MISSOC Info

Social security & social integration

Long-term care

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Employment & social affairs

European Commission

LONG-TERM CARE

Employment & social affairs

Social security and social integration

European Commission
Directorate-General for Employment and Social Affairs
Unit E.2

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FOREWORD

Some improvements have been made as part of the process of making Missoc (Mutual Information System on Social Protection in the European Union) more user-friendly.

Missoc on the Internet:
The Missoc home page was launched at the beginning of 1999 as an aid to reliable and rapid access to information. The Missoc database can be found at **http://www.europa.eu.int/comm/dg05/soc-prot/missoc99/.** At present the site contains the last version of the database describing the situation that appeared in the most recent printed edition of the 'Comparative Tables'. Thereafter the database will be updated to reflect the situation on 1 January, with a further update planned for the autumn covering the situation on 1 July. The printed edition will continue to appear annually, describing the situation on 1 January each year.

Missoc-Info:
Starting with this edition, the content and design of *Missoc-Info* have been improved. These special editions will be produced from time to time, each dedicated to a specific subject. The subject of this present issue is Member States' experiences of assessing and meeting care needs. We hope that this new approach will improve our ability to provide readers with topical comparable information, a key aim of Missoc.

The Missoc Secretariat

PROVIDING FOR CARE

Providing for care needs is of increasing political interest in Member States, and there has been a wealth of studies and events on the subject. Among these was the study of social protection arrangements for dependent elderly people in need of long-term care in the Member States and Norway, commis-sioned by the European Commission and the Belgian Minister of Social Affairs. The findings of this study, which was coordinated by the Catholic University of Leuven, were presented at a conference in June 1998 under the United Kingdom EU Presidency. The European Commission report *Social protection in Europe 1997* also contains an analysis of developments in Member States (Chapter 7 of the report).

Descriptions of the comprehensive institutional changes some Member States have already made bear witness to the growing importance of providing for the risk of future care needs, which is clearly, but not exclusively, linked to changes in demography.

The format of Missoc comparative tables is not best suited to describing the range of solutions that Member States are adopting in a way that does justice to the subject. Therefore this special edition of Missoc-Info uses a conventional text to describe the variety of provision for the risk of the need for care in the Member States. The material here shows differences in approach: for example whether the need for care is treated as a special risk of ageing or as a social risk regardless of age, and differences in the manner of defining the status of those needing care which are reflected in forms of protection chosen. It also reveals similarities between Member States in protection against the risk of needing care.

The remainder of this introduction offers a brief comparative overview of the various protection systems, with reference to their general principles and those for granting benefits.

General principles

There are three basic approaches to organising social protection for care needs: as an integral part of a universal protection system; under an independent specialised scheme; or under different branches of the social protection system.

Whatever the approach, financing is from tax revenues alone or in combination with contribution income.

Fundamental characteristics

In Denmark, Finland and Sweden, with their universal social insurance, the need for long-term care and assistance arising from age, handicap or invalidity is met by social and health care benefits administered on a decentralised basis by the communities and municipalities.

In the Netherlands insurance is under the general health insurance system.

Germany, Luxembourg and Austria have introduced specialised independent insurance schemes offering capped benefits as partial compensation for the costs of care. Needs above these maxima may be met from social assistance provision.

In Belgium, Greece, Spain, France, Italy and Portugal, benefits are available from the contributions-based protection schemes for various risks (notably the branches for sickness, invalidity, occupational accidents and old age) as well as from minimum incomes schemes. Greece, Spain and Italy also have special programmes administered at local or regional level.

In Ireland and the United Kingdom provision is principally non-contributory. Ireland has a special meanstested care allowance scheme. In the United Kingdom the duty to ensure and fund care lies chiefly with local authorities. Non-contributory benefits under the general scheme help people meet any contribution they must make to costs. In both countries community services under the non-contributory health systems play an important role.

Financing

In Denmark, Ireland, Austria, Finland, Sweden and the United Kingdom, benefits for care requirements are financed from taxes. In the Netherlands, the special benefits provided by the general health insurance are financed through contributions and tax revenues. In Germany care insurance is funded from contributions, additional benefits from taxes. In Luxembourg care insurance benefits are financed

through contributions, taxes and a special levy on the electrical energy industry. In Belgium, Spain, France, Italy, Portugal and Greece, the reliance on various branches of social insurance and social assistance is reflected in a mixture of contributions and tax financing.

Benefits

The need for care is defined in similar terms in all Member States. The key criteria are whether a person requires assistance in carrying out the usual activities of everyday life (such as those related to personal hygiene, nutrition, mobility, and household management) or where there is a risk of self-endangerment. There are clear differences between Member States in benefit entitlement conditions, such as the coverage of schemes and income rules.

Those entitled

Benefits may be available to those in need of care or those providing it in the home.

Persons in need of care

The reason for the need for care, e.g. age, disability, may determine how benefits to meet care needs are granted.

Under the dedicated schemes of Denmark, Germany, Luxembourg, Austria, Sweden, Finland and the Netherlands benefits have no regard to the cause of the need for care. Elsewhere, the cause has a bearing on the source of support, e.g. on which branch of social protection provides care and whether special supplements related to a particular condition are payable.

People giving care in the home

In some Member States informal care in the home is supported by the benefits scheme. This is achieved in a variety of ways: a specific allowance to the carer; the continued payment to them of other social benefits; payments to the person in need of care; or the entitlement to paid leave in order to care for family members.

In Belgium, Ireland, Finland and the United Kingdom an allowance is available for carers. In Denmark, Germany and Luxembourg the person in need of care can opt to receive benefits-in-kind or a cash benefit with which to purchase or compensate the provision of suitable care. Paid leave to care for family members is possible in Italy and Finland.

The pension rights of informal carers may be protected. In Austria, pension contributions are subsidised; in Germany and Luxembourg, they are met in full.

Income limits

The granting of benefits can be based solely on the need for care, or may have regard to income. In the Netherlands costs are met in full without regard to income, while in France, Sweden and Finland income is taken into account. Elsewhere incometesting may apply according to the nature of the scheme. In Denmark benefits for temporary need are meanstested, those for long-term need are not. In Ireland, Italy and the United Kingdom, the position depends on the particular benefit in question; in the other Member States only non-contributory benefits have regard to income.

BELGIUM

COMPETENCE

In Belgium, coverage of health care costs by sickness and disability insurance, particularly the funding of care for nursing-dependent persons in their own homes or in nursing homes, comes within the remit of the federal State. However, social policy and health policy are the responsibility of Community institutions (the Flemish Community, the French-speaking Community and the German-speaking Community) and local institutions.

At Community level, in principle competence extends to what are known as 'customisable' matters (i.e. policy for the elderly, health education and prevention, as well as control over planning (in the case of nursing homes, for instance, competence covers the conditions for their approval and the definition of staff standards, as well as granting subsidies to public or non-profit-making nursing homes). The Community also subsidises personal assistance, particularly home helps, and coordinates home care.

At local level, social policy is primarily the responsibility of the public welfare centres *(Centres publics d'aide sociale — CPAS)*.

There are political difficulties, due to the fact that the powers of the different levels of authority are sometimes very closely related. This applies particularly in the case of sickness insurance, health policy and family welfare.

THE PROBLEM OF NURSING DEPENDENCY

It is primarily in relation to elderly people that the problem of nursing dependency has been raised in Belgium.

During the 1960s and 1970s, care for nursing-dependent elderly people was mainly hospital-based. From the 1980s onwards, attention gradually turned to other forms of residential care and the importance of home care for the elderly was recognised. The development of home care corresponded both to the desire of elderly people to remain in their own family environment for as long as possible and to the concern of the public authorities to curb rises in health spending. Consequently, various legal texts and decrees were issued organising care in such a way as to remedy the loss of autonomy of elderly people and to reduce hospital costs.

In the mid-1980s and in 1983 in particular, it was decided to implement a new hospital policy. This consisted of a general rationalisation of hospital beds and the creation of 'rest and nursing homes' *(maisons de repos et de soins)* especially for elderly people who require the permanent help and assistance of a third party in order to perform the basic activities of daily living. This policy was accompanied by a specific limited financial contribution from sickness insurance for nursing care: this is the fixed-rate system.

In parallel, there was a redefinition of hospitals with the aim of limiting their welfare accommodation function. In 1985, a contribution towards home care was introduced to eliminate gradually financial discrimination between hospital and home care. Hospital geriatric services were also created especially for the diagnosis and short-term treatment of illnesses which are often complex in elderly people.

THE IDEA OF NURSING-DEPENDENCY INSURANCE

Discussions have been in progress for around ten years concerning nursing-dependency insurance (or autonomy insurance) to cover the needs of elderly people. Indeed, difficulties have emerged in organising the protection of elderly (nursing-dependent) people and in health care. Population ageing, the varying degrees of nursing-dependency of elderly people when performing everyday activities, the inadequate and often costly development of home-care services to meet the needs of the elderly, the desire of elderly people to remain at home – or of others to care for them there – for as long as possible, insufficient home helps, the drain on the resources of nursing-dependent persons and sometimes of families obliged to support them, are all issues that are being raised with increasing frequency.

It has been recognised that sickness insurance, which already covers strictly medical aspects, is unable to cover all of the costs relating to nursing-dependency. Consequently, the idea of nursing-dependency insurance was launched in 1990, which was to have been organised by the mutual insurance companies under the supplementary insurance scheme. Member contributions were to be used to allocate a monthly allowance to nursing-dependent persons to cover the extra costs incurred by their situation. The idea sprang from the inexorable growth in assistance costs for elderly people, not only to the beneficiaries themselves, but also to the social security system and the State. The project never came to fruition.

Since 1991, the national institute for sickness and disability insurance *(Institut National d'Assurance Maladie Invalidité — INAMI)* has been granting a daily fixed-rate care allowance to the residents of rest and nursing homes and of nursing homes, as well as to people receiving nursing care at home, the amount of which varies depending on their state of physical and mental dependency (degree of need).

In 1992, the idea of nursing-dependency insurance resurfaced. This time it was to be financed from a supplementary social security contribution by the working and retired population. Once again, the project failed to materialise.

In 1993, the government considered setting up an 'autonomy' insurance scheme. This insurance was meant to cover the supplementary costs incurred by elderly people aged over 65 resulting from a condition of nursing-dependency, to be evaluated not only on the basis of medical criteria but also by taking into account financial and social criteria.

Discussions on the project for organising insurance to cover the risk of a need for assistance and care for the elderly are currently in full swing. This insurance would cover the non-medical costs of care and services for nursing-dependent elderly people (accommodation expenses in nursing homes (retirement homes) and in rest and nursing homes, user charges, etc.).

Private insurance companies have also adopted initiatives, in particular by developing a new personal insurance sector. Several official and private proposals for nursing-dependency insurance have been formulated, in addition to those from welfare organisations.

There is no specific legislation in Belgium addressing the problem of nursing-dependency as a whole. However, various initiatives have been adopted at different levels of authority to remedy this problem.

These initiatives include the following.

The introduction of an allowance for assistance to the elderly

This is a federal grant for disabled persons of at least 65 years of age who have been certified as lacking autonomy or as having reduced autonomy. In order to evaluate the disability, or degree of autonomy, account is taken of their ability to: move around, eat and prepare their meals, wash and dress themselves, clean their home and perform household tasks. Their ability to live without supervision, their awareness of and ability to avoid danger, and their ability to communicate and have social contacts are also taken into consideration.

The allowance for assistance to the elderly is for elderly people who are certified as being in some need of assistance and who satisfy a number of supplementary conditions with regard to age, income, accommodation (residence in Belgium) and nationality (they must be a national of Belgium or of an EU Member State, a refugee, stateless person or person of indeterminate nationality, or have benefited from supplementary family allowance up until the age of 21 years or be able to claim rights under international agreements).

The introduction of an allowance for third-party assistance

This daily fixed-rate allowance is granted to disabled persons who benefit from the disability allowance for people with dependants and who satisfy the criteria for receiving help from a third party.

The introduction of the allowance to compensate for the high health costs of certain groups of chronically sick people

This annual fixed-rate allowance is granted, in certain circumstances, to the chronically sick whose personal contribution towards health costs over a given period rises above a certain threshold.

The introduction of services provided by the community and home services

In hospital: geriatric services, specialised hospital sections, psychogeriatric services, rest and nursing homes, rest homes (or retirement homes).

- Rest homes are mainly for elderly people who are relatively ablebodied. Such people require only limited care but are no longer able to live totally independently. They have a bedroom (either single or with several beds), are housed on a full-board basis and are also able to receive certain types of nursing care.

- Rest and nursing homes are for people who need extensive health and welfare care.

  Outside of hospital: home care, services for assisting families and elderly people, meals-on-wheels services.

In most cases this form of assistance is both less costly and better suited to the desire of elderly people to remain in a familiar environment. It is therefore generally considered to be a priority.

Intermediate care: outpatient hospital care, day care, short stays in a retirement home, night care, service centres, service flats, housing for the elderly, housing developments with services provided. These services are aimed at providing elderly people and their families with the support required to keep the elderly at home. They provide the persons housed there with collective services to match their needs.

FINANCING

The allowance for assistance to the elderly is financed from the federal State budget. The allowance for the help of a third party and the allowance to compensate for the high health costs of certain groups of chronically sick people are funded from the health care and benefits insurance.

The care (services) provided to cover the needs of dependent persons in rest and nursing homes, rest homes or at home is financed in part from the health care insurance for the care itself (including assistance with the activities of daily life) in rest and nursing homes, and in part by the Ministries for Social Affairs in the Communities for support and services.

Residential institutions and home services are managed by the private profit- or non-profit-

making sector and by the public sector. They are subsidised in cases where they meet the standards set by the authority and have obtained the latter's approval.

At local level, centres for coordinating home care provide access to care and services, working to coordinate these where several types of professions are involved. A financial participation is also requested from the beneficiary of care and services. The public welfare centres are required to contribute in cases where the person does not have sufficient income to afford the cost of medicines, care and services. However, this grant must be reimbursed by those who have an obligation to support the beneficiary.

DENMARK

In Denmark there is only one system of care, within which everyone who, due to old-age or disability, needs help and care is entitled to such help from the municipality where he or she lives, at a level that he or she needs in order to live an acceptable existence. This help is part of the help service which the municipalities give their inhabitants.

The care is not dependent on insurance. Care or help is offered to anyone who due to old-age or disability needs it. Help is given either as benefits in kind or as cash benefit in order for the person to arrange the help needed.

Any injury or infirmity, regardless of how it has occurred, where a person is not capable of caring personally for himself or herself, cleaning or shopping or other functions necessary is defined as dependence.

Care requirements are assessed by the municipality in which the person is residing. The municipality makes an individual assessment (if necessary in collaboration with the person's general practitioner), of what kind of help is optimal for the person in question. It is important to underline that while the assessment is based on centrally-decided upper limits, the municipality is free to decide the extent of help/care to be provided within this framework. Variations in the help given by different municipalities can therefore occur.

The municipalities decide on the basis of the fundamental idea that persons who for various reasons cannot function without help are entitled to help, until a level where they are maintained at the maximum stage of self-esteem and independence possible, depending on the actual circumstances.

Elderly and disabled people for whom it is expected that they will always be in need of help/care are entitled to help regardless of their personal income or fortune.

In cases of temporary need in relation to accidents or the like, help is allotted in accordance with the need. Persons receiving such temporary help are expected to pay towards the cost as a function of their personal income.

With the exception of the temporary care for which persons who are capable of paying themselves pay part of the cost, the entire social security system (all included) is financed via taxation, namely municipal taxes or income tax to the State. For persons under 67 the municipality pays 50 % and the State 50 %.

CARE

Benefits are mainly benefits in kind, although this depends on policy in the municipality, and on actual needs.

The fundamental idea is to help persons who require care to be able to remain in their own home as long as possible. Primary care is therefore given as domestic help/care, where necessary in collaboration with the person's general practitioner. Domestic help can be composed of various elements e.g. cleaning, shopping or personal care. If the person's health so requires, a home nurse too is a part of this. There is also the possibility of placing the person in an apartment specially designed for the need of such persons. These apartments are individual and help from nurses is available.

If the person is entirely incapable of taking care of himself or herself, and it is considered to be in the person's interest, the person can be admitted to a rest home. Pensioners admitted to a rest home receive their pension like persons living in their own home, and pay a rent for their apartment or room at the rest home and pay for the different forms of care they actually receive. All of this is likewise intended to preserve the highest level of individual treatment and independence.

Furthermore a person living at home can be attached to a day-care home one or more days a week. This also serves to relieve the partner of the person needing care.

CASH BENEFITS

A person under 67 with a permanently physical or mental impairment and requiring help for more than 20 hours per week can choose to receive cash benefits instead of benefits in kind and engage the help required himself. This, however, is conditional on the person's ability to administer the service himself.

Cash benefits are also given when the person's sickness/handicap results in an increased cost of living, e.g. special diet, clothes, medicine, etc.

Help/care is provided at the lowest level possible depending on individual circumstances and the person's health and general condition.

Family members taking care of and nursing their permanently sick (physically/mentally) children, partner or other close relatives are paid cash benefits by the municipality.

All benefits are a function of the person's need and are paid whether the person receives other social benefits or not. However, overlapping benefits will not be accepted.

CARE INSURANCE ACT

Category of insured persons

Nearly the entire population was incorporated under insurance protection pursuant to the Care Insurance Act. The obligation to insure, however, is not linked to maintaining a domicile or to permanent residence in the Federal Republic of Germany but rather to the existing health insurance protection. Approximately 90 % of the population are covered against the risk of sickness in the statutory health insurance, little less than 9 % in private health insurance and the remainder in special schemes or through special statutory social services systems. Under the Care Insurance Act, the obligation to insure is in accordance with the principle, 'care insurance follows health insurance'. Those insured under the statutory health insurance are incorporated into social care insurance; those insured under private health insurance are obliged to take out private insurance against the risk of needing care as well. In this way, those with private health insurance, and those with social health insurance, have the related risks of sickness and need for care insured through a single organisation. Some of the persons who have their health insurance protection in special schemes or on the basis of special benefits laws were included in the care insurance under the social insurance, and some under private care insurance.

Private care insurance schemes must guarantee that their benefits correspond to those of social care insurance. In addition, private insurance companies were obliged to include those already in need of care under the protection of private care insurance, immediately and in full, and to make adjustments among themselves for those unequal financial burdens arising in particular out of this coverage. Private care insurance must make provision for reasonable conditions and premiums. For example, the highest contribution may not exceed the highest contribution under the social care insurance.

With the introduction of the care insurance on 1 January 1995 the protection against the risk of needing care was put on a new basis. Hitherto the social assistance had had the main burden of bearing the costs of financing care in outpatient and in-patient areas. The care insurance represents in essence a minimum basic protection. If the care insurance benefits, limited according to contributions, are not adequate to ensure care, social assistance covers all care requirements of the person needing care, including the costs for room and board as well as investment costs, in both outpatient and inpatient areas, supplementing the care insurance in cases of need. The assistance for care in accordance with the Federal Social Assistance Act (BSHG) takes over with (supplementary) benefits only if the person in need of care cannot be expected to finance the costs of such care because of his income and financial circumstances.

Entitled persons

Those persons are considered in need of care who — as the result of a physical, mental or emotional illness or a handicap — are expected to need substantial long-term assistance in the execution of normal daily living for at least six months. The substantial need of help covers the areas of bodily hygiene, nutrition, mobility and housekeeping. The determination of whether and to what extent the need for care obtains is made through the medical service. Those in need of care are divided into three categories of care according to the frequency with which assistance is required:

Care category I: Help required at least once daily for at least two of the activities set forth in the legislation and lasting at least 90 minutes;

Care category II: Help required at least three times daily at different times of the day and lasting at least three hours;

Care category III: Help required around the clock, during the night on a regular basis as well, and lasting at least five hours per day.

Assistance by the community of insurance contributors only becomes necessary in the event of a daily requirement of help equal to care category I. If the amount of help required does not rise to this level, it is reasonable to expect the person needing help to finance this help on his or her own, or — in case of need — social assistance may be claimed.

The benefits

The benefits under the care insurance are not dependent upon the insured person's income or assets. Insured persons may begin drawing benefits only following a preliminary insurance period; following completion of a transitional phase in which shorter terms apply, this period shall amount to five years beginning in 2000.

The care insurance provides for benefits for care at home, partial inpatient or complete inpatient care. Priority is placed upon care at home versus partial inpatient care and upon partial versus complete inpatient care. In the case of care at home, in addition to cash benefits, provision is made for benefits in kind as well, for which the care insurance funds pay agreed-upon sums to compensate for services provided by certified institutions up to a level equal to the maximum benefits amounts set forth below.

Care at home since 1 April 1995

The benefits in kind for care at home are graduated according to the degree of need of care, in monthly amounts of:

- for those with a considerable need of care (Category I), up to DEM 750;

- for those severely in need of care (Category II), up to DEM 1 800;
- for those most severely in need of care (Category III), up to DEM 2 800, while in cases of particular hardship the benefits in kind may be increased to a maximum of DEM 3 750.

In place of these benefits in kind, the person in need of care may claim cash benefits if care is ensured through the family of the person involved:

- DEM 400 for those with a considerable need of care;
- DEM 800 for those seriously in need of care;
- DEM 1 300 for those most seriously in need of care.

Cash benefits and benefits in kind may be combined on a *pro rata* basis.

Particularly significant in this connection is the improvement of the old-age protection for those care-givers who, on a weekly basis and not in an employment capacity, provide at least 14 hours of care to a person in need of care in his or her home environment and who, as a result of this provision of care, are not gainfully employed or who are at least not gainfully employed for more than 30 hours per week. The care insurance funds discharge care-givers of their contributions to the statutory pension insurance at a current level of DEM 704 per month. The level of contributions is a function of the degree of severity of the need for care and the range care services it generates. Care is also covered by statutory accident insurance. Through old-age protection for care-givers and the statutory accident insurance, provision of care is in many respects placed in the same category as an occupation with compulsory social insurance contributions.

Additional benefits are provided for in support of care at home:

- underwriting the costs of a substitute care provider once a year for up to four weeks in an amount of up to DEM 2 800;
- day and night care of up to DEM 2 100, depending upon the care category;
- short-term care of up to four weeks per calendar year in the amount of up to DEM 2 800;
- auxiliary materials for provision of care and subsidies toward adaptation of the home according to care needs;
- courses of instruction in the provision of care, free-of-charge, for family members and volunteer care-givers.

Inpatient care since 1 July 1996

In the case of in-patient care, the care insurance underwrites care-related expenses of up to DEM 2 000/2 500/2 800 per month, depending upon the care category. For those most seriously in need of care, in exceptional cases, up to DEM 3 300 per month is available to prevent hardship. The costs for room and board are borne by the person in need of care. Financing for the investment costs of the care facilities devolves upon the *Bundesländer* (German States), and, to the extent that the *Länder* do not bear this financing in its entirety, it is charged separately to the persons in need of care.

Prior to introduction of the care insurance, there was, beyond means-tested social assistance, no general protection against the risk of the need of care; on the contrary, there were only selective regulations, particularly in the statutory accident insurance, under legal compensation, including pensions and related benefits to war victims, and within the framework of assistance for civil servants.

The coexistence of benefits under the care insurance alongside other social benefits for care is dealt with in the following manner: damages benefits now take precedence over care insurance benefits. Claims of a public assistance nature, i.e. claims the award of which depends upon a means test (e.g. social assistance, war victims' assistance, equalisation-of-burdens law), are, in relation to any benefits provided by the care insurance, of secondary importance and in individual cases continue to have a supplementary function.

For handicapped persons needing care in in-patient facilities for the assistance of the handicapped, the care insurance contributes a lump-sum equal to 10 % of the amount payable to the care facility, with a ceiling fixed at DEM 500 per month. The costs over this amount are covered in case of need — as hitherto — by the social assistance, since the objective of such facilities is mainly the integration of the handicapped.

The benefits of the statutory health insurance take precedence: the care insurance funds are obliged to work toward provision of these benefits, above all rehabilitation benefits.

Financing the social care insurance

The social care insurance is financed via current income financing ('pay as you go') through the contributions of the persons insured. A comprehensive financial equalisation is in effect among the social care insurance funds. Essentially, the same regulations governing assessment and payment of contributions are in effect as in the statutory health insurance. As of 1 July 1996, a uniform federal contribution rate is imposed in an amount equal to 1.7 % of income subject to contribution (e.g. of gross salary in the case of employees). Because of the contribution assessment ceiling, contributions may not exceed DEM 107.10 per month. In principle, the contributions are paid half-and-half by the insured persons and the employers (i.e. 0.85 % each). In the case of pensioners, the pension insurance covers one-half of the contribution. The contribu-

tions for the unemployed are paid for by the Federal Labour Office.

It was imperative that the burden to employers resulting from payment of one-half of the contributions be equalised and that an increase in ancillary wage costs be prevented. For this reason, the principle of payment of one-half of contributions was made subject to the condition that the *Bundesland* in which the employee is employed abolish one holiday. Only in the *Bundesland* of Saxony is this not the case, which is why employers there do not pay 0.85 %, but only 0.35 %, of their employees' gross salary as their share of the contribution.

Children entitled to maintenance and spouses whose monthly overall income does not exceed the insignificance threshold (DEM 620 in the old *Länder*) are co-insured free of contribution within the scope of the family insurance.

Organisation of the social care insurance

The social care insurance, which represents the fifth pillar of the German social insurance system, is organised under the roof of the statutory health insurance. A care insurance fund — as a legally independent corporation under public law — has been set up for every health insurance fund. The care insurance fund does not have any administrative personnel of its own; rather, the personnel of the health insurance fund are simultaneously employed in the name of the care insurance fund as well.

Improvement of the care infrastructure and care benefits

More encouragement for investments in the *Bundesländer*, on the one hand, and the creation of new general conditions for employment in the care providers (nursing homes, social service facilities and other outpatient services) on the other hand, has paved the way for the creation and expansion of an adequate, maximally broad-based, high-quality availability of care.

The care insurance funds have the legal task of ensuring, as part of their duty to provide benefits, needs-based and even-handed care for insured persons, consistent with the state of generally recognised medical-nursing knowledge. For this purpose, the care insurance funds enter into care contracts and remuneration agreements for certification and compensation with the nursing homes and outpatient care service agencies. The contractual agreements, which are supplemented by frame-work agreements and quality arrangements, ensure that the homes and the outpatient services make the care services available to the insured persons in need of care as benefits in kind. The content, scope and quality of the benefits, as well as the rates of compensation to be paid, depend on the agreements entered into with the organisations which are responsible for payment costs. In this connection, attention is to be paid to the special fact that the benefits levels of the care insurance funds are capped, whereas the partners to the agreement may agree to higher rates of remuneration, to the benefit or detriment of those in need of care. Thus, the facilities can pass any portion of remuneration in excess of the benefit rates under the care insurance on to the persons in need of care themselves.

ASSISTANCE TOWARD CARE UNDER THE FEDERAL SOCIAL ASSISTANCE ACT (BSHG)

With the introduction of the care insurance (SGB XI), the criteria for need of care and amount of cash benefits for care in § 69a BSHG (Federal Social Assistance Act) were harmonised with the corresponding provisions of SGB XI, so that the benefit recipients in accordance with SGB XI, above all in cases of need for care at home, often are no longer entitled to assistance toward care under the Federal Social Assistance Act. This act is essentially only still responsible:

- for those in need of care who do not fulfil the criteria of Category I of §15 SGB XI ('considerable need of care');
- in cases of cost-intensive (most severe category) care, for which the limited benefits of the care insurance are not sufficient;
- for the financing of the costs of room and board as well as investment costs for care in facilities, which are not covered by the care insurance;
- for persons not insured under the care insurance.

GREECE

The Greek system of social security does not provide for a special insurance branch covering the contingency of dependency. On the contrary, in many cases the concepts of invalidity, dependency and old age overlap.

1. There are contributory benefits in the context of social insurance that could be considered as dependency benefits. First, there is the allowance for persons suffering from paraplegia/tetraplegia to which pensioners and persons affiliated with social security institutions are entitled. Another *sui generis* social security benefit that could be considered as a dependency benefit is the absolute disability allowance. In this case, the amount of an invalidity pension is increased by 50 % if the disabled person is in permanent need of continuous supervision, care and support provided by another person.

2. At the same time, in the context of social welfare seven basic benefits as well as three complementary benefits are provided, aiming at covering persons with special needs (handicapped). These are non-contributory benefits financed through general tax revenues. Basically, they are aimed at covering non-insured invalid persons and are paid without means-testing.

However, benefits are also paid to persons affiliated with social security institutions in cases where such persons cannot be entitled to social security benefits, e.g. no entitlement to the paraplegia/tetraplegia allowance mentioned above. In that case, social welfare also covers insured persons suffering from paraplegia/tetraplegia by offering them the same allowance. Only a few of the above mentioned seven basic and three complementary benefits when granted to certain categories of invalid persons could be considered as dependency benefits. For instance, in the category of blind persons, only allowances for blind children under 18 years of age and the benefits for persons having more than one disability (e.g. blindness plus another invalidity) could be considered as dependency benefits. As such, benefits could be considered as allowances for mentally handicapped persons with a very low intelligence quotient (0-30), persons suffering from haemophilia and AIDS, spastics, seriously disabled persons (67 % invalidity, especially autistic persons), certain categories of persons suffering from paraplegia/tetraplegia. In all the above cases the kind and status of invalidity should be taken into account when considering whether one of the above benefits is a dependency benefit. Moreover, there can be an accumulation of welfare benefits, e.g. in cases where a person has more than one disability.

By contrast, in every case of invalidity, it is first determined whether a person is entitled to social security benefits (such as paraplegia/tetraplegia allowance, absolute disability allowance, etc.). Welfare benefits are either social security benefits substitutes (e.g. in cases of non-insured persons or insured persons not entitled to social security benefits) or complements to social security benefits.

As far as invalidity status test for benefits continuation purposes is concerned, certain categories of invalid persons are checked every second year, whereas for other categories, e.g. seriously disabled persons, spastics, etc.), allowances are granted once and for life.

3. Finally, there are social assistance benefits (social advantages) for the dependent elderly. One of these programmes is 'Help at Home' for elderly persons who are in absolute need of help provided at home by another person in order to meet their basic everyday needs.

A more detailed outline of those mentioned above follows below.

CONTRIBUTORY BENEFITS PAID BY SOCIAL SECURITY INSTITUTIONS

- For pensions granted to persons suffering from paraplegia/tetraplegia and blind persons.
- For absolute disability increment of benefits.

A. Paraplegia/tetraplegia

A benefit is paid in cases of paraplegia/tetraplegia under Law 1140/81. Persons entitled to the benefit are insured persons and the members of their families regardless of age provided that:

- they are at least 67 % medically disabled due to paraplegia/tetraplegia,
- they have been entitled to sickness benefits under the legislation of a social insurance institution,
- they have completed a minimum number of days or years of insurance.

Under Law 2042/92 benefits can be paid even when a beneficiary is active. The amount of the benefit cannot exceed the 20 % of the statutory wage of the unskilled worker (GRD 123 900). Pensioners may also be entitled to this benefit.

B. Old age pension

Qualifying conditions:

- blindness
- invalidity due to paraplegia/tetraplegia
- 4 050 days of insurance
- no age limit
- not being in receipt of an old age or invalidity pension from the special scheme of civil servants or any main insurance fund (except the Organisation of Agricultural Insurance, OGA).

C. Blind persons' benefit

Under Law 612/1977 preferential treatment is provided for blind persons who are affiliated with any social insurance fund supervised by the Ministry of Labour and Social Security.

Beneficiaries are entitled to a full old-age benefit regardless of age limit, if they have completed 15 years or 4 050 days of insurance under the legislation of the relevant fund.

The amount of the benefit (cases B and C) is equal to the amount of old age pension corresponding to 35 years or 10 500 days of insurance.

Absolute disability increment of benefits

The basic amount of disability benefit paid by all social security funds supervised by the Ministry of Labour and Social Security is increased by 50 %, if a disabled beneficiary is in permanent need of continuous care, supervision and support provided by another person (absolute disability).

Under the same conditions, the benefit to which a disabled survivor is entitled is increased by 50 %, while there is no reduction to the benefit to which the other members of the family are entitled.

Absolute disability increment is also paid to old-age pensioners in cases where they become blind.

SEVEN BASIC NON-CONTRIBUTORY WEL-FARE BENEFITS FOR PERSONS WITH SPECIAL NEEDS

Allowance for seriously disabled persons and persons suffering from nephropathy (Beneficiaries in 1997: 47 314)

This allowance is paid to persons suffering from a serious mental disability or nephropathy and elderly persons who are totally disabled, regardless of age limit, provided that they have not been insured or have been insured as an insured person's family member and are not in receipt of any special financial support. The monthly allowance amounts to GRD 41 950.

Allowance for uninsured persons suffering from paraplegia/tetraplegia and maimed persons. (Beneficiaries in 1997: 1 116)

This allowance is paid to the above mentioned persons who are unable to work, regardless of age limit.

The allowance is also paid to:

- any maimed person who has been insured with the Organisation of Agricultural Insurance (OGA) and over 65 years of age, and
- any insured person or pensioner who belongs to the categories in question, provided that he or she does not receive such an allowance from the social security institution to which they have been affiliated.

The monthly allowance amounts to GRD 123 900.

Allowance for deaf/mute persons (Beneficiaries in 1997: 4 050)

This allowance is paid to deaf/mute persons who are 0–18 or above 65 years of age, regardless of their social insurance record. The allowance is also paid to deaf/mute persons who are 18–65 years of age, if they suffer from another chronic physical or mental disease. The monthly allowance amounts to GRD 29 300.

Allowance for mentally handicapped persons (Beneficiaries in 1997: 12 184)

The allowance is paid to mentally handicapped persons with a very low intelligence quotient (0–30), regardless of age limit. The monthly allowance amounts to GRD 55 750.

In cases where beneficiaries are, for the same reason, in receipt of a pension or financial support from another institution, the monthly amount of the allowance is reduced to GRD 36 800 or 50 000.

Allowance for persons suffering from congenital hemolytic anaemia, haemophilia and AIDS (Beneficiaries in 1997: 5 265)

This allowance is paid to persons of the above categories regardless of age limit and its monthly amount comes to GRD 39 750 (for congenital hemolytic anaemia) and GRD 82 800 (for haemophilia and AIDS).

Allowance for blind persons (Beneficiaries in 1997: 21 565)

The allowance is paid to:

- blind active persons as well as blind pensioners (monthly allowance amounts to GRD 31 500);
- blind unemployed and uninsured persons (monthly allowance amounts to GRD 86 900);
- blind insured persons who continue to be covered for medical care after dismissal from their work, as well as blind persons who are insured as members of an insured person's family and are not in receipt of a pension in their own right (monthly allowance amounts to GRD 86 900);
- blind working students up to the age of 25 (monthly allowance amounts to GRD 86 900) and blind working students beyond the age of 25 (monthly allowance amounts to GRD 31 500);
- blind persons from 0 to 18 years of age who do not go to school or are not boarders at boarding school regardless of their social security cover

(monthly allowance amounts to GRD 86 900) as well as blind persons from 0 to 18 of age who either go to school or are boarders at boarding school regardless of their social security cover (monthly allowance amounts to GRD 31 500);

- blind high-school graduates (monthly allowance amounts to GRD 31 500);
- blind lawyers (monthly allowance amounts to GRD 72 450) and blind trainee lawyers (monthly allowance amounts to GRD 60 450).

Allowance for children suffering from cerebral palsy (spastics) (Beneficiaries in 1997: 176)

The allowance is paid to children 0-18 years of age who belong to the above category regardless of their social security cover (monthly allowance amounts to GRD 54 050).

OTHER BENEFITS

Centres for the Protection of the Elderly (KAPI)

These centres aim at:

- preventing biological, psychological and social problems of the elderly;
- coordinating the cooperation of competent institutions and the public sector in dealing with the problems of the elderly;
- researching relevant matters.

They provide:

- entertainment (excursions, summer camps, further education, etc.)
- instructions for medical and pharmaceutical care
- social work
- physiotherapy
- ergotherapy
- help at home, etc.

Currently, a total of 320 centres have been established throughout the country. They fall within the remit of the local authorities and are supervised by the Ministry of Health and Welfare.

The 'Help at home' programme

This is a programme aimed at providing first-rate medical care at home and is applied in cooperation with the local authorities and Centres for the Protection of the Elderly (KAPI).

The programme helps persons and their families, regardless of age and financial status, to cope with their particular problems without having to leave their house and neighbourhood.

There are 102 'Help at home' programmes in operation throughout the country.

The programmes provide:

- medical care and visits at home,
- nursing care and physiotherapy,
- social work within a group, a community or a family,
- various practical services e.g. shopping, payment of bills, visits at home, etc.,
- house cleaning

The staff involved in the programme include doctors, district nurses, physiotherapists, social workers, psychologists, family helpers and volunteers.

The 'need for long term care' risk has not been independently established in Spain, but similar coverage could be found within some of the traditional schemes of the social protection system (both at their contributory and non-contributory levels) or outside these schemes, through certain programmes whose implementation and administration are the responsibility of the different Autonomous Communities. The fact that this risk is not treated as a separate issue prevents establishing a definition of this risk for Spain, but it is possible to say that the coverage of this risk is directed to old age persons and to those people who suffer some incapacity, although it does not entail any grading or scale.

With regard to the benefits included within the contributory level of the system, there is only one benefit related to incapacity. In order to establish the entitlement to this benefit, a certain contribution period is required, as well as a mandatory medical examination confirming that the worker concerned needs assistance from a third party to carry out everyday activities, such as getting dressed, moving around, eating or similar actions. The acknowledgement of the right to this benefit is responsibility of the *Instituto Nacional de la Seguridad Social* (*INSS*). At a non-contributory level, the *Instituto de Migraciones y Servicios Sociales* (*Imserso*) or the relevant autonomous institution is responsible for granting incapacity benefits to persons who suffer from a chronic disease or an incapacity with a level over 65 %, according to the medical examination required, and whose assets or income are below a certain level.

Apart from the social security system, there are some programmes whose establishment and administration are the responsibility of the Autonomous Communities, which apply economic and social criteria in order to establish the entitlement to their benefits.

This type of benefit — whether or not included under the scope of the system — could either be cash benefits or benefits in kind. With regard to cash benefits within the contributory level of the system, the full amount of the 'permanent absolute incapacity benefit' can be increased by an additional 50 %. With regard to the non-contributory level, when the level of incapacity is over 75 % and the assistance of a third party is required, the person concerned will be entitled to an additional 50 % increase. Outside the system, some financial aid can be provided, although the amount depends on the funds that the relevant Autonomous Community allocates for these purposes in its budget.

As for benefits in kind, within or outside the system, they include home assistance, aid to convert homes, sheltered housing, old age homes and residential day care in nursing homes or day centres — with a different specialised assistance for in-patient and outpatient care. There is no time limit for these benefits as long as the need for them persists.

With regard to their financing within the scope of the system, only the 50 % increase of the 'absolute invalidity benefit' — that turns this benefit into 'severe invalidity benefit' — is funded through contributions. The remaining benefits are funded exclusively by the State through taxes. With respect to the Autonomous Communities, these benefits are financed through budget funds, as it has already been noted.

Finally, it must be pointed out that the needs resulting from this new situation are being studied and assessed; for this purpose, a preliminary draft which regulates the situations involving dependence to any extent through cash benefits and other schemes is being drawn up.

SPECIAL DEPENDENCY BENEFIT

Law No 97-60 of 24 January 1997 — which, 'pending the vote on the law instituting an autonomy benefit for dependent elderly people, aims at providing a better response to the needs of elderly people by instituting a special dependency benefit' — has transformed the compensatory allowance for third parties, created for disabled adults in 1975, into a benefit for the care of dependent elderly people.

The special dependency benefit *(Prestation spécifique dépendance — PSD)* is a benefit in kind (i.e. it is granted for the payment of pre-defined expenses). The PSD is designed to cover the assistance needed by dependent elderly persons over the age of 60 with a disposable income under a variable threshold, in their own home or in an institution in order to accomplish basic daily tasks, or if such persons require regular supervision, notwithstanding any care which such persons may be receiving.

The PSD is not a social security benefit but a social welfare benefit. As such, it comes within the remit of the regional councils for each *département*, *(conseils généraux* or regional councils), which finance it out of their social welfare resources, notably by redeploying the share of appropriations formerly earmarked for the compensatory allowance for third parties *(allocation compensatrice pour tierce personne — ACTI)*, a cash benefit awarded to people aged over 60. These resources come from taxes and duties levied by the regional councils.

PSD for home care

The assistance which the PSD beneficiary needs in the home can be provided either by one or more wage-earners directly recruited as home-care workers, or by the employees of a home-care service provider. In the first case, the PSD is paid to its beneficiaries under conditions which do not allow them to pay it in advance; in the second case, it is paid to the home-care service provider.

The home-care worker may be a member of the family employed as a wage-earner (except the spouse or cohabiting partner). The PSD may not be granted to remunerate persons who are themselves already benefiting from an old-age allowance. The PSD may also be paid to persons who, in return for payment, house in their home a dependent elderly person and can be assigned for the payment of the services which they render. A part of the benefit (10 %) may be used for other expenses (disposable sanitary protection, remote alarm service, meals-on-wheels, etc.).

PSD for institutional care

In the case of dependent elderly people in institutions, the PSD is paid to the institution for financing additional costs related to the condition of dependency. Implementation of this principle requires a reform of the price scale for institutions housing dependent elderly people, in order to isolate the costs imposed by the loss of autonomy of the persons being housed. The law sets the general framework for this reform. It is due to be introduced before autumn 2000. Meanwhile, the PSD allocated to people in institutions will be paid to the institution at a reduced rate, in order to contribute to the payment of the total costs of housing the parties concerned.

Characteristics of the special dependency benefit

General conditions for granting the benefit (age, residence, dependency)

Entitlement to PSD starts from the age of 60 for people residing in France (metropolitan France, overseas *départements* and the semi-autonomous region of St Pierre and Miquelon), including foreigners who are able to provide evidence of their uninterrupted residence in France for at least 15 years prior to the age of 70.

The two partners of a couple may each claim the PSD, provided that they both satisfy the conditions for receiving the benefit.

Entitlement to the PSD is subject to certification of a situation of dependency, which is defined as the condition of persons who, notwithstanding any care which they may receive, require assistance in order to accomplish basic daily tasks or need regular supervision (Law No 97-60, Art. 2, para. 3).

The dependency status of the party concerned is evaluated by the medico-social team according to a national scale, called the AGGIR scale (Autonomy, Gerontology, Iso-Resources Group).

This scale includes criteria which enable the medico-social team to classify applicants into six groups, according to the amount of direct aid needed by the person as a result of his condition.

Persons classified into groups 1 to 3 benefit from the PSD, provided that they satisfy the other conditions for receiving the benefit.

- Iso-resources group I corresponds to elderly people who are confined to a bed or armchair whose mental capacities are seriously impaired and who require the essential and continuous presence of care-providers. This group includes the terminally ill.
- Iso-source group II includes two groups of elderly people:
  - those who are confined to a bed or armchair, whose mental capacities are not

totally impaired and who require help in carrying out most basic daily tasks;

— those whose mental capacities are impaired but who have retained their ability to move around (often referred to as 'the perambulatory mentally ill' (*'déments déambulants'*).

- Iso-resource group III corresponds to elderly people who have retained their intellectual capacities, and partially their ability to move around, but who require help for their physical requirements several times a day. Furthermore, the majority of such people are unable to take care of their own hygiene and to eliminate body waste without assistance.

- Iso-resource group IV essentially includes two groups of persons:

  — those who are unable to shift positions themselves but who, once standing, are able to move around within the home. They sometimes have to be assisted with washing and dressing. The great majority are able to feed themselves;

  — those who have no problems in moving around but who need to be helped with bodily functions, as well as with meals.

- Iso-resource group V corresponds to persons who are able to move around their home, eat and dress without help. They require help from time to time to wash, prepare meals and do housework.

- Iso-resource group VI includes all those who are still able to carry out basic daily tasks independently.

Persons who do not fulfil the required conditions for receiving the PSD (people classified in iso-resource groups 4 and 5, as well as persons classified in groups 1 to 3 whose income level exceeds the PSD ceiling) are still entitled to receive domestic help, which comes under the welfare scheme of pension funds.

Means testing

The PSD is subject to means testing: the income ceilings are currently fixed at FRF 72 792 per annum for a single individual and FRF 121 320 per annum for a couple (by way of comparison, the basic old-age pension is FRF 41 650 per annum for a single individual and FRF 74 720 per annum for a couple).

The PSD can be drawn concurrently with the resources of the party concerned and, where applicable, his spouse or cohabiting partner, up to the decreed ceilings (Law, Art. 6, para. 1).

Nevertheless, where the amount of resources available to the applicant and, where applicable, his or her spouse or co-habiting partner during the calendar year preceding the request for benefits, exceeds the decreed ceilings (which differ according to whether or not the party concerned has a spouse or cohabiting partner), the amount of the benefit paid is equal to the amount of the benefit payable, minus the amount of resources exceeding the ceiling.

Allocation of the PSD is not subject to the implementation of the obligation to provide maintenance.

Allocation of the PSD

The application for PSD, accompanied by supporting documents, is sent to the chairman of the regional council of the *département* where the applicant resides. Applicants inform their district council of residence that this application has been submitted.

The PSD application is examined by a medico-social team, at least one member of which visits the person concerned.

PSD for home care

The degree of dependency of the persons concerned determines their need for assistance and supervision, evaluated by the medico-social team. The assistance plan, drawn up by the said team in order to respond to this need, takes into account the persons' environment, and, where necessary, any State assistance or free help which they may be receiving.

The assistance plan, based on the reference cost determined by the chairman of the regional council for the different forms of assistance provided, makes it possible to determine the amount of benefit to be granted, depending on the scale of need.

PSD for institutional care

The dependency status of people housed by an institution for the care of elderly people is evaluated either when the application for benefit is made, or upon admission into an institution, and thereafter periodically by the medico-social team. This evaluation determines the amount of reimbursed expenses which the elderly person will receive, in line with the price scale in application.

The PSD is granted by substantiated decision of the chairman of the regional council.

The maximum and minimum amounts of the PSD are set out in the social welfare regulations of the *département*.

These amounts vary from one *département* to another.

The amount of the PSD that will actually be paid to the beneficiaries depends on the amount of their resources (see point 1.1.4). In addition it is adjusted, according to the regulations of the départe-

ment and the price scale which it establishes for each type of aid, and depending on the amount of supervision and assistance required by the dependency status of the persons concerned, as evaluated by the medico-social team. The amount paid also varies according to whether the individual concerned lives at home or in an institution (Law, Art. 5, para. 2).

The law does not establish the period during which the PSD should be allocated, but stipulates that its allocation should be subject to periodic review.

Rules on drawing PSD concurrently with other benefits

The PSD cannot be drawn concurrently with:

- the allowance for household services or with assistance in kind granted in the form of household services financed from the social welfare system;
- the compensatory allowance for third parties (ACTP) awarded to handicapped people. Entitlement to the compensatory allowance ceases at the age of 60, subject to the provisions for the transition from the ACTP to the PSD. Thus persons who under the former legislation were entitled to receive the ACTP prior to the age of 60, are allowed when they reach the age of 60, and each time this allowance is renewed, to choose whether to continue to receive this allowance or to change to the PSD.
- the supplementary allowance for the constant aid of a third party, allocated to holders of an invalidity pension who are totally incapable of exercising an occupation, and to holders of an old-age pension replacing an invalidity pension.

Recovery of benefits from an inheritance

The sums paid under the PSD are recoverable from the beneficiary's inheritance out of that part of the net assets of the inheritance, defined by common law rules, exceeding FRF 300 000. Only costs exceeding FRF 5 000, for the part exceeding this amount, may be recovered.

Quantified data

The number of PSD beneficiaries is currently around 15 000. However, the scheme is being introduced only gradually into the *départements*. Ultimately the number of beneficiaries should be much higher.

SUPPLEMENTARY ALLOWANCE FOR A THIRD PARTY

People receiving certain social security benefits, who are not eligible for the PSD, may benefit from a supplementary allowance for a third party.

Thus, invalidity, employment injury and old-age pensions may be increased where the holder of the allowance is obliged to resort to the aid of a third party in order to carry out ordinary everyday activities.

The texts do not enumerate the activities that cannot be accomplished. However, in common practice these include basic activities such as getting up, going to bed, dressing, moving around, eating and performing natural bodily functions. In general, the jurisprudence of the national invalidity committee is rather strict about granting this supplementary allowance.

The supplementary allowance for third parties is awarded in addition to invalidity, employment injury or old-age pensions. In the latter case, the necessity of the aid of the third party must be declared prior to the 65th birthday of the old-age pensioner.

The gross amount of the pension is raised by 40 % and this increase may not be less than an annual decreed minimum. This minimum was set at FRF 67 897.45 as from 1 January 1998.

BENEFITS PROVIDED BY THE DEPARTMENT OF SOCIAL, COMMUNITY AND FAMILY AFFAIRS

Social assistance

Carer's allowance

The carer's allowance is a social assistance scheme which was introduced in November 1990. It is an income maintenance payment which is made to people who are providing elderly or incapacitated pensioners or certain persons with disabilities with full-time care and attention and whose incomes fall below certain limits. There were 11 138 persons in receipt of carer's allowance at the end of September 1998, at an estimated annual cost of IEP 45 million.

The *Review of the carer's allowance* (see below) estimates that there are some 40 000 adults in need of full-time care. In addition, there are 9 000 children in need of full-time care.

Conditions for receipt of carer's allowance

To qualify for a carer's allowance a person must satisfy a number of criteria, as follows;

- be aged 18 or over and living in the State
- satisfy a means test
- live with the person(s) being looked after
- care for the person(s) on a full-time basis
- not be employed or self-employed outside the home
- not be living in a hospital, convalescent home or other similar institution

and the person(s) being cared for is/are:

- so disabled as to need full-time care and attention (medical certification is required)
- not normally living in a hospital, home or other similar institution
- aged 66 or over

or

- under the age of 66 and getting a blind person's pension, invalidity pension or disability allowance from the Department of Social, Community and Family Affairs or an equivalent payment from a country covered by EU regulations or a country with which Ireland has a bilateral social security agreement.

People being cared for also include those who transferred from invalidity pension to retirement pension at age 65, or people in a similar situation who are getting a retirement pension from other countries covered by EU regulations or countries with which Ireland has a bilateral social security agreement.

Full-time care and attention

The person(s) being cared for must be so disabled as to require:

- continuous supervision and frequent assistance throughout the day in connection with their normal personal needs, for example, help to walk and get about, eat or drink, wash, bathe, dress, etc.

or

- continuous supervision in order to avoid danger to themselves

and

- so disabled as to be likely to require full-time care and attention for at least 12 months.

Rates of payment

The carer's allowance is a means-tested payment, and income of either spouse/partner, from property or any asset which could bring in an income, will be regarded as means. The first IEP 6 of weekly means will not affect payment but for every extra IEP 2 means, the weekly payment will be reduced by this amount. However, some items such as the carer's residence, child benefit payments, a spouse/partner's social insurance/assistance payment and the first IEP 150 of a spouse/partner's weekly earnings are not counted as means.

	Maximum rate
One person	IEP 73.50 p.w.
More than one person	IEP 110.30 p.w.

Review of the carer's allowance

In October 1998 the Minister for Social, Community and Family Affairs launched the publication of the Review of the carer's allowance. The review, which was carried out by an interdepartmental working group, serves two main functions:

1. It seeks to assess the purpose and future of the carer's allowance and its role in the wider debate on the needs of carers, care in the community, and the demand for long term care.

2. It evaluates the expenditure on this scheme and assesses what is actually being achieved, in line with Government policy to analyse all areas of expenditure systematically.

The following is a summary of the proposals set out in the review.

- Needs assessment — a needs assessment covering both the needs of the care recipient and the carer should be introduced. A working group should be set up to advance the proposals for a multi-disciplinary assessment that will examine a person's care needs for all social and health services. This will allow income support needs to be separated from care needs and will recognise that people requiring care are not a homogeneous group and that, within the caring role, there are differences relating to care intensity, time involved, stress and the abilities of the carers.

- New continual care payment — a new non-means tested 'continual care payment' should be introduced, following the introduction of a needs assessment, for all carers who are providing the highest levels of care, i.e. where the care recipient is highly dependent. The purpose of such a payment would be to promote care in the community and to formally recognise the work of the carer. However, the payment of such a benefit has to be balanced against the view that such a payment would not be targeted at those with an actual income need and it may be the case that carers themselves would, for example, prefer to see additional resources put into respite care which, in theory, would be of benefit to all carers.

- Improvement in carer's allowance — options include:
  - — relax the requirement that the carer must be in residence with the care recipient;
  - — relax the full-time care and attention requirements;
  - — extend the scope of the scheme to allow carers of children in receipt of domiciliary care allowance to apply for carer's allowance;
  - — extend the scope of the scheme to include care recipients between the age of 16 and 65 who are not in receipt of a qualifying payment;
  - — extend the free telephone rental allowance to all recipients of carer's allowance;
  - — pay an additional annual flat-rate payment to all recipients of carer's allowance as a contribution towards respite care;
  - — amend the means-test to give income disregards to all carers in their own right;
  - — amend the PRSI system to preserve the carer's social insurance record.

- Carer's benefit — The introduction of a carer's benefit to facilitate carers in employment to temporarily leave work should be examined further, and a separate consultancy study should be established to consider the introduction of a benefit to insure oneself against being in need of long-term care.

Social insurance

Constant attendance allowance

Where a person is disabled as a result of an accident at work or a prescribed disease contracted at work, a disablement pension is payable where the degree of disablement is 20 % or upwards. A constant attendance allowance can be paid weekly as an increase to a disablement pension if a person is so seriously disabled (at least 50 %) as to require someone to help daily in the home to attend to personal needs for a period of at least six months.

Constant attendance allowance is paid at rates varying from IEP 19.50 per week to IEP 74.60 per week depending on the degree of disablement and the level of care required. The allowance is paid to the disabled person, not to the person providing the care and is not subject to a means test. It cannot be paid where the carer is in receipt of a carer's allowance.

SERVICES PROVIDED BY THE DEPARTMENT OF HEALTH AND CHILDREN

Structure and funding of the Irish health service

Health boards are responsible for providing, directly or indirectly, all health and personal social services in their functional areas. Health services are both institutions- and community-based. The health service is funded through central taxation.

Entitlement

Entitlement to health services is primarily based on means rather than payment of income tax or social security and there are two categories of eligibility. Persons in category one are medical card holders and they are entitled to a full range of public health services free of charge. Persons in category two (non-holders of medical cards) have limited eligibility for health services including an entitlement to public hospital and public consultant treatment subject to only modest statutory charges.

Services available

The range of services available to medical card holders includes general practitioner services, prescribed drugs and medicines, all in-patient public hospital services in public wards including consultant services, dental, ophthalmic and aural services and appliances as well as maternity and infant care service. Non-holders of medical cards are entitled, subject to certain charges, to all in-patient public hospital services in public wards including consultants services and outpatient public hospital services including consultants services. Dental and routine ophthalmic and aural services are excluded from outpatient services available.

Policy

The years ahead — A policy for the elderly, which was published in 1988, provides a framework for the development of health, personal social services and housing to assist older people. The cornerstone of policy towards older people recommended in the report is to support people at home in dignity and independence, and when this is no longer possible, to ensure that ill and dependent older people have access to the highest quality hospital and residential care when they require it. The report outlined what needed to be done to achieve these objectives.

The National Council on Ageing and Older people recently published a review of *The years ahead*. This review provides a comprehensive evaluation of the extent to which the recommendations of *The years ahead* have been implemented and points to areas where a reorientation of policy may be required.

1998 developments

IIn this connection, in the current year over IEP 7 million additional revenue funding has been put into health services for older people. This will provide, amongst other things, staffing for new and existing community nursing units and expansion of community services in order to improve support for older people in their homes. Funding has also been provided for the establishment of specialist services for older people with mental health problems.

Capital programme

In addition, a capital programme of IEP 14 million has been put in place which is more than twice the level previously allocated for older people. It is the intention that this investment will accelerate the provision of extended care facilities, including community nursing units and day care facilities for older people throughout the country, as well as enhancing existing services.

Nursing home care

Health (Nursing Homes) Act, 1990

The Health (Nursing Homes) Act, 1990, which came into effect on 1 September 1993, has two principal objectives. The first is to ensure high standards of accommodation and care in all nursing homes registered under the Act and the second is to provide a new system of nursing home subvention so that dependent persons most in need of nursing home care will have access to such care. The subvention scheme provided for in the Act is intended to assist persons in need of nursing home care in meeting the cost of such care but is not intended to meet the full costs involved.

Number of people in receipt of subventions

At 31 December 1997, 380 homes had been registered, 24 027 applications for nursing home subventions had been received and 12 920 approved. At this date 6 080 were actually already in receipt of subvention.

Rates of payment

There are three maximum rates of subvention payable in accordance with the three levels of dependency which are eligible for subvention. These rates are IEP 70 per week, IEP 95 per week and IEP 120 per week.

Hospital-based services for older people

Specialist departments in medicine of old age

It has long been recognised that older people have particular medical needs that can be dealt with most effectively in a specialist department in medicine of old age located in an acute general hospital. In 1988 there were eight such departments attached to general hospitals. This number has now risen to 25, with one in all Health Board areas. The number of consultants in geriatric medicine has risen to 27.

Day hospitals

Day hospitals are a facility on the campus of either an acute hospital or a community hospital, providing secondary level health care. They enable the investigation, treatment and rehabilitation of older patients without the need to stay overnight. There are currently 54 day hospitals in operation throughout the Boards.

Assessment and rehabilitation

Community hospitals are smaller hospitals which have either been purpose built or adapted from geriatric homes and district hospitals, based in the community, with the aim of providing high quality care to older people closer to their homes. They are also designed to reduce the demand on general hospitals. The range of services available in these hospitals includes respite, day care, extended care, convalescence, day hospital and day care. Assessment and rehabilitation services are provided in some of these hospitals but these services need to be further developed.

Community-based services

Home helps

There are almost 12 000 home helps in-volved in the health services, of whom a significant proportion are engaged by voluntary bodies. The vast majority work part-time and their earnings are excluded from social welfare means tests. The number of beneficiaries of the home help service throughout the country is around 20 000.

The current cost of the service is approximately IEP 19 million per annum. The important role

played by home helps in the care of older people is widely recognised and there is a growing demand for the home help service to be better organised and developed. In this regard an examination of the operation of the home help services is currently being finalised.

Respite care

Respite care has been defined as 'temporary care, either community or centre based, which provides relief and personal development opportunities for the carer and the person requiring care within a variety of facilities. The need for care ranges from crisis intervention to planned regular breaks'. Carers require relief care of various kinds, i.e. day centres, short-term and holiday relief care, night-sitting (freeing the carer for a number of hours) and domiciliary relief care.

The provision of respite beds is a vital part of the support services for carers. This facility enables the person requiring care to be admitted to a facility for up two weeks to enable the carer to have a break. The number of times a person may be admitted annually to a facility will depend on the individual needs of the carer and the person concerned, particularly the level of dependency. Respite beds are now provided as part of all new extended care facilities being constructed by health boards.

Day care

Day care centres provide facilities for older people to meet on a social basis in the locality. The centres provide services such as a midday meal, a bath, physiotherapy, occupational therapy, chiropody, laundry and hairdressing. They promote social contact among older people and prevent loneliness. The centres relieve caring relatives, particularly those who have to go to work, of the responsibility of caring for elderly persons during the day. Finally, they provide social stimulation in a safe environment, particularly for older people with mild forms of dementia.

Community ward teams

In recent years, professional support staff have been appointed by the Eastern Health Board to work with older people in their homes. These are known as community ward teams and they facilitate the early planned discharge of older people from acute general hospitals by the provision of rehabilitation and care in the person's home. They also prevent, or delay, the admission of older people to long-stay care and enhances other service supports including public health nursing, carer support and respite services. As a result, more dependent older people are maintained in their own home.

Dementia information centre

A dementia information centre has been established in Dublin. It is planned that this service will provide information and assistance to carers and be able to respond to enquiries from the public.

Elderly mentally infirm

The development of mental health services for older people, both in terms of functional mental illness and dementia has been identified by the Department as a priority. This will include the development of inpatient and respite and day care services and, particularly, the appointment of consultants in psychiatry of old age. Over IEP 1 million has been allocated to the health boards in 1998 to enable Consultants in the psychiatry of old age to be appointed in health boards where no such service exists.

ITALY

In Italy there is no legal definition of dependency. Italian legislation provides for benefits that can be considered as dependency benefits under both the social security and the social welfare scheme.

BENEFITS FOR DEPENDENT PERSONS UNDER THE SOCIAL SECURITY SCHEME

The main aim of benefits for dependent persons under the social security scheme is to provide home care, generally in the form of cash benefits. The law does not usually stipulate age conditions for obtaining this type of benefit, the only condition being the degree of disability.

The following are the principal benefits.

- The ordinary disability pension: this type of benefit is not dependent on age but on the degree of disability. According to Italian legislation, individuals are considered disabled if they are permanently and totally unable to work. The person concerned must have made a minimal contribution to the IMPS for five years and be submitted to a regular check every three years. If disability is still observed after three consecutive checks, the person concerned will be acknowledged as permanently disabled.

- The monthly personal assistance allowance for persons on a disability pension: this allowance is granted, on the basis of disability, to pensioners who need the help of a third party to move around, or who require permanent assistance in order to carry out basic daily tasks.

- Social security cover for non-professional and non-remunerated carers: Italian legislation does not provide any specific benefit to cover employment injuries or sickness for people taking care of dependent persons. Law No 104 of 5.2.1992 provides for the possibility of leaving a professional activity for a period of three days per month in order to take care of dependent persons. Such periods are taken into consideration for insurance purposes.

DEPENDENCY BENEFITS UNDER THE SOCIAL WELFARE SCHEME

As indicated above, dependency also comes under the social welfare scheme. Different benefits are provided at national level, depending on the type and degree of invalidity, for the blind, the deaf-and-dumb and non-working invalids, and come within the remit of the Ministry of the Interior.

These cash benefits are granted without means testing and are financed exclusively by the State:

- a monthly pension of ITL 388 000 in 1998 which cannot be paid to survivors;

- a monthly carer's allowance of ITL 783 000, granted to people who are unable to accomplish basic daily tasks;

- a monthly 'communication' allowance of ITL 318 000 in 1998, for people who are totally deaf-and-dumb;

- a monthly education allowance of ITL 388 000, for the social integration of young people aged under 18 into a school or vocational training.

At regional level, there are also benefits which may be considered as dependency benefits. These are essentially benefits for very elderly people, which are provided in cash or in kind depending on the region. Major differences exist between the regions in this matter. All of the benefits are financed out of local taxes or from State appropriations.

In general, the support provided is as follows:

- Elderly people
  - — domestic assistance: housework, nursing care;
  - — financial cash assistance (means-tested) and contribution towards special requirements, allowing elderly people to stay at home;
  - — housing service: this refers to residential communities organised differently depending on the elderly person's degree of autonomy and family situation.

- Handicapped people

Here we find all of the benefits already mentioned, adapted of course to the specific needs of the beneficiaries. With regard to financial assistance, provision is made for contributing towards:

- — the purchase of prostheses or other necessary medical equipment;
- — the purchase or modification of private means of transport;
- — the removal of architectural obstacles in both offices and private homes;
- — the purchase of tools making it possible to carry out a self-employed activity.

LUXEMBOURG

A new law concerning dependency insurance came into force in Luxembourg on 1 July 1998, with the exception of certain articles concerning benefits and financing which did not take effect until 1 January 1999. The main aim of this law is to ensure cover for care and assistance to dependent persons, who are receiving home care or have been placed in a care and assistance institution, by providing:

- benefits in kind;
- products needed for care and assistance, equipment and home conversions.

For dependent persons receiving home care, this cover may also include cash benefits and measures to assist carers.

DEFINITION OF DEPENDENCY

Dependency is considered to be the condition of a person who, following a physical, mental or psychiatric illness or deficiency of a similar nature, regularly needs a considerable amount of assistance from a third party in order to carry out basic daily tasks.

Basic daily tasks cover:

- personal hygiene: washing, brushing teeth, skin care, bodily functions;
- nutrition: preparation of suitable nourishment and assistance in taking this nourishment;
- mobility: shifting and changing position, getting dressed and undressed, moving around, maintaining the correct posture, going up and down stairs, and leaving and entering the home.

DETERMINATION OF DEPENDENCY

The amount and frequency of the care and assistance required by the dependent person are evaluated by means of a questionnaire and determined, in accordance with a standard allocation, in the plan for the reimbursement of expenses.

Apart from basic daily tasks, the standard allocation includes:

- certain domestic tasks: mainly shopping, housework, ensuring that essential equipment is maintained, washing dishes, and laundering and upkeep of household linen and clothing;
- support: attendance of a specialised day centre, shopping and outings with the dependant person, individual carer and household aid;
- counselling for the different basic daily tasks and counselling for the family and household members.

The standard allocation type allows a standard period for providing the different types of care and assistance. The standard period can be weighted by means of a coefficient that takes into account the intensity of the care and assistance, or the qualifications required for the professionals dispensing them. Such weighting applies to all of the different periods for providing the planned care and assistance.

A plan for the reimbursement of expenses, established jointly with the beneficiaries or with the members of their family and the care and assistance network or institution, determines, on the basis of the standard allocation, the duration of the care and assistance to be provided by a care and assistance network in the case of home care, or by a care and assistance institution.

For children, dependency status is determined on the basis of whether the supplementary assistance of a third party is required, compared with a child of the same age who is sound in body and mind.

BENEFICIARIES

The benefits are accessible to persons who are covered by sickness insurance.

However, those who have taken out an optional sickness insurance are entitled to benefits only after an insurance waiting period of one year. The rules concerning the maintenance of rights in the case of sickness insurance apply also to dependency.

BENEFITS

The aim of dependency insurance is, at least in part, to offset the heavy costs generated by care and the need for the assistance of a third party to carry out basic daily tasks. Reimbursement of these expenses by the local authorities is justified, both by the general nature and uniformity of the risk which can affect anyone at any age, and by the size of the costs, which can hardly be assumed by one person alone, or even by their family, without jeopardising their material survival. Dependency insurance therefore creates an unconditional entitlement to benefits, i.e. without means-testing of the dependent persons.

Priority is given to home care rather than to housing dependants in an institution. This priority stems from a concern to allow everyone to live for as long as possible under favourable conditions in their own home, thereby avoiding early recourse to care institutions. In order to maintain this priority, the dependency insurance provides several types of benefit within the framework of home care:

- benefits in kind, designed to remunerate specialised professional services;
- cash benefits, which can be combined with bene-

fits in kind and are designed to remunerate persons who do not belong to such a service;

- various support measures to provide for the replacement and social security cover of the above-mentioned persons;

- the provision of special equipment and home conversions.

Benefits in the case of home care

Benefits in kind in the case of home care consist of the reimbursement of expenses for care and assistance for basic daily tasks, up to a weekly limit as determined above, without such reimbursement of expenses exceeding 24.5 hours per week for basic daily tasks.

This reimbursement of expenses may be increased by 2.5 hours per week for household tasks. This fixed sum may be increased to four hours per week should this be certified as necessary by the competent institution.

Care activities are covered by the insurance for a period not exceeding 12 hours per week.

The amount of benefits in kind available from care and assistance institutions and networks is determined by multiplying the weekly duration of required care by the cash values negotiated separately each year by the organisation managing the dependency insurance with professional organisation(s) of care and assistance providers. Notwithstanding the aforesaid provisions, the cash values for 1989 and 2000 are determined by a Grand-Duchy regulation which is in the process of being drawn up.

The benefits in kind may be replaced by a cash benefit, insofar as the latter is used to provide care and assistance covered by the plan for the reimbursement of expenses to dependent persons in their home, unrelated with any care and assistance network.

Benefits in kind may be replaced by a cash benefit only up to a limit of seven hours per week. If the entitlement to benefits in kind is greater than seven hours per week, the replacement may, in addition, cover half of the benefits in kind of between 7 and 14 hours per week.

The amount of the cash benefit totals half of the value of the benefits in kind which it replaces.

The cash benefits are not subject to social security and tax deductions. They can be neither seized nor transferred.

Without prejudice to the benefits granted in cash or in kind, dependent persons are entitled, in the case of home care, to reimbursement of the cost of the products needed for care and assistance, as well as of the equipment and home conversions required to allow them to maintain or enhance their independence.

The apparatus is hired to the dependent persons at the expense of the dependency insurance, if such apparatus is included in the list proposed by the advisory committee. If it is not possible or advisable to hire such apparatus, the dependency insurance reimburses the necessary apparatus within the support limitations set by the competent institution and taking into account the specific needs of the dependent person.

The dependency insurance reimburses the contributions to pension insurance for anyone who, before the age of 65, provides care and assistance to dependent persons in their home, unrelated with a care and assistance network, up to a contribution limit calculated on the basis of the contributory scale.

In order to ensure the replacement of one or more persons providing care and assistance to the dependent person at home, the insurance annually reimburses, for three weeks, double the amount of the cash benefit and, in the case of a temporary stay in a care institution, the required care and assistance in addition.

Benefits in a care institution

Where dependent persons receive care and assistance in an institution, they are entitled to the reimbursement of benefits in kind under the same provisions as those which apply to home care.

A Grand-Duchy regulation which is in the process of being drawn up may provide for reimbursement in care and assistance institutions, in line with a fixed rate to be determined in accordance with the levels of dependency, without the maximum fixed sum exceeding LUF 16 800 (n.i. 100) per month.

In care and assistance institutions, the maximum of 24.5 hours per week allowed for help with basic daily tasks may be increased to 31.5 hours per week for exceptionally serious cases duly certified by the competent institution.

ENTITLEMENT TO BENEFITS

Benefits are payable at the earliest as from the day of submitting the request. Benefits may be granted for a fixed or indefinite period.

Benefits in kind are granted in the form of direct reimbursement of expenses by the organisation managing the dependency insurance, with the provider having a claim on the person covered only for the portion in excess of the reimbursement by the insurance.

Benefits are payable weekly. If the right to benefits does not extend to a full week, each day counts as one-seventh of a week.

Benefits in kind are paid following the month for which they are owed.

The benefits are reviewed following further evaluation, carried out either at the request of the beneficiaries, members of their family, the care and assistance network or institution providing the services, or at the initiative of the organisation managing the dependency insurance or the evaluation and guidance unit.

The benefit is re-evaluated in line with the criteria for determining dependency. All dependency insurance benefit is with-drawn should the conditions which gave rise to it no longer apply.

RELATIONS WITH CARE AND ASSISTANCE PROVIDERS

Any institutions which house dependent persons day and night, by providing them with the required care and assistance in accordance with their dependency status, are considered as care and assistance institutions according to the legislation on dependency.

The public or private care and assistance institution must be approved and have concluded an institutional care and assistance contract with the organisation managing the dependency insurance.

All of the care and assistance provided within the framework of a care and assistance network and unrelated with a care and assistance institution, may be provided by persons approved to carry out such activities and who have concluded a home care and assistance contract with the organisation managing the dependency insurance. The care and assistance contract is concluded for an indefinite period. It may be terminated by either of the parties, subject to six months' notice.

It is compulsory for the institutional care and assistance contract to include an undertaking from the institution to respect the conditions relating to the following points:

- undertaking to provide the dependent person with all of the care and assistance set out in the plan for the reimbursement of expenses;
- documentation required for the care and assistance provided under dependency insurance;
- terms for the payment of the services provided;
- undertaking to declare available places to the evaluation and guidance unit;
- terms and conditions according to which the dependent person subscribes to the contract for the reimbursement of expenses and is able to terminate it;
- undertaking to keep cost accounts in accordance with a uniform chart of accounts.

It is mandatory for the home care and assistance contract to include an undertaking from the service providers to respect the conditions relating to the following points:

- provision of care and assistance to the dependent person in line with the plan for the reimbursement of expenses;
- coordination for this person of not only the care and assistance services defined under the dependency insurance, but also all of the services and care providers required to provide home care to the dependent person;
- continuous provision of care and assistance, day and night, every day of the year;
- definition of the group of persons covered by the insurance;
- provision of care in line with the quality rules determined by the authority which issued the approval, and under the latter's control;
- the requisite documentation, invoicing and payment of the services provided;
- keeping of cost accounts in line with a uniform chart of accounts;
- terms and conditions according to which the dependent person:
  - — subscribes to the contract for the reimbursement of expenses and is able to terminate it
  - — is able to instigate changes to such reimbursement.

FINANCING OF DEPENDENCY INSURANCE

In order to pay the charges incumbent on it, the system applied by the dependency insurance is to distribute charges by setting up a reserve of no less than 10 % and no more than 20 % of the annual amount of current expenses.

Apart from investment income and any other resources, the resources required to finance the insurance are comprised as follows:

- 45 % of total expenditure, including the appropriation to the reserve, comes from a contribution from the State budget;
- a special contribution, consisting of the charge payable by the electrical power sector, of which two-thirds of the 3.5 % surcharge is allocated to financing the dependency insurance;
- the remainder comes from a dependency contribution, as determined above.

Dependency contribution

The assessment of the dependency contribution is based on earned income and replacement earnings, as well as income from property.

The rate of the dependency contribution is fixed at 1 %. The dependency contribution based on earned income and replacement earnings is payable by the persons insured under the sickness insurance scheme.

The dependency contribution on earned income and replacement earnings is determined according to the assessment basis for health care, but without applying the minimum and maximum contributions payable.

For persons earning a salary, or receiving a replacement benefit from social security, the monthly assessment basis is reduced by the equivalent of one quarter of the basic minimum wage for unskilled workers aged at least 18.

The dependency contribution is established and collected by the joint centre for social security in accordance with the provisions for social security contributions.

The establishment and collection, on behalf of the organisation managing the dependency insurance, of the dependency contribution on income from property is the responsibility of the administration for direct taxation. The same applies to the dependency contribution levied on the basis of the net income earned from pensions or private capital in accordance with the aforementioned law, with the exception of personal pensions or survivor's pensions paid by virtue of the legislation on Luxembourg social security and the regulations on statutory pensions.

Contribution payable by the State

With regard to the State contribution of 45 % of the total costs of the dependency insurance, the State is obliged to pay monthly in advance.

Asset management

The organisation managing the dependency insurance places the financial reserve in short-term investments with one or more credit institutions approved by the minister responsible for social security.

The management organisation is only allowed to take out loans or to benefit from lines of credit in order to cope with cash-flow problems. The term of such loans or lines of credit may not exceed one year and they must be authorised by the minister responsible for social security.

THE ORGANISATION MANAGING THE DEPENDENCY INSURANCE

The dependency insurance is managed by the union of sickness insurance funds. (Pending the introduction of dependency insurance, the powers devolved to the management organisation are provisionally being exercised by the general inspectorate for social security until 1 January 1999.)

To this end, the board of directors is responsible for:

- deciding on the annual budget and the annual statement of revenues and expenditure for the dependency insurance, to be approved by the minister responsible for social security, with the advice of the supervisory authority;
- preparing the negotiations to be conducted by the chairman or his/her representative with the care and assistance providers and giving its opinion on the result of these negotiations;
- taking individual decisions about benefits.

For such matters, the deliberations of the board of directors do not include the five employers' representatives.

Evaluation and guidance unit

The law which introduced a dependency insurance created an evaluation and guidance unit which is responsible for:

- certifying dependency status and determining the care and assistance required;
- issuing opinions concerning the allocation of benefits, provision of the necessary products, equipment and home conversions, as well as measures for withdrawing benefits;
- where required, proposing measures for physiotherapy and rehabilitation;
- proposing home care or admission to a care and assistance institution;
- determining a plan for the reimbursement of expenses for use by the network responsible for coordinating care and assistance for the dependent person, in the case of home care, or by the care and assistance institution;
- classifying dependent persons for admission into an institution, in accordance with emergency criteria for both the condition of the dependent persons and their family's ability to care for them;

- centralising the data about provision in an institution or a day-care or night-care centre;

- advising the organisation managing the dependency insurance and the ministries responsible for financing infrastructure and for approving care and assistance services and institutions about setting up an infrastructure suited to the needs of the dependent population which is both of high quality and economically effective. To this end, it prepares a report each year;

- informing and advising the persons covered, doctors and the care and assistance professions, about preventing dependency and caring for dependent persons.

The opinions of the evaluation and guidance unit on individual cases, in accordance with their powers to certify dependency and allocate benefits, are binding on the organisation managing the dependency insurance.

The evaluation and guidance unit is a public service which comes under the authority of the minister responsible for social security. In administrative terms it is attached to the general inspectorate for social security.

THE NETHERLANDS

INTRODUCTION

In the Netherlands, the risk of needing long-term care has been covered within a traditional branch of the general health insurance system since 1968. Long-term care, treatments and services that cannot be insured by individuals through private insurance are largely covered by the Exceptional Medical Expenses Act (AWBZ). The target group for services provided under the Act has expanded significantly, becoming much more diverse over the past few years. This group presently comprises long-term hospitalised patients, elderly people, the disabled and mentally disabled patients with chronic problems. Long-term care is provided in the form of benefits in kind.

NATURE OF THE SCHEME

Insurance under the Exceptional Medical Expenses Act is statutory: everyone meeting the criteria set in the Act is insured – whether or not they wish to make use of the treatments and services offered – and they must pay the relevant contributions.

ELIGIBILITY FOR COVER

As a national insurance scheme, the Exceptional Medical Expenses Act covers:

- *People resident in the Netherlands:* Whether someone is regarded as resident in this country is decided in the light of the circumstances of each case (with Dutch-based ships and aircraft being considered part of the Netherlands for this purpose). Indeed, the courts have determined that under certain circumstances even people currently living outside the Netherlands may be regarded as resident for the purposes of the Act, generally provided that their social and economic links with this country are such that it can nevertheless be regarded as their home. By contrast, a person who has a house in this country may not be regarded as resident in the Netherlands for the purposes of the Act.

- *Non-residents:* Non-residents liable to Dutch wages and salaries tax in connection with employment in the Netherlands: this category comprises mainly cross-border commuters and guest workers. The general rule that everyone resident in the Netherlands is covered by the Exceptional Medical Expenses Act applies regardless of nationality.

REGISTRATION AND ADMINISTRATION

Entitlement to services provided under the Exceptional Medical Expenses Act depends, according to the Act, on registration with one of the bodies that implement the Act.

To ensure their entitlement to the services provided under the Act, insured persons residing abroad must register with one of the bodies authorised to implement the Act in the Netherlands. Registration is governed by the same regulations that are applicable to residents of the Netherlands.

ENTITLEMENT TO CARE/BENEFITS

Registration with one of the bodies that implement the Exceptional Medical Expenses Act confers entitlement to preventive care, medical treatment, nursing and care, services aimed at maintaining, restoring or enhancing capacity for work or improving quality of life, and social services. The Exceptional Medical Expenses Act specifies the basic forms of health care to which those covered are entitled. The benefits are provided irrespective of the patients' means. Patients over 18 who are staying in an institution or home at the expense of the AWBZ, pay, an income-related contribution of a maximum of NLG 3 215 per month. This contribution is sometimes enforced after a period of six months. People who do not (yet) pay this contribution are required to pay a flat rate contribution, which is between NLG 210 and 1 105 per month, depending on their income.

The treatments and services available under the Exceptional Medical Expenses Act are:

- *Admission and stay in hospital:* Nursing care provided in hospitals other than psychiatric hospitals and the psychiatric wards of general and teaching hospitals, in the lowest class of accommodation, is covered by the Exceptional Medical Expenses Act after the first 365 days. The first year of care must therefore be covered as a normal health risk by a health insurance fund, a private insurer or a scheme for public servants.

- *Nursing-home care and care in a home for the physically disabled:* The services supplied on admission to a nursing home or home for physically disabled people include medical help and treatment, care and nursing provided by the home. In a nursing home this means accommodation, the nursing care required by the individual, including 24-hour care, medical treatment under the supervision of a nursing home doctor and the associated rehabilitation, physiotherapy and occupational therapy. Care of the physically disabled also includes care in a family, organised and guaranteed by the institution.

- *Care of the disabled in Het Dorp in Arnhem:* Among the facilities covered by the Act is residence (where indicated by the individual's condition) in Het Dorp, the special village for the disabled near Arnhem. Insured persons are entitled to the care they require, including specially adapted accommodation and, where necessary, nursing care (day and night), medical treatment, dental care, physiotherapy, speech therapy, occupational therapy, aids, drugs, dressings, wheelchairs and invalid cars.

- *Placement in a hostel for the physically disabled:*

Placement includes 24-hour-a-day accommodation, care and leisure activities (designed to facilitate integration in society) provided by the hostel. Placement in a hostel is available to those with a physical handicap (normally aged over 18) who are able to go out to work or follow a daytime course of education or training or who spend their days in a day centre for the disabled. Such hostels are not intended for individuals requiring frequent or continuous assistance or more than occasional nursing care.

- *Placement in a day centre for the physically disabled:* The cover provided includes the activities run by the centre during the whole day or part thereof that are designed to foster self-reliance as well as care in the day centre and transport. Placement in a day centre for the physically disabled is available to those with a physical disability whose primary handicap is of a relatively static nature and who cannot (yet) participate in education or employment or for whom education or employment is not indicated, and who are assumed to possess or be capable of acquiring social skills sufficient to enable them in principle to remain in the community and play their part in it.

- *Day care in a nursing home:* This consists of care provided during the day or a part thereof, the aim of which is to enable patients to remain in their own environment for as long as possible. The necessary supervision and counselling of the patient's family, neighbours, etc. is provided, as is transport. Day care in a nursing home is available to those with physical or mental disorders for which all the necessary care is not available in their own environment.

- *Home care:* This includes nursing and other care, support and counselling required by the patient at home in connection with illness, recuperation, disability, old age, death or a psycho-social problem. Nursing equipment is also available on loan for up to 26 weeks.

- *Rehabilitation:* This consists of examination, treatment and counselling by medical specialists, paramedical staff and behavioural or rehabilitation therapists. Rehabilitation may be accompanied by care, nursing or full-time or part-time accommodation in an appropriate establishment. The aim of rehabilitation is to prevent or reduce handicaps resulting from motor disorders, thus providing the patient with a degree of independence (or ensuring that such is maintained) that is feasible given the nature of the condition. Patients are only entitled to cover under the Act if they have received care in an institution for a period of 365 consecutive days.

- *Psychiatric care in a psychiatric hospital:* This consists of the tests, treatment and guidance required by the patient (including observation and counselling) plus associated nursing and other care (day and night) in a therapeutic environment and additional tests and treatment that are necessary to enable the patient to function at an optimum level physically.

- *Care provided by the psychiatric ward of a general or teaching hospital:* This consists of the tests, treatment, guidance and counselling, nursing and other care required by the patient either on a residential or an outpatient basis. If the patient is required to stay in the psychiatric ward of a general or teaching hospital, he or she is entitled to care for a period of 13 weeks, if it is expected that this will be sufficient. The stay may be extended once for a further 13 weeks.

- *Services provided by a Regional Institute for Outpatient Mental Health Care (RIAGG):* The services provided by the Regional Institutes for Outpatient Mental Health Care include psycho-social treatment and short-term psycho-social treatment, counselling and guidance in acute cases, together with support and counselling in a multidisciplinary framework for patients and their family and friends.

- *Services provided by a regional organisation for sheltered accommodation:* These services entail the provision of accommodation and care in a suitable environment and also include counselling aimed at helping the person in question to build up and sustain social relationships, to develop a daily routine, to learn and apply social skills, to develop or maintain other skills, to engage in social activities and to build up self-reliance.

- *Non-clinical psychiatric care:* Treatment by a psychiatrist or neurologist, following referral by a general practitioner.

- *Psychiatric outpatient services:* These services include psychiatric help (examination, treatment and assessment) for up to two hours a day, given by a psychiatrist or neurologist in a hospital outpatient department.

- *Part-time psychiatric treatment:* Part-time psychiatric treatment comprises examination, treatment, counselling or care in a psychiatric day or night centre for periods of at least four consecutive hours, up to a maximum of eight hours a day.

- *Care of the blind and partially sighted:* This encompasses tests, treatment, counselling and full-time or outpatient admission to an institution with the aim of fostering and sustaining self-reliance. This service also includes admission to and full-time residence in a hostel for the blind and partially sighted, care and leisure activities designed to integrate patients with a visual handicap into society.

- *Care of the deaf and partially hearing:* This encompasses care provided by an audiological centre and includes tests, treatment, counselling, transport and residential or outpatient care in an institution aimed at fostering and sustaining the self-reliance of persons with a hearing impairment. Cover is

also provided for full-time residence in a hostel, care and leisure activities aimed at the integration of the hearing impaired into society.

- *Care of the mentally handicapped:* This comprises admission and stay in an institution for the mentally handicapped plus medical help, care, nursing and treatment provided by the institution and rehabilitation, physiotherapy and occupational therapy in connection with medical examinations and treatment. The nature and extent of care are determined by the purpose of the institution. Care of the mentally handicapped also includes nursing in a family, organised and guaranteed by the institution.

- *Placement in a day centre for the mentally handicapped:* This consists of care during the whole day or part thereof aimed at fostering and sustaining self-reliance. Transport is also covered. Social training and educational activities are provided on the basis of the advice of the selection and supervision team, together with the associated special educational and psychological tests, treatment and supervision, speech therapy, physiotherapy and music therapy.

- *Admission and stay in a hostel for the mentally handicapped:* Full-time residential care and leisure activities are provided with the aim of integrating the mentally handicapped into society. Mentally handicapped persons are, as a rule, eligible for admission to a hostel if they do paid work outside the hostel, are on a training course, attend a day centre for the handicapped or are deemed to be capable of doing any of these.

FUNDING

The cost of insurance under the Exceptional Medical Expenses Act is covered by percentage contributions and government funds. Under the provisions of the National Insurance Financing Act insured persons are liable to pay contributions. This means that people who do not receive wages or a salary but who are liable to tax and social security contributions are issued with an assessment for percentage contributions, while for those in employment, contributions are deducted from their earnings and paid to the tax authorities by their employer. National insurance contributions, which include contributions under the Exceptional Medical Expenses Act, are levied on taxable income as a lump sum, together with income tax. In 1998 the percentage contribution under the Act was 9.6 % of taxable income in the first tax band (NLG 47 184 for 1998). No percentage contribution is payable for children under the age of 15 or for insured persons over 15 who have no taxable income of their own.

ACCUMULATION WITH OTHER SOCIAL BENEFITS

Persons receiving long-term care are in most cases eligible for a socialsecurity benefit under one of the Dutch schemes for incapacity for work or for old age.

STATISTICAL DATA

Data on the number and age structure of the dependent persons in need of long-term care are available only for general groups. In 1998 about 420 000 people will need psychiatric care. About 110 000 people are staying in nursing homes. Furthermore, about 510 000 people will be asking for home care. For this particular group there are data available concerning, for instance, age structure. Some 80 % of these persons are over 65 years old. They receive 75 % of the care, in terms of working hours.

Apart from the system prescribed above, an experiment is being carried out with the 'Persoonsgebonden Budget (PGB)' or 'Individual or person-related budget'. In this experiment persons who need home care for longer than three months and persons who are mentally disabled, can opt for benefits in cash and choose their own way of getting care instead of benefits in kind that are offered by the present system. The PGB is currently an experiment in the Netherlands and will undergo an evaluation in the near future.

GENERAL REMARKS FROM A SYSTEMATIC PERSPECTIVE

With the reorganisation of the long-term care system which went into effect on 1 July 1993, the last large gap in the Austrian social welfare system was closed. With the Federal Long-term Care Benefit Act *(Bundespflegegeldgesetz — BPGG)* — accompanied by similarly phrased long-term care benefit Acts in the *Länder* — a uniform long-term care benefit system was created for more than 300 000 persons in need of care and handicapped persons. Parallel to these laws, an agreement was reached between the Federal Government and the *Länder* in accordance with Article 15a B-VG concerning joint measures of the Federal Government and the *Länder* for persons in need of care, which went into effect on 1 January 1994. In this agreement the *Länder* commit themselves to setting up and consolidating decentralised and broad-based outpatient, partial inpatient, and inpatient services. Furthermore, quality criteria for social services and — in order to safeguard these minimum standards — the creation and implementation of requirement and development plans were established. The Federal Government committed itself, among other things, to making provision for the protection of care-givers under social insurance law.

The granting of the various benefits in kind when care is required are under the jurisdiction of the nine Austrian *Länder*, which already have at their disposal an extensive network of corresponding measures. An important criterion for these benefits in kind is the distinction from comparable benefits offered by the Austrian health insurance (e.g. hospitalisation, medical assistance, care through care personnel). The health insurance is responsible for covering costs as long as an improvement or the return to a normal state of health is possible. In those cases in which the constant care and assistance is necessary, the health insurance is no longer responsible for coverage, but rather the care insurance.

THE LONG-TERM CARE BENEFIT

Through the long-term care benefit a lump-sum contribution, regardless of income, is paid for the additional expenses necessary for care. This ensures that as far as possible persons in need of care receive the necessary care and assistance, and have a better chance of leading a self-determined life oriented toward the fulfilment of their needs.

The long-term care benefit applies after completion of the third year of life when the need for constant care and assistance (need for care) due to a physical, mental or emotional disability or sensory deficiency is expected to last at least six months. Entitlement to the long-term care benefit before the completion of the third year of life also exists, however, in order to prevent hardship cases.

The need for care, the cause of which is usually irrelevant, must reach an extent of over 50 hours per month on average.

Those entitled to the long-term care benefit according to the Federal Long-term Care Benefit Act are persons who have their primary residence in Austria and who receive a pension, retirement pension or other retirement or maintenance benefits in accordance with the provisions of federal law. Those persons who do not belong to the circle of entitled persons in accordance with the Federal Long-term care benefit Act, are granted the long-term care benefit according to similar provisions by the *Länder*. These persons include, for example, family members of those who receive pensions or social assistance. An accumulation of the long-term care benefit with other cash benefits of the social protection system is therefore possible.

The long-term care benefit is paid — on the basis of the classification criteria valid as of 1 January 1999 — according to the extent of the need for care, for the duration of this need, as a lump-sum cash benefit in seven categories:

Category	Need for care in hours per month	Amount per month (ATS)
1	more than 50 hours	2 000
2	more than 75 hours	3 688
3	more than 120 hours	5 690
4	more than 160 hours	8 535
5	more than 180 hours, if an exceptional amount of care is necessary	11 591
6	more than 180 hours, if: 1. care measures which cannot be co-ordinated in time are necessary and these must regularly be done both day and night or 2. the continual presence of a care-giver both day and night is necessary due to the likelihood of endangerment of other persons	15 806
7	more than 180 hours, if: 1. no voluntary movements of the four extremities with functional change of position are possible or 2. a comparable condition exists	21 074

The more exact criteria for judging the extent of the need for care can be found in the respective classification regulations issued with the long-term care benefit Acts, in which it is established what constitutes a need for care and which time values are to be taken into consideration for the individual care and assistance measures. The need for care is judged fundamentally not according to diagnosis, but according to ability to function — that is, on the basis of the individually required care and assistance measures.

For certain groups of disabled people, who have a substantially similar need for care (those confined to wheelchairs, the blind, those with a high degree of vision impairment, the deaf-blind), however, minimum classifications are designated.

Responsibility for granting the long-term care benefit is borne fundamentally by those institutions in charge of granting the basic benefits (e.g. pensions).

The decision on classification is based on a medical expert opinion, for which the physician submitting the expert opinion must consult as necessary with specialists in other fields such as, for example, the care service, in order to form an integral judgment on the care situation. A legal action can be filed against this decision, which is issued in an official notification, with the competent Labour and Social Court, and the ruling of this court can be referred to the Higher Regional Court in charge; for this decision an appeal can be lodged in turn at the Highest Court of Justice.

A distinction with regard to the amount of long-term care benefit between in-home care, day or short-term care is not provided for, although the entitlement to the long-term care benefit is suspended during an inpatient stay in a hospital or stationary facility for medical rehabilitation measures, preventive health care measures, stabilisation of health or the treatment of accidents, in Austria or on foreign soil, beginning on the day following that on which the patient is admitted, if an Austrian or foreign social insurance agency, a State fund (as defined in the agreement in accordance with Article 15a B-VG on the Reform of the Health Care System and Hospital Financing for the years 1997 to 2000), the Federal Government, or a social health care institution covers most of the costs of care provided for in the general fee class or the costs of the hospital stay.

Financing for the long-term care benefit comes out of general budgetary means and not, for example, through insurance contributions.

Since 1 January 1998 a favoured further insurance in the pension insurance exists for those persons who look after a close relative in the long-term care benefit categories 5, 6 or 7 and who for this reason were forced to give up their earning activity. These persons are favoured insofar as the Federal Government takes over the theoretical employer contribution and the care-giver thus need pay a contribution not of 22.8 % but only 10.25 % of the assessment basis.

Further, the Federal Ministry for Labour, Health and Social Affairs offers, also since the beginning of 1998, an advisory service for all private care-givers and all who are affected by problems concerning care. This advice for care-givers is available throughout Austria, by telephone or mail, through the Social Service of the Federal Ministry for Labour, Health and Social Affairs in 1050 Vienna, Geigergasse 5-9, Telephone (41-1) 54 41 59 73 00.

Above and beyond this, a three-part document Old people's homes and nursing homes in Austria, which lists the available public and private homes according to quality standards, was put together by the Federal Ministry for Labour, Health and Social Affairs to provide information to those affected. Furthermore, three volumes on 'Social services in Austria' were published in which the available outpatient and partial in-patient services are presented.

PORTUGAL

The Portuguese social security system does not include a specific branch for protection against the risk of dependency. Dependency situations are covered by invalidity, old-age and survivor's pensions, as well as family benefits and occupational sickness insurance under the general social security scheme, voluntary social insurance and the non-contributory scheme, by granting an allowance for assistance by a third party.

This allowance is aimed at old-age pensioners and people receiving invalidity and survivor's pensions under social security schemes, as well as handicapped children or youths in a situation of dependency.

Dependency giving entitlement to the allowance is defined as the condition of persons who have lost their autonomy and need to be helped by a third party in order to accomplish basic daily tasks, notably eating, moving around and personal hygiene.

Assistance is considered to be permanent when it is provided for a period of at least six hours per day, either by a third party or through the successive and combined assistance of several persons.

A family member providing such assistance is considered as a third party for the purposes of granting the allowance.

No allowance is payable where the dependent person is receiving benefits in kind from either public or private non-profit-making health or social services, or institutions which are financed by the State or by another public, private or State-approved legal entity.

In the case of family benefits, the allowance for the assistance of a third party is designed to offset additional costs related to the dependency status of the beneficiary's descendants who are at the same time receiving disability benefits.

Dependency status is evaluated by the disablement verification department of the regional social security centre in the beneficiary's place of residence.

Furthermore, beneficiaries who, following an occupational illness, are unable to rely on the continuous aid of other people, are also entitled to a supplementary benefit. Payment of this benefit is also provided for under the employment injury scheme.

The responsibility for evaluating dependency in connection with occupational sickness insurance falls to the National Centre for Protection against Occupational Risks, in liaison with the national health service.

People applying for an allowance for the assistance of a third party under the family benefits scheme must declare the existence of a third person on the date of the application, as well as the terms under which the assistance is provided.

In the event that the report fails to confirm permanent assistance but the verification committee is of the view that a condition of dependency does exist, the beneficiaries are notified that they must fulfil this condition within a period of 60 days.

The allowance for the assistance of a third party may not be drawn concurrently with either the special education allowance or with other benefits to cover dependency, unless the value of the equivalent benefit is lower, in which case the amount paid is equal to the respective difference.

However, this benefit may be drawn concurrently with invalidity, old-age, or survivor's pensions under the social security schemes, with the lifelong monthly allowance and the family allowance supplementary disability allowance for each handicap for children and young people.

The allowance is paid throughout the entire period of dependency, but beneficiaries are required to notify any situation which may invalidate entitlement to the allowance, such as the cessation of the condition of dependency, the non-existence of the assistance of a third party or admission into a social or health-care institution.

The benefit is financed from the social security budget for contributory schemes, and from the State budget for the non-contributory scheme.

The allowance for the assistance of a third party is never dependent on income.

The allowance is a fixed-rate amount of PTE 10 875 for the general social security scheme and PTE 9 290 for the non-contributory scheme. The allowance is reviewed annually at the same time as all family benefits and pensions.

The amount of the supplementary benefit awarded under the occupational sickness insurance may not exceed 25 % of the value of the pension which has been set.

In addition to the cash benefit from the social security, benefits in kind are also provided under the social welfare scheme, which are funded from State appropriations and generally used for health care and institutions.

These benefits are granted either directly by the regional social security centres or indirectly by means of cooperation agreements with private

community-support institutions. Such institutions rely on the technical and financial support of the social security system for implementing initiatives for managing social institutions.

Benefits in kind include domestic help and home care, foster homes, day care and full or short-term institutional care.

The total number of beneficiaries of the allowance for the assistance of a third person totalled 160 569 in 1996, including 6 086 disabled children/youths, 10 064 people on survivor's pensions, 29 780 people on invalidity pensions and 114 639 old-age pensioners (1).

(1) No data concerning beneficiaries of the allowance under occupational sickness insurance are available.

SYSTEM OF SOCIAL PROTECTION FOR THE RISK OF NEED FOR LONG-TERM CARE

Social and health care services in Finland are based on the principle of universality. There is no separate legislation on services for the elderly and on long-term care. Every person in need of social welfare or help is eligible for social and health services.

The local authorities are responsible for providing social and health care services. The way these services are arranged is decided by the municipality; it can produce the services itself, have a joint service provision with neighbouring municipalities or buy services from other municipalities, joint municipal boards or private service providers. The way services are arranged differs according to the service in question. The amount of services bought from private service providers has been relatively small (around 10 % of the expenditure), although their share in some services is increasing.

The allocation of care is a responsibility of the local authorities. Decisions on allocation are made either by one official or, and nowadays more and more often, by a multiprofessional team working in the local area. Multi-professional teams are usually composed of a GP, a social worker and home help and home nursing professionals.

THE DEFINITION OF LONG-TERM CARE

The criteria for long-term care differ to some extent in outpatient and institutional care. In outpatient care, mainly in respect of home services and home nursing the client is defined as a client of long-term care if he or she is in need of continuous care. The definition of the continuity of care varies to some extent from one municipality to another, but more often than not it means need for help or care at least once a week. As regards institutional care, the need for care can at the admission be defined as continuous, but after at least 3 months' institutional care the need for care is considered to be continuous.

The client fee systems are tied to the continuity of care. The client fees for long-term care are income-related both in outpatient care and institutional care, whereas the client fees for short-term care or sporadic care are fixed, the same for all clients.

THE SERVICE SYSTEM IN LONG-TERM CARE

The service system for long-term care covers the whole country, since municipalities are responsible for providing services according to their inhabitants' needs. The services are mainly financed by the municipalities' and the State's tax revenue (90 %). In 1998, the average State subsidy for the financing of social welfare and health care was about 20 %. The clients' share is about 10 %, varying according to service. For home help it is about 10 % and for care in old age homes 20 %. The State has for years participated in the building up of the service system through the State subsidy system.

Long-term care can be received both within the social welfare and the health care system. Social and health services can today still be regarded as separate functions, even though at policy level the aim has been for years to increase the cooperation and to integrate these systems. Within outpatient care, the integration of home services and home nursing has advanced farthest, although there are great differences between municipalities. It is not, however, rare to see a home service unit in a municipality which is responsible for home services and home nursing. This development is supported by the Act on Client Fees, that entered into force on 1 January 1993 and that provides for a common client fee for home help and home nursing for those clients who receive care on a regular basis. The fee is based on a care and service plan drawn up in cooperation between these functions.

The most important service forms of social welfare are home services (= home help and various auxiliary services), day activities, support for informal care, service housing, and care in an old people's home.

Coverage of most important social care services for the elderly in 1997

Service type	Number of clients aged 65+	Coverage, % persons aged 65+	Coverage, % persons aged 75+
Home help services, clients	85 401	12	29
Auxiliary services, clients	103 215	13	33
Informal care allowances, recipients	12 705	2	4
Service housing, Old people's home, clients	17 916	2	5
Altersheim, Bezieher	22 232	3	7

Source: SOTKA, 1998

The most important health care services for dependent elderly people are home nursing, day hospital care and short- and long-term care in institutions. These services are provided mainly by the public sector at both regional (joint municipal boards for public health) and local levels. In Finland the health sector is an important provider of long-term hospital (nursing) care for the elderly. There are no special nursing homes, but bed wards for

long-term care in the primary care (health centre) hospitals can be classified as such. A vast amount of long-term care has until recent years been provided in specialised hospitals. This was considered a misallocation of resources. In 1992 the Ministry of Social Affairs and Health launched a national programme to replace expensive forms of care. Community care is the main target.

Use of most common health care services by the elderly in 1995

Service type	Number of clients aged 65+	Coverage, % persons aged 65+	Coverage, % persons aged 75+
Home nursing*	66 733	9	22
Day hospital care, primary care*	7 735	1	3
Primary care, hospital ward, long-term care	12 392	2	4
Specialist so-matic hospitals, long-term care	1 020	0.1	0.3
Psychiatric Khospitals, long-term care	823	0.1	0.3
Long-term hospital care, total	14 235	2	5

(*) 1994 figures

Source: SOTKA and HILMO registers 1996, Vaarama 1997

In 1994, 85 % of home nursing services were provided for elderly people. 93 % of the beds in health centre hospitals' long-term care were occupied by the elderly (Vaarama 1995).

CASH BENEFITS

The pension of elderly people is based on a comprehensive statutory pension scheme composed of the national pension and employment pension schemes. The national pension ensures a minimum livelihood for the pensioners who do not receive any other pension or whose pension cover is small. The amount of the national pension for those in institutional care is reduced.

In order to support dependent people to live at home the social insurance institution pays pensioners' housing allowance and pensioners' care allowance. Housing allowance for pensioners is determined on the basis of income, property and housing costs. 156 914 pensioners (of whom 99 273 were aged 65+) received housing allowance in 1997. This was 13 % of all pensioners.

Pensioner's care allowance is granted to pensioners with a reduced functional capacity due to an illness or injury. The allowance is paid graded according to the need for help or the amount of special costs. The care allowance is FIM 278 per month, the increased rate is FIM 691 per month and the special rate FIM 1 382 per month. Income and property do not affect the entitlement to the special rate. A total of 144 046 pensioners (of whom 98 068 were aged 65+) received this allowance in 1997 which was about 12 % of all pensioners.

THE SUPPORT FOR INFORMAL CARE

Caring for elderly people, people with disabilities and people suffering from a long-term illness at home has been supported by legislation in Finland since 1984. In July 1993 the relevant law was revised, and the support for informal care scheme was expanded. The informal care allowance involves an agreement made between a carer and the municipal social welfare board to arrange the care of an elderly, disabled or chronically ill person in his/her own home. The carer receives the allowance as a remuneration for this work. The law also sets the minimum allowance, which is FIM 1 156.69 per month in 1998. The range is wide, the maximum being FIM 5 500 per month. Besides the allowance the support may also involve services, such as transportation services, to facilitate the care at home.

In 1997, about 12 700 elderly (65+) people were cared by this support. This was almost 2 % of this age group.

Since the beginning of 1998 those carers who are engaged in very demanding care have had a statutory right to one day off per month.

Other cash benefits received by the person cared for do not affect the entitlement to informal care allowance or its amount.

PROSPECTS FOR DEVELOPING THE CARE OF THE AGED

In 1996 Finland got a new official national ageing policy up to 2001. The policy was outlined by the Ministry of Social Affairs and Health. It includes recommendations to develop the Finnish care system for the elderly. There are six main recommendations:

- maintaining the health and working ability of the post-war baby boom age classes,
- maintaining a good standard of living for the elderly,
- maintaining a good standard of housing for the elderly,
- developing a needs-based service supply,
- improving the performance of the care system (integration and continuation of care),
- creating an enabling society, where elderly

people have similar rights to participate and live their lives as do other groups of people.

The developments of the last few years, the increased emphasis on outpatient care and home services in order to increase both the clients' privacy and their standard of living have brought about a need to improve the housing and the living environment so as to take account of the needs of ageing people. Living at home can be supported by various and often simple means when consciously assessing the physical environment and the service supply from the point of view of ageing people. Various development projects have given rise to extensive local value discussions about the ageing society, as a result of which it has been possible to improve the prerequisites for people to live in their own homes. It is very significant that this kind of work is no longer confined to the social and health sectors only, and the cooperation partners include today e.g. those engaged in town and traffic planning and planning of shopping centres, those engaged in developing the countryside, and NGOs.

The notion of long-term care is no longer being used in Swedish legislation. Elderly and disabled dependent persons in need of long-term care and assistance are instead entitled to public services in the form of home care in ordinary housing or a place in special housing.

Each municipality is, according to the relevant legislation, responsible for the elderly and disabled persons resident in the municipality. The fundamental principle is that these individuals should feel safe and be treated with dignity and respect. Individual desires and personal integrity should be taken clearly into consideration. If individuals wish to remain in their residential home (ordinary housing), they should be given this opportunity, even if they are in need of extensive assistance and care. The municipalities are obliged to establish special housing for elderly and disabled dependent persons. Whenever there is a desire or need, it should be possible for the dependent person to move to special housing. The municipalities are responsible for health care in special housing. In approximately half of the Swedish municipalities, the municipality is also responsible for home care in residential ordinary housing.

HOME CARE SERVICES

Home care services is a notion comprising different forms of services and help offered by the municipality to elderly and disabled persons living in ordinary housing. The most extensive assistance is social assistance in the home, but it can also include safety alarm, distribution of food, etc.

Home care services to people, who, due to age or handicap are in need of help and support in their home, is carried out by assistant nurses. The services are means-tested and a form of social assistance in accordance with the Social Services Act. These social contributions may concern personal treatment, practical personal help or help with running the home. When there is a special need, assistance may also be given during evenings, weekends and nights.

After means-testing and affirmative decision according to the Social Services Act, persons living in ordinary housing can also take part in daily activities or daily care.

Most elderly and disabled people living at home see the district nurse or doctor at a district health centre. Home visits to those who have difficulty in getting to their local centre are paid mainly by district nurses and assistant nurses. The former divide their time between health-centre-based care and home visits, while the latter spend most of their time on house calls.

SPECIAL HOUSING

Special housing and housing offering special services may be organised in various ways, due to historical and local circumstances. The notion of special housing comprises old-age homes, individual rooms with access to joint facilities and fellowship in direct connection with private living areas. Persons resident in special housing are entitled to individually suited health and care, also comprising health-care. When needed, these services can be carried out every 24 hours. After an application has been made to move to special housing, an individual means-test is carried out and a decision is taken concerning assistance according to the Social Services Act.

GENERAL

The municipalities are entitled to charge for services and care in ordinary housing as well as special housing according to principles decided by the municipality itself. The charge should be reasonable and may not exceed the cost. Furthermore, the individual is allowed to keep an amount corresponding to personal needs.

Individuals who due to a handicap have difficulties using public transport services, may be entitled to a municipal mobility service. Mobility service comprises local use of taxis or special vehicles. Each municipality decides the rules concerning the mobility service such as the numbers of trips offered to the entitled person, the length of the trip and the charges (as of 1998, the legislation concerning mobility service constitutes a part of the common public transport legislation).

Concerns about the arrangements and funding for the long-term care of the elderly in the United Kingdom (UK) resulted in the Government setting up a Royal Commission on the Long Term Care of the Elderly in December 1997. The Royal Commission was asked to examine the short and long-term options for a sustainable system of funding long-term care for elderly people and to provide costed recommendations of how, and in what circumstances, the cost of such care should be apportioned between public funds and individuals. However, the Commission's 'terms of reference' also include the long-term care of younger disabled people, as the care needs of this group of people may be met via the same mechanisms as those for the elderly.

The Commission completed its work and published their report on 1 March 1999. The Government is considering the report carefully and will announce its response in due course.

CURRENT ARRANGEMENTS

Currently, there is no single, discrete social protection scheme covering the need for long-term care within the UK. Under the National Health Service, all residents are entitled to receive health care on the basis of clinical need and which is essentially free at the point of service. Such services include general medical services, acute hospital care and services provided by a district nurse or community psychiatric nurse. Charges can be made for some services, for example, prescriptions for medicines and surgical appliances, but many people receive these services free of charge, either because they have a low income, or because they belong to a category of people, such as pensioners, who are exempt from charges (see Missoc Table III 'Health Care' for details). The following paragraphs outline the current provision for long-term care needs, other than health care costs, in the UK.

CARE IN THE COMMUNITY

In April 1993, responsibility for assessing the needs of the elderly and people with disabilities and for making provision for care was devolved to local authorities. The provision for the elderly falls into two main groups: domiciliary care and day care (for example, home helps, home carers, meals on wheels, aids and adaptations to the home, day care centres, etc.) and residential services (for example, full-time residential care as well as respite and short stay care).

Financial control of these provisions lies with local authorities and they have the responsibility for assessing needs and deciding on the nature of the community care services to be provided. Broadly speaking, the local authorities devise a 'care package' and meet the full cost, assessing the resident's ability to contribute. The contribution is calculated using an assessment based on the rules for income support (see below).

CASH BENEFITS

The UK social security system provides a range of cash benefits which are designed to help with the additional costs encountered by people who require extra care and attention because of age, illness or disability, or as a result of an industrial injury or disease and their carers. The main benefits are:

- Attendance allowance paid to disabled people over age 65 who have personal care needs as a result of illness or disability;
- Disability living allowance paid to disabled people under the age of 65 with extra costs incurred because they need help with personal care and/or mobility needs;
- Invalid care allowance paid to people of working age who are caring for a severely disabled person.

Details of these and other benefits are set out in Missoc Table VI (Invalidity), Table IX (Employment injuries and occupational diseases) and Table XII.2 (Guaranteeing sufficient resources).

In general most of the benefits, such as attendance allowance and disability living allowance, which are designed to help with specific care needs are tax-financed, non-contributory, not means-tested and are paid in addition to any contributory benefits (covering such contingencies as sickness and old age) which the person receives.

The main social assistance benefit in the UK is income support. This is a tax-financed, means-tested benefit which pays flat-rate premiums for groups recognised as having special needs such as the disabled and the elderly. People living in residential care and nursing homes can claim income support, together with most premiums, plus a special residential allowance. (Until April 1993, when the new community care arrangements described above came into operation, there was a system of special higher levels of income support to help these residents meet their fees. Most people who were already in residential and nursing homes at 31 March 1993 have 'preserved rights' to the old system of special higher levels.)

The terms of reference for the Royal Commission on Long-Term Care for the Elderly were set as:

'To examine the short and long-term options for a sustainable system of funding of long-term care for elderly people in the United Kingdom, both in their own homes and in other settings, and, within 12 months, to recommend how, and in what circumstances, the cost of such care should be apportioned between public funds and individuals, having regard to:

— the number of people likely to require various kinds of long-term care both in the present and through the first half of the next century, and their likely income and capital over their life-time;

— the expectations of elderly people for dignity and security in the way in which their long-term care needs are met, taking account of the need for this to be secured in the most cost-effective manner;

— the strengths and weaknesses of the current arrangements;

— fair and efficient ways for individuals to make any contribution required of them;

— constraints on public funds, and

— earlier work done by various bodies on this issue.

In carrying out its remit, the Royal Commission should also have regard to:

— the deliberations of the Government's comprehensive spending review, including the review of pensions;

— the implications of their recommendations for younger people who by reason of illness or disability have long-term care needs.

The Commission's recommendations should be costed. The Commission is asked to give an opportunity to all interests likely to be affected by its recommendations, in particular users and carers, to give their views on issues within the terms of reference.

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BELGIQUE/BELGIË

Jean De Lannoy
Avenue du Roi 202/Koningslaan 202
B-1190 Bruxelles/Brussel
Tél. (32-2) 538 43 08
Fax (32-2) 538 08 41
E-mail: jean.de.lannoy@infoboard.be
URL: http://www.jean-de-lannoy.be

La librairie européenne/ De Europese Boekhandel
Rue de la Loi 244/Wetstraat 244
B-1040 Bruxelles/Brussel
Tél. (32-2) 295 26 39
Fax (32-2) 735 08 60
E-mail: mail@libeurop.be
URL: http://www.libeurop.be

Moniteur belge/Belgisch Staatsblad
Rue de Louvain 40-42/Leuvenseweg 40-42
B-1000 Bruxelles/Brussel
Tél. (32-2) 552 22 11
Fax (32-2) 511 01 84

DANMARK

J. H. Schultz Information A/S
Herstedvang 12
DK-2620 Albertslund
Tlf. (45) 43 63 23 00
Fax (45) 43 63 19 69
E-mail: schultz@schultz.dk
URL: http://www.schultz.dk

DEUTSCHLAND

Bundesanzeiger Verlag GmbH
Vertriebsabteilung
Amsterdamer Straße 192
D-50735 Köln
Tel. (49-221) 97 66 80
Fax (49-221) 97 66 82 78
E-Mail: vertrieb@bundesanzeiger.de
URL: http://www.bundesanzeiger.de

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ESPAÑA

Boletín Oficial del Estado
Trafalgar, 27
E-28071 Madrid
Tel. (34) 915 38 21 11 (Libros),
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