between them. If necessary, we will point out the main differences in this chapter.

The provision of care and support for the elderly has always been a mixture of state, commercial, voluntary and family sources, but over time the importance of these resources has changed (Baldock, 1991). The National Health Service and Community Care Act of 1991 has implemented fundamental changes in the delivery of care and support for the elderly. The national government is responsible for the legislation of all services and for the funds, health service and grants to municipalities. Before the National Health Service and Community Act became effective, the local authorities provided (personal) social services and housing facilities. Now, the split between purchaser and provider is also made in social services (Lawson et al., 1991). Moreover, a shift from public to private initiatives has occurred. Withdrawal of the state from direct provision of welfare services has led to a changing and uncertain situation in the field of care for the elderly (Baldock, 1991).

Like in most of the European countries, the main aim of the national government regarding the elderly is to maintain people in their own homes as long as possible. Therefore a shift is made from institutional care towards community services for the elderly. In the whole UK about 90% of the elderly live in the community: more than one third live alone (Nijkamp et al., 1991). Traditionally, elderly are often care for by their children. But, because of social-demographic

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changes in the community, formal professional care has become more important to the elderly. There are, however, differences in this respect between the countries and the province. Northern Ireland has a higher potential for informal care than the rest of the UK. The families are larger and family members liver closer to their parents (Giarchi, 1996).

The improvement and strengthening of community services for the elderly is an important focus of policy towards the elderly in the UK. Besides home care services (home nursing and home help services), a number of other community services are available for the elderly in the United Kingdom, such as meals-on-wheels, day centres, community psychiatric nursing, health visiting, and social work. Most of the services are provided by health or local authorities or contracted out to private agencies. The policy in favour of community services is supported in all provinces of the UK. However, the interpretation and available means differ a lot between them. E.g. in Northern Ireland the 26 district councils that are involved have only limited powers and few resources (Giarchi, 1996). In Scotland a higher proportion of public expenditure is devoted to care for the elderly than is seen in other parts of the UK. But, this is mainly spent on institutional care for the elderly. Community care is less well resourced in Scotland than in England.

Recently it has been recognised that a comprehensive system of community services is not enough to maintain people in their own homes. More attention must be given to the often insufficient housing conditions of the elderly (Giarchi, 1996). Elderly people remaining at home in unsuitable houses because there are not enough places available in institutions such as hospitals, old people's homes and nursing homes, must be avoided.

Finally, attention must be paid to the so called Attendance Allowance. This benefit is paid to people who need constant attention and help. Eligibility depends upon a doctor's assessment of the need of the client. His/her income is not taken into account. People receiving this benefit are free to pay it to the carers they prefer: a relative, friend, neighbour or (commercial) care agency. The public social services have encouraged their clients to apply for the allowance and, later on, charge them for the services they receive. In this way the cost of care does not burden the budget of the local authorities.

SOCIAL SECURITY

There is a two-tier pension scheme in the UK: an employment-related flat-rate (state pension) and an earnings-related pension (Giarchi, 1996). The payments in the flat-rate scheme are rather low and only meant to avoid poverty. The other income-related scheme covers employees, self-employed and voluntary contributors. The pension age is 60 for women and 65 for men.

In general, the incomes of the elderly in the UK are relatively low (Nijkamp et al., 1991). Older women living alone are especially near the borders of poverty.

RESIDENTIAL SERVICES FOR THE ELDERLY

About 5% of the British population over 65 live in institutions (old people's homes, nursing homes and hospitals); another 5% live in so called sheltered housing (Tinker, 1992).

Old people's homes are managed by both local authorities as well as private organisations. There is a shift from old people's homes in the public sector to homes which are privately run. An increase of places in private old people's homes of more than 300% is reported between 1976 and 1986, while the number of places in public old people's homes is kept constant in the same period of time (Baldock, 1991). This development was caused by a liberalisation of the reimbursement system in favour of private home owners. However, these regulations have changed again and no further increase of private old people's homes is expected in the near future. One of the important policy measures of the 1990 National Health Service and Community Care Act is a change in the payment of the residential services. The care element of the social security income support for nursing and residential home care was in the old system directly paid to the people through a means-test. Now it is paid to the local authorities which means that potential new applicants need to approach these authorities for support. As a consequence publicly funded places in nursing homes are no longer available without the agreement of the local social services, unless paid for by the health service or the individuals themselves.

For the elderly with severe (mental) handicaps or impairments, beds are available in nursing homes, geriatric and psychiatric hospitals. In recent years, there has been a decrease in reliance on hospital beds, which is only partly compensated for by the growth in the number of places in other residential services.

Another important facility for the elderly is sheltered housing: grouped houses where elderly people can live on their own but can make use of some joint facilities and there is special supervision by resident or peripatetic wardens. This type of housing has mainly developed in the for-profit sector, e.g. by housing associations.

ORGANISATION OF HEALTH CARE

Since 1948, health care has been provided by the National Health Service (NHS). All inhabitants of the United Kingdom are offered free medical care by the NHS, irrespective of income and contribution paid (Boerma et al., 1993). Co-payments are required for e.g. drugs, visual aids, and dental care. Certain patient groups, for instance children, pregnant women, the elderly and persons with certain chronic illness, are excluded from co-payments. The NHS is mainly funded by general taxation, completed by social premiums of employers and employees (National Insurance), co-payments by patients, and reimbursements from private health insurances.

The Department of Health is responsible for the broad arrangements and general policy regarding health, assessment of needs, the definition of priorities, and the allocation of resources.

Since the mid 1980s, the position and functioning of the NHS has been the subject of a lot of discussion. Critics concentrate on the financial situation of the NHS, the cost-effectiveness of the services, the long waiting lists for hospital care, the limited influence of patients on the care provided, and the strong dependency of health professionals and organisations on the political decisions of government and parliament (Maynard, 1990). As a reaction, the so called white paper 'Working for patients' was published in 1989. This policy paper contains a large number of proposals to radically reform the NHS. The central idea is the formation of an internal market introducing competition and market mechanisms (structured incentives) in the provision of health care. A market structure requires a separation between demand or purchase and supply.

In April 1991, the National Health Service and Community Care Act came into force. In the new situation, the District Health Authorities (DHAs) have been reformed and now purchases services for the people in their district. Hospitals and their staff, community nursing organisations and other care agency are the providers and can compete with each other.

The position of the GPs is equivocal: on the one hand they are the independent providers of primary health care, but on the other hand some of them, the so called fundholders, are the purchasers of health care for their own patients.
Parallel to the NHS, there is a private sector which is small in primary care but significant in secondary care and currently increasing, especially in the richer south (McCarthy et al., 1990).

As mentioned there are differences in the organisation of health care in England, Wales, Scotland and Northern Ireland. An important difference between Northern Ireland and the rest of the UK is that social and health services are jointly administered. The Department of Health and Social Services (DHSS) is responsible for health and personal social services, social security and child support. The organisation of social and health care in this part of the UK can be compared to the Irish health board system. There are four Area Boards which are divided into different units such as a community care management unit which is directly involved in the provision of services (HPSS Management Executive, 1996).

Primary health care

Traditionally general practitioners have a central position in the British health care system. Almost the entire population is registered with a general practice. Furthermore, except in an emergency, patients do not have direct access to the hospital. The GP is the gatekeeper which means that the patients need a formal referral if specialist or hospital care is required.
Most of the GPs work in partnerships or group practices: only 10% run a single handed practice (Boerma, 1993). The average personal list consists of less than 2000 patients. The general practice employ a large number of practice nurses who are especially involved in the preventive activities and treatment of the older patients on the GPs' lists.
General practitioners are independent contractors to the NHS, through the Family Health Services Authorities (FHSA). The remuneration of GPs is based on a mixture of a capitation fee per patient (differentiated by age meaning that the fee is higher for elderly patients), special fees for (mostly preventive) activities and special targets and special allowances (e.g. for GPs in deprived areas).
As mentioned, the National Health Service and Community Care Act of 1991 allows GPs to become fundholders on a voluntary basis. GP fundholders are free to negotiate contracts for diagnostic facilities, hospital consultant services and community services such as district

nursing and chiropody within their assigned budget. Prescribing costs are also included in the budget. GP budgets are presently based on previous spending but it is intended that eventually will be determined by list size and relevant characteristics of the practice population. Services for patients of non-fundholding GPs are purchased on their behalf by the DHAs. There is some concern that the scheme might lead to a 'two-tier' service, in which the advantages gained for the patients of fundholding practices are achieved at the expense of patients in other practice. In April 1992, more than 500 fundholding general practices were already established in the United Kingdom.

Next to general practice, primary health care is the domain of the Community trusts which provide home nursing services: a relatively large number of district nurses, health visitors and auxiliaries are involved in home care.

Secondary care

Most of the hospital services in the UK are part of the NHS. Since the reforms all hospitals were transformed into trusts which are operating independently from the DHAs. The DHAs contract the hospitals and make specific arrangements about prices and levels of quality. The hospitals are capable of providing services to a wider range of purchasers and can generate funds in new ways e.g. dispose of assets such as land and borrow money. Hospital specialists have fixed salaries.

There are often complaints about the long waiting list for specialist care in the UK (Fleming, 1993). Therefore, there is an increase of private practices for medical specialist services.

Health care figures (1993) (OECD, 1995)

Expenditure	
Total expenditure on health	
Absolute per head in ppp$	1213
Percentage of GDP	7.1
Public expenditure on health	
Absolute per head in ppp$	1007
Percentage of GDP	5.9
Manpower	
Physicians per 1000 pop.	1.5 (1992)
GPs per 1000 pop.	0.6 (1992)
Qualified nurses per 1000 pop.	4.3 (1988)
Hospital care	
In-patient care	
Beds per 1000 pop.	5.4 (1992)
Admissions per 100 pop.	20.9
Mean length of stay	12.3 (1992)
Acute hospitals	
Beds per 1000 pop.	2.1
Admissions per 100 pop.	19.1
Mean length of stay	5.1
Long-term care	
Beds per 1000 pop.	3.2

GENERAL PRACTICE

In the UK, care for the elderly is mainly the responsibility of primary health care. The role of the GP is crucial in this respect. They treat most of the elderly and are the referrers to other health facilities. An average list of a GP in the UK contains about 15% of patients of 65 year and over; 6% is even above 75. There are, however, large differences between the practice: e.g. in some practice in the south of England, almost half of the patients are elderly (Giarchi, 1996). GPs are not only responsible for the elderly who still live in the community, but they are also the main providers of health care in old people's homes, nursing homes and some hospital wards.

The dominant role of GPs in the care for the elderly is demonstrated by the fact that three-quarters of all elderly have a consultation with their GP at least once a year and one-third at least once a month (Buckley, 1989).

In 1993, NIVEL co-ordinated a large international comparative study of the task profiles of primary health care physicians/general practitioners in 32 European countries. This study also contains information of 297 doctors from the United Kingdom. In this section we present the data related to care for the elderly. An important question concerns first contact to the health care when a person experiences a health problem. The respondents were asked to what extent patients would in the first instance contact them for 27 health problems. Five problems concerned elderly people (see table).

Percentage of British GPs who are almost(always) or usually the doctor of first contact for the following health problems (N=297)[1].

Woman aged 60 with deteriorating vision		79.6%	
Woman aged 60 with polyuria			100.0
Woman aged 60 with acute symptoms of paralysis/paresis		98.6	
Man aged 70 with joint pain			99.3
Woman aged 75 with moderate memory problems	99.3		

[1] Source: Task profile study, NIVEL, 1993

The percentages in this table confirm the important position of GPs in the UK as gatekeeper for their patients. Elderly people will mostly go with their health problems directly to a GP. It is also possible, although to a lesser extent than in most of the other European countries, to go directly to the ophthalmologist in case of deteriorating vision.

The topic of another question was disease management. It was asked to what extent GPs or primary care physicians were involved in the treatment and follow-up of patients with specific diagnosis. Again we selected the conditions relevant for the care for the elderly.

Percentage of GPs involved in the treatment and follow-up of the following diagnoses[1]

Acute cerebro-vascular accident	45.8%
Congestive heart failure	89.0
Myocardial infraction	27.7
Chronic bronchitis	90.8
Pneumonia	96.2
Parkinson's disease	38.4
Uncomplicated diabetes type II	95.0
Rheumatoid arthritis	49.2

[1] Source: Task profile study, NIVEL, 1993

The results show a clear division between conditions such as generally treated in primary health care (such as congestive heart failure, uncomplicated diabetes II, chronic bronchitis and pneumonia) and diseases or conditions which are the domain of specialists (such as myocardial infraction, Parkinson's disease).

HOME CARE

In most parts of the UK, there are still separate organisations for home nursing care on the one hand and home help services on the other hand. Only in Northern Ireland and some parts of Scotland a longer tradition of integrated health and social services exists. However, one of the major conditions for the new approach in home care in the whole UK is an extended co-operation between home nursing and home help services. The new legislation requires e.g. consultation between social services and health agencies. Where more than one agency is involved in arranging for care to be delivered, the service delivery should be co-ordinated so that the users and carers experience a 'seamless' service. A new development is the introduction of the so called care manager to manage the care, from a variety of sources, for each individual. The care manager under the new legislation is supposed to co-ordinate the care. Evidence so far is that they have little influence over the supply of community nursing.

Home nursing care

Community nursing is a part of the National Health Service and, as stated above, the NHS system is going through a period of significant change. Community nursing is still the responsibility of the District Health Authorities or NHS Community Trusts. There were 192 DHAs, but their number has been reduced in favour of the NHS Community Trusts. Most of the remaining DHAs have a community unit within which community nursing is located. Each trust or community unit is usually subdivided into geographical local units for the purpose of management. These units have a manager who may or may not be a nurse. Fundholding GPs may purchase nursing services from the community trusts or community units of the DHAs.

The NHS covers the whole population of the United Kingdom. Additional private health insurance does not cover home nursing services. Public community nursing services are fully funded by the central government from general taxation. No co-payments are required.

There are also private nursing agencies in the United Kingdom, but there is hardly any statistical information available about them. In 1990, there were at least 500 commercial home care organisations caring for an estimated 45,000 people (Fielding, 1990). It must be noted that the nursing care provided by these agencies often differs from the nursing care of the public organisations. The majority of the work of the private nurses contains personal care such as bathing, dressing, and putting a patient back into bed. These private agencies are mostly used by the rich (who have to pay the costs themselves) and in some districts, the NHS community trusts are utilising the private agencies for staff (Hutten, 1996).

The nurses working in home care in the United Kingdom can be divided into four levels of expertise. The highest level are the registered district nurses (RDNs). They have had a three year hospital-based training followed by a nine month training for community nursing (District nursing certificate). The second level are the so called RGNs (registered general nurses) working in the community. They have had three years basic nursing training in a hospital, but no district nursing certificate. Enrolled district nurses, who received a two year training, are the third level of expertise. Although a number of them are still working in the community, enrolled district nurses are not trained any longer. Finally, there are nursing auxiliaries or health care assistants who only receive on the job training which requires no formal qualifications.
Since 1988, there is also differentiation within these four levels. The clinical grading scale consists of nine grades (A through I) with their own task profiles and required qualifications. The G-grade district nurses are mainly involved in the process of (re)assessment, evaluation and co-ordination of care. They have a minor role in the provision of actual nursing procedures. All other types of nurses and assistants provide hygienic and other personal care such as bathing, help with going to the toilet, and assistance with other activities of daily living. Also the stimulation of help from the social network (family members, neighbours and friends) is part of the work of all types of nurses and assistants. Routine technical nursing procedures (e.g. injections, dressings, stoma care and bladder washout) are performed by district nurses. In addition, G and H grade district nurses and specialist nurse are also involved in more complicated nursing procedures such as epidural anaesthesia, handling respirators and catheterization. Patient education and the provision of psychosocial care are also elements of the work of district nurses and specialist nurses.

Home nursing care is mostly provided in the own homes of the elderly, but 6% of the contacts took place in residential accommodation because some of them do not employ nurses themselves.
After the first contact, an assessment visit takes place by the team leader, usually a G-grade district nurse. This assessment of the patient's needs and the decision about the amount, type and duration of the required care is mostly a personal and subjective judgement of the nurse. Within some local teams, standardised assessment forms may be used, but there is no national form available for the whole country.
In most health authorities or trusts, nurses work in a team. There is a distinction between primary health care teams and nursing teams. The latter consists of a team leader, qualified district nurse(s), staff nurse and enrolled nurse(s) or nursing assistant(s). Primary health care teams are multi-disciplinary teams: besides district nurses, GPs, practice nurses, social workers, health visitors and e.g. midwives can participate in these kind of teams.

Home help services

The public home help services are part of the social services, but there are also a number of private home help agencies, especially in wealthier areas (Lawson et al., 1991). The National Health Service and Community Care Act has also important implications for the way in which social services are delivered. The role of local social services authorities is changed from being the provider of a range of services into the purchasing agency role. This means that the social services departments will have to assess the needs of individual clients, arrange individually tailored services to meet those needs, and commission the services as appropriate where possible. More and more, privately managed organisations will be contracted in to provide social services. Local authorities are required to spend 85% of their budgets on independent providers. This means that in an increasing number of local authorities the home help service has been privatised and the staff now work for independent providers who have to negotiate contracts with Local Authority Social Services Department for the provision of home help services (Hutten, 1996). The number of hours bought and provided varies enormously across the UK.
The formal home help organisations are funded for 80% by general taxation. The arrangements about co-payments for the home help services vary among the authorities because there are no national guidelines. A distinction is made between four types of arrangements (Lawson et al., 1991):

1. free service (no co-payment by clients);
2. flat-rate charge (each client pays the same amount regardless of the available means);
3. two-tier system whereby those on supplementary benefit (or equivalent income) receive free service or pay less than the other clients);
4. payment according to means (a means-tested sliding scale is used to determine the amount of co-payment).

Besides home help services from professional organisation, it is also common that domiciliary help is supplied on an individual basis and that the home helps are paid directly by the client.

The actual provision of the services is done by home helps. Generally, the training of the workers is minimal, containing a simple introductory course, accompanying an existing home help, and sometimes participation in a series of in-service courses on particular aspects of caring and safety. There is no formal legislation with regard to training and there is a large variation between local authorities (Lawson et al., 1991).

The actual delivery of home help services differs between the local authorities. Home helps can for example operate from different places such as own homes, health centres, nursing homes or home help services buildings. Also regarding the question of whether they work in teams or alone, no national pattern can be seen, though solo work is by far the most common. There is also a large variation among the authorities regarding the specific tasks of home helps. No national task profile exists by which different kinds of home helps do different tasks. Recently, a shift has been made from domestic to personal care. The statutory home help service has been re-defined in many authorities as 'home care' and the job descriptions of home helps re-written to emphasise provision of care rather than domestic help (Leat & Ungerson, 1991).

Home helps are mostly involved in the following activities: homemaking activities (preparing meals, washing dishes, washing an ironing, cleaning), hygiene and other personal care (bathing, help with activities of daily living) and giving general and family support (shopping, take for a walk, administrative support). Simple routine nursing procedures, moral support, and encouraging help from the social network are not the responsibility of the home helps.

TECHNICAL AIDS

The provision of special supporting devices such as wheelchairs and technical aids for bathing, washing, and household activities is a very complicated system. A lot of organisations can be involved (depending on the type of device and the region) (de Witte et al., 1994). In England and Wales, the provision of ADL equipment and home adaptations is mainly the responsibility of the Social Services Department of the Local Authority. In most cases an application for a device must be supported by a letter from a GP or consultant. The assessment procedure is performed by Occupational Therapists. Devices can be given on loan.

With regard to therapeutic or medical equipment (e.g. mobility aids, hearing aids, etc.) a prescription from a physician, mainly a GP but also in some cases a specialist, is even more essential.

DAY CARE FOR THE ELDERLY

There are day care centres for the elderly which are visited by 5% of the people of 75 and over (Giarchi, 1996).

CONCLUSION

The care system for the elderly in the UK is still in transition. The original system mainly depended on the supply of public social and health services by governmental, district and local authorities. Since the 1990s market mechanisms have been introduced and the system depends, to a larger extent, on private initiatives. This makes it difficult for people in need to get the required care and leads to large differences between authorities.

Historically GPs play an important role in the primary health care for the elderly in the UK. This role is even becoming more significant in the new system.

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