



European Network of Economic Policy  
Research Institutes

# NEW EU MEMBER STATES AND THE DEPENDENT ELDERLY

---

CORINNE METTE

ENEPRI RESEARCH REPORT NO. 19

JULY 2006



**ENEPRI Research Reports** are designed to make the results of research undertaken within the framework of the European Network of Economic Policy Research Institutes (ENEPRI) publicly available. This paper was prepared when the author was participating in **REVISER – a Research Training Network on Health, Ageing and Retirement** – which has received financing from the European Commission under the 5<sup>th</sup> Research Framework Programme (contract no. HPRN-CT-2002-00330). Its findings and conclusions should be attributed to the author/s and not to ENEPRI or any of its member institutions.

ISBN 92-9079-644-8

AVAILABLE FOR FREE DOWNLOADING FROM THE ENEPRI WEBSITE ([HTTP://WWW.ENEPRI.ORG](http://www.enepri.org))

OR THE CEPS WEBSITE ([WWW.CEPS.BE](http://www.ceps.be))

© COPYRIGHT 2006, CORINNE METTE

# **New EU Member States and the Dependent Elderly**

***ENEPRI Research Report No. 19/July 2006***

**Corinne Mette\***

---

## **Abstract**

The 10 new member states that joined the European Union in May 2004 have increased the population of the EU-15 by 20% and together account for almost 16.4% of the total EU-25 population. The current ageing of the population in the EU-15 has highlighted other challenges besides the well-known problems of financing pension and health care systems. It has also highlighted the risks of a rise in the dependent elderly population and the need to adjust social welfare systems accordingly. Given the emerging risks and problems in the EU-15, one may wonder about the situation in the new member states. This study shows that while the new member states do not yet appear to be facing the problem of elderly dependency on the same scale as the EU-15 countries, in the coming decades it is likely they will have to contend with it to a much greater degree.

The study also indicates that provision for dependent elderly care in the 10 countries does not yet seem to be fully established. That being said, Malta and Slovenia, countries that will have a considerable proportion of the oldest old among their populations in the near future, are distinguishable from the others in that they appear better prepared in terms of dependent elderly care. Although Poland is considered far from prosperous as regards economic and social development, in terms of population ageing – particularly provision for the dependent elderly – it also looks better placed than most of the other new member states, which appear to be less generous in assistance provided to the dependent elderly. The three Baltic States are notable in that the share of GDP they allocate to this category is lowest, even though they are expected to have the oldest populations in the years to come.

**Key words:** ageing, dependent elderly, new member states, welfare system

\* Corinne Mette is with FEDEA, C/Jorge Juan 46, 28001 Madrid, Tel: +34 91 435 0401; Fax: +34 577 9575; e-mail: cmette@fedea.es. The author would like to express her appreciation to Jose Maria Labeaga and to Simon Sosvilla-Rivero for their valuable advice and to the institutions in the new member states that have furnished data for this study.

# Contents

---

|     |  |    |
|-----|--|----|
| 1   | Introduction .....                     | 1  |
| 2   | Population ageing .....                | 2  |
| 2.1 | Demographic developments.....          | 2  |
| 2.2 | Dependency status .....                | 7  |
| 3   | Institutional provision.....           | 11 |
| 3.1 | Types of institutional provision ..... | 12 |
| 3.2 | Form of allocation.....                | 15 |
| 4   | Availability of care providers .....   | 17 |
| 4.1 | Informal care providers.....           | 17 |
| 4.2 | Formal care providers .....            | 19 |
| 5   | Concluding remarks.....                | 20 |
|     | References .....                       | 22 |
|     | Further reading .....                  | 23 |

## List of Figures

|     |   |    |
|-----|---|----|
| 1.  | Share of the very old in the population aged 65 and more according to the share of the elderly in the total population of European countries (2002) ..... | 3  |
| 2.  | Evolution of the share of elderly persons (65+) between 1995 and 2015 in European countries.....  | 3  |
| 3.  | Fertility rate: 1950-2050.....  | 5  |
| 4.  | Life expectancy at birth: 1950-2050.....  | 5  |
| 5.  | Share of persons aged 80+ among the population aged 65+ according to the share of 65+ among the population as a whole .....                               | 9  |
| 6.  | Life expectancy at birth and the difference between life expectancy at birth and healthy life expectancy – (a) for women and (b) for men .....            | 10 |
| 7.  | Number of long-term care beds (except psychiatric care) per 100,000 inhabitants.....  | 13 |
| 8.  | Relative ratio of median incomes between persons aged 65+ and younger than 65 .....   | 16 |
| 9.  | Evolution of the average number of persons per household during the last decade .....   | 18 |
| 10. | Number of nurses per 10,000 inhabitants .....   | 20 |

## List of Tables

|  |    |
|--|----|
| 1. Countries in Europe ranked among the 20 nations with the oldest populations in the world (in 2005 and 2050).....                    | 4  |
| 2. Net international migration in the eight transition economy countries that joined the EU in May 2004.....                           | 6  |
| 3. Countries in Central Europe ranked by ascending order of the old-age dependency rate among the EU-25 countries (2005 and 2050)..... | 7  |
| 4. Share of disabled persons by country .....  | 8  |
| 5. GDP share of social security benefits allocated to the elderly (excluding pensions) (2001).....                                     | 12 |
| 6. GDP share of social security benefits allocated to assisting the elderly in daily life activities (2001).....                       | 13 |
| 7. Proportion of elderly persons living in institutions.....   | 14 |
| 8. GDP share of social security benefits allocated to housing assistance for the elderly (2001).....                                   | 14 |
| 9. Share of benefits allocated to the elderly in cash and in kind (2001) .....   | 15 |
| 10. Make-up of households including a person aged 65+ and 80+ .....  | 17 |
| 11. Average number of persons per household (2003).....  | 18 |
| 12. Proportion of women in employment .....  | 19 |

# New EU Member States and the Dependent Elderly

*ENEPRI Research Report No. 19/July 2006*

Corinne Mette

---

## 1 Introduction

The Czech Republic, Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, the Slovak Republic and Slovenia joined the European Union in May 2004. The combined population of the new member states – almost 75 million – increased the population of the EU-15 by 20%. Together they account for almost 16.4% of the EU-25 (Monnier, 2004). Since the fall of the Soviet Union in 1991, the countries of Central Europe have had to reform their economic systems in order to make the transition from a planned economy to a market economy. Their economic output depends on the type of restructuring undertaken. On the whole, even if the countries are less wealthy than those of the EU-15, the rate of development is very high. Whereas the annual GDP growth rate at constant prices (1995) of the EU-15 countries has averaged around 1.85% since 1995, it is more than 3% for Central Europe overall, except the Czech Republic (1.75%).<sup>1</sup> The rate is 6% for Estonia, which has enjoyed the highest annual growth since 1995. Most Central European countries have been able to capitalise on globalisation. Malta and Cyprus, neither of which had to suffer the destruction of their economy, have experienced the lowest average annual growth rate of the 10 new member states. Yet while Malta's average annual growth (1.08%) is below the EU average, that of Cyprus exceeds it by almost 2 percentage points.

As the EU-15 confronts one of the major problems related to population ageing, namely the emerging risk of a rise in the share of the dependent elderly, one can wonder about the demographic evolution of the 10 new member states in the years to come. One characteristic of relatively poor countries that have experienced considerable growth is an improvement of the health of the population, at least when the funds from such growth are invested by the authorities in social and health care sectors (Sen, 1999). Growth affords better coverage of health care. In transition countries, growth has effectively provided the means to introduce social health insurance and increase private financing. Consequently, spending on health care began to rise in these countries at the beginning of the 1990s (Busse, 2002).

Moreover, improvements in health are generally accompanied by increases in life expectancy, i.e. an overall ageing of the population. Among the 10 new member states, the percentage of GDP spent on illness/health care in the Czech Republic rose from 6.3% in 1995 to 7% in 2002, while life expectancy at age 65 increased by at least one year during the same period for both men and women (from 12.7 to 14 more years for men and from 16 to 17.4 more years for women). But as Western countries know well, population ageing is not without repercussions on the economy. The resulting imbalance between the proportion of elderly persons and the share of the working population entails problems for pension financing. In the EU-15, the elderly dependency ratio – the ratio of the total number of elderly persons of an age when they are generally economically inactive (65+) to the number of persons of working age (from age 15 to 64) – increased from 23 to 25.9 between 1995 and 2005. Population ageing also implies an increase in the proportion of the elderly who need assistance to carry out daily life activities. In

---

<sup>1</sup> Data are derived from the Eurostat online database.

France for instance, according to a mainstream hypothesis, the number of dependent elderly persons is expected to rise by 25% between 2000 and 2020 (Bontout et al., 2002). Because of changing family structures and the growing proportion of working women, the number of potential care providers has already fallen and is expected to continue to do so.

In view of the decreasing availability of family care, the dependent elderly have to turn to the two other players: the public and private sectors. Notwithstanding aspirations towards a certain degree of liberalism in most of the new member states, private insurance – at least that which is voluntary in nature – for ageing-related contingencies is virtually non-existent. Where pension systems have already been established or are nearing completion, provision for long-term care, as in most EU-15 countries, is not covered by a specific law. The dependent elderly simultaneously need medical care and assistance for daily life activities. Long-term care is covered by health insurance, through legislation for other contingencies such as disability and may come under social assistance. All Central and Eastern European countries have a social health insurance system, except Cyprus (which is expected to introduce one this year) and Malta, where the public health care system covering the entire population is supplemented by a private system that operates independently (Cho et al., 2002). In almost all the countries, it is the welfare system that provides the long-term care given by health services. But what about the care provided by social services? What role is played by the public authorities in the provision of this type of care in the 10 new member states? These are the questions this study aims at answering, after first describing the demographic situation in the new member states. Assistance to elderly persons who require help as a result of disability, their choice of where to live, etc., are important issues in an international context in which the preservation of the autonomy and dignity of the elderly is a primary objective that social policies should seek to achieve.

Section 2 of this report looks at the demographic challenges that the systems face at present and in the future. Specifically, it highlights the loss of self-sufficiency on the part of the elderly, which will be a major characteristic of the future scenario, and assesses whether new EU member states need to anticipate this social risk. Section 3, on institutional provision for elderly dependency, describes public provision and the conditions governing public interventions. The availability of informal and formal help is discussed in Section 4. Finally, Section 5 offers some concluding remarks.

## 2 Population ageing

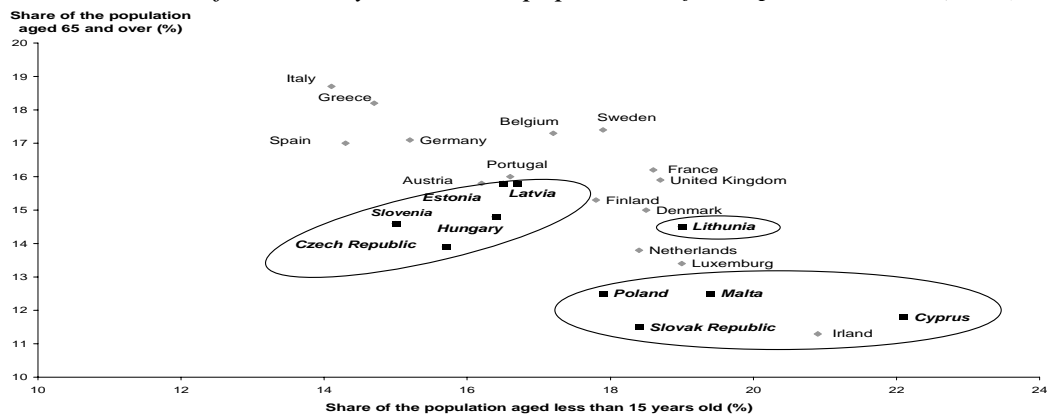
### 2.1 Demographic developments

Figure 1 shows on the Y-axis the proportion of persons aged 65+ among the overall population in each EU country, while the X-axis indicates the proportion of persons aged younger than 15, in both cases for the year 2002. The graph thus characterises the population in terms of age and shows that the 10 new member states of the EU are, generally speaking, younger than the EU-15 countries. They have the highest proportion of persons aged 15 and under. By way of example, in Cyprus more than 22% of the population is under 15, compared with 21% for Ireland, which has the youngest EU-15 population. Conversely, the proportion of persons aged 65+ is, on the whole, smaller than in the EU-15. The highest figure (15.8% in 2002) is lower than that found in eight of the EU-15 countries (Italy, Greece, Sweden, Belgium, Germany, Spain, France and Portugal). Three groups can be discerned among the new member states:

- First, there is the group with the youngest population, which comprises Cyprus, Malta, Poland and the Slovak Republic. Here, young persons represent a large proportion of the population (over 18%), while the share of older persons is lower than in the other countries (less than 13%). This group is quite similar to Ireland in terms of population ageing.

- Second, there is the group with the oldest populations among the 10 new states: Latvia, Estonia, Slovenia, Hungary and the Czech Republic. The proportion of young persons is less than 16.6% while that of the 65+ category exceeds 14%. In terms of population ageing the characteristics of these five countries are similar to Austria or Portugal.
- Third and finally, Lithuania appears somewhat isolated from the others, as its share of young persons is above 18% and the elderly represent more than 13%. Among the EU-15, Lithuania's ageing characteristics resemble those of Denmark and the Netherlands.

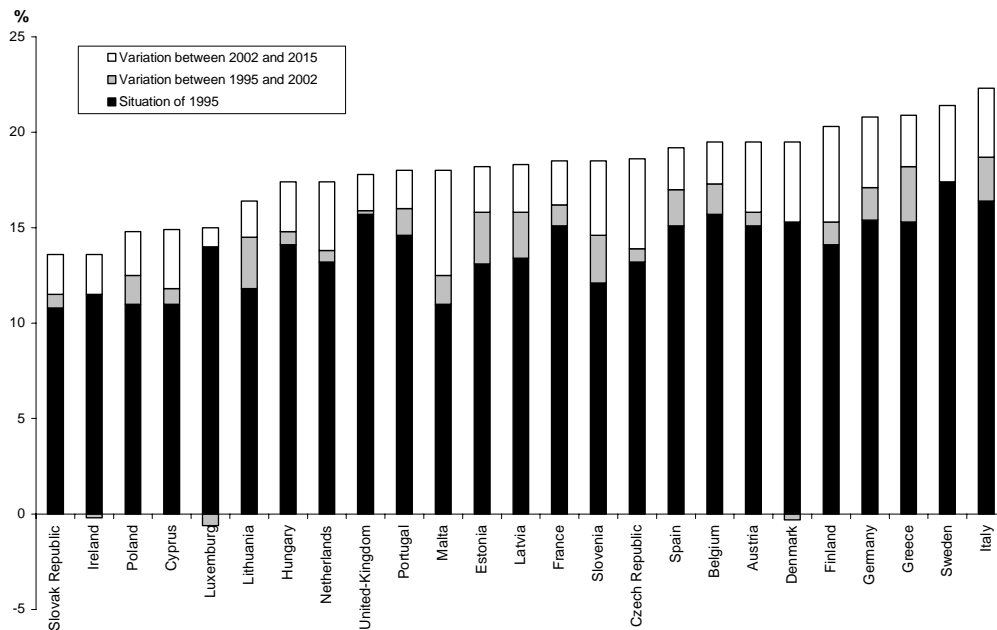
Figure 1. Share of the very old in the population aged 65 and more according to the share of the elderly in the total population of European countries (2002)



Source: United Nations Development Programme (2004).

Although the populations of the 10 new states appear to be younger than in the EU-15, like the latter their societies have already aged and will continue to do so in the coming years (Figure 2). Figures from the United Nations Development Programme (UNDP) show that since 1995 the proportion of the elderly has increased and will continue to rise for each country until 2015.

Figure 2. Evolution of the share of elderly persons (aged 65+) between 1995 and 2015 in European countries



Sources: UNDP (2004) for 2002 data and projections for 2015; European Commission for 1995 data.

Among the Central European countries, the Czech Republic is expected to have, in 2015, the highest share of the elderly (18.6%) and only slightly less than Spain, Belgium, Austria, Denmark, Finland, Germany, Greece, Sweden and Italy.

Further, between 1995 and 2015 the evolution is forecast to be greater in the new member states overall. Indeed, of the 10 countries with the highest anticipated rate of growth in the proportion of elderly persons, six are new member states: Malta (+7 percentage points), Slovenia (+6.4), the Czech Republic (+5.4), Estonia (+5.1), Latvia (+4.9) and Lithuania (+4.6).

Other UN projections estimate the distribution of world population by age for the longer-term future. The median age – which divides the population into two equal parts – gives some indication of population ageing. In 2050, the median age of the population is expected to have increased in much of the world. Whereas in 2005 only 3 Central European countries are listed among the 20 with the oldest populations, 6 are likely to figure in the classification in 2050 (Table 1).

*Table 1. Countries in Europe ranked among the 20 nations with the oldest populations in the world (in 2005 and 2050)*

| 2005 |                       |             | 2050 |                       |             |
|------|-----------------------|-------------|------|-----------------------|-------------|
| Rank | Country               | Median age  | Rank | Country               | Median age  |
| 2    | Italy                 | 42.3        | 4    | Italy                 | 52.5        |
| 3    | Germany               | 42.1        | 7    | <b>Slovenia</b>       | <b>51.9</b> |
| 4    | Finland               | 40.9        | 9    | <b>Slovakia</b>       | <b>51.8</b> |
| 6    | Austria               | 40.6        | 10   | <b>Lithuania</b>      | <b>51.7</b> |
| 7    | Belgium               | 40.6        | 11   | <b>Czech Republic</b> | <b>51.6</b> |
| 10   | <b>Slovenia</b>       | <b>40.2</b> | 14   | <b>Poland</b>         | <b>50.8</b> |
| 11   | Sweden                | 40.1        | 15   | <b>Latvia</b>         | <b>50.5</b> |
| 13   | Greece                | 39.7        | 18   | Austria               | 50.0        |
| 14   | Denmark               | 39.5        | 19   | Spain                 | 49.9        |
| 15   | <b>Latvia</b>         | <b>39.5</b> |      |                       |             |
| 16   | Portugal              | 39.5        |      |                       |             |
| 17   | France                | 39.3        |      |                       |             |
| 18   | Netherlands           | 39.3        |      |                       |             |
| 19   | United Kingdom        | 39.0        |      |                       |             |
| 20   | <b>Czech Republic</b> | <b>39.0</b> |      |                       |             |

*Note:* The hypotheses retained for projections are the median variant with a moderate recovery of fertility.

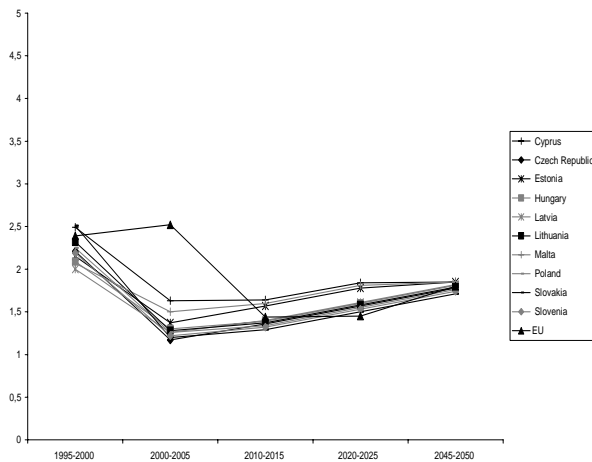
*Source:* United Nations Secretariat (2005).

Thus, according to demographic indicators, the new member states are also confronted by the problem of population ageing. Although their populations are currently younger than those of the EU-15, the magnitude and pace of their evolution should eventually result in an ageing share exceeding that of the EU-15.

As in other countries, in the 10 new member states population ageing is the product of the cumulative effects of a lower fertility rate up to 2005 and the very slight increase in the rate anticipated after 2005 (Figure 3), together with a constant increase in life expectancy up to 2050, which is to a large extent attributable to improved health conditions and public health care provision (Figure 4).

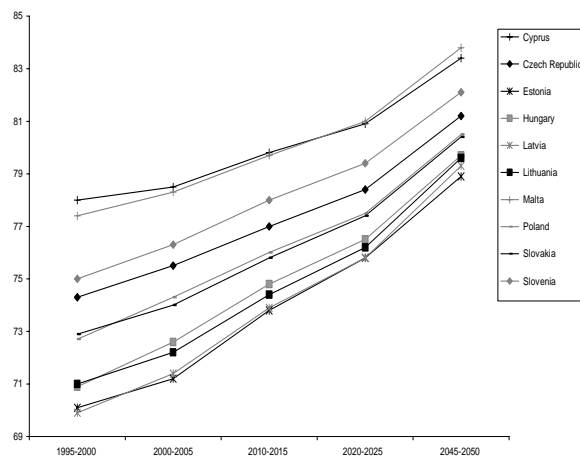


Figure 3. Fertility rate: 1950-2050



Source: United Nations Secretariat (2005).

Figure 4. Life expectancy at birth: 1950-2050



Source: United Nations Secretariat (2005).

The evolution of the fertility rate and of life expectancy at birth will clearly affect pension sustainability and, indirectly, the possibility of allocating expenditure to dependency care. Yet the cumulative effects of increased life expectancy and a decrease in the fertility rate do not, on their own, explain population ageing and the problems posed for the sustainability of the system. In the case of Central Europe, account also needs to be taken of the effects of emigration. Political and economic changes resulting from the disintegration of communist regimes led to international migration among countries with economies in transition, as well as migration from these to countries with established market economies.

Overall, since 1980, net migration rates have decreased in five of the eight countries of Central Europe. Table 2 shows a positive net migration rate solely for the Czech Republic and Slovenia. In these two countries, inflows are positive owing particularly to the population influx from countries in transition. Between 1990 and 1999, for example, 84% of inflows to the Czech Republic were from other countries in transition. Migration has a significant impact on the

population trends in these countries. During the 1990s, the Czech Republic gained 44,000 migrants although its population declined by 30,000.

Net immigration in both countries is accounted for by the fact that they have become poles of attraction. Slovenia, for instance, has the highest GDP per capita in the entire region and enjoyed the strongest GDP growth during the 1990s (United Nations Secretariat, 2002).

Of the other six countries, Latvia and Estonia have experienced the largest negative net migration rate (-10% and -7.4% between 1990 and 1995 respectively, and -4.7% and -2.5% between 1995 and 1998). Yet, the three Baltic States have put in place restrictive policies concerning entry for permanent settlement.

*Table 2. Net international migration in the eight transition economy countries that joined the EU in May 2004*

| Country        | Net migration rate (%) |         |
|----------------|------------------------|---------|
|                | 1990-95                | 1995-98 |
| Czech Republic | 0.6                    | 0.7     |
| Estonia        | -7.4                   | -2.5    |
| Hungary        | -0.6                   | -0.0    |
| Latvia         | -10.0                  | -4.7    |
| Lithuania      | -3.9                   | -1.1    |
| Poland         | -2.0                   | -0.9    |
| Slovakia       | 0.0                    | 0.0     |
| Slovenia       | 0.1                    | 0.3     |

*Source:* United Nations Secretariat (2002).

Moreover, according to recent research, EU enlargement can be expected to produce an impact on migration flows in the years following accession. The opening up of borders should facilitate the migration of workers from new member states towards the EU-15 countries, particularly Germany and Austria (United Nations, 2002).

The migratory situation of these countries is largely driven by the desire to improve one's economic circumstances. Hence, the persons most likely to emigrate are those of working age (15 to 64 years). The age structure of the population is thus affected by a fall in this age bracket, which in turn leads to a fall in the employment rate and, therefore, a reduction in financial support for the ageing. As in the countries of Western Europe, it involves a reduction in the 'potential support ratio' for the future. Whereas in 2005, more countries from the 10 new member states were ranked among the EU-25 countries with a lower old-age dependency rate, by 2050 they are expected to be ranked among those EU countries with a higher old-age dependency rate (Table 3).

It is important to note, however, that emigration also has an impact on the population ageing of the host countries, affecting their age structure by increasing the share of the 15-64 bracket. The resulting evolution of the population pyramid entails, on the one hand, an increase in the fertility rate, given that this age bracket includes those of procreation age and, on the other hand, a decrease in life expectancy, since the immigrant population comes from countries with a lower life expectancy. These two elements contribute to a slowing down of population ageing in the host country. Lastly, the employment rate of the host countries also increases, thus helping to reinforce the financial sustainability of the welfare system.

Table 3. Countries in Central Europe ranked by ascending order of old-age dependency rate among the EU-25 countries (2005 and 2050)

| 2005 |                |                 | 2050 |                |                 |
|------|----------------|-----------------|------|----------------|-----------------|
| Rank | Country        | Dependency rate | Rank | Country        | Dependency rate |
| 12   | Latvia         | 0.46            | 3    | Slovenia       | 3.53            |
| 13   | Estonia        | 0.44            | 4    | Czech Republic | 3.22            |
| 15   | Lithuania      | 0.43            | 8    | Slovakia       | 2.25            |
| 18   | Hungary        | 0.40            | 9    | Poland         | 2.17            |
| 19   | Slovenia       | 0.38            | 11   | Latvia         | 2.04            |
| 20   | Malta          | 0.36            | 12   | Hungary        | 2.04            |
| 21   | Cyprus         | 0.34            | 13   | Malta          | 1.96            |
| 22   | Czech Republic | 0.34            | 16   | Lithuania      | 1.79            |
| 23   | Poland         | 0.30            | 20   | Estonia        | 1.43            |
| 25   | Slovakia       | 0.28            | 24   | Cyprus         | 1.03            |

Note: *The old-age dependency ratio is the ratio of the population aged 65 years or over to the population aged 15-64. The hypotheses retained for projections are the median variant with a moderate recovery of fertility.*

Source: Data from UN online database.

The challenge already faced by the EU-15 countries as regards pension and health system financing will emerge to a greater extent in the new member states in the future. Although the above data can give some indication of population ageing in these countries and the consequences this will have for pension and health system financing, they say little concerning the situation of the dependent elderly, which could impact negatively on the financial sustainability of the systems.

## 2.2 Dependency status

Little information is available on the dependency status of the elderly. The World Health Organisation (WHO) and national statistics services provide some pointers as to the proportion of disabled persons, but the data do not allow comparison between countries. The reference years are not the same, for example the data for Cyprus are from 1992 and for Lithuania from 2001. The underlying definitions are also very different and thus result in very disparate figures as regards the proportion of dependent persons. While the share of Cypriots aged 60 and over with a disability is put at approximately 12%, the figure for Hungary is almost 36% (Table 4). Finally, not all definitions correspond to the exact definition of dependency, which includes any intervention by another person for the performance of daily life activities.

In view of the shortage of precise data concerning the dependent status of the elderly population, the singling out of the proportion of persons aged 80+ appears a more appropriate approach to help identify the number of the dependent elderly. The prevalence of dependency increases greatly with age, with an upward surge between ages 80-85, at least in Western European countries.

Figure 5 presents, for 2005 and 2050, the proportion of persons aged 80 and over plotted against the share of the over 65s, according to the proportion of the latter group in the population overall. Plotting in this way allows us to avoid the effects of population ageing that essentially result from a fall in the birth rate by observing only the age structure of the elderly population. The first result to be noted is the lower proportion of the oldest persons in the new member states compared with the other EU countries, for both 2005 and 2050. The new member states will, however, see an increase in their oldest populations. In all cases, the share of this category among the over 65s is forecast to be between 26% and 33% in 2050, compared with 19% and 22% in 2005.

*Table 4. Share of disabled persons by country*

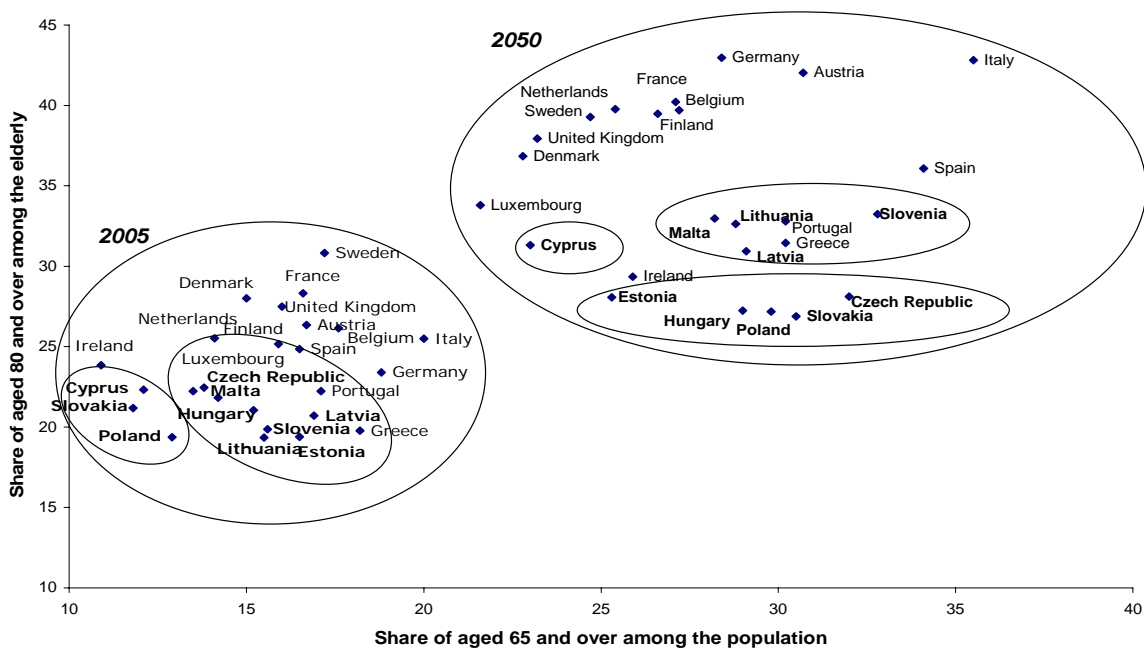
| Country   | Share of disabled (%) | Age         | Year | Sources                     | Disabled dependency  |
|-----------|-----------------------|-------------|------|-----------------------------|--|
| Cyprus    | 12.9                  | 60 and over | 1992 | WHO                         | Activity limitations:<br>a. Are ... usual activities limited because of a long-term physical or mental condition or health problem?<br>b. Does ... have any long-term disability or handicap?<br>c. What kind of disability or handicap does ... have:<br>– Disability of the sense organs?<br>– Other physical disability?<br>– Intellectual disability?<br>– Psychological disability?<br>– Other? |
| Estonia   | 19                    | 65 and over | 2000 | National statistic services | Mobility, hearing, sight/vision, mental and internal organs  |
|           | 21                    | 80 and over |      |                             |  |
| Hungary   | 36                    | 60 and over | 2001 | National statistic services | Limitation in motion, lack of upper or lower limbs, other deficiencies in the body<br>Amblyopic, blind in one eye, blind in both eyes<br>Mental deficiency, poor hearing, deaf, deaf and dumb, dumb, defective speech and other  |
| Lithuania | 18                    | 65 and over | 2001 | National statistic services | Not specified  |
|           | 17                    | 80 and over |      |                             |  |
| Malta     | 15.6                  | 60 and over | 1995 | WHO                         | Does this person have any long-term disabilities or handicaps?   |
| Poland    | 34.2                  | 60 and over | 1988 | WHO                         | Not specified  |

*Note:* Data are not available or are non-existent for the Czech Republic, Latvia, Slovakia and Slovenia.

In the case of 2005, two groups of countries can be distinguished. The first comprises Cyprus, Slovakia and Poland, where the share of the oldest persons is similar to the other countries, but the share of the elderly among the population as a whole is somewhat smaller. The other countries' share of the oldest persons is similar to this first group, but they have a higher proportion of over 65s. Thus, in 2005 the differences in terms of population ageing among the new member states depends not so much on the oldest segments but on the youngest within the elderly category. In 2050, the 10 countries will be distinguishable on the basis of the proportion of the oldest segment, with three distinct groups:

- Malta, Lithuania, Latvia and Slovenia are estimated to have a proportion above 31%.
- Estonia, Hungary, Poland, Slovenia and the Czech Republic are projected to have the lowest proportion of oldest persons of all the Central European countries (i.e. below 28%).
- Lastly, Cyprus is rather different in that its share of elderly persons in terms of the overall population is quite low but the proportion of the oldest segment within the overall category of the elderly is somewhat higher (23% and 31% respectively).

Figure 5. Share of persons aged 80+ among the population aged 65+ according to the share of 65+ among the population as a whole



Note: The hypotheses retained for projections are the median variant with a moderate recovery of fertility.  
 Source: United Nations' projections.

Therefore, although the previous section revealed that the populations of new member states will experience more extensive ageing than the general EU population in 2050, this should not affect the share of the oldest persons to the same extent that it affects the share of the elderly among the population overall. In other words, the proportion of oldest persons is not expected to increase as heavily as that of the elderly among the population as a whole.

Life expectancy at birth can help explain this circumstance. The countries of Central Europe generally have lower life expectancy at birth than the other EU countries (Figures 6(a) & 6(b)). While women can expect to live on average to at least 79 years in Western Europe, in the new member states they are unlikely to live beyond this age. Malta and Cyprus have a life expectancy close to that of Western Europe. The same distinction among countries can be drawn in the case of men's life expectancy, although the threshold age here is 72.

Another notable point from Figures 6(a) and (b) is the relation between life expectancy at birth and healthy life expectancy for European countries. For men and women, the lower the life expectancy, the longer is the life expectancy with bad health. The age at which the prevalence of dependency occurs appears slightly lower in Central European countries, although the elderly in these countries are likely to require help for a longer period of time.

Figure 6(a). Life expectancy at birth and the difference between life expectancy at birth and healthy life expectancy

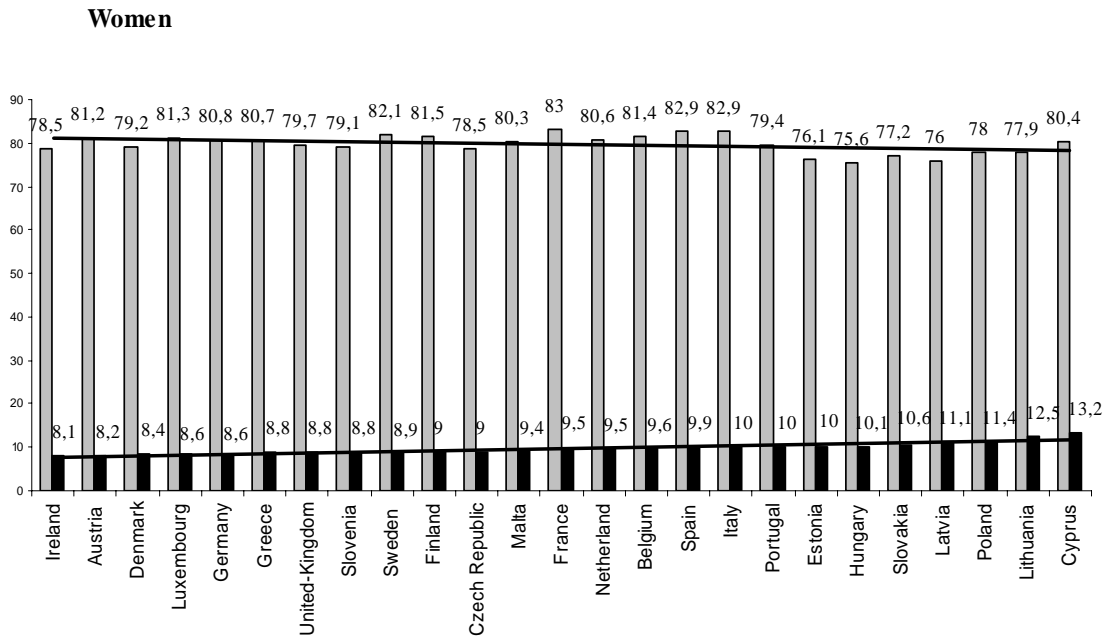
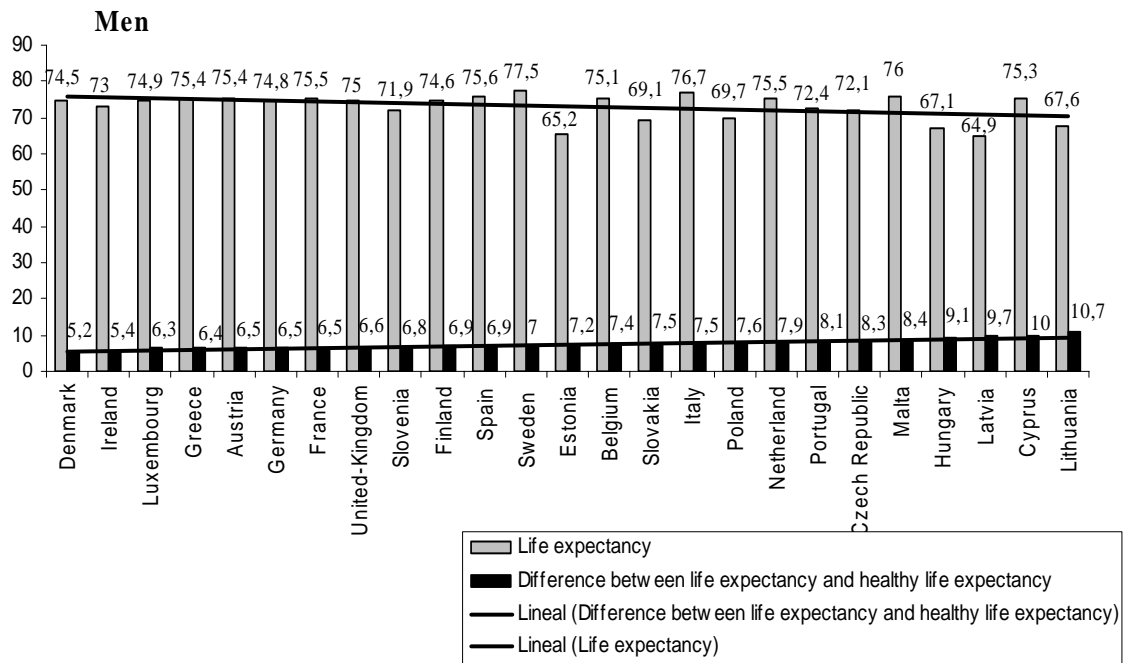


Figure 6(b). Life expectancy at birth and the difference between life expectancy at birth and healthy life expectancy



Source: Country profiles report from United Nations Economic Commission for Europe (UNECE).

Finally, although the populations of the new member states are not yet as old as their counterparts from Western and northern Europe, they are expected to age more quickly. Notwithstanding the lack of data on the proportion of elderly persons who have lost their self-sufficiency, and even though their life expectancy is lower than that in EU-15 countries, the data from UNECE show that the end-of-life period in poor health is longer in the new member states. The recent setting up of health insurance systems should be accompanied by an improvement in the health status of the population in decades to come and, consequently, by an increase in life expectancy and a higher proportion of elderly persons who lose their self-sufficiency. Therefore, although the new member states are not yet confronted to the same degree as EU-15 countries by the problem of elderly dependency, they can be expected to experience a similar problem in the coming years. This situation, however, only prevails if the elements taken into account are assumed to remain constant. Let us imagine, for example, that citizens from Central Europe decide to retire in Cyprus or Malta. The situation would be reversed for the Central European countries and would worsen in Malta and Cyprus.

Now, what measures have been put in place by the new member states to assist with daily life activities and will these measures provide adequately for the increased proportion of the dependent elderly? The next two sections of this report seek to answer these questions, which are important given the context of imbalance in the financing of population ageing.

### **3 Institutional provision**

As previously mentioned, provision for the loss of self-sufficiency among the elderly population does not come from one specific law alone. Where health care is guaranteed through a social health insurance system, needs arising under social services may be covered by other legislation. In the Czech Republic, Cyprus and Estonia, long-term care legislation is being contemplated in the form of a national assistance law, for instance. Consequently, allowances specifically for elderly persons requiring help for daily life activities have not been created. Except in Malta, Slovenia and Slovakia, allowances benefiting the dependent elderly in the new member states are granted to all persons who need daily life assistance, with no age criterion applied. In Slovenia and Slovakia, the age requirement is 65. Malta is distinguishable by the fact that it does not use the well-known definition of long-term care. In fact, needs and types of illness are a precondition for persons aged 60 and over to have access to an institution or a day care centre.

Malta is the only country where long-term care is included under a universal national insurance system. In the other countries, such care depends partly on national assistance, which involves income criteria being applied in order for benefits to be granted.

In Central and Eastern European countries, the moves towards decentralisation of welfare systems that followed the fall of the Soviet Union have led to regional organisation of long-term care in the majority of cases. Yet, whereas long-term care is organised at the regional level in Estonia and Poland, it is jointly insured by the state and the regions or by local government in the Czech Republic, Latvia, Lithuania, Hungary and Slovenia. Among the countries of Central Europe, only Slovakia centralises its long-term care services at the state level. In Cyprus and Malta long-term care is also organised at the state level.

Given that in the majority of the 10 countries long-term care provision is covered by legislation for other contingencies, it is difficult to obtain data concerning precise expenditure on the dependent elderly. That being said, in its online database Eurostat offers details of social protection expenditure on the aged. As can be seen in Table 5, the GDP share of social security benefits allocated to the elderly is lower in the new member states than elsewhere in Europe. Only the spending by Slovenia and Malta on social benefits for the elderly is close to the

average spent (in GDP terms) by European countries (1% and 0.9% respectively, compared with 0.9%, in 2001).<sup>2</sup> The three Baltic States spent a very low share of GDP on social benefits for the elderly (0.3% or less), while other countries allocated between 0.6% and 0.7%.

*Table 5. GDP share of social security benefits allocated to the elderly (excluding pensions) (2001)*

| <b>Country/region</b> | <b>% GDP</b>         |
|-----------------------|----------------------|
| EU-25                 | 0.9 <sup>(e)</sup> * |
| EU-15                 | 0.9 <sup>(e)</sup>   |
| Czech Republic        | 0.6 <sup>(t)</sup>   |
| Estonia               | 0.2 <sup>(t)</sup>   |
| Latvia                | 0.3 <sup>(t)</sup>   |
| Lithuania             | 0.2 <sup>(t)</sup>   |
| Hungary               | 0.7                  |
| Malta                 | 0.9                  |
| Poland                | 0.7 <sup>(t)</sup>   |
| Slovenia              | 1                    |
| Slovakia              | 0.6                  |

\* Social security benefits dedicated by the EU-15 equal those dedicated by the EU-25, even though the percentages for the 10 new member states are substantially lower, generally speaking, than for the other 15. This merely indicates that the global GDP of the 10 new member states represents a very low proportion of the global GDP of the EU-25. Indeed, the volume index of GDP per capita in purchasing power standards (PPS), expressed in relation to the EU-25, is 110.2 for the EU-15 and below 90 for the 10 new member states (the figure for the Czech Republic is 65.5; for Estonia, 44.4; for Cyprus, 88.5; for Latvia, 37.1; for Lithuania, 40.5; for Hungary, 55.9; for Malta, 72.9; for Poland, 45.4; for Slovenia, 74.6 and for Slovakia, 48.5).

<sup>(e)</sup> Estimated value

<sup>(t)</sup> Temporary value

*Note:* Data for Cyprus are missing.

*Source:* Eurostat.

### 3.1 Types of institutional provision

A wide range of help can be given to elderly persons who have lost their self-sufficiency. Those who live in their own home can avail themselves of community care services; otherwise, they may need residential home services.

As in most EU-15 countries, services for persons living at home vary. Basic services relate to assistance for daily life activities, such as home help, meals on wheels and incontinence care. Day centres have been created to provide care during the day for such elderly persons. Other more specific services – e.g. support centres providing vocational training – have also been established (Estonia and Latvia). The most widespread service is help in the home for dressing, personal hygiene or doctor's visits. Providers of such care also look after housework and, for example, monitoring. The Czech Republic, Hungary, Malta and Slovenia allocate the largest share of their GDP to daily life assistance (0.1%) (Table 6). Their expenditure on these social

<sup>2</sup> Pensions are not included in the GDP share of social benefits allocated to the aged. The figures are the sum of cash benefits including periodic care allowances, other periodic cash benefits and lump sum cash benefits, together with benefits in kind such as accommodation, assistance for carrying out daily tasks and other forms of benefits.



security benefits is close to that estimated for EU countries overall. Except for Cyprus, help with daily life activities is often the responsibility of local government or municipalities.

*Table 6. GDP share of social security benefits allocated to assisting the elderly in daily life activities (2001)*

| <b>Country/region</b> | <b>% GDP</b>         |
|-----------------------|----------------------|
| EU-25                 | 0.1 <sup>(e)</sup> * |
| EU-15                 | 0.1 <sup>(e)</sup>   |
| Czech Republic        | 0.1 <sup>(t)</sup>   |
| Estonia               | 0.0 <sup>(t)</sup>   |
| Latvia                | 0.0 <sup>(t)</sup>   |
| Lithuania             | 0.0 <sup>(t)</sup>   |
| Hungary               | 0.1                  |
| Malta                 | 0.1                  |
| Slovenia              | 0.0                  |
| Slovakia              | 0.1                  |

\* The very low proportion of the EU-25's global GDP that is represented by the global GDP of the 10 new member states explains the minimal impact of these 10 countries' share of social security benefits allocated to assisting the daily life activities of the elderly in the GDP share of the EU-25.

<sup>(e)</sup> Estimated value

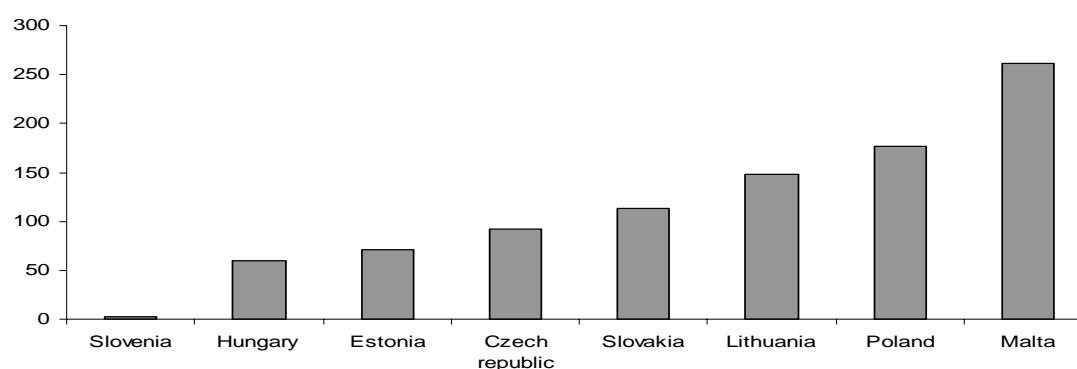
<sup>(t)</sup> Temporary value

*Note:* Data for Cyprus and Poland are missing.

*Source:* Eurostat.

Residential homes are generally organised at local level, although provision also exists in the form of non-governmental organisations in Lithuania for instance. Institutions caring for the dependent elderly can be of various types: rest homes, old people's homes, long-term care institutions, specialised institutions and geriatric units in hospitals. In Malta the number of long-term care beds is proportionally higher than in the other countries (over 200 per 100,000 inhabitants) (Figure 7). The figure for Poland and Lithuania is lower than for Malta but higher than the other countries (100-200 per 100,000 inhabitants). Slovenia is distinguishable by the extremely low number of long-term care beds (less than 5 per 100,000).

*Figure 7. Number of long-term care beds (except psychiatric care) per 100,000 inhabitants*



*Note:* Missing Cyprus and Latvia.

*Sources:* European Observatory on Health Care Systems (1999) for Hungary and Eurostat for the other countries.

The proportion of elderly persons in institutional care appears lower than in Western Europe. The proportion of the elderly aged 65+ in institutions does not exceed 3.6% (Table 7), compared with an average of 4.8% in OECD countries (2000).

*Table 7. Proportion of elderly persons living in institutions*

| <b>Country</b>              | <b>65 and over</b> | <b>80 and over</b> |
|-----------------------------|--------------------|--------------------|
| Cyprus                      | 3.6                | 11.4               |
| <i>Estonia</i> <sup>1</sup> | 5                  | 8                  |
| Latvia                      | –                  | 2.5                |
| Lithuania                   | 1                  | 2                  |
| Slovenia                    | 3                  | 10                 |

<sup>1</sup> Share of elderly persons in institutions among the disabled elderly.

*Sources:* Cyprus (Census 2001), Estonia (Census 2000), Latvia (data provided by the Ministry of Welfare), Lithuania (Census 2001) and Slovenia (Census 2002).

Other services provided to the elderly include home improvements, technical assistance and help with heating or rent costs, among others. Social security benefits granted for housing are on a par, in GDP terms, with the figures allocated by countries in Western Europe to housing assistance for their elderly (Table 8). Countries from the EU-15, like the EU-25, spend 0.2% of GDP on housing benefits for the aged. Malta (with 0.4% of GDP), and the Czech Republic and Latvia (0.3%), exceed the EU average. Hungary and Slovakia's spending is similar to that of EU countries as a whole, while Estonia, Lithuania and Slovenia devote just 0.1% of GDP to housing assistance for the elderly.

*Table 8. GDP share of social security benefits allocated to housing assistance for the elderly (2001)*

| <b>Country/region</b> | <b>% GDP</b>        |
|-----------------------|---------------------|
| EU-25                 | 0.2 <sup>(e)*</sup> |
| EU-15                 | 0.2 <sup>(e)</sup>  |
| Czech Republic        | 0.3 <sup>(t)</sup>  |
| Estonia               | 0.1 <sup>(t)</sup>  |
| Latvia                | 0.3 <sup>(t)</sup>  |
| Lithuania             | 0.1 <sup>(t)</sup>  |
| Hungary               | 0.2                 |
| Malta                 | 0.4                 |
| Slovenia              | 0.1                 |
| Slovakia              | 0.2                 |

\* The very low proportion of the EU-25's global GDP that is represented by the global GDP of the 10 new member states explains the minimal impact of these 10 countries' share of social security benefits allocated to elderly housing assistance in the GDP share of the EU-25.

<sup>(e)</sup> Estimated value

<sup>(t)</sup> Temporary value

*Note:* Data for Cyprus and Poland are missing.

*Source:* Eurostat.

In terms of the overall assistance provided, Malta can be differentiated on account of its more generous provision for the dependent elderly. At the opposite end of the scale, Slovenia appears to be the least generous.

## 3.2 Form of allocation

### *Form of help provided*

Institutional help can be allocated in the form of benefits in kind or in cash. In the case of home care services, the help can take the form of a range of services made available to the elderly, which are often rendered by communities. Public authorities employ home nurses to look after domestic maintenance and to provide personal care for the beneficiary, for instance. Dependent elderly persons can also access these services through cash allowances designed to pay someone to provide such care. As regards residential care, help in kind is characterised by the setting up of care institutions where the accommodation is subsidised by the authorities. Where help is given in cash to elderly persons living in an institution, the authorities pay a monthly allowance to cover costs. Data from Eurostat's online database enable us to distinguish benefits in cash from benefits in kind allocated by each country to the aged. On the whole, benefits in cash are less widespread than benefits in kind (Table 9). This trend can be explained by the fact that assistance for daily life activities, in the majority of the 10 countries, is provided through social assistance, which tends to take the form of community services.

*Table 9. Share of benefits allocated to the elderly in cash and in kind (2001)*

| <b>Country/region</b> | <b>% of benefits in kind</b> | <b>% of benefits in cash</b> |
|-----------------------|------------------------------|------------------------------|
| EU-25                 | 44                           | 56                           |
| EU-15                 | 44                           | 56                           |
| Czech Republic        | 83                           | 17                           |
| Estonia               | 100                          | 0                            |
| Latvia                | 100                          | 0                            |
| Lithuania             | 100                          | 0                            |
| Hungary               | 71                           | 29                           |
| Malta                 | 56                           | 44                           |
| Slovenia              | 10                           | 90                           |
| Slovakia              | 67                           | 33                           |

*Note:* Data for Cyprus and Poland are missing.

*Source:* Eurostat's online data.

Two types of benefits in cash can be identified. A 'care envelope' may be paid directly to enable the elderly to pay for any services required (Lithuania, Poland and Slovenia). This tends to be the case when the community cannot provide the services needed. The other solution is to pay the benefit to a relative who provides the care (Czech Republic, Hungary and Malta). In some countries, the two forms coexist (Cyprus, Latvia and Slovakia).

### *Elderly participation*

In most cases contributions by the elderly are a feature of dependency benefits, with means-testing a commonly used approach. Even though benefits are already awarded on the basis of income, the beneficiaries tend to have to contribute. Beneficiaries of services in kind – such as technical help, home care, day centres or meals on wheels – pay a sum proportional to their income in Hungary, Slovenia and Slovakia, although some variants exist. In Slovenia services are free of charge for those whose only source of income is their social benefits. In Poland, elderly persons with an income of less than €6 per month are exempted from making a contribution. In some cases, a ceiling on the amount of participation is set (European Commission, 2005). In Lithuania, for example, a beneficiary cannot contribute more than 50%

of his/her income (pensions for the most part) to the cost of a day centre. In Estonia, participation in the cost of technical assistance can vary from 10% to 50% of income.

For its part Malta has established fixed amounts of participation for the four types of care mentioned above. The fixed amount for home care services depends on the living arrangements and if the beneficiary requires meal preparation. According to these criteria, participation ranges from between €2.35 and €5.28 per week. For day centre services, beneficiaries pay between €2.35 and €5.37 per month, €2.23 per week for meals-on-wheels services and between €0.17 and €0.27 for technical assistance such as the provision of incontinence pads. As can be seen, elderly persons in Malta contribute only very slightly to dependency services.

Elderly persons living in institutions must pay accommodation and cutlery costs in Estonia. In other countries participation in residential institution costs is means-tested. Some countries, however, have set up a maximum contribution threshold for those receiving social assistance. In Cyprus the elderly have to contribute up to 80% of their social insurance; Estonians can pay up to 85% of their social security income (pensions) and Lithuanians 80%. Lastly, in Hungary, elderly persons who have no income or do not have relatives who can afford to meet their family obligations are not asked to contribute to residential home costs.

Malta therefore stands out from the others owing to the high level of generosity of its provision for elderly persons needing assistance with daily life activities.

Along with their counterparts in Poland, elderly persons in Malta are the only ones to have an income higher than that of the under-65 population in their country (Figure 8). The elderly in Latvia, Slovakia, Estonia and Cyprus appear to have a considerably lower level of income than the rest of population.

Figure 8 shows the relative ratio of median incomes between the over 65s and under 65s. In 2000, the income of elderly persons in Malta was 12% higher than that of the working population (11% in the case of Poland). Although in Lithuania, Hungary and Slovenia the elderly have an income that is lower than the rest of the population in their country (12%, 11% and 11% less respectively) and closer to the average EU-15 ratio (86.3%), in Latvia, Slovakia, Estonia and Cyprus the general level appears much lower than that of the rest of the population.

Figure 8. Relative ratio of median incomes between persons aged 65+ and those younger than 65



Note: The ratio for the Czech Republic is not given.

Source: Eurostat database.

## 4 Availability of care providers

### 4.1 Informal care providers

The role of the family is of considerable importance in elderly care, not just because of cultural values but also because the law sets out an obligation to assist a needy relative. In Hungary, for instance, social assistance is allocated to an elderly person who does not have a relative who can afford to meet their family obligations.

Data on living arrangements collected from statistical services or government ministries in new member states show that the population aged over 80 in new member states and the countries of southern Europe appear to live in the company of several persons more frequently than those in northern Europe. According to data for 5 out of the 10 new member states (Table 10), the proportion of over 80s living accompanied by someone other than their spouse is close to the figure for southern European countries in 4 cases. While between 33% and 45% live accompanied by persons other than a spouse in Italy, Greece and Portugal, the figure is between 27% and 45% in Hungary, Estonia, Lithuania and Slovenia (and below 27% for the majority of other EU-15 countries).

*Table 10. Make-up of households including a person aged 65+ and 80+*

| Country   | Age  | Living alone % | Living in a couple % | Other % |
|-----------|------|----------------|----------------------|---------|
| Cyprus    | 65+  | 22             | 68                   | 10      |
|           | 75 + | 29             | 57                   | 14      |
| Estonia   | 65 + | 36             | 41                   | 22      |
|           | 80 + | 43             | 18                   | 39      |
| Hungary   | 60 + | 28             | 57                   | 15      |
|           | 80 + | 19             | 54                   | 27      |
| Lithuania | 65 + | 30             | 47                   | 22      |
|           | 80 + | 34             | 23                   | 41      |
| Slovenia  | 65 + | 25             | 50                   | 25      |
|           | 80 + | 32             | 23                   | 45      |

*Sources:* Cyprus (Census 2001), Estonia (Census 2000), Hungary (Census 2001), Lithuania Census 2001), Slovenia (Census 2002).

Another indicator of housing arrangements is the average number of persons per household. Even if this indicator concerns the entire population of a country, and not just the elderly, it shows that people in the 10 new member states live in larger households than the rest of the European population (Table 11). Whereas households in the EU-25 on average comprise 2.4 people, in the Czech Republic, which has the lowest average number of persons per household among the new member states, the figure is 2.5. The average number per household is higher for the other new countries, reaching 3.1 in Poland and Slovakia.

Moreover, since the new member states do not have a higher fertility rate than the population in Europe overall, we can assume that the higher average number of persons per household is owing to the cohabitation of several generations and not to larger families.

Table 11. Average number of persons per household (2003)

| Country/region | Average number       |
|----------------|----------------------|
| Czech Republic | 2.5                  |
| Estonia        | 2.6                  |
| Hungary        | 2.6                  |
| Slovenia       | 2.6                  |
| Latvia         | 2.8                  |
| Lithuania      | 2.9                  |
| Cyprus         | 3.0                  |
| Malta          | 3.0                  |
| Poland         | 3.1                  |
| Slovakia       | 3.1                  |
| EU-25          | 2.4 <sup>(e) *</sup> |
| EU-15          | 2.4 <sup>(e)</sup>   |

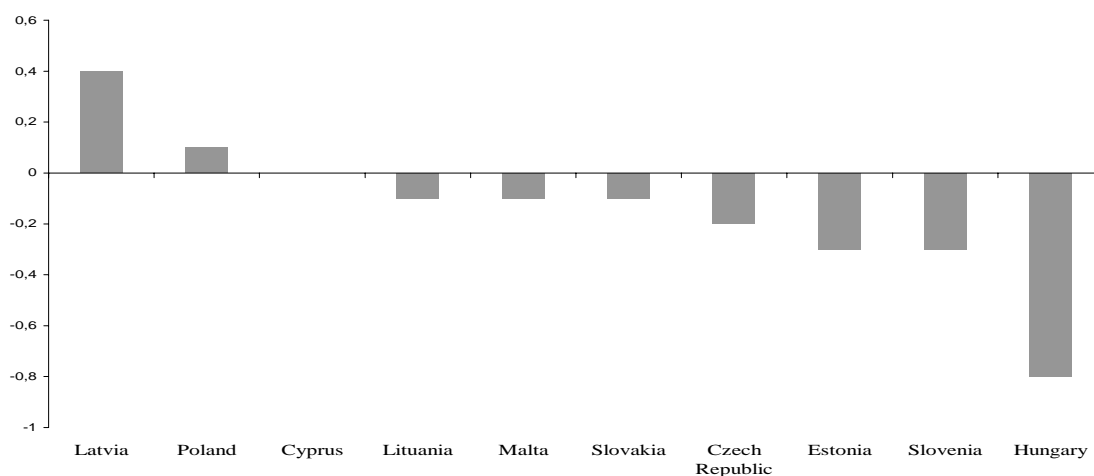
\* The low proportion of the new member states' population in the EU-25 (16.4%) explains the low impact of these 10 countries on the average number of persons per household in the EU-25.

<sup>(e)</sup> Estimate

Source: Eurostat.

The average number of persons per household has nevertheless decreased in recent years in most of the new member states (Figure 9).

Figure 9. Evolution of the average number of persons per household during the last decade



Source: Eurostat.

According to these results, therefore, the social support provided by family members can be assumed to have decreased.

In tandem with changes in family structures, the increase in the numbers of women in employment also contributes to the drop in the number of potential providers of care to the dependent elderly. Among the 10 new member states, only in Poland, the Czech Republic and Lithuania did the proportion of women in employment decrease between 1999 and 2003, albeit on a much smaller scale (by -1.7 percentage points for Poland and by -0.4 percentage points for

Czech Republic and Lithuania) (Table 12). The proportion increased by less than 1 percentage point in Slovenia, Malta and Slovenia, more than 2 percentage points in the other countries and by as much as 12 percentage points in Cyprus.

*Table 12. Proportion of women in employment (%)*

| <b>Country/region</b>          | <b>1999</b>   | <b>2003</b>  |
|--------------------------------|---------------|--------------|
| Czech Republic                 | 54.30         | 53.90        |
| Estonia                        | 55.50         | 56.40        |
| Hungary                        | 43.00         | 45.10        |
| Slovenia                       | 53.60         | 53.70        |
| Latvia                         | 52.60         | 54.50        |
| Lithuania                      | 58.50         | 58.10        |
| Cyprus                         | 44.80         | 56.50        |
| Malta                          | 24.90*        | 25.40        |
| Poland                         | 53.20         | 51.50        |
| Slovakia                       | 54.30         | 56.80        |
| <i>EU-10 new member states</i> | <i>51.70*</i> | <i>51.80</i> |
| <i>EU-15</i>                   | <i>48.30*</i> | <i>48.80</i> |
| <i>EU-25</i>                   | <i>48.80*</i> | <i>49.30</i> |

\* Data from 2002.

Source: Eurostat.

Indicators commonly used in studies concerning the elderly in the EU-15 and illustrating the fall in family support show that the elderly in new member states are confronted by the same trend, albeit on a much larger scale owing to the higher proportion of women in employment in these countries.

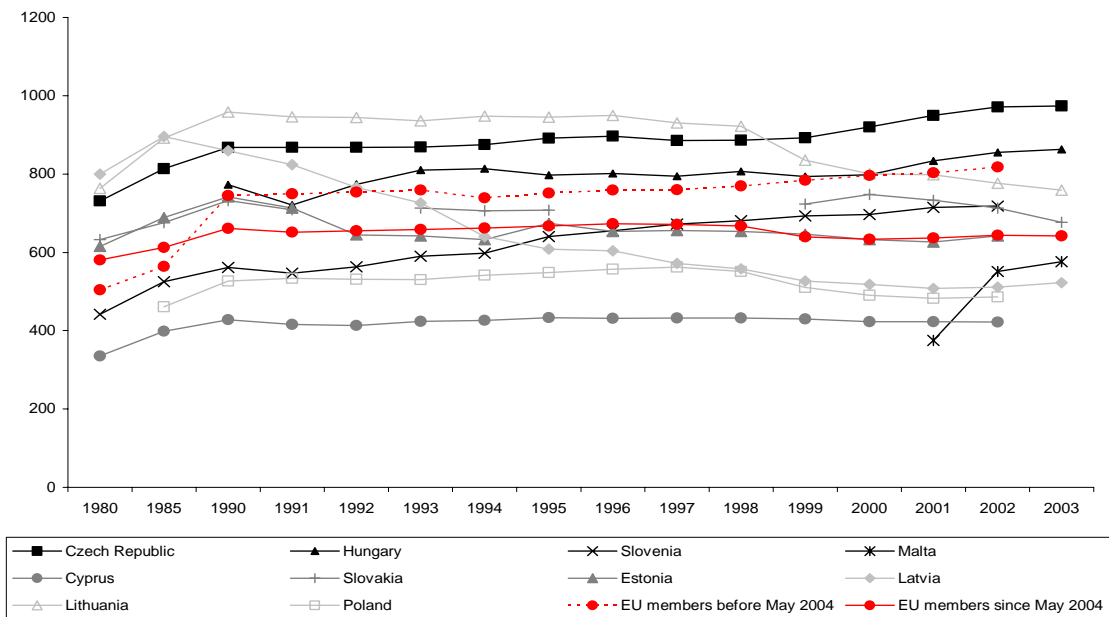
## **4.2 Formal care providers**

Although little information on home help is available, information on nurses does exist for all the new member states. The needs of the dependent elderly come under both social services and health care services, and thus it is difficult to know the distribution of tasks under each (i.e. home help and nursing). In practice, nurses are often used for jobs that do not require their expertise, such as help in the home. In Estonia, the limited budget of local administrations or municipalities leads nurses to perform roles theoretically falling under the home help category.

Different measures have been taken by states to relieve the nurses of some of the tasks not in line with their qualifications. In Malta, the government has introduced health assistants and nursing aides. In Slovenia additional training is required for geriatric nurses.

In some countries, governments have made an effort to enhance the attractiveness of the profession. In Hungary, the level of education of nurses has been raised to post-secondary, for instance. In Malta, Estonia and Slovakia nurse training has been developed. Figure 10 shows that in the Czech Republic, Hungary, Slovenia and Malta, the number of nurses per 10,000 inhabitants has increased in recent years. In Cyprus, Slovenia and Estonia it has remained stable, whereas it has fallen in Latvia, Lithuania and Poland. For the most part, the poor wages on offer explain the low number of nurses in these countries.

Figure 10. Number of nurses per 10,000 inhabitants



Source: Data from UN online database.

A characteristic of formal/informal care provision in the 10 new member states is the replacement of one form by the other. Indeed, the countries where fewer persons live under the same roof tend to be those that invest most heavily in nursing training and, consequently, have the highest number of nurses per inhabitant. This is true of the Czech Republic, Hungary and Slovenia. Conversely, countries with a higher average number of persons per household tend to be those with the lowest number of nurses (Slovakia and Poland).

## 5 Concluding remarks

Given the consequences of an ageing population on the sustainability of welfare systems in the EU-15 and the emerging risks associated with a rising share of the dependent elderly, it has been considered important to examine the situation of the 10 new member states with respect to loss of self-sufficiency and the role currently played by the state in addressing such loss. We have felt it important to identify, in terms of demographic evolution, the extent to which these countries will face similar problems and, if so, whether their welfare systems are equipped to respond accordingly.

As the first part of this report shows, the new member states have not yet been confronted by the problem of elderly dependency on the same scale as EU-15 countries. According to UN projections, however, the old-age dependency rate between generations is expected to increase more in the new member states than in the rest of Europe over the next five decades and potential family support is also expected to decrease in most of the 10 countries. Hence the new member states will be faced with the problem to an even greater degree.

From the data presented in the second and third sections, provision for caring for elderly persons who lose their self-sufficiency does not appear fully established in the 10 countries as yet. The data are imperfect of course, particularly owing to lack of availability, but at least they



give an outline of the current situation regarding help for aged persons who lose their self-sufficiency. The lack of available data is indicative of the weakness of institutional provision for such care.

According to the data, distinctions may be drawn among member states as regards provision. The provision of care for the dependent elderly in Malta and Slovenia appears better than in the other countries and consequently they seem better prepared for the future. These two countries will have a sizeable proportion of the oldest segment among their elderly populations in the near future and they currently spend the largest share of GDP on the aged. Similarly, they have a high number of long-term care beds and nurses per inhabitant, which is not surprising since both countries are considered to be the most prosperous of the 10 new member states in terms of economic and social development (Le Plan, 2004). Although Poland is considered to be far from prosperous in terms of economic and social development, in the field of ageing and the provision for the dependent elderly in particular it appears better placed than most of the other new member states. It spends a considerable share of GDP on the aged, has a high number of long-term care beds and, as in Malta, the elderly appear to have greater purchasing power than their fellow citizens. The other countries seem less generous as regards the help granted to the dependent elderly. The three Baltic States are distinguishable from the others in that the GDP share allocated to the dependent elderly is low despite the fact that they are expected to be among the countries with the oldest populations in the coming decades.

The fact that provision for dependent elderly care is covered by several different laws explains this poor degree of development. Perhaps the new member states should set up a specific mechanism to provide the care required by the dependent elderly. The challenge appears to be greater than that faced by the EU-15 countries, notably in terms of financing, given that the new member states can expect to suffer a more substantial drop in the size of their workforces. Nevertheless, one has to wonder as to the direction the EU should take concerning the dependent elderly and the development of welfare systems, namely, whether it should maintain the existing heterogeneity or foster a harmonious approach to the current situation, given that – as seen above – migratory effects can benefit the most prosperous economies but impact negatively on the least prosperous.

## References

---

- Bontout, O., C. Colin and R. Kerjosse (2002), “Personnes âgées dépendantes et aidants potentiels : une projection à l’horizon 2040”, *Etudes et Résultats*, No. 160, DREES, February.
- Busse, R. (2002), “Health Care Systems in EU Pre-Accession Countries and European Integration”, *Arbeit und Sozialpolitik*, No. 5-6/2002, pp. 40-9.
- Cho, E., S. Horstmann, M. Kaiser, W. Schmahl, E. Mossialos, M. McKee, L. MacLehose, M. Evans and M. Pellny (2002), *Study on the Social Protection Systems in the 13 Applicant Countries, Synthesis Report*, Second Draft, GVG, Köln and Brussels, November.
- Le Plan (2004), “Future Studies in the EU’s New Member States”, *Les Notes d’ALEPH*, No. 24, Commissariat Générale du Plan, Paris.
- European Commission (2005), *La protection sociale dans les Etats membres de l’Union européenne, de l’Espace économique européen en en Suisse : situation au 1er mai 2004*, DG for Employment and Social Affairs (MISSOC), European Commission, Luxembourg.
- European Observatory on Health Care Systems (1999), *Health Care Systems in Transition: Hungary*, European Observatory on Health Care Systems, Brussels.
- Monnier, A. (2004), “L’Union européenne élargie: quinze+dix=455”, *Population et Société*, No. 398, INED, Paris.
- Sen, A. (1999), *Development as freedom*, Oxford: Oxford University Press.
- United Nations Development Programme (2004), *Human Development Report 2004*, United Nations, New York.
- United Nations Secretariat (2005), “World Population Prospects: The 2004 Revision”, *Highlights*, Population Division of the Department of Economic and Social Affairs, United Nations, New York.
- (2002), *International Migration from Countries with Economies in Transition: 1980-1999*, Population Division of the Department of Economic and Social Affairs, United Nations, New York.

## Further Reading

---

- Abela, A.M., G. Cordina and N.M. Azzopardi (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Malta Country Study*, GVG, Köln and Brussels, January.
- Bite, I. and V. Zagorskis (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Latvia Country Study*, GVG, Köln and Brussels, January.
- Buivydas, R. and A. Dobravolskas (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Lithuania Country Study*, GVG, Köln and Brussels, January.
- European Observatory on Health Care Systems (1999), *Health care systems in transition: Cyprus*, Brussels.
- (1999), *Health care systems in transition: Czech Republic*, European Observatory on Health Care Systems, Brussels.
- (1999), *Health care systems in transition: Estonia*, European Observatory on Health Care Systems, Brussels.
- (1999), *Health care systems in transition: Latvia*, European Observatory on Health Care Systems, Brussels.
- (1999), *Health care systems in transition: Lithuania*, European Observatory on Health Care Systems, Brussels.
- (1999), *Health care systems in transition: Malta*, European Observatory on Health Care Systems, Brussels.
- (1999), *Health care systems in transition: Poland*, European Observatory on Health Care Systems, Brussels.
- (1999), *Health care systems in transition: Slovenia*, European Observatory on Health Care Systems, Brussels.
- (1999), *Health care systems in transition: Slovakia*, European Observatory on Health Care Systems, Brussels.
- Gál, R.I., Z. Mogyorósy, Á. Szende and P. Szivós (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Hungary Country Study*, GVG, Köln and Brussels, January.
- Golinowksa, S., K. Pietka, C. Sowada and M. Zukowski (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Poland Country Study*, GVG, Köln and Brussels, January.
- Haulikova, L. and L. Vagac (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Slovak Republic Country Study*, GVG, Köln and Brussels, January.
- Hungarian Central Statistical Office (2003), *The Elderly People in the Contemporary Hungary Data of Household Budget Survey from 1993–2001*, Budapest.
- Koldinská, K., I. Tomeš, K. Koldinská and J. í N mec (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Czech Republic Country Study*, GVG, Köln and Brussels, January.
- Leppik, L. and R. Kruuda (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Estonia Country Study*, GVG, Köln and Brussels, January.
- Republic of Latvia (2004), *Social Report for 2002-2003*, Ministry of Welfare, Riga.

- Monnier, A. (2000), “La population de l’Europe: 1950-2050”, *Population et Société*, No. 353, INED, Paris.
- Pashardes, P. (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Cyprus Country Study*, GVG, Köln and Brussels, January.
- Potucek, M. (2001), “Czech Social Reform after 1989: Concepts and Reality”, *International Social Security Review*, Vol. 54, No. 2/3, pp. 107-26.
- Prevolnik-Rupel, V., N. Stropnik, T. Stanovnik and M. Rebolj (2003), *Study on the Social Protection Systems in the 13 Applicant Countries, Slovenia Country Study*, GVG, Köln and Brussels, January.
- Statistical Services of Republic of Cyprus (2001), *Census of the Population: Households and Housing Units*, Vol. III, Government Printing Office, Nicosia.
- United Nations Secretariat (2001), *World population ageing: 1950-2050*, Population Division of the Department of Economic and Social Affairs, United Nations, New York.