Innovations and Care of the Elderly: The Front Line of Change for Social Welfare Services

*by John Baldock and Adalbert Evers**

How are western European countries facing up to the growth in the number of older people needing at least some daily care? A multi-national project funded by the Netherlands Ministry of Social Welfare in which we were involved attempted to find answers to this question by evaluating innovative alternatives to institutional care for the frail elderly in the Netherlands, Sweden and the United Kingdom.[1] The project's objectives were initially based upon the simple observation that in these and in other industrialized countries there was considerable interest and some experimentation in innovative ways of supporting dependent old people in their own homes. We thought that there might be something to be learned by comparing national experiences.

On further investigation we found that this pressure for innovation in the care of the elderly is part of a wider restructuring of European welfare systems. Paradoxically, the frail elderly are on the front line of these changes. They may reap the benefits of successful reform but they will also be among the first to pay the price of failure.

Patterns of Change

Throughout Europe there is movement from unicentric welfare systems dominated by state provision to more mixed forms in which state provision is explicitly integrated and balanced with private and informal sources. This shift involves alterations in the dominant ideologies of welfare in which traditional social rationales are expanded to include economic and market criteria (Table 1).

In all three of the countries we studied, fundamentally new patterns of public service provision for dependent old people that will come into effect during the period between 1990 and 1994. In each case the changes followed a period of debate and legislation set in motion by the reports of high level committees of inquiry: the Dekker Report *"Willingness to Change"* in April 1987, the Griffiths Report *"Community Care: Agenda for Action"* in March 1988, and the report of the Swedish Advisory Committee on Services for the Elderly in May 1989. There are strong similarities among these three reports. In rather prosaic and technical language, they effectively describe and call for fundamental changes in the classic post-war welfare state.

They do so, in part, because of demographic, economic and ideological pressures common to all European nations. Substantial increases in the number of old people who need some regular care are inevitable throughout the industrial world.[2] This is at least partly a result of the success of these nations in raising living and health standards and, hence, longevity. New expectations and assumptions about acceptable forms of care have also been brought about by higher living standards. In particular, people find institutional care for themselves and their relatives less acceptable. Higher incomes in retirement and better housing mean that people wish to remain in their own homes. At the same time, governments everywhere are unable or unwilling to sustain the care commitments made in the heyday of the post-war welfare state.[3] Public provision has always existed alongside commercial, voluntary and informal forms of care. Now governments of all political hues are much more explicitly pursuing policies to integrate and coordinate these sources.

Over the twenty-five years to 2010, the three nations we studied face considerable increases in the numbers of retired people at risk of dependency. The 85 plus age group, half of whom currently need help with an activity of daily living, will grow by 99% in the Netherlands, 76% in Sweden and by 92% in the United Kingdom. These ineluctable trends will be accompanied by two other near certainties. First, the provision of institutional care in hospitals and nursing homes, will not match this near doubling of the numbers who might, by current criteria, need it. Indeed, in each of the countries it is either explicit or implied policy to reduce the number of institutional places. Second, the supply of those people conventionally seen as potential carers for the frail elderly will not grow as fast as the numbers needing help. For example, the number of women age 50 to 69, a prime source of informal, family care for old people will actually fall during the period to 2010 in Sweden and the United Kingdom and, in the Netherlands, grow only a third as fast as the numbers in need of care. What is more, women in this age range are one of the few groups for whom labor force participation is unlikely to decline. In addition, institutional care will need to be much more precisely targeted on those with the greatest need and patterns of home care, and the policy and cultural assumptions that lie behind them, will have to change dramatically.

*See biographic information at end of article.

Table 1. Patterns of Change in Welfare

	Traditional Pattern	New Pattern
Changing Personal Care Services		
a. From standardized to flexible services	institution-based	home-based
	standard services	tailored services
	rigid, bureaucratic timetables	flexible, client-centered timetables
	independent services	coordinated services
b. From implicit to explicit interaction with informal care system	client as passive recipient	client as active co-producer
	informal care a private matter	informal care part of overall package
	informal care implicit and unrecognized	monitored, regulated
	formal and informal care operate as substitutes	formal and informal care are complementary
Changes in Welfare Systems		
a. From bureaucratic centralism to regulated pluralism	monopolistic public provision	pluralistic mix of welfare providers
	fragmented services	coordinated services
	state responsibility for the dependent	division of responsibility between state, family and voluntary sectors
	commitment to universalism	selectivity and targeting
b. From need-determined to cost-limited services	service volume determined by need	service volume limited by cost
	post factor budget limits	costs limits built into service delivery
	efficiency only at macro bureaucratic level	efficiency at micro-level of individual service decisions

Care for the Elderly in Sweden

In Sweden there is an established and relatively well-funded system of universal and standardized provision by the state. Even at quite low levels of need, old people can and do expect to receive well-known and off-the-shelf services from local government and the municipalities. The mildly disabled can get home help and this escalates with need until levels of residential or hospital are reached. The private and voluntary sectors play little part in this pattern and the considerable input informally by families and neighbors has, until recently, received little official recognition. The chief

The Sundsvall Project

Much of the policy debate in Sweden has centered around structural changes that will oblige the various medical and social professionals involved in the care of the elderly to cooperate more effectively. A notable innovation that demonstrated the fruits of cooperation was the *Sundsvall Project.* Sundvall is a municipality of about 100,000 people. At the end of the 1970s, as in many other parts of the country, all the institutional care facilities were bed-blocked and big waiting lists had built up. An academic study pointed out that as many as 40% of those in the ten residential homes (800 beds) were inappropriately placed. Some should have been more intensively cared for in the bed-blocked nursing homes, but most could have stayed at home with a more developed home help service (then limited to 10-12 hours a week) and with more collaboration between the home helps and the district nurses.

Many of the professionals had not met each other before beginning to meet in 1980 to plan a response to the research report. In time, the specific recommendations of the report became of less importance than these regular meetings between all the relevant participants. As the academics observed, "these discussions seemed to work as a catalyst for hidden energy and a desire among many people to change their working patterns."

Resources were shifted to the community care services. More flexible and appropriate home help was arranged, but, above all, the various participants perceived they had a common cause and began to work with each other in reaching decisions about the most appropriate placement for individual older people. The unblocking of hospital and institutional beds helped to assure both the elderly and their carers that a place would be found in an emergency and that they did not need to enter a home purely as an insurance policy. By 1987, the number of occupied beds in residential homes, nursing homes and geriatric wards had almost halved. Almost by accident considerable gains had been made by introducing flexibility into a system that had become too standardized and rigid in its operation. The services had operated in parallel without taking sufficient account of each other. Coordination on a case-by-case basis was found to be relatively simple once the key participants got to know and to trust one another. This innovation is notable for its very clear demonstration of what has become a central plank of Swedish reforms, the need to get all the relevant professionals to work together. It is largely to achieve this that the responsibility for care, both medical and social, is to be concentrated in the smallest unit of local government, the municipalities or 'kommunerna."

M. Thorslund, "The De-institutionalisation of Care of the Elderly: Some Notes About Implementation and the Outcome of a Swedish Case Study," *Health Policy,* 10, 41-56, 1988.)

difficulty with this system, which corresponds closely to the traditional forms in our table, is its inflexibility. As the population of elderly grew, the care system tended to become blocked at all levels. Individuals are allocated forms of care, not according to need, but in terms of its availability. In recent years there have been considerable attempts to reduce the bias to institutional forms of care by shifting public resources to domiciliary services and by encouraging coordination between home care and residential care. Thus, there is some movement to the new patterns outlined in Table 1. Nonetheless, the central criterion of service allocation remains functional need and there is little experience of using cost efficiency criteria or of encouraging a plurality of sources of help.

The 1989 report of a parliamentary committee, "The Advisory Committee on Services for the Elderly," has led directly to government legislation which will fundamentally reorganize the provision of public services by 1992.[4] Concentrating on a reorganization of public responsibilities for care of the elderly at the local level, the proposals include measures to improve and increase home care and to support informal carers. They are widely regarded as a turning-point in the development of Sweden's care-policy.[5]

Care for the Elderly in the Netherlands

The Netherlands is a little "behind" Sweden and the U.K. in terms of demographic development. It is just beginning to encounter the rapid growth of numbers in the age of high dependency. The system of care is unusual in that it consists of a considerable pluralism of providers most of whom provide rather traditional and uncoordinated services. The social care system is built on an insurance-based structure largely designed to provide health care for a younger population. Care is financed by the insurance funds and provided by voluntary and private agencies. The advantage of this pattern, from the point of view of users, is that it guarantees care, but with a strongly medical and institutional bias. An exceptional proportion of the Netherland's mildly dependent elderly have found themselves in high cost nursing homes which are close to long-term hospitals in their character. The government and the insurance funds are anxious to encourage substitution downwards towards cheaper and less institutional forms of care. In order for this to work it has become clear that greater cooperation is required by the various professional services and between them and the informal systems of

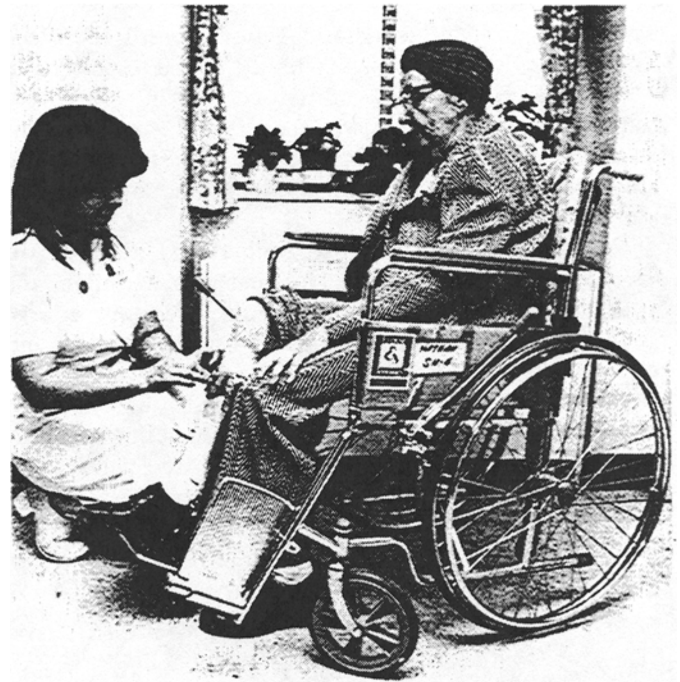
family care. Thus the Netherland's social care system is very much concerned with the problems of moving from the traditional to the new forms outlined in Table 1.

An advisory committee, set up by the government and chaired by Professor **Wisse Dekker**, the former president of the Board of Directors of Philips, the electronics firm, published a report in 1987 on the future of health care in the Netherlands, "Willingness to Change." Its principal remit was to advise on "strategies for volume and cost containment against the background of an aging population." Included within it were proposals that would substantially alter the existing forms of care for the dependent elderly by giving a much greater role to market forces and competition. These ideas have broadly been accepted by all the main participants in the care system but their detailed implementation is currently delayed by vigorous debate and battles for advantage among the many participants in the Dutch health care system. However, there is little doubt that a more market-oriented system will result.

Care for the Elderly in the United Kingdom

Care of the elderly is much less uniform in the United Kingdom than in the other two countries. Individual old people with similar needs may receive very different levels and forms of care. This is because the care system has been chronically underfunded for a long time. In principle there is a commitment to state-funded universal services. In practice these have never been able to meet the needs of more than a proportion of those nominally entitled to care. The result has been the growth of a considerable variety of forms of voluntary (not-for-profit), private (for-profit) and informal patterns of care. Many of these are quite innovative and low cost. The chief problems have been the inequity, unpredictability and consequent inefficiency that has resulted from the lack of effective collaboration by the state system of care with this considerable array of non-state provision. To some degree this was because of the continuing, if unrealistic, assumption of universalism on the part of managers and professionals in the public sector. The voluntary, private and informal systems have therefore developed considerable innovative ingenuity in filling the gaps left by inadequate and inflexible state help. March 1988 saw the publication of the "Griffiths Report," whose proposals have largely been accepted by the government in a "White Paper" and subsequent legislation.[7] The changes, which began to come into effect in April 1991, are designed to limit public responsibilities for the provision of care services and to actively encourage the growth of the mixed economy of care, particularly provision by commercial and voluntary agencies. Like Professor Dekker, **Sir Roy Griffiths** is a business man, formerly managing director of the Sainsbury's supermarket chain, rather than a member of the welfare policy-making community.

Thus, in all three of the nations studied there is now governmental recognition that the existing systems providing care for the elderly are unacceptable and unsustainable. It is clear that home care must be developed and that this requires a plurality of suppliers and services. Each country has some experience of small-scale innovations and experiments in coordinated home care provision. However, if these are to become generalized, then the very nature of the post-war welfare state needs amendment. Considerable changes will have to occur in the forms of the organizations that currently provide care and in the manner in which they normally relate to one another. More fundamental still, all this also involves a renegotiation of the nature of citizens' social rights and obligations.



UN Photo 148,959 by John Isaac

Local Innovations in the Care of the Elderly

In all three countries the debate about the future of care has been very much influenced by small-scale experiments in new ways of caring. These experiments are typical of systems under stress where the established modes of operation have become manifestly ineffective and discredited. It then usually becomes possible for energetic individuals to obtain support for experimentation with alternative methods for reaching social goals. This is sometimes referred to as "bottom up" innovation, though, in fact, the initiatives may as often come from ambitious middle management as they do from disaffected street-level professionals or outsiders in voluntary or private agencies. The next step in the process, though by no means an inevitable one, is for the methods used in the innovations to become the basis for substantial revisions in governments' social policy. This appeared to be what had happened in the three countries we studied.

In Sweden the influential innovations are still those that demonstrate "de-institutionalization." This is a society that in 1985 placed nearly 8% of its over 65s in one sort of institution or another and was spending 71% of its public sector care costs on those forms of care. The Hudiksvall and Sundsvall experiments are two that have had an impact on thinking about the system.

Care of the elderly in the Netherlands exhibits two distinct features which play a large part in determining the types of innovation found there. First, there are a large number of different agencies involved—state, voluntary and commercial. Second, the elderly are "protected" by considerable insurance-based entitlements to care—particularly in hospitals and nursing homes. Both these features push the overall system to higher than necessary costs. Consequently, innovations are typically initiated, or at least funded, by those responsible for paying for the insured benefits—the insurance funds and the government that subsidizes them.

The most influential Dutch innovations have been those that demonstrate substitution downwards and agency collaboration. The single point of entry approach is central to the government's substitution policy. For example, in the municipality of Venlo the Ministry of Welfare is funding an experiment under which all applications for help from the elderly, whether they be for volunteer aid or to move into a residential home, and dealt with initially at one of eight neighborhood welfare offices known as '*wijksamenwerkingsverbanden.*' As part of the innovation the number of residential home and nursing home beds have been reduced but upgraded to deal with a more needy clientele. This experiment typifies the pluralist approach to

Community Care: Expanding the Griffiths Report

*by Carole Cox**

Since 1946, with the enactment of the National Health Services Act, British social policy has reflected a consistent interest in community rather than institutional care as a means of assisting the dependent elderly both in respect of older persons' wishes and the belief that community care is less expensive than institutional care. Amendments to the National Health Services Act and new provisions enacted in the past 45 years have provided the framework for the expansion of community services such as home delivered meals, day care, telephone and alarm services, chiropody, social and recreational programs, and home help to older persons.

Further emphasis was given to the role of community care services as the appropriate system to provide assistance to older persons in *Community Care: Agenda for Action* (1988), also known as the "Griffiths Report." Based on a review of existing services, the report provides recommendations for a more effective and efficient community care system. Many of these recommendations were subsequently incorporated into the government's White Paper, *Caring for People: Community Care in the Next Decade and Beyond (1989)* and the *National Health Service and Community Care Act of 1990.* These proposals now constitute the framework for the development of policies and services in community care for the coming decades. The first stage of implementation took place in April, 1991.

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The White Paper and Community Care Act, as it has come to be called, gave further endorsement to the view that, for most persons, community care is the best form of care. A conscious effort has been made to promote choice and independence. Consequently, community care is envisaged as involving flexible and sensitive services, a wide range of options, the fostering of independence rather than dependence, and to be concentrated on those with the greatest needs. Local authorities will be obliged to assess the need for help when asked to do so by clients or professionals, and draw up individual care plans. Service delivery systems must promote the development of domiciliary, day, and respite services, and needs assessments must take into account the roles of informal caregivers.

Assessments are fundamental to the revised systems of care. They are necessary for the effective targeting of services and for assuring that care plans are congruent with individual needs. Careful assessments of problems, circumstances and resources must be made by interdisciplinary teams which explore what is necessary for the person to continue to live at home and, if necessary, what type of residential care would be most appropriate.

Care managers will play pivotal roles in insuring that individual requirements are met, that resources are effectively managed, and that each person has a single point of contact. Additionally, the care manager will be responsible for monitoring the quality of care. Each local social service agency is expected to outline how it will use the care manager and how the manager will be linked with available resources.

The new arrangements make it compulsory for the local authorities to explore the possibility of using non-statutory sources of care. Thus, where voluntary and private sources of care can be shown to be cheaper or better, they must be used and encouraged. The rationale behind this recommendation is that it will offer a wider range of services and stimulate

service coordination pursued by the Dutch. All the agencies are enticed into cooperation by the offer of extra resources and subsidies from government or the insurance funds. Case management is by agency collaboration, usually through regular joint committee meetings of all the relevant service suppliers, rather than through one coordinating individual. This however still tends to produce generalized solutions which work best when the elderly at risk are gathered together, rehoused on distinct sites, where they can be subject to regular monitoring and standardized routines.

The Zorghuis innovation is an example of one that pursues downward substitution—the avoidance of expensive and elaborate care when cheaper and simpler forms may be more appropriate. No one in the Zorghuis is likely to be treated at a level in excess of their needs. Neither are people likely to enter over-protective care merely as a form of insurance. At the same time, the presence of all the clients on the single site makes efficient collaboration between all the various agencies easy and efficient.

The "*Voorbij de laatste stad*" experiments in home care for terminal patients combine all the elements typical of Dutch innovation. They are a dramatic form of downward substitution—from acute care hospital to home; they involve a very wide range of collaborating providers—GPs, district nurses, voluntary and private for-profit care workers and organizations, family care workers and back-up support from hospital staff. They are funded by a complex array of sources—private funds, subsidies from the municipalities and from the nursing homes that would have normally accepted the insurance-funded patients, as well as direct payments for care from the funds themselves. The Dutch appear to excel in sustaining extraordinarily complex

competition between agencies which will result in more cost-effective services. Thus, a mixed economy of care has become explicit government policy. The social services, however, will determine the specifications for service contracts and also design procedures for assuring quality.

As of April 1993, a large proportion of the money previously spent by the social security system to pay for institutional care in private and voluntary nursing and residential homes will be transferred to local authorities. (This sum now tops £1 billion a year.) These monies can be used to either provide or purchase home care services of institutional care. Whether this rerouting of monies will actually lead to an increase in the amount and variety of home care services will depend very much on the inventiveness and flexibility of social workers.

As in the Griffiths Report, a requirement for implementing these changes in community care is the formation of local plans made in accordance with national objectives upon which the effectiveness of programs in achieving designated aims can be monitored. Some of the key points expected to be included in the plans are a needs assessment of the population, objectives for community care in the next three years, eligibility procedures, the procedure by which services will be purchased, training provisions, case management provisions, quality assurance systems, and how inspection is to be conducted. It is important to note that these plans are expected to complement those of the health and housing authorities and take into consideration the recommendations of other service providers and consumers. The first community care plans are to be developed by April, 1992 with full implementation planned for April, 1993.

Although the government is making great strides in its efforts to support and strengthen community care, there are several issues which remain to be addressed or clarified. Comments from *Age Concern England* (1990) regarding the proposals highlight some of the major points on which further information is required. Specifically, practical suggestions are needed for local authorities on how to improve services to caregivers.

Attention must also be given to the way in which the coordination of community care programs will be conducted without the proposed Minister of Community Care recommended in the Griffiths Report. To date, the government has not endorsed the establishment of such a position. Moveover, the absence of explicit requirements that local health, housing, and social services be involved in the design of community plans or the way in which this integration is to occur further threatens program cooperation. Without coordination at the national and local levels, there is concern that appropriate policies will not be developed or implemented.

In order to have standardized procedures throughout the country, Age Concern has recommended that guidelines and criteria for community assessments be developed at the national level.

With regard to service provision, older persons will be assessed a financial contribution for social services. Only individuals whose incomes are below the income support level and who have less than £3,000 in capital, including the value of their homes, will have their care paid for by local authorities. The remainder will either have to pay for the public services they receive or, more likely, will be advised from which private suppliers these can be purchased. Presently, it is not clear whether there will be separate means or income tests for housing and income support, as well.

However, even with the existing ambiguities in the government's proposals, the anticipated changes in community care are both exciting and impressive. They testify to the nation's interest and commitment to meeting the service needs of older persons.

The Hudiksvall Experiment

Hudiksvall is a town of 50,000 in the center of Sweden. By 1978 it appeared that the growth in demand was putting its care services under severe strain. All institutional beds were occupied and there were long waiting lists. Care staff felt themselves to be under excess pressure, morale was low and turnover was high. But instead of expanding institutional care, Hudiksvall became known for dramatic reductions in bed-blocking and a substantial rise in turnover in its geriatric wards with large numbers being returned to care in the community.

This was achieved by the enforcement of two basic rules by a new and charismatic geriatrician at the local hospital. First, families and patients were discouraged from regarding entry into a hospital as the beginning of long-term institutionalization. They were, for example, no longer allowed to bring their own furniture as had become customary. Second, the district nurses and the home helps were given the unilateral power to admit an old person back into hospital at any time and without first seeking the approval of a physician. Thus, families and the community care teams knew that they had a guaranteed fall-back position in an emergency should home care fail for any reason.

The consequences were dramatic. By 1988 the number of patients using each hospital bed a year has risen from 2 to 8 and the average length of stay had been reduced from 130 days to 20. At the same time, numbers in the local nursing home had fallen to an extent that there were always vacancies. The result was not experienced as extra pressure by families and care professionals. Rather, they reported higher levels of morale. Much of the fame of this innovatory approach resulted from the fact that it involved almost no overall increase in expenditure.

(L. Sundman, *Utvärdering av Hudiksvallsmodellen,* Doctoral thesis, Department of Social Medicine, Uppsala, 1990)

collaborative arrangements which would be almost bound to fail in other countries. The explanation would seem to be the very broadly-drawn entitlements under the health insurance schemes which generate powerful incentives for the funds to pay generously for innovative and potentially cost-cutting schemes.

In the U.K., compared with Sweden and the Netherlands, a chronic shortage of funds is more characteristic of the care system for the dependent elderly. This, however, provides rich soil for the growth of small scale innovation. It is clear from the recent policy documents that the most significant experiments have been those that demonstrate how to target public services more effectively and those that demonstrate how private and voluntary care can fill the gaps left between the two poles of state care and family care. Specifically mentioned in the 1989 community care White Paper were the innovative experiments in Kent (Thanet), Gateshead and Durham. These innovations were very much influenced by the large American literature on case management, and they now form the basis upon which the British government is currently implementing a reorganization of the care system for the elderly that will target those with high levels of dependency and endeavor, where possible, to provide support to people in their own homes rather than in institutions.

A corollary of this policy is that those with lesser needs will be encouraged to seek help from private and voluntary sources. Voluntary initiatives in the care of the elderly have usually been deliberately designed to do those things the statutory sector omits to do. In particular, British innovations often seek to provide help to those old people determined to stay at home and to the relatives supporting

Projectplan Zorghuis

An excellent example of the Dutch approach to welfare pluralism is the *Projectplan Zorghuis W. Drees* in the Hague. One-hundred nineteen housing units have been constructed on the site of a former nursing home. The object is to house retired people across the range of health and disability. Twenty-four of the units are for those who need intensive nursing while, at the other end of the spectrum, 65 are for those who would like to enter sheltered housing—in other words those who are largely independent but are concerned about the future. Another 30 units are for those who would have been accepted into a residential home.

The goal of this project is to minimize the need for old people to move if and when their disabilities grow. Since many of the residents are married couples, they will not become divided should one of them require nursing care. The communal facilities, meals, laundry, hairdressing and recreational facilities are also available to other elderly persons living in the neighborhood. The local home help and nursing agencies provide most of the services in the Zorghuis and help is available 24 hours a day.

Projectplan Zorghuis is an expensive solution in terms of the capital investment in buildings, at least in the short-term, and it does threaten to treat all the retired as if they have more in common with each other than with the wider community of all ages.

(C. Tunissen and A. Knapen, "Strengthening Home-Based Care in the Netherlands," in R.J. Kraan *et al. Care for the Elderly: Significant Innovations in Three European Countries.* Frankfurt and Boulder Colorado: Campus Westview, 1991)

Hospitals at Home in the Netherlands

The Netherlands has developed a particular speciality in innovating in the intensive care of the dying at home, called *"Vorbij de laatste stad."* For example, special projects have been carefully monitored in IJsselmonde, Beverwaard and Lombardije' since 1984 and in Amsterdam, Breda and Groningen since 1987. To date, they have dealt with well over 1,000 cases. These experiments are generally funded by the Ziekenfonds (insurance funds) responsible for hospital and nursing home costs, usually up to limits of about Dfl 200 (circa $112) a day. At these levels there are savings on hospital costs.

These experiments are, of course, made possible by individuals' frequent desire to die at home and close to their relatives. Much of the care and most of the coordination is taken on by the relatives. However, some of the patients who have received the service have had no one at home capable of carrying out this role. In these cases, someone from the many agencies involved, voluntary or professional, has taken on the role of coordinator. In all these experiments a key tool that is both simple and effective has been to keep a "log book" beside the bed of the patient in which all the helpers and professionals record the times of their visits, what they have done and what they think needs to be done. In this way all the participants are made visibly accountable to each other and to the patient.

These experiments test the limits of multi-agency cooperation in the intensive care of people in their own homes. They show the complex ways in which the market (in this case for care services) and informal sector can operate together in an interactive relationship. However, they do so under conditions of ample resourcing.

(C. Tunissen, and A. Knapen, "Strengthening Home-Based Care in the Netherlands.")

them. The *Family Placement Schemes* are an established example.

Voluntary groups have played an important part in developing services to give short breaks to the family carers of the dependent. In our review we found dozens of voluntary day centers run at very low unit costs. Some are targeted at specific groups among the elderly, for example the dementing or the mentally ill. Public domiciliary services are less likely to be provided where there is a carer than where the old person lives unsupported. There is growing evidence that some regular and simple in-the-home relief can enable carers who would otherwise give up to continue in their role. This is therefore a very cost-effective way of delaying or even avoiding entry into residential care. The *Crossroads Schemes,* which supplies helpers to take over for a few hours so that the carer can leave the house, have become well-known and are being replicated in the Netherlands.

Voluntary organizations have also begun to experiment with the provision of "paid helpers" who will go into the homes of elderly people in order to perform almost any needed task—dressing, cooking, cleaning, shopping, minor house repairs. Payment of small sums directly from the old people to the volunteers has been shown to work well in some cases, both increasing the supply of volunteers and encouraging some old people to accept help.

The Wider Implications of Innovations in the Care of the Elderly.

As we suggested earlier, these innovations and experiments have a wider relevance. Care of the elderly results in a demographic pressure point. Welfare systems generally change first at such pressure points and the reforms then spread. In the rest of this paper we discuss the wider implications of these, still local, innovative developments for European welfare—first for the provision of personal care services and then for the public welfare systems more generally.

From Standardized to Flexible Service Production

Once services are brought into peoples' own homes the apparent uniformity of their needs breaks down. The nature of the welfare task itself changes. It becomes less possible to ignore the variety, individuality and complexity of needs. The timing of services has to vary according to the routines of individual households. Greater sensitivity to the parts played by family carers is necessary. The monitoring of services and their outcomes is more difficult as they become relatively invisible in people's homes. In short, bulk production becomes inappropriate and relatively inefficient. More flexible, small-scale welfare institutions are required.

"Care tailored to the needs of the users" is a central phrase and idea in the Netherlands' Dekker report. However, a tailor-made service approach requires the system to move from uncoordinated and parallel services to coordinated service management, packaging the right bundle of services for the individual client. The intensive domiciliary care experiments suggest that the biggest problem lies in coordinating the efforts of the different bodies providing assistance and in the division of responsibilities between them.

Similarly, the Swedish Advisory Committee argued that "service, attention and care should be organized so that the help can be provided in a flexible manner on the basis of the needs and at different times through the day and night." The central mechanism for achieving this is to be the devolution of the provision of almost all public home care services to the level of municipalities ("kommunerna"). These will be responsible for the planning and coordination of home care with powers to contact provision from other

public sources—primarily county health services—and, where need be, from private suppliers. These proposals also require the public providers to take into account the work of family carers and to "enhance complementary roles for formal and informal care givers."[6]

In the United Kingdom, too, the Griffith's report recommended "that social service authorities should develop and manage packages of care tailored to meet most effectively, within their budgets and priorities, the needs of individuals" and that, in cases where "a significant level of resources are involved, a care manager should be nominated . . . to oversee the assessment and re-assessment function and manage the resulting action."

Thus, in all three countries what may at first have appeared to be a relatively simple goal—replacing unwieldy, expensive and unpopular residential care with better domiciliary services—has led to a complex reassessment of the fundamental model of state welfare itself. What might be called the "industrial model" is being replaced with a sytem of "bespoke tailoring" in which the state's function is to ensure the coordination of a range of specialized service producers.

On the face of it, welfare systems that aim to provide individualized services in peoples' own homes rather than mass-produce them in institutional "care-factories" are a step forward. However, there are considerable welfare risks attached to this pattern of progress.

One of the most uncertain areas concerns the welfare of those who do the caring work. A much criticized but, yet, at least partly valid function of residential care has been to protect the interests of the staff who work there.[8] The work is almost always poorly paid and the hours long, but a degree of unionization, at least in the public sector, and the shared nature of the workload have given residential workers some degree of protection from exploitation. It is much less clear how they are to be protected in home care systems. The most obvious way of obtaining the required flexibility is to deregulate the labor market of social care. A more ethical, but expensive approach is to renegotiate those regulations and to compensate workers for the extra burdens home care service may impose.

These problems have been more explicitly recognized in the Netherlands where new labor agreements are reached to compensate care workers for "unsocial" hours. In the United Kindgom, on the other hand, recognition of these special needs on the part of service providers, as distinct from those of the recipients, has been conspicuous by its absence. One clear lesson of successful innovations is that providing good home care is indeed a new occupation with considerable risk of labor exploitation. There is some evidence that the very viability of publicly-funded home care services sometimes depends on the use of personnel, usually women, who are in such a weak market position that they will accept exceptionally low pay and poor work conditions.[9] The post-industrial production of welfare is reminiscent of pre-industrial conditions. It would be a sad irony if the return to bespoke tailoring in the production of care were to recreate 19th century forms of homework and "sweat labor."

Family Placement Schemes

Family Placement Schemes are organized to give family carers some relief, yet do not involve sending an older person temporarily into an institution—an arrangement which both carers and cared-for often dislike. Family placements permit an elderly person to stay and receive care in a private home. The principal purpose is to offer respite to informal carers so that they may go out, go on holiday or just have some time to themselves. The assumption is that if this is not offered, the care may break down. It is also important to return the older person in as undisturbed a state as possible—otherwise another program objective is undermined. The best known of these schemes began in Leeds in 1977. Over 4,500 placements were made in the first decade, and it is a model that has been widely copied across the country.

The major task is to build up a panel of suitable "families," to train them and to support them. In Leeds and elsewhere, placement homes are initially vetted by social workers, but the training and support is often done by organizing the short-term carers into support groups. Not surprisingly, the key carers in the placement homes are middle-aged women, often with a residential home or nursing background. The placement families are paid, usually by the local authority, which then charges the client or obtains reimbursement from the social security system. Since the charge to the client is usually a good deal less than the payment, there is a large element of subsidy involved.

Variations on the original idea have evolved over time. For example, in 1987 the social services department in Cheshire set up a scheme which places elderly mentally ill with foster families. These are old people whose behavior is disruptive in a residential situation. The Cheshire scheme includes a day care element where two or three elderly persons go for day care in the private placement home, thereby offering day care to individuals who would be unable to use or be acceptable in a conventional day center. In Liverpool, the voluntary Personal Service Society has developed a scheme in which, instead of moving the client to the short-term carer's home, the carer goes to the client's home, usually while the regular carer is away on holiday.

(D. Leat, "A Home from Home: A Report of a Study of Short-term Family Placement Schemes for the Elderly." Mitcham: Age Concern Research Unit. 1983.)

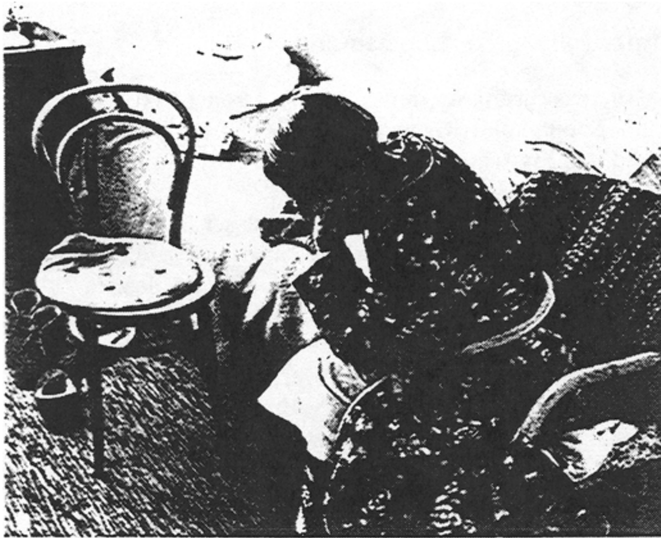

Photo: UNHCR/11180/A. Egger

From Implicit to Explicit Interaction with Informal Care Systems.

Public policy has traditionally operated in ignorance of the nature of informal care, either offering a complete alternative where it breaks down (residential homes and hospital care) or supplying a ragbag of off-the-shelf domiciliary services to which family carers have adjusted as best they can. As a result, the informal care system, though usually the much larger partner, has silently adapted itself to the advantages and constraints set by the smaller public sector.[10] Now, under demographic and economic pressures, governments have moved quickly to attempt to encourage, mold and incorporate family care into public policy. Indeed, this incorporation is often essentially what governments mean when they speak of mixed economy of welfare as a policy goal.

We found examples in all three countries of innovations whose object is to manage informal care in some way. Indeed, many of the experiments we encountered were testing forms of care that allowed state professionals to regard informal carers as in some way reliably contracted to play a regular part in a care regime. Again, the more generous examples were to be found in Sweden. The reforms, which came into effect in July 1989, allow local authorities to pay informal carers of working age as employees of the municipality. In the U.K., too, the Invalid Care Allowance pays people who give up work to become full-time carers, though the level of benefit (currently $60 a week) is too low to be regarded as a wage and is rather a form of minimal compensation.

One way of predictably including informal care is to make it a part of an organized program. The British Government's white paper "Caring for People" makes case management one of its six key objectives and speaks of designing care arrangements that "take account of sources of support available in the community—whether from family, friends, neighbors or local voluntary organizations—and which seek where necessary to provide assistance and respite for the carer."

All of these innovations depend upon an appropriate response, from policy-makers' points of view, from the informal sector. However, there is now a growing body of literature that suggests that the level and quality of informal care in a community is not easily influenced or managed. It is the outcome of complex patterns of kinship, tradition and reciprocity,[11] which are unlikely to be readily amenable to policy manipulation. Attempts to tamper with complex cultural forms can be dangerous; they tend to react in unpredictable ways. There is the risk of killing the goose that lays the golden egg. Encouraging the informal sector to take on additional loads may merely lead to a reduction in the willingness to care. Furthermore, research has shown that many informal carers themselves already operate as case managers, often combining various public and private sources of help in imaginative ways and against considerable odds.[12] There is a danger that professional attempts to manage informal care might lead to conflict with family carers.

Last, there are those initiatives which are largely exercises in cost shifting. Their object is to transfer to the non-state sector burdens and obligations previously borne by the state. These initiatives are often presented as forms of targeting or as substitution policies. There is clearly great merit in using the least intensive form of care appropriate to a person's need—for example, home care rather than institutional care, or a residential home rather than a hospital. However, there is always the danger that these will place burdens where they are more cheaply rather than more appropriately dealt with. In the Netherlands, home care experiments in intensive home nursing which were financed by the insurance funds not only demonstrated that high quality care could be obtained at home but that it could be obtained more cheaply. Part of the cost reduction was due to the free input of care and care organization by the patients' relatives. In the case of these experiments there is no doubt that this contribution was willingly given, but once the new system is established and the availability of institutional care is reduced, there will clearly be a risk of exploitation of the low-cost home alternative as a way in which the insurance funds can fulfull their contractual obligations.

These risks of inappropriate cost-shifting are most manifest in the United Kingdom where availability of institutional care for the old in state hospitals and residential homes has been allowed to decline substantially relative to the number of persons over age 75 and, so, increasing pressure on public home care services which have not been able to expand enough to keep up with demand. They have responded with new rationing or targeting devices designed to concentrate services on the most needy. In some parts of the country this has meant actually withdrawing home help services from dependent old people who have become used to them on the grounds that they are not among the most

The Thanet and Gateshead Community Care Experiments

In the *Thanet* and *Gateshead Community Care Experiments* which ran from 1977 to 1986, older people received home care services organized by social workers acting as case managers and operating within fixed budgets. The clients were matched with control samples of people of similar ages and disabilities who did not receive the innovative services.

During the experimental periods care was provided for highly dependent people (97 in Thanet, 90 in Gateshead). They were selected on the basis of being on the margin of needing institutional care—that is they were clients who the social workers would otherwise have considered for immediate admission to an old people's home or even to a hospital. A system of "case management" replaced the normal system of care that would have operated. Normally, the elderly people would probably have received some community nursing service, home help service, day center or day hospital care, meals on wheels, social worker visits, voluntary care and informal care by family or friends. However, none of these would have necessarily been available and almost all of them would have been supplied according to their own eligibility criteria and timetables.

Under the *community care experiments,* on the other hand, a single social worker oversaw all the clients needs. Each social worker had about 30 cases to manage. A key instrument was the development of a chart which mapped out the client's week with the days on the vertical axis and the critical periods of the day such as getting-up, lunch time and going to bed on the horizontal axis. Using this simple chart it was possible to identify who was providing the person's needs and when there were critical gaps.

Case managers were made cost sensitive by being given a budget of up to two-thirds of the cost of a residential place for each client. A good deal of the budgets was consumed by the provision of the existing standard social services: home helps, day center places, aids and adaptations. However, social workers were able to coordinate and vary this provision in more planned and innovative ways. The major innovation that occurred was the payment of small fees to local people to act as regular "helpers" in the care program. These were people who, for one reason or another, were unable to enter the conventional labor market. They included housewives with young children, retired nursing and care staff and fit widows, particularly those who had experience of caring.

The schemes were successful in achieving their basic objectives. Most of the experiment sample were able to remain in their own homes for substantially longer than individuals in the control group.

(D.J. Challis and B.P. Davis, *Case Management in Community Care,* Aldershot: Gower, 1986; D.J. Challis, R. Chessum, J. Chesterman, R. Lucket, and K. Traske, *Case Management in Social and Health Care: The Gateshead Community Care Experiment,* University of Kent, Canterbury: PSSRU Monograph, 1990.)

needy. The gap then has to be filed by voluntary or family care. In the process, the whole public system may have moved to better targeting and a more efficient use of its resources, but it has also shifted costs to the informal sector.

The close relationship between the efficiency of public services and their ability to complement rather than substitute for family provision is widely recognized now in the research and policy literature, if not yet in the actual distribution of services. In all three of the countries we have described, the key policy documents speak of the crucial contribution of the informal sector and in all three countries we observed public funding for innovations that would offer "breaks for carers" or "care for the carers."

On the face of it, explicit recognition by the state of the immense and essential contribution of informal carers *is* progress and could alleviate some of the stress they endure. On the other hand, implicit in much of the policy debate we have analyzed, and in some of the innovatory schemes themselves, a redefinition of citizens' rights to welfare is taking place. These cease to be absolute but become contingent upon the input of some informal component. The production of state services begins to depend on what needy people or their families can put into the care package. Eligibility and worthiness are in danger of becoming related to a willingness to collaborate. In this kind of mixed economy of welfare, some groups, particularly women may find themselves incurring more social obligations than others.

From Bureaucratic Centralism to Regulated Pluralism. What do developments in home care mean for European welfare systems more generally? The new forms of care require a different organization of public services and a new conception of the state's relationship to the for-profit, non-profit and informal sectors. The classic post-war welfare state paid little attention to the roles played by the family and the voluntary and private sectors. One reason for this was the commitment to universalism. If, as the rhetoric sometimes implied, the new post-war welfare systems would offer care from cradle to grave, there was no need to consider the contribution of other sectors. In practice, we now know that even in places like Sweden, where the commitment to universalism came close to reality in practice, a substantial contribution by the non-state sectors

has continued, if only because people preferred them to the public services available. Certainly, welfare systems have carried within their policies assumptions about the nature of family and community life. For example, much research has been done on the prejudicial assumptions social security systems have made about marriage and the role of women in the family and in work.[13] Similarly, much of the recent work "discovering" the contribution made to the care of the elderly by the informal and voluntary sectors has, in effect, been revealing the implicit assumptions that exist about the division of responsbility between state services and other sectors.

Paradoxically, the development of a mixed-economy of care would seem to require an increase in state inspection and control of private welfare. Now that states everywhere are seeking to set limits to their responsibilities and even to withdraw from some of them, the need has arisen to be more specific about the roles of the non-state sectors and even to attempt to regulate them.[14]

In addition, pluralism in the care of the elderly means admitting and accepting a greater variety of outcomes and that, in turn, is a force for inequality. In the U.K. where public provision has signally failed to generate greater equality this may be no great loss. In Sweden and the Netherlands, where comprehensive and universally available services have meant that old age has been a leveler upwards, there is more to be lost.

It is expecting a good deal of consumers to asssume that, confronted by what are often experienced as the sudden crises of old age, they and their carers will be able to choose wisely among a range of service providers and care solutions. Acting appropriately may require a high level of skills, of cultural capital, and of education. While there is no doubt that todays' citizens generally are much better prepared for such responsibilities, obvious issues of equity arise. Successful planning for old age, or carers' abilities to construct reliable, long-term care arrangements for a dependent may depend very much on the social background of a household or on the existence of a skilled and informal social support network. The outcomes of a more "enabling" but less "protective" public policy approach will therefore depend to a large extent on the availability of special services offering advice and information that enable people to qualify and act as informed citizens, consumers and co-decision makers in care strategies. It is in this field of information and consultation that new and additional public responsibilities emerge.

So far there is more rhetoric than solid evidence about the superiority of state-regulated pluralism. The Swedish proposals, which decentralize yet still maintain the established state near-monopoly in the actual provision of services, offer fewer hostages to fortune. Yet it is remarkable, when one reads both the Griffiths and Dekker reports, how little of the systems of care established over the 45 years are thought worth preserving and how much hope is placed in untried systems of pluralist provision. What is

Population Aging Threatening Swedish Welfare State

The projected increase in Sweden's older population, especially among the very old, jeopardizes a fundamental tenet of Sweden's welfare state—that of free or low cost health and social services provided by the public sector to all citizens on an equal basis, according to rsearcher **Mats Thorslund** of Uppsala's University Hospital.

Even if the monies could be found in this already highly taxed country to pay for the estimated 25% increase in the cost of care considered necessary by the year 2000, there is no way that sufficient numbers of personnel could become available to fill the 270,000 staff positions required. This number exceeds the total estimated increase in the labor force, and 80% of Swedish women are already gainfully employed—one of the highest proportions in the world.

What are the likely consequences to be? Thorslund believes the following scenarios are possible. Families will be requested to provide more care at a time when the number of spouses available to provide care will be reduced because of high divorce and widowhood rates. This will "represent a step backwards in the striving for sexual equality." At the same time, families and the public sector will be forced to cooperate more closely. This is already evident in new Swedish legislation providing for paid leave for up to 30 days in order to take care of an elderly relative.

"It will be necessary to make tougher decisions about priority . . . Already . . . certains groups, namely the single elderly, are given priority." Public sector services are likely to become "chiefly concentrated upon those elderly persons who are without families." The slack may be picked up by the private, for-profit sector who, in turn, will be drawing staff from the public sector, weakening it further. "This is, of course, a development which will be accompanied by increasing inequities between society's 'haves' and 'have-nots'." Finally, some of the slack may also be picked up by self-help and other voluntary groups, tapping particularly the energies latent among the "young" old.

All these scenarios "deviate in various ways from several of the principles and hallmarks which hitherto characterized the Swedish model of the welfare state... Sweden will remain a welfare state, but the fundamental commitment to universalism will be diluted and selectivity will creep in."

(Mats Thorslund, "The Increasing Number of Very Old People Will Change the Swedish Model of the Welfare State," *Social Science and Medicine,* Vol. 32, No. 4, 1991.)

more it is the frail elderly who will bear the brunt of experimentation. This willingness to risk the future may be a reflection of deep discontent with present systems, but there is little evidence of this. The pressure for review and reform has come not from electoral or widespread citizen pressure but from within government and specialist professionals and researchers.

From Need-Determined to Cost-Limited Services. Clearly, a prime source of pressure for the reform of modern industrial welfare systems has been concern about the open-ended expenditure commitments they appear to entail. Much has been written of the fiscal crisis of the welfare state, yet the more dire predictions of the early seventies have not materialized. Welfare systems remain largely intact, they have not been deconstructed.[15] However, it is in areas of acute and growing demand, such as the care of the dependent elderly, that the predictions have been more valid. Change and even deconstruction are not happening abruptly in a revolutionary way, as some of the "crisis theories" suggested, but incrementally.[16] Perhaps this should not surprise. Welfare systems that have grown through a series of small steps might be expected to decline by the same route. Many of the innovations we observed in the three countries, particularly those funded by the state or insurance funds, were designed to seek acceptable outcomes in new ways and at lower costs.

This was as true in Sweden as elsewhere. The care innovations that have had the most impact on policy-makers are those that appear to demonstrate that more people could be acceptably, even better, cared for without an expansion of resources, largely by finding ways of substituting home care for institutional care. Nonetheless, it remains the case that in Sweden the debate about costs and resources has had to remain a muted, even underground, one. There has been little discussion "of whether we can actually afford to maintain previous ambitions in the face of growing numbers of the elderly people, of whether there is sufficient money to establish new types of care and treatment without at the same time phasing out some of the old ones."[17]

In the United Kingdom, on the other hand, the primacy of cost containment in the debate about care of the elderly is very explicit and has led to considerable alarm among those who represent the interests of the old. As Sir Roy Griffiths pointed out, "my remit is not to deal with the level of funding but rather to suggest how resources, whatever the level, may be better directed. . . . On the other hand, many social services departments and voluntary groups grappling with the problems at the local level certainly felt that the Israelites faced with the requirement to make bricks without straw had a comparatively routine and possible task." The solutions Griffiths proposed contain clear rationing devices: financially accountable case managers, the substitution of private for public care whenever possible, and the targeting of public services on the poor. The better-off are to be encouraged to save or insure to meet their own care costs. In these ways European welfare systems are being forced to abandon their universal commitments to the elderly. Targeting means they will become class-driven rather than need-driven.

The creation of better services to support old people in their own homes is, like community care for the mentally ill before it, an issue which allows the social and economic arguments for welfare reform to be easily, and possibly usefully, confused. Few would want to oppose the policy goal as such. In all three countries there is considerable evidence that many more dependent old people and their carers would like good home care than can obtain it. The reform and expansion of home care services therefore appears an undeniable good from the consumer's point of view. So indeed it would be if it meant care services at home for those who currently go without them. However, a close reading of the policy proposals in the Netherlands and the United Kingdom show a clear intention to concentrate the reformed home care services on those high need cases who currently enter institutional care.

An examination of the experimental innovations that have influenced the arguments confirms this conclusion. Demographic certainties, the rapid growth in numbers over 75 both absolutely and relative to the rest of the adult population, mean that in these countries plans are effectively being made to provide home care to people who will need very high levels of support. Yet, at these levels the cost advantages of home care become small or even non-existent. Therefore, home care services will need to become more intensive and selective. Levels of need that hitherto have been defined as entitlement to service will no longer be sufficient. Only in Sweden is there no clear intention to use the improved home care system largely as a substitute for institutions. As we have shown, there the policy documents explicitly argue for more support for those currently at home and particularly for their carers. However, Sweden too faces resource constraints, particularly in the supply of labor. This means that institutional care will certainly not keep pace with the numbers who are currently defined as suitable for it. The same constraints preclude a substantial expansion of home care.

Pushing those with lower needs out of the target area for publicly provided, or at least publically funded, services also amounts to a form of indirect privatization. Those with lesser needs who still want care from outside the family will have to pay for it out of their own resources and purchase it in the market. In Sweden, there is as yet very little evidence of private, for-profit, suppliers emerging to fill a gap in the market except in the area of luxury, sheltered housing schemes. In a country long-used to universal public provision it may be some time before the public can even conceive of buying their care privately as they might their apples and oranges.

In the U.K., on the other hand, the encouragement of a private market in care is an explicit government objective, set out in the White Paper and the legislation that followed,

and the local authorities and the national health service have actually been made legally bound in many areas of care to ensure that private suppliers have been able to tender for work traditionally carried out by the welfare state. In the last few years there has been a dramatic growth in the number of private care firms seeking government contracts. So far, however, they have been most prominent in offering various forms of institutional care where there is clear potential for profit.

At the same time, the longstanding scarcity of public care services has meant that many older persons still at home only have a choice between private care, family care or no care at all. They can turn to the growing number of home care agencies, but as yet there is no evidence that these reach more than 1-2% of the retired. The levels of charges necessary to run profitable agencies exclude all but well-off persons. Publically-funded innovations like the Thanet project have tended to use "paid volunteers"—labor obtained at well below market rates. As yet British insurance companies have not risen to the challenge of offering plans to cover the potential costs of personal care at home. The targeting of public care on those with highest need and lowest incomes seems principally to be shifting the burden to the family and to women.

Only in the Netherlands is there a long established tradition of private supply. But this developed in response to demand generated by the insurance funds, not directly by consumers. The "total" institution emerged in the nineteenth century because that was the cheapest way for the private market to care for the very dependent. There is as yet little evidence to support the assumption, made by some, that the balance of costs and profitability has shifted to community care.

It is when all these factors are put together that one can see how developments in what has until recently been a rather marginal and uncontested area of social policy, care of the dependent elderly, add up to a redefinition of the role of governments in the provision of welfare and a renegotiation of the relative balance of obligations and rights between citizen and the state. Whether or not these developments in a small, but highly pressured, part of the welfare state are the precursors of more widespread shift in the nature of the post-war welfare state, only time will tell.

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case for the elderly a few decades ago. Our survey cohorts indicate that they have a wide range of interests. Among leisure activities to which they will give high priority upon retirement are further education, community work and other activities which promote contacts with others. They also indicate a preference for cultural services that are open to all age groups; they are less interested in exclusive arrangements for the old.

However, there will still be a group of elderly who are in a weak position. They have never had cultural interests, they have few outside contacts and remain lonely and inactive. For this group special initiatives are needed.

9. Future Relations Between Generations

Our survey and other data have indicated that the relations between younger and older people in Denmark show no manifest conflicts. They are rather harmonious. Traditionally, older people have been viewed as a weak group, and old age pensions and services for the elderly have always been given a high priority in public decisions. It is likely that the balance will shift. In the future, smaller cohorts of young people will have to support an increasing number of healthy elderly. Future pensioners will more often than presently have disposable incomes which are higher than those of many working young families. Formerly pitied, older members of society may become an envied group.

The costs of old age pensions and health and social services for the aged amount to 20% of public expenditures in Demark. They are fully financed through general taxation. If the Danish level of income and consumption taxation during the 1990s is reduced in order to conform with the lower tax levels in other EEC countries, cuts in public budgets will be unavoidable and reduction of pension and service costs will be in the cards. The interests of the young and the old on welfare state priorities are then likely to diverge. The traditional harmony between the generations may then be in danger.

Conclusion

The ten reports prepared in relation to the future of Danish elderly have been well received by both government and private organizations concerned with developing aging policy. DaneAge Foundation itself has held three conferences to present the findings to the public, and they serve as cornerstones to its own planning for the future.

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