CHAPTER 6

The Netherlands

Box 6.1.
General characteristics of the Netherlands.

- Local government in the Netherlands is based on 549 municipalities and 12 provinces. Nine in ten Dutch people live in urban areas. All of the cities are quite small with less than 1 m inhabitants; in all around 15 m people live in the Netherlands. With a population of 457 persons per square kilometre, the Netherlands is one of the most densely populated countries in the world. But this varies across the country, with the western provinces having between 777 and 1,500 inhabitants per square kilometre and the northern provinces which have the lowest, 170 and 237 residents per square kilometre. In total, the Netherlands covers an area of 41,500 square kilometres.
- Ethnic minorities make up a large proportion of the Dutch population (16%). Part of this group is of Dutch citizenship as they are from the former colonies, Indonesia, Surinam or the Antilles. The 400,000 Friesian who live in the province of Friesland, use the Frisian language as their official language.
- In the labour market, nearly one in five Dutch workers (22.7%) are employed in the industrial sector, with three in four (73.3%) in services, while nearly one in twenty (4%) work in agriculture, fishery and forestry. The Netherlands is renowned for its low activity rate among women (59.2%) who mainly work part-time (68.5%) Overall unemployment rates have fallen since the 1980s to reach 6.3% in 1996.
- Around one fourth of GDP (26,71%) is in the Netherlands spent on social expenditure. Most of the costs for long-term care and domiciliary services are today covered by the insurance system, whereas costs for day care for children is financed on a tripartite basis, between state, parents and employers.
- In 1996, annual disposable income for an APW (Average Production Worker) income couple with 2 children was NLG 56,888; for a single APW pensioner NLG 16,293 and for a couple NLG 23,368 (Hansen, 1998). The main income of older people is the Dutch Old Age Pension. For two in three pensioners this flat-rate state pension represents their total income, while for one in four work related pensions supplements the basic pension, and one in five having supplements from other sources, such as capital. Many older people have limited resources and 12% of pensioner households have disposable incomes which are lower than the minimum income.
- The total population has doubled since the turn of the century. Older people over 65 years currently comprise 13% of the population with life expectancy at 74.7 years for men and 80.3 years for women. The fertility rate has reduced by nearly a quarter since the 1960s and today fluctuate around 1.5 children per women. Pre-school children aged 0-4 years make up 6.3% of total population in 1996.

6.1. Introduction

Organisation of welfare in the Netherlands displays characteristics of the social democratic model in having high welfare spending and universal access to social benefits. At the same time politics have been heavily influenced by Christian Democratic ideology for which reason the social insurance model has also been

implemented. Traditionally, the principle of welfare was based on pillarisation, meaning that Catholic, Protestant, socialist and liberal associations and political parties each set up their own funding schemes. Welfare services were provided by these non-profit associations and public responsibility has until recently not involved securing individual rights but rather to make sure that a certain volume of provision was maintained. During the last 30 years, however, a process of de-pillarisation along with financial constraints, labour market and household changes has contributed to the process from volume-oriented policies to market-oriented and needs-led services. A particular characteristic of the Dutch system is, however, still the mix of public funding and private provision of care and also the specific nature of decision-making, where policies are shaped in interaction between government and interest groups.

6.2. A history of care

Poor laws

Even before the formation of the Netherlands, measures to care for the needy had been introduced in the poor laws of 779 and 1543. Care was mainly the responsibility of the guilds and churches and although the constitution of 1815 for the first time obliged the state to care for the poor, churches and private bodies persisted as the main actors in subsequent years. Partly due to a historically strong influence of the Protestant and Roman Catholic churches, these private associations had traditionally been divided along the lines of political and religious ideologies in being either socialist, liberal, Catholic or Protestant. The municipal poor law of 1818 only confirmed the role of private bodies and the subsequent law reform of 1854 mainly strengthened supervision of private provision for people who were poor, old or disabled. The first changes occurred with the industrial revolution in the 1870s which produced unforeseen destitution among the working class in the cities. This led to calls for public interventionary measures and increase in public financial assistance was subsequently made for the new urban poor (SZW, 1990). The first associations for home help and home nursing services were formed in these years, also based on the pillarisation principle under secular, Catholic or Protestant auspices. Home help services were mainly offered to families where the mother was ill and provided help with household tasks (Linden, 1996).

Caring for the poor and disadvantaged children

Infant schools, *Bewaarscholen*, had already in the early 19th century been initiated by members of the bourgeoisie to socialise and civilise disadvantaged children. With the concentration of workers in the urban areas, however, the need for day care for children outside the family increased and in 1872 nurseries, *Kinderbewaarplaatsen*, were established as charitable institutions for single, lower

class women who were forced to work in order to support their family. In contrast to the infant schools, where focus was on disciplining the children, the nurseries focused on good child care. By the turn of the century, the Fröbel movement made its entry to the Netherlands also and some kindergartens, *Kleuterscholen*, based on this philosophy were set up.

A national education system

The need for day care was most pressing for working mothers with young children as the school system absorbed some of the need for day care once the children turned seven years. Admission rates to school were improved in 1901, when the Elementary Education Act was passed, laying the foundations for a national education system. Up until then the Catholic and Protestant schools were excluded from state funding and it was not until the '1917 Pacification' that the political battle ended in equal financial treatment of all private and public schools (Eurydice, 1998). In the 1920s, the municipalities began to subsidize the nurseries but admission was usually restricted to working mothers. The number of institutions remained low, around 30, and most children continued to be cared for in the home by their mother or by private nannies in families of higher social class (Pot, 1995; Van Dijk, 1996).

Expanding public responsibility in times of growing secularisation

Following the 1930s depression and WWII, however, a general change in attitude toward public responsibility for welfare took place, which especially for older people meant some changes in provision of welfare. Inspired by Beveridge in England, the Dutch government in exile set up a commission which considered the introduction of a compulsory insurance system providing flat-rate benefits at a uniform subsistence level. This resulted in the establishment of a general old-age pension scheme and a health insurance scheme, and from 1948 government subsidies replaced private funding of home help provision. The latter was also caused by a growing trend toward secularization whereby the support for the ideologically based associations weakened (SZW, 1990). In the post-war years, the first residential homes for older people were set up, partly to stimulate older people to make room for families with young children during the general housing shortage. There was quickly a steep increase in the number of older people being accommodated in these homes. Practically anyone who applied for a place was admitted and more than 75,000 older people were living in a home in 1960 (Tunisen & Knapen, 1991). The expansion was rooted in a general consensus about the growth in volume among political actors. These consisted not only of political administrators but also of associations providing the services which in many cases were part of the advisory and administrative bodies in health care (Borst-Eilers, 1996; Pijl, 1991). Some community services were also developed with public funding; in 1954 the Ministerial Department of Social Work was

established to promote and finance welfare, e.g. by subsidizing neighbourhood groups which provided auxiliary care services for older people.

Expanding part-time day care

Following the Second World War, the objective for day care for children changed from care to education and the Fröbel based kindergartens started becoming more accepted by middle-class parents in being primarily concerned with education of the children. After legislation was passed in 1957, opening hours in the kindergartens were reduced and admission age was raised from 2½ to 3½ and later to 4 years, available for all children without fees (Pot, 1993). Child care for younger children consisted to be regarded as a private responsibility and mothers were encouraged to stay at home with their children as it was believed that placement of children outside the home could prove harmful for them. This ideal of the mother's place being in the home was underlined by the policy of dismissing female civil servants when they married. This policy continued until 1957 (Pot, 1995). Women were encouraged to have many children and the introduction of fertility-oriented family benefits ensured financial support for families with 3 or more children.

A National Assistance Act and a new insurance for long-term care

In 1965, the poor law was replaced by the National Assistance Act which confirmed the basic duties of the state to financially support people unable to provide for themselves. Long-term care had not so far been part of the health insurance scheme and the individual costs of care in many cases proved impossible to bear. In 1968, AWBZ, a special insurance scheme for serious medical risks was implemented to cover the costs of long-term care in hospitals and the newly established nursing homes but not covering costs for help in the home. Gradually, however, care policies for the older people changed to focus more on community care and the first explicit policy for older people, the White Paper of 1971, stressed the loss of independence which older people felt when having to move from their home.

The Women's Movement in favour of day care for children

During the 1960s, a combination of labour shortages and more women taking up education meant that the traditional male breadwinner family norms loosened by the increasing labour market participation of women; the proportion of women aged 15-64 years actively engaged on the labour market rose from 7% in 1960 to 17% in 1971 (Van Dijk, 1996). Despite the increase in female labour force participation, children's day care was, however, still regarded as mainly being a private responsibility. Although the state regulated the provision of day care, the few publically subsidized places were intended for children of low income parents and children of disadvantaged groups. The day care centres now numbered a total of 150 and most younger children therefore continued to be cared for at home by their mother or other family members (Eurydice, 1998). Following

protests from amongst other the Women's Movement in the 1960s against the traditional division of work and women's lack of opportunities to participate on the labour market, a fiscal benefit was introduced, giving double income families with children and single parents a tax relief of NLG 5 per child care place. A new form of day care for children in playgroups, *Peuterspeelzalen*, was started. These took some of the pressure of the demand although provision is only for two to three hours, twice a week.

Introducing principles of cost-efficiency and needs-led provision

The 1970s changed the welfare agenda from a supply system with an open-ended budget to a cost-oriented system, this being the decade when economic decline set in with a drastic increase in public debt. While part of the economic decline was caused by external factors it was also that the basic social structure was responsible for the crisis (SZW, 1990). The policy of cost-containment was more than an economic necessity, however, for the coalition government, consisting amongst other of the Christian Democratic Party, it was equally imperative to support the (re-)creation of a caring society in which individual responsibility would replace state dependency. This thought gained weight up through the 1980s and included more involvement of society as a whole and recognition of family members and relatives as important sources of care. Within health care, escalating costs forced the government to reform the administrative structure of the care system. The private associations maintained the initiative for setting up provision but the government took on responsibility for administration and planning. Social services were decentralized and the principles of substitution of institutional care for community care, increased efficiency and tailor-made services gradually gained weight (Baar et al., 1993). Common admission criteria and selection criteria for institutional care were introduced to ensure admittance of only very frail elderly people (Tunisen & Knapen, 1991). However, the traditional supply-led policy-making proved resistant to changes and although costs were to be kept down, the costs for residential care continued to increase in subsequent years, and more than 10% of older people aged 65+ were living in residential homes in the mid-1970s.

Creating a cheaper alternative to home help

Costs for home help which had previously been borne by central government were now shared between users, health insurance and public subsidies, creating a cost-efficiency incentive. Cuts in the home help provision were made and as a consequence a new and less costly domestic service was established in 1982, the Alpha help, which provided help with household chores. Mainly through employing less educated staff members, costs were reduced and administration of the new system was also cheaper since the client became the employer; therefore the home help organisations had no employer obligations.

The Dekker plan

The ideological changes were carried further in 1987 when the Dekker Committee published its report on the future health and social care system. Here, the cost-efficiency stance was repeated as a prerogative for quality and accessibility but it was further emphasized that medical care and social care should be integrated; market-elements should ensure effectiveness and flexibility; and services should be needs-led stressing the function specific approach; but at the same time principles of solidarity and righteousness should be maintained. The new system was to further emphasize the principle of substitution by replacing costly institutional care with less expensive home care. The financing of care services was to be based on a new health insurance system which would force insurance companies to compete on premiums and providers of care to compete on price. However, when a Christian Democratic/Socialist coalition government took over in 1989, a revised plan was implemented instead, the so-called Simon plan. This new insurance scheme included more services leaving only a few for optional insurance and raised the income-related fee from 75% to 85% of premiums while the rest was to be flat-rate. Insurance companies still had to compete on the flat-rate premiums but market efficiency and competition to reach cost-efficiency was less pronounced in the new public quality control (Baar et al., 1993; Pijl, 1991 & 1993).

More welfare mix in financing but also more weight on informal sources of help

The reform of the health and care system was rooted in new ideas about the role of the state which gave more responsibility to other actors in the decision-making and funding of services. With more services financed through health care insurance, an increasing share of costs has been placed on municipalities, employers and individuals who must also to a larger degree ensure quality and efficiency (Baar et al., 1993). These new ideas have also had an impact on the development of day care for children, especially from the end of the 1980s. With the increasing female labour force activity rate, the use of day care centres had become more generally accepted and were no longer seen as being predominantly for lower income groups but public support for day care for children continued to be patchy. The Women's Movement fought to get expansion of places on to the political agenda but in the late 1970s public preference was for informal day care. Instead of expanding day care provision, a maternity leave was introduced in 1977 giving mothers a right to 12 weeks in all with 100% wage compensation, extended to 16 weeks in 1989. For children in the education system, parents were still required to look after them during lunch hours, but since 1983, parents have been permitted to organise supervision for their children on school premises during the lunch break. Policy changes also included the introduction of a fiscal benefit for families with children, and the inclusion of pre-school children in primary school due to criticism about lack of coordination

between nursery schools and primary schools. From 1985, the two systems were integrated providing for 4 and 5-year-olds in primary education.

The Stimulative Measure

Most initiatives did not increase the supply of day care. In 1989, however, a landsliding policy change took place when the government decided to set aside an amount, part of which previously went to finance tax relief for day care, for expanding provision of day care, the so-called Stimulative Measure (*Stimuleringsmaatregel Kinderopvang*). For a period of 4 years from 1990 central government would provide funding to municipalities for establishing new day care places, increasing from NLG 145 m in 1990 to NLG 260 m in 1993, including NLG 130 m yearly previously allocated through the tax benefit system. The goal was to create 49,000 new day care places for the under 5's. However, the places were mainly for working parents and subsidies covered less than 1/3 of costs. Employers were therefore expected to subsidize the remaining costs; in all 70% of places were to be bought by employers (Pot, 1995; Van Dijk, 1996). As in care for the older people, the regulation of quality is partly market based as the institutions are to develop criteria for standards on a common basis while parents are to exercise regulatory control.

Modernising care for older people

In the 1990s, the policy of cost-containment in health and care services for older people has been followed up. A new White Paper on older people was published, emphasizing that society has a common responsibility for the development of welfare and that too little use is made of older people's own resources. Older people were defined as the group aged 55 years and over and the paper considered their early exit from the labour market as one of the most pressing problems. The substitution policy has continued and further coordination of housing and care services has been undertaken. A new scheme for care and accommodation complexes was implemented in 1993 which allows older people to live outside institutional accommodation and still receive necessary care. Much emphasis has been placed on a client-oriented approach giving older people a say in the decision-making, reflecting the entering of parliament two parties representing older people, the Federation of the Old and the 55+, at the last election in 1994. Individual choice has also been favoured in so far as older people and others in need of personal care could from 1994 apply for a Personal Budget instead of receiving care in kind. This measure was introduced under a Liberal and Christian Democratic government but the strong emphasis on user empowerment has continued under the current 'Purple' government, consisting of Social Democratic Party, Liberals and D66, a Progressive Liberal Party.

Improving leave rights for parents and day care provision

Contrary to the somewhat contractionary policies for older people, leave entitlements for parents have been improved, giving parents a right to 6 months

part-time leave from 1991, and to 3 months full-time leave in 1997. However, the leave is without any wage compensation. Alongside the expansion of child care for the younger children, further steps were also taken to improve out-of-school care for those children attending school who are without care during lunch hours, afternoons from 3:15 p.m., and during the Wednesdays when schools are open only part-time. Single mothers have been targeted as the next group of parents for whom day care will be established in order to improve their labour market position and possibility to take up education. In 1996, NLG 85 m have been made available for the municipalities in order to establish special care facilities for single parents dependent on welfare benefits, and approximately 5,000 new places should be established (European Commission, 1998). Also, a career break leave which can in principle be used by parents and informal carers of older people has been passed. This gives employees a right not to leave but to receive payment during leave. Inspired by the Danish leave schemes, the position shall in the meantime be replaced by a person receiving unemployment benefit. Fathers do not have the right to take paternity leave but the introduction of emergency breaks, which gives employees a right to negotiate for short-term leaves for solving specific problems such as when a child is ill or the mother has given birth, applies to fathers.

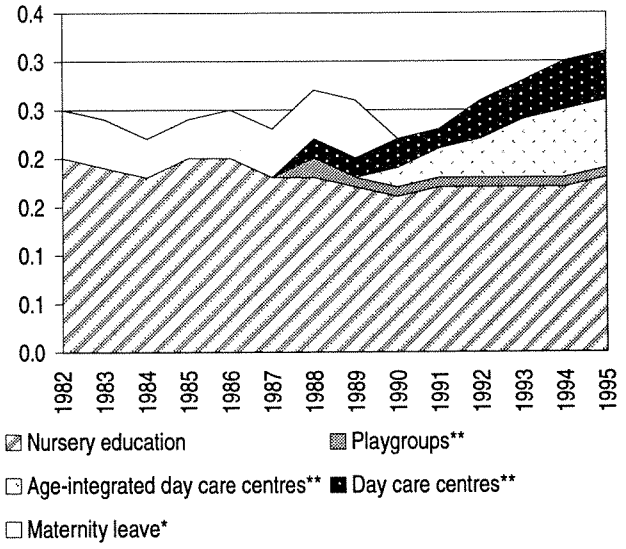
The Netherlands approaching a new millennium

Approaching the turn of the century, the Netherlands can look back on the last decades of a welfare state which was created relatively late and was quickly forced to accommodate to emerging economic problems. Born of a universal welfare model mixed with Christian Democratic ideology and a Bismarckian insurance system, welfare services for older people today retain their comprehensive nature in providing universal benefits. Also, the inclusion of care services under the health insurance scheme should ensure less patchy provision. At the same time, services are much attuned to efficiency and a more business-oriented approach and culture. Commercialisation has been less pronounced than in England but regulation of services are increasingly left to market principles. This includes day care for children where the institutions to a larger degree have to compete on price and quality for employer subsidies. Day care places have increased in numbers but mainly for working parents and job position is in most cases the determining factor for obtaining a place. Low income families with no strong labour market position are less likely to obtain a place as fees are very high. Expansion of day care has been stimulated by public funding but responsibility still lies predominantly with parents and now also employers. Yet, day care for children has been placed on the public agenda resulting in improvements in leave schemes and in great concern for the development of good standards in day care, although in the initial phase following the Stimulative Measure this is mainly for the market to develop.

6.3.
Financing
6.3.1. Social expenditure

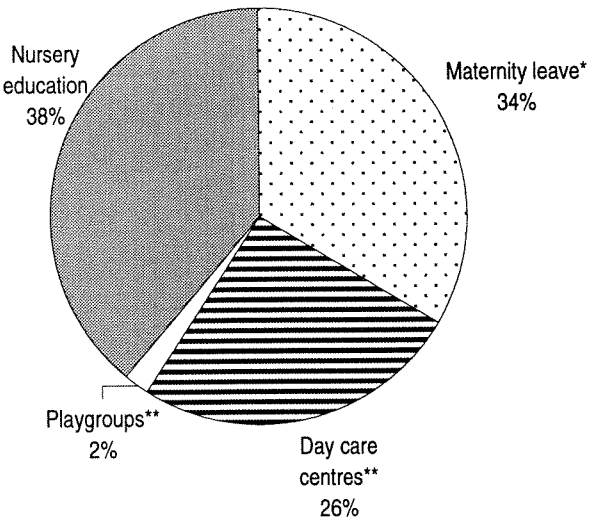
In the early 1980s, policies were marked by the fiscal problems; in order to achieve fiscal consolidation benefits were cut, eligibility criteria was tightened and cost-containment was introduced as the main objective. During the 1990s, real growth has, however, returned with GDP growth averaging nearly 3% a year.

Figure 6.1.
Development of the net-expenditures for main social services and cash benefits for children (aged 0-4), as a percentage of GDP, 1982-1995.



Source: CBS: Kindercentra (annual publication). CBS (1998): Personal communication. LISV (1998): Personal communication.
Note: * Gross expenditures. ** Running costs. Expenditure for family day care too low to be included.

Figure 6.2.
Division of the net-expenditures into main social services and cash benefits for children (aged 0-4), 1995.

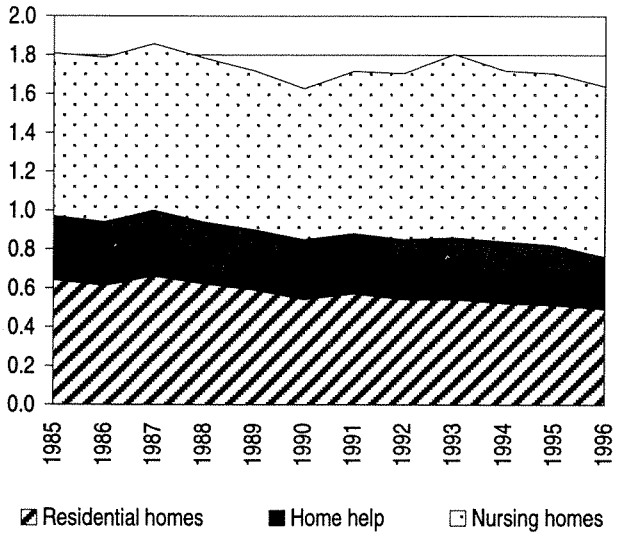


Source: CBS: Kindercentra 1995. CBS (1998): Personal communication. LISV (1998): Personal communication.
Note: * Gross expenditures. ** Running costs.

For expenditure for children, cost for maternity leave increased from NLG 188 m in 1982 in 1990 fixed prices to 276 milion in 1989 (latest available data), but the main increase is in costs for day care where expenditure has risen from NLG 128 m in 1988, also in fixed 1990 prices, to NLG 862 m in 1995 – mainly due to the introduction of the Stimulative Measure. Expenditure for playgroups has increased also during the same years, but with slower expansion, from NLG 99 m to NLG

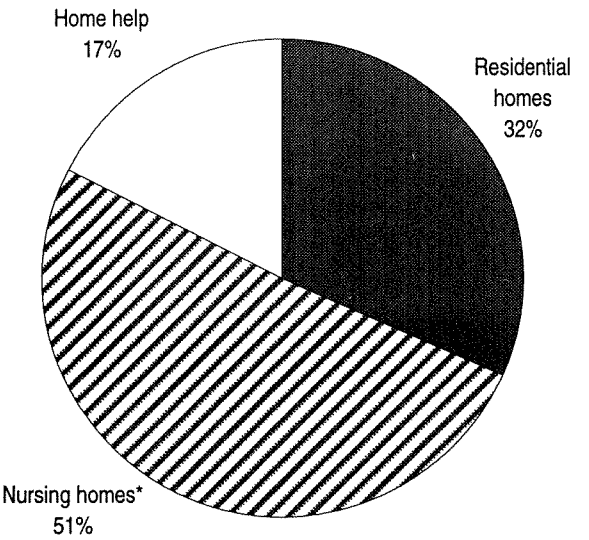
125 m in fixed 1990 prices. Expenditure for nursery education has remained at the same level as in the early 1980s, currently making up NLG 7,702 m in fixed 1990 prices. Measured as part of GDP, expenditure for children made up slightly more than 0.3% of GDP in 1995 (Figure 6.1). Expenditure is currently mainly divided between nursery education (38%), maternity leave (34%) and day care centres (26%), while playgroups take up only a smaller part (2%) (Figure 6.2).

Figure 6.3.
Development of the net-expenditures for main social services and cash benefits for older people (65+), as a percentage of GDP, 1985-1996.



Source: CBS: Kosten en financiering van de gezondheidszorg (annual publication). VWS (1998): Personal communication. CBS: Statistiek van de bejaardenoorden (annual publication).
Note:* Running costs. Data on residential homes only available since 1985.

Figure 6.4.
Division of the net-expenditures into main social services and cash benefits for older people (65+), 1996.



Source: CBS: Kosten en financiering van de gezondheidszorg 1997. VWS (1998): Personal communication. CBS: Statistiek van de bejaardenoorden 1996.
Note:* Running costs. Residential homes for 1995.

Expenditure for older people is currently at the same level as in the late 1980s and the policy of cost containment seems thus to have worked. Expenditure for residential homes has increased only slightly, from NLG 4,409 m in 1982 in fixed 1990 prices to NLG 4,780 m in 1995, and so has expenditure for home help, from NLG 1,734 m in 1982 to NLG 1,765 m in 1996. The highest increase in expenditure is actually found in costs for nursing homes which increased from NLG 3,571 m in 1982 to NLG 5,201 m in 1996, when measured in fixed 1990

prices (Figure 6.3). Most expenditure for older people thus goes on nursing homes (51%) whereas residential homes take one third (32%) and home help nearly one fifth (17%) (Figure 6.4).

6.3.2. Financing through insurance

The insurance model has traditionally been widespread in the Netherlands in relation to costs for health care. Apart from nursing homes, no other long-term care nor domiciliary care for older people was, however, until the end of the 1960s covered by the health care insurance. The increase in the number of older people, coupled with the need to introduce more efficiency led in 1968 to the introduction of a new financing system for long-term care, the Exceptional Medical Expenses Act (AWBZ). Over the years, its provision has been extended to cover more and more areas of health and social care. Today, the AWBZ insures medical risks which are not covered by compulsory or private health insurance, such as psychiatric hospital care, out-patient mental care, rehabilitative services, community nursing, nursing homes, and covers also part of the costs for domiciliary care such as home help. In addition, the newly introduced Personal Budget is covered by the insurance. With effect from 2002, also costs for residential homes will be covered by the AWBZ. The period from 1997 to 2001 will be a transitional phase during which the residential homes will be subsidised by a statutory body, the Health Insurance Funds Council.

All residents, and non-residents subject to the Dutch income taxation, are covered by the AWBZ. The scheme is compulsory except for people who have a conscientious objection to the principle of insurance who instead pay an income tax surcharge. Funding comes from state subsidies and compulsory premiums for employees, levied through the income tax. Premiums and taxes are levied together as one sum of taxable income. Contribution rates to the AWBZ for employees were 7,35% of the contribution payable under the Old Age Pensions Act and the General Widows and Orphans Benefits Act with a ceiling of NLG 45,325 per year in 1996. A personal allowance applies, depending on individual income. Contributions for the AWBZ are later reimbursed by the employers or the benefit paying organisation or by awarding a higher benefit. Premiums are collected by the national tax revenue and later transferred to the Central Administration Office (CAK) of the AWBZ, which is supervised by the Health Insurance Funds Council. The central office draws up model contracts for provision, pays the providers directly, and sets user fees. The CAK will also take over this role as regards the residential homes (Ministry of Social Affairs and Employment, 1990; Scheerder, 1996).

The AWBZ today covers most costs of care; in 1995, the AWBZ covered 86% of total costs for home help. Previously, home help was mainly financed through public subsidies, however, since the incorporation of home help under the insurance system the subsidies have been transferred to the AWBZ. For nursing home care, the AWBZ, covered 86% of costs in 1996, and since the gradual transfer of the residential homes to the AWBZ in 1997, 68% has been covered by the insurance. Before 1997, governmental subsidies financed the major part of the residential homes (Table 6.1).

Table 6.1.
Sources of financing (%) and gross expenditures (m NLG) for main social services and cash benefits for children (aged 0-4) and older people (aged 65+), latest available year.

	Year	Gross expenditure (m NLG)	Sources of financing (%)			
			Public	AWBZ	Employers	Clients
Children (0-4)						
Day care centre*	1995	960	33.10	<>	24.80	42.10
Playgroups*	1995	139	38.13	<>	..	56.12
Nursery education**	1995	1,142	100.00	<>	..	..
Older people (65+)						
Residential homes*	1996	5,381	61.40	<>	..	38.97
Home help*	1995	2,206	..	86.40	..	9.52
Nursing homes*	1996	5,866	4.04	85.95	..	10.01

Source: CBS: Kindercentra 1995. CBS (1998): Personal communication. CBS: Kosten en financiering van de gezondheidszorg 1997.VWS (1998): Personal communication. CBS: Statistiek van de bejaardenoorden 1996.
Note: * Running costs. ** Net-expenditures.

A fixed budget is from the AWBZ distributed to the different provider organisations based upon the number of older citizens in the area and the age distribution. From this budget, the organisations provide the care that is considered necessary. Minimum criteria for the provision of home help were de-regulated in 1994, and since then funding from the AWBZ has paid the costs for home help if the organisation can prove using a nationally complying assessment system (LIER) that the older person needs help (Kerksta, 1996). The organisations are, however, under no legal obligation to provide home help and may place people on waiting lists if the budget has run out (Weekers, 1998). Regional assessment teams are paid by the municipalities for the assessment for institutional care. The

Health Insurance Funds Council is responsible for the monitoring of provision, and must advice and inform the Crown and the Minister responsible on all matters concerning the AWBZ (Ministry of Social Affairs and Employment, 1990).

6.3.3. Division of financial responsibility between state, provinces and local authorities

Local authorities have no power to levy income taxes but can tax land and housing. In addition, local authorities receive a central block grant based on size of population and the need for restructuring of the city.

The specific grant for the increase in day care, the Stimulative Measure, is awarded by the Ministry of Health, Welfare and Sport. Although provision of day care is private, some day care places are thus subsidized by the state and the local authority, around 30% of all places. Subsidized day care was previously funded by central subsidies which covered the costs for personnel, while parents and the local authorities paid the rest. In 1987, the central budget for day care was transferred to the local authorities, which thus took over the responsibility for funding, regulation and administration of day care. This funding system did, however, not increase the number of day care places and as a consequence central government in 1990 introduced the Stimulative Measure. From 1990-1995 around NLG 200-250 m has yearly been paid out to the local authorities to increase the number of places in family day care and day care centres. Funds for tax relief for day care which previously went to the employers when they funded day care, were now divided among the local authorities to increase the number of child care facilities. Distribution of money depends on the number of inhabitants and the number of child care places. In addition to an investment budget for each new place created, the local authorities receive a fixed sum of NLG 5,200 for each full-time place and extra money is set off for small local authorities that cooperate to build a day care centre. The Stimulative Measure is also intended to stimulate tripartite funding, where the local authorities, parents and employers cover the costs. Funding is therefore conditioned upon that a certain number of places must be sold to or hired by employers. In 1996, the yearly sum was transferred to local fonds to administrate; in the same year the local authorities and the state financed around 33.1% of costs for day care. In the education system, early admission to primary school for the 4-year-olds is fully funded by the Ministry of Education who compensate the local authority for the staff costs and costs for day-to-day running (Janssen-Voss & Pot, 1994; Pot, 1996; NISW, 1998) (Table 6.1).

For the financing of the residential homes in the transition period from 1997 to 2001, the providers of homes are compensated by the provinces and the four

major cities which receive a specific payment from the Ministry of Health, Welfare and Sport. During this period, there will be a settlement process where the provinces and the four major cities will negotiate on a new calculation of the central grant. Today, payment of providers is mainly supply-led as it depends on the capacity of homes; in the future the grant should be based on the number of older people over 75 years in the area. Other local social services such as meals on wheels, transport services and community services are financed over the central block grant (Baars et al, 1993) (Table 6.1).

6.3.4. Employer and employee contributions

While employees contribute to the AWBZ over the income taxes the role of the employers in funding of welfare is less formalised, except for the payment of contributions to the maternity leave and the payment of wages during the parental and the career break leave. The Stimulative Measure, however, places more focus on employer sponsoring of day care who, through their new role, have become involved not only in payment of fees but also in setting up day care provision and in regulation of standards. The intension behind the Stimulative Measure was to increase the employer funded places to cover in all one third of day care places and this goal has been met. 70% of new child care places were to be reserved for profit and non-profit making companies who requested places for their employees before 1st July 1992. To support this, in 1996 a new tax measure for employers who subsidize places for their employees was introduced, reimbursing employers some of the costs. Employers in 1996 covered 24.8% of total costs for subsidized day care (Table 6.1). In comparison, only 5% of total costs were funded by employers in 1989.

Although today leave rights have improved for parents, the employer also plays an important role in finally accepting the number of days to be taken and in regards to the emergency leave, the employee and the employer must negotiate whether a wage compensation will be paid out during the leave.

6.3.5. User fees

In addition to the cost covered by the state and municipalities, and for day care, by employers also, users contribute to the cost for using the social services. Within day care for children parental fees make up a considerable part of costs, especially as most day care is not subsidized. Parents using non-subsidized day care must therefore cover the full costs, NLG 18,000 annually for a full-time place, while parents with employer sponsoring pay on average 37,3% of costs (SGBO, 1997). On average, parents pay 18% of costs for the use of day care centres, and higher fees, 56% of costs, for playgroups. Nursery education is free (Table 6.1).

For services for older people, fees are also income related. For the use of home help services, older people thus paid 10% of total costs in 1995, depending on household income and the number of hours of service. A maximum hourly rate is set by the Ministry of Health, Welfare and Sport at NLG 10 which again must not exceed a certain amount per week. This weekly amount depends on net household income and household composition, varying from NLG 5-250 weekly. Nursing homes are principally covered by the AWBZ, but in the early 1980s fees were introduced; most costs are, however, still covered over the insurance (Baar et al., 1993).

In residential homes, residents are individually responsible in principle for the payment of services until the transfer to the AWBZ in 2001. In 1996, total fees made up 24.3% of total expenditure, 10% in nursing homes and 39% in residential homes (Ministry of Health, Welfare and Sport, 1998 and own calculations) (Table 6.1).

6.3.6. Funding of non-profit provision

A great deal of social services are provided by the non-profit welfare associations which according to denomination were traditionally divided into so-called pillars. Today, however, most operate on general terms. The activities are no longer dependent on voluntary contributions but are fully financed over either the insurance, government contracts or fees. Especially the financial bonds to the governmental sectors are strong, why this is often referred to the 'golden subsidy cords' in tying the organisations to the government. Funding of non-profit associations has, however, gone from lump sum financing to contract, to avoid the tendency to monopolise provision and to enhance efficiency and cost-effectiveness (Baar et al., 1993; Pijl, 1992).

The help from volunteers is a significant resource which is used especially in institutional care services for older people, and for children within playgroups and lunch services in schools. Most volunteers are attached to a welfare association which mediates the care arrangement and sometimes the volunteer may unofficially be paid by the person they work for (Pijl, 1992).

6.3.7. Funding of for-profit provision

The welfare associations providing home help have enjoyed near monopoly of provision so far. To introduce market competition between home help providers, a part of the AWBZ budget set off for home help is now channelled towards newly established profit-making providers, to help them establish on the market. In all, NLG 37,5 m, or around 1,25% of total home help budget was set aside in 1997 for profit-making providers to compete for (Weekers & Pijl, 1998). The

creation of the Personal Budgets where the recipient individually choose the provider may also stimulate the private provision. Likewise, to promote entrepreneurship a subsidy scheme was introduced in 1998 for the use of commercial business offering domestic services. The user is reimbursed 50% of the gross price of services, at a maximum of NLG 17,50 per hour. Only few people have so far made use of the scheme and the increase in commercial domestic services has slowed down recently (Kwekkeboom, 1998).

6.3.8. Fiscal subsidies and social security

Parental fees for day care for children were previously indirectly subsidized through the tax system as employers received some reimbursement for funding a day care place. With the introduction of the Stimulative Measure, the money was channelled to provision of day care. Where subsidized day care was not available parents were, however, not able to benefit from the Stimulative Measure and in 1995 the tax relief was re-introduced for the costs of using services that are not publicly subsidised. The above mentioned tax relief for employers subsidizing day care is another indirect means of supporting day care for children.

There are no fiscal benefits for older people for the use of social services, although tax reductions are sometimes available for informal carers for extra costs in relation to caring (Ditch et al., 1996). Volunteers may receive a tax-free, yearly amount of NLG 1,000 as reimbursement for expenses for transport and the like from the municipality or the organisation they work for. Subject to strict criteria, carers with only minimum income may also receive a social security supplement *(Bijzondere Bistand)* paid by the local authority who set up entitlement criteria (Kwekkeboom, 1998).

6.4. Provision

6.4.1. Public provision

Most provision of welfare is in the Netherlands arranged by the non-profit associations which are heavily dependent upon funding from the state, local authorities and the insurance system. Public responsibility for welfare is thus expressed not in actual provision but in financing of welfare. Beyond stating that welfare should be provided, the Social Welfare Act does not refer to how and how much and there is only little regulation whether local authorities spend their money according to the planned goals. The introduction of the Stimulative Measure is one such example of public volume control over services, where the actual provision and setting of standards are left to the providers.

6.4.2. Private non-profit provision

The non-profit associations providing care amongst other for older people are numerous in the Netherlands, taking their starting point in the last century. As mentioned most have been set up by volunteers on a denominational basis with an outset in the Protestant and Roman Catholic churches and the Socialist and Liberal movements. Within the Protestant denomination, further subdenominations exist, e.g. the Hervormde Kerk and the Gereforeerde Kerk which each have their own organisation for provision of services. Especially the associations involved in care giving and education have traditionally had strong religious and idealistic orientation. Today, with the de-pillarisation of the social organisations, most have given up their religious goals and have moved away from charity to become professionalised. Because of their origin, most claim a considerable amount of autonomy as to the kind and content of the services they provide (Baar et al., 1993).

The associations are organised in national umbrella organisations which have previously been strongly involved in policy-making both on national, regional and local level. After WWII, the associations shared with political leaders and administrators the general consensus for the continuous growth of welfare, which gradually developed into a supply-led system of welfare provision. With the concern during the 1970s for the increasing costs, the national organisations merged into non-denominational umbrella organisations and slowly lost some of their say in policy-making (Pijl, 1991).

A part of the care work especially in institutional care homes is carried out by volunteers who are either attached to the provider association or to the municipality. Often volunteers are engaged in arranging social activities for residents. In residential homes, there are on average 18 volunteers per 1,000 residents while the number is lower in the more care intensive nursing homes, 13 per 1,000 residents.

6.4.3. Informal care

The subsidiarity principle has traditionally been strongly embedded in Dutch culture and the expectations to and the help from informal sources is therefore widespread. On average, family members spend 5 hours a week for caring (Ditch et al., 1996). Children are often cared for by grandmothers who must step in even for those children who are in day care, as provision of day care is mainly part-time. From the parents' point of view, this is often also the preferred solution. Today, however, women at this age also participate more often on the labour market.

There is no formal obligation for families to contribute neither in cash nor in kind for the care of older people, as is seen in France and Germany. In recent years, more focus has, however, been placed on the resources of the family and networks, both because of the increasing need for care and because of the policy to provide for older people in their own home. The spouse is expected to provide care and other family members may also be requested to provide some care. One fourth (23,6%) of old people over 65 years thus receive help from the family, relatives and others, while only one in twenty (5%) receive help from a home nurse and one in ten (9%) from a home help (CBS, 1997). To illustrate the volume of the informal care, in 1985, the total of effective informal care were 8 times the amount of home help hours (Kwekkeboom, 1991). The provision of informal care is, however, often complementary with the use of formal care, at least when it concerns older people who require help with personal care. Often people who need help with bathing, getting dressed etc. receive help from both a home help and the family. In contrast, older people who need help with domiciliary tasks are less likely to receive help from formal sources (Timmermans, 1997).

Much of the criticism of the overload of informal carers has been related to the lack of help and support for carers. To facilitate informal care, the care system has, however, become more geared to catering for the carers' needs. The introduction of the career break and the emergency leaves may thus give carers an ability to combine caring and working life. Support programmes and information centres for carers have been set up, and the relief of carers has been improved by the introduction of short-term stays in institutional care homes. Also, district nurses and home helps today receive training in emotional support for carers and the government has imposed on the insurance funds to set off NLG 4 m to help informal carers (Tester, 1996).

6.4.4. Private profit-making provision

The Dekker plan intended to promote the private profit-making sector in general and although the revision of the plan curtailed some of the market-oriented ideas, support for profit-making providers is increasing. The government has thus launched a new initiative with support for entrepreneurship amongst other by the setting up of government agencies which provide advice in enterprise houses.

And although social provision is still dominated by the non-profit providers, provision from profit-making providers is on the increase, especially within day care for children where the Stimulative Measure has created a new market. A business oriented approach and culture is slowly gaining grounds here, as providers now have to compete for clients and for the employers' subsidies. This

has created new forms of more flexible services, such as night day care and more flexible attendance hours (Pot, 1995).

Within care for the old, profit-making provision has so far not gained ground, although provision of sheltered housing is often provided by profit-making providers. Commercial provision of institutional care homes has thus been limited, whereas today some home care is provided by profit-making providers, often providing complementary care (Weekers & Pijl, 1998).

6.4.5. Employer provision

Not only do employers subsidize the use of day care for their employees, large companies more and more offer child care for their employees, set up at the workplace. Although the Stimulative Measure resulted mainly in an increase of the employer subsidized places, the work place day care places still make up 4% of all full-time places in day care centres and funding of day care provision for children of employees is laid down in over 220 collective agreements. In contrast to the employer sponsored places which are found especially in the private sector, workplace day care is mainly in the non-profit sector, such as hospitals and universities (van Dijk, 1996).

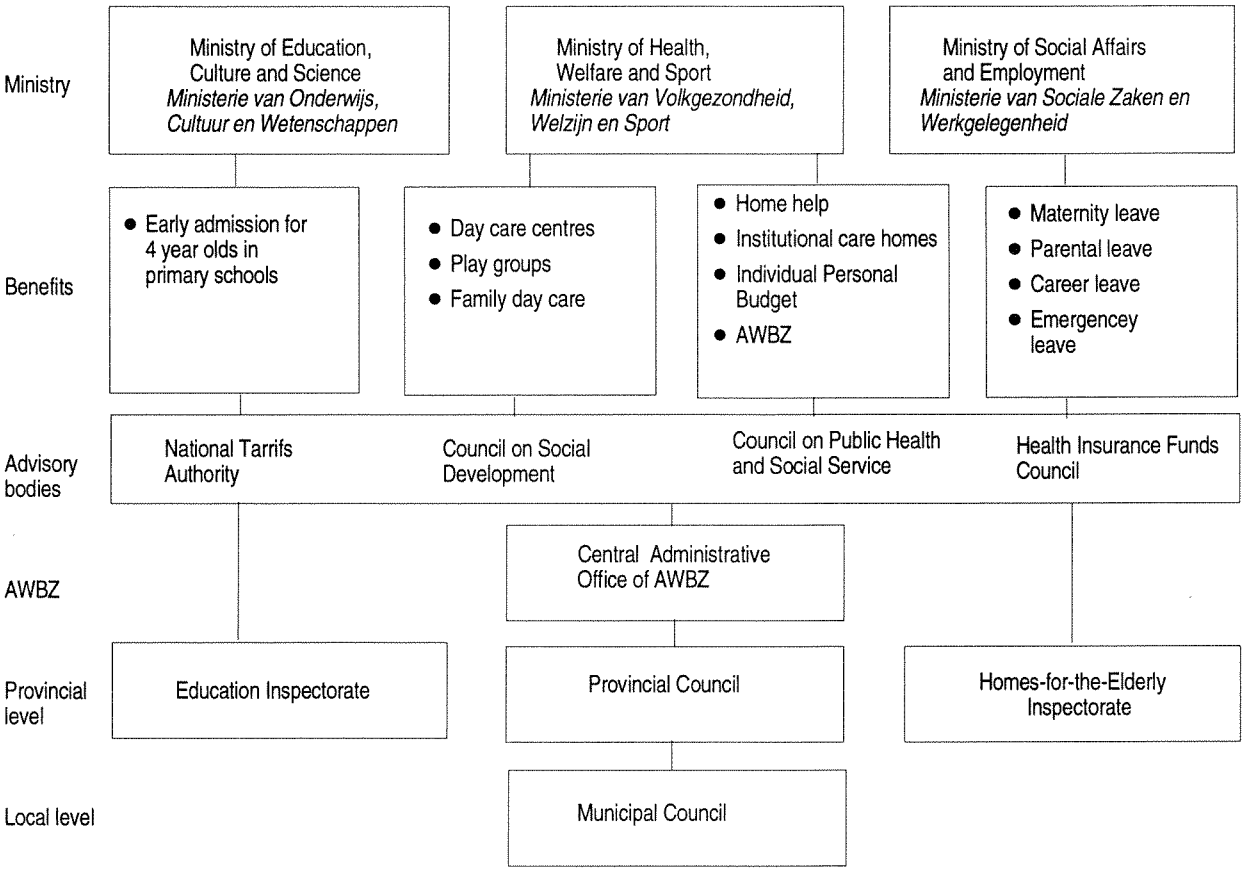
6.5. Organisation

6.5.1. Central government bodies

The Ministry of Health, Welfare and Sport is the main agency responsible for social services, such as day care for children and care for older people, including long-term care under the AWBZ. The Ministry is in charge of national policy making, overall financial supervision, sets planning, supplies standards and formulates propositions of plans for the provinces, while the actual implementation is executed at local level.

However, embedded in a long history of consensual processes of consultation and policy debate, interest groups have traditionally been involved in policy-making. Often, these participate in advisory bodies, the number of which the Ministry has, however, restructured and cut down in order to make decision-making more transparent. Agencies include the national umbrella organisation of the *Health Insurance Funds Council* which supervises the AWBZ, the *National Tarriffs Authority*, the *Council on Social Developments* and the *Council on Public Health and Social Services* which are all often advising the government in coverage and premium levels (Borst-Eilers, 1996).

Figure 6.5.
Organisational diagram.



Outside the social area, the *Ministry of Education, Culture and Science* regulates education, including the early admission in primary school, and holds responsibility for funding, management, inspection and examination.

The Ministry of Social Affairs and Employment is responsible for work related issues, such as the maternity, parental, career and emergency leaves.

Also on a central level, the *Central Administrative Office* (CAK) of the AWBZ is in charge of administrating insurance premiums, sets fees and handles the contact with providers of social services. Supervision is carried out by the Health Insurance Funds Council. Appeals concerning decisions whether a person is insured should be made to the *Social Security Appeals Tribunal,* whereas appeals relating to a service should first be made to the Health Insurance Funds

Council. Appeals relating to the contributions payable under the AWBZ must, however, be made to the *Inspector of Direct Taxes* (Ministry of Social Affairs and Employment, 1990).

6.5.2. Regional bodies

On a regional level, the 12 provinces are responsible for planning of mainly hospitals and nursing homes. Also, macro budgets for the care allowance is divided over the regions by the regional contact-office. The provinces are each administered by *Provincial Councils*, a provincial *Executive* and the *Queen's Commissioner*. The members of the Provincial Council are directly elected by the inhabitants in the province. Each provincial Council appoints from its own members a Provincial Executive who is responsible for the day to day administration of the province (Ministry of Foreign Affairs, 1994).

Residential homes are inspected by the provincial *Home-for-the-Elderly Inspectorates* who supervise the standards. This is organised by the AWBZ. The inspectors are intended to work together with the *Health Care Inspectorate* and to pass on monitoring to them by 2002 at the latest.

The provinces do not hold responsibility for the domiciliary care but the home help and home care organisations are organised on a regional level. Besides the 31 home care organisations which provide integrated home help and home nursing, there are 38 regional cross organisations providing nursery care and 85 home help organisations providing home help (Kerkstra, 1996).

For day care for children, the 12 provinces are not involved with provision nor standards either but together with the 4 largest cities, each has an organisation that offers advise to local child care centres on adequate implementation of their work.

In regards to the early admission of the 4-year-olds in primary school, this is regulated by the *Education Inspectorate*, which besides the head office has 13 regional offices. The inspectorate ensures compliance with state regulations, keeps up to date with the state of education and advises the minister (NIZW, 1998),

6.5.3. Local bodies

In the 549 local authorities, administration is the responsibility of the *Municipal Council*, a *Municipal Executive* and a *Mayor*, the Burgemeester, who is appointed by the Queen's Commissioner. The Municipal Council is directly elected by the inhabitants in the municipality and elects some of its number to serve as

aldermen. The Municipal Executive is responsible for day to day administration, including the implementation of directives issued by central and provincial government. The Municipal Executive, however, has to account for its decisions towards the Municipal Council as the local electorate's representative. In principle, the Council can reject the Executive's suggestions bar those for the implementation of directives of higher authorities (Kwekkeboom, 1998).

Dutch policy-making has traditionally been very centralised with the various ministries in charge of most main policy decisions. Only few policy decisions have been left to the local authorities, such as functions of planning and budgeting of local social services. The local authorities have also been responsible for certain social security services, such as the topping up of fees in residential homes. But some de-centralisation is taking place, which for example the allocation of the funds from the Stimulative Measure to the local authorities shows. An increasing number of tasks are laid out to the local authorities and especially in urban areas, inter-departmental cooperation is increasing (Ministry of Foreign Affairs, 1994). Although the local authorities hold responsibility for ensuring standards in day care for children in practice, these have, however, only a limited regulatory role as the providers will take over the responsibility for setting higher standards than the basic. The local council must lay down minimum standards for subsidised as well as non-subsidised day care which are imposed on the child care facilities but the individual provider is the final assurance of quality. Some local authorities perform regularly inspections of the day care institutions, mainly of the ones that receive public subsidies. The inspection is carried out by the local *Health Service* and the local *Fire Department*.

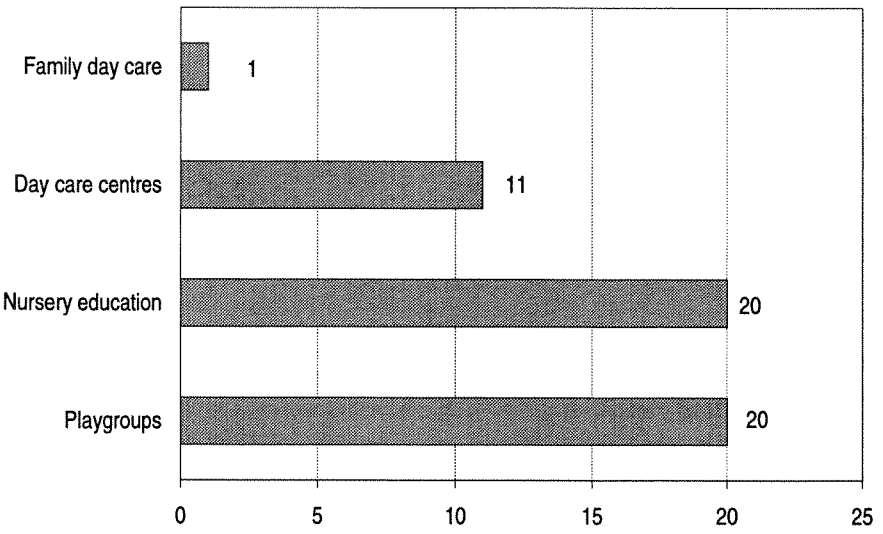
Within the education system, the local authorities perform two roles, one being the local authorities for the schools in the area, including the private schools, and two, being the competent authority, i.e. the school board for the publicly run schools. The local educational authorities must thus ensure that public schools comply to the Compulsory Educational Act, and hold responsibility for planning, coordinating accommodation, facilities and material provision and appointment of staff (Eurydice, 1998).

As regards the AWBZ, implementation of the AWBZ is done by the health insurance funds, private insurers and the bodies that implement insurance schemes for public servants. The administrative work is carried out by liaison offices which are responsible for monitoring the services provided. Each liaison office receives data from insurers and maintains a register of admission for each institutions in the area (Ministry of Health, Welfare and Sports, 1995).

6.6.
Caring for children
6.6.1. Introduction – Main services and cash benefits

Dutch mothers are entitled to 14 weeks of *Maternity leave* of which 8 should be taken after confinement. The compensation rate is relatively high, at 100% of previous earnings. There are no statutory rights for fathers to take *Paternity leave* although most fathers take at least two days following the birth, and collective agreements can include up to 10 days. Parents can now take 3 months full-time *Parental leave* without wage compensation, but the leave can be taken on a part-time basis if preferred, extending the period to 6 months.

Figure 6.6.
Day care arrangements, enrolled children (aged 0-4) as a percentage of the age group, 1995.



Source: CBS: Kindercentra (annual publication). SGBO (1998): Personal communication. CBS: Personal communication.

As a substitute for paternity leave and care days an *Emergency leave* offer parents – and other employees – short-term leave for solving specific problems, e.g when a child is sick. Finally, as a new initiative a *Career leave* has been carried through which entitles employees to between 2 and 6 months leave for caring or educational activities. Career leave can thus be used for paternity leave, care leave, adoptive leave, etc.

In the Netherlands, children start school when they turn five. Four-year-olds can, however, attend *Nursery education* set up in the primary schools. For smaller children, several types of day care arrangement are available: *Day care centres* where children can attend all day – although most children attend 2-3 days a week; *Playgroups* which provide part-time day care and *Family day care*, where a child minder cares for the child in her home or the home of the child.

6.6.2. General principles for child care

Although recent years have witnessed an increasing public intervention in the supply of day care places, parents continue to have primary responsibility for arranging care for their children. Due to the Stimulative Measure, day care services are now also acknowledged as labour supply needs in that it is succeeding in increasing employers' participation in the funding of day care. Provision of child care is therefore mainly intended as a caring function while parents are working and is seen as a means of enabling women to (re-)enter the workforce; as a secondary goal child care should offer an educational, pedagogical as well as stimulating setting. In playgroups in particular, the objective is playing with other children in order to develop basic skills, but playgroups increasingly provide assistance for disabled children or help children through the transition phase between care and the education system (Pot, 1996). The use of day care is now more generally accepted although a strong male breadwinner ideology dating back to the Calvinist influence still remains. However, some loosening of the traditional gender pattern has taken place and equal sharing of household tasks as well as child rearing is currently on the public agenda. A new norm of good parenting has developed and 3 days per week in a day care centre is increasingly considered to be the maximum period compatible with good parenting. Parents therefore often choose to arrange part-time employment between them.

Child care methods in day care are to resemble the norms and values found in the home, and parents and staff should agree on the principles of child care as far as possible. Parental influence has become increasingly important as their position as consumers is to safeguard quality of service and this has been strengthened by the establishment of a national association of parents (Eurydice, 1998). Interculturalism is one of the pedagogical approaches, i.e. paying attention to bilingualism and different values and norms, and ensuring ethnically mixed groups of staff (Pot, 1996). Provision of day care furthermore is to stimulate the cognitive, social and emotional development of children through play.

Provision of municipal day care is discretionary but most municipalities are now involved in day care for children. Although most places are intended for

employees and often funded through employer subsidies, a number of the places funded by the municipality are reserved for disadvantaged groups, e.g. low income families and in particular single parents dependent on social assistance. A single parent with a child aged under 5, planning to start work or take up training can thus obtain a free place in day care.

Most children in day care are either from a family who receives a free place for social reasons or from a 2 parent family with high incomes who can afford to pay the fees themselves. Particular attention has been paid to the number of low income families who do not occupy a strong position in the labour market and who are therefore less likely to obtain an employer-sponsored day care place. For these groups, there has been talk of introducing reduced employer subsidies, e.g. through fiscal measures.

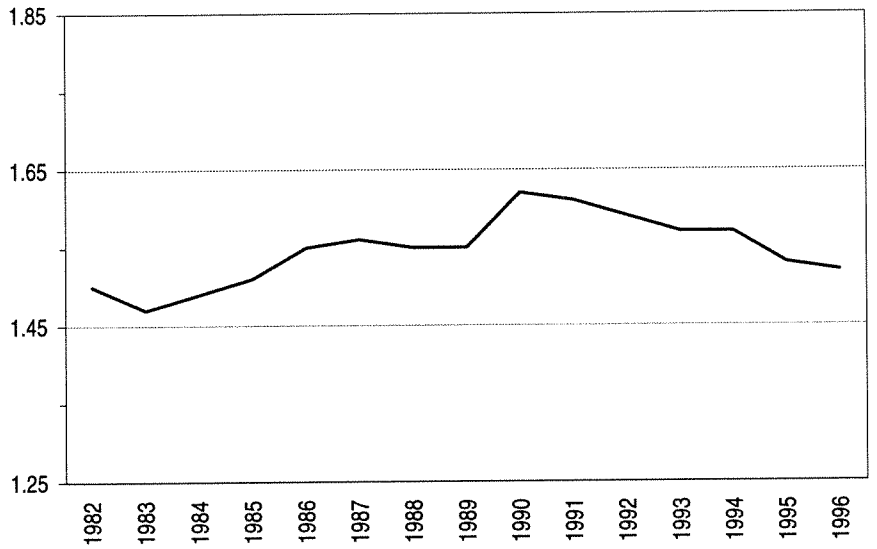
The compulsory school age is 5 but almost all children attend from the age of 4 and in contrast to the care system, primary school is attended by children of non-working parents also. The school system is based on freedom of choice in education, and private organisations are free to set up schools and determine the principles upon which they are based. The aims of primary school are oriented towards the emotional, creative and intellectual development of the child and the acquisition of essential knowledge and social, cultural and physical skills. Also in primary school, children should become accustomed to multi-cultural aspects. The very specific instruction about subjects and objectives has raised doubts about the suitability of primary education for younger children's needs. Specific attention is now given to 4 and 5-year-olds and special training for teachers of children in this age group has been introduced (Jansen-Vos & Pot, 1994).

6.6.3. The need for day care

The school system thus absorbs a great many children from the age of 4, whereas the bulk of pre-school children are cared for at home, and mainly by the mother. Although Dutch family ideology has changed in favour of more shared parental responsibility – in 1991 88% of Dutchmen believed that parents were equally responsible for day care compared to 77% in 1985 – it is still mainly mothers who look after children. 65% of child care is thus provided by the mother while 8% of children are cared for by the father, and 27% by a non-parental care provider (van Dijk, 1996). And even when a child is in primary school or day care, the structure of day care and education systems is based on the assumption that a parent will take care of children during lunch hours when for example primary schools and playgroups are obliged to close (Ditch et al, 1996).

Women therefore tend to leave the labour market when they become mothers, more than half of working women do this, but a number return after shorter or longer periods; 59% of women choose to return to work again after maternity leave (Statistics Netherlands, 1995). Today, women are encouraged to remain in work or to quickly return to the labour market while raising children – partly because of increasing labour shortages and partly because female employees increasingly constitute a highly qualified labour market resource which would be difficult to replace. Women's educational levels have thus increased sharply in recent years, from 6% of women with a higher education degree in 1981 to 14% in 1994 (Ibid).

Figure 6.7.
Total fertility rate, 1982-1996.



Source: CBS: Statistical yearbook (annual publication).

Mothers often work fewer hours than non-mothers and tend to work part-time after having children; more than half reduce their working hours in order to care for children (Statistics Netherlands, 1995). Labour participation of married women almost trebled between 1975 and 1995, from 15% to 42% (Kraan, 1997) but among the 25-49 age group 50.7% of non-married women in employment work part-time compared to 60.3% of married women in the same age group (Eurostat, 1997b). In all, 59.2% of women are active in the labour market, and of these 68.5% work part-time. Most men are active in the labour market (79.9%) and although men are to an increasing degree taking more responsibility for child rearing, most work full-time (73%) but the Netherlands also has the highest part-time rate among men (27%) (European Commission, 1997). On average, men work 38.1 hours per week, while women work 25.2 hours (Eurostat, 1997b).

With increasing labour force participation among women, the shortage of day care has undoubtedly influenced decision about if and when to have children. Fertility rates thus dropped from 2.57 in 1970 to 1.66 five years later and currently fluctuates around 1.5 (Figure 6.7). Families are getting smaller and now mainly consist of one or two children. Of households with children 40.5% have one child, 43.5% have 2 children and 15.9% have 3 or more children. Single parents make up 10.7% of households with children, and of these nine in ten are headed by a woman[1)] (CBS, 1997; Eurostat, 1997a).

6.6.4. Child care in the home

During recent years leave schemes for parents have improved considerably, in terms of extending the maternity leave and by the introduction of two general leaves which can also be used by parents. Fathers are however still not entitled to an individual, statutory paternity leave.

Maternity leave (Zwangerschapsverlof)

As from 1990, statutory maternity leave has provided women with benefit for 16 weeks, previously it was 12 weeks. All employees are covered, part-time as well as full-time employees. The leave does not apply to self-employed or housewives. Adoptive parents may also with time be entitled to maternity leave. Payment is made from 4-6 weeks before birth with benefit levels of 100% of earnings. All social rights and pension payments are maintained during the leave (Figure 6.8). In 1982, the maternity leave was used by 38,500 mothers, increasing to 85,600 in 1996 (Figure 6.8).

Paternity leave (Kraanverlof)

There is no statutory right for fathers to take time off work after child birth although most fathers take at least two days following the birth, and collective agreements can include up to 10 days. Most collective agreements specify that this leave is rewarded only on the birth of a child to a spouse, not a cohabitant. Parliament has recently asked the government to ensure that unmarried and married couples are treated equally and has also appealed to the social partners to extend the paternity leave to 5 days (Ditch et al, 1996).

Parental leave (Ouderschapsverlof)

Since 1991, parents of children aged under 4 have been entitled to reduce their working hours for 6 months to a minimum of 20 hours a week. From July 1, 1997, the leave has been extended including children up to 8 years. Natural parents as

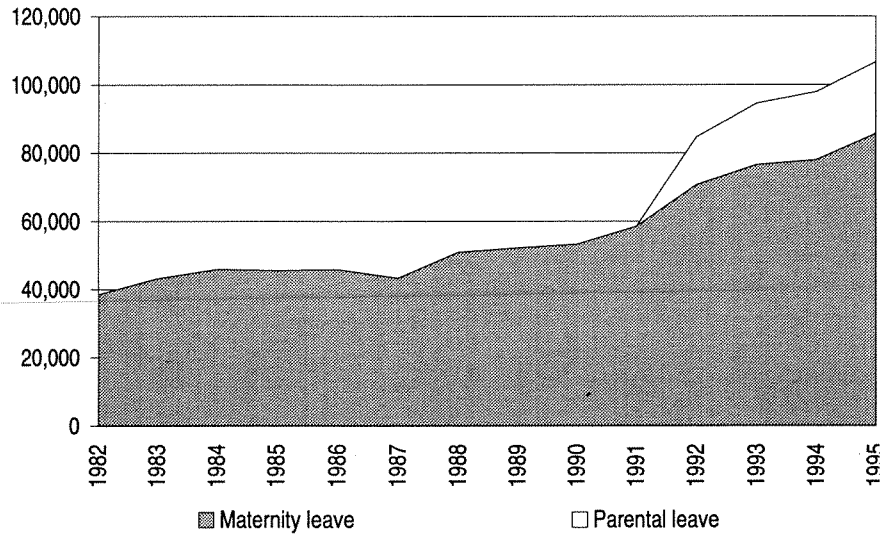
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1) Single households include also those who are cohabiting without being married.

well as adoptive parents are eligible for the leave. The leave is unpaid, apart from public employees who receive 75% of previous earnings. Previously, the parent must have worked for at least 20 hours a week in order to be entitled. As this excluded 75% of women and 30% of men who worked less, the system has from 1997 been changed to 3 months full-time leave without wage compensation, but the leave can be taken on a part-time basis if preferred, extending the period to 6 months. The minimum period of leave is 13 weeks. The leave entitles the parents to one leave per child. The employer must approve of the leave and must be notified a minimum of 2 months before the leave. During the leave, the parent upholds pension rights as well as holiday allowance entitlements, and must contribute to the sickness insurance. There is a right to be installed in same work position afterwards.

From the introduction of the scheme to 1995, 19% of all entitled employees have taken up the leave, 10% of fathers and 41% of mothers. In general, more women than men take parental leave but women tend to take longer leave periods. On average, leave lasts for 26 days. Of the men who take parental leave, most are employed in the public sector where wage compensation is available. Of the total number of entitled parents in 1996, 23,000 took the leave, an increase of 10,000 since introduction of the scheme (Figure 6.8). This is in the context of 190,000 children born in 1996 (CBS, 1997).

Figure 6.8.
Cash benefits for maternity and parental leave, number of recipients, 1982-1995.



Source: LISV (1998): Personal communication.

Emergency leave (Calamiteitenverlof)

As a substitute for paternity leave and care days the emergency leave offer natural and adoptive parents – and other employees – short-term leave for solving specific problems, e.g. when a child is sick. It is not intended only for parents and can also be used for other purposes, e.g. caring for older family members living in the same house as the employee, or – as stated in the official guidance – when the water pipes break down. Emergency leave does not entitle employees to a specific number of days, nor to a specified amount of wage compensation; these must be negotiated with employers. In some collective agreement, employees receive full wage during emergency leave. The extent of use of the leave is not widespred, but in general between 2 and 3% of employees take emergency leave during the year.

Career leave (Loopbaanonderbreking)

As a new initiative, a career leave has been carried through in April 1998. The leave entitles employees to 2 and 6 months' leave for caring or educational activities and not for sabbatical purposes. Career leave can thus be used for paternity leave, care leave, adoptive leave, etc. All employees who work for more than 12 hours per week and have been working for 1 year are entitled not to leave which must be negotiated with the employer but to receive a benefit during the leave. The full leave period is 2 months as a minimum and 6 months as a maximum which can be taken as full-time or part-time basis. The reduction in hours must, however, be more than 50% and can be separate in periods with 1 year in between. Then the employee position has to be replaced by a recipient of a welfare allowance, a disabled person or a women re-entering the labour market; if the employer hires a low-skilled employee a tax reduction is available.

During the leave, the right to pension credits depends on the specific collective agreement whereas the disability credits and survivors' credits are maintained in most cases. The benefit is related to last earnings but makes up a maximum of NLG 960 a month before taxes which is lower than the national assistance of NLG 1,200 monthly. The benefit is taxable but exempt of social security premiums and is funded through the unemployment fund, as part of job creation measures, and through government subsidies.

Collective agreement

Many collective agreements include the right to 4-5 days of either paid or unpaid leave or contain extensions to statutory leave periods. As mentioned some collective agreements also include the right to receive partial wage compensation. Also, funding for day care facilities for children of employees forms part of over 220 collective agreements.

6.6.5. Day care for children outside the home – the welfare system

Under the *welfare system,* day care places are provided by private providers who may receive funding from the Stimulative Measure, which is paid out by local authorities who may also provide additional local subsidies. However, a great part of the financing for day care places comes from employers, 47% of places for the 0-4-year-olds are funded in this way.

Day care centres (Kinderdagverblijven)

In day care centres, child care is provided throughout the year on a part-time or full-time basis for children aged 6 weeks to 4 years, but sometimes children up to the age of 8 or 13 are looked after in day care centres, e.g. during school lunch hours and after school from 3:15 p.m. Group sizes are normally between 9 and 10 children, often provided as age integrated day care, *combined kinderdagverblijf* where children are toghether in groups from 0-4 or 4-12 years. Some day care centres have been set up exclusively for providing for children outside school hours and during lunch hours. Children may attend 5 days a week or for only part of the week. The institutions are normally open from 7:00 a.m. to 6:00 p.m.

Admission

Admission to public places in day care centres depends on need or employment situation and the local authority can decide to admit a child because of developmental or social needs. Most places, however, are for parents who are in employment or for single parents who want to return to employment or training. Of the places funded by employers, admission is negotiated with the employer and will often depend on employment and family situation. Parents using employer sponsored day care must also be able to pay their share of fees.

Provision and coverage

Day care centres were founded and are owned and managed by private, for-profit or non-profit-making organisations. Some non-profit-making centres are run by parents who also care for the children, in which case they are called *Oudercreche* and sometimes employ paid workers as well (Pot, 1995). Most centres are now part of an umbrella organisation which is responsible for administration, staff, resources and development. Most umbrella organisations are run on a non-profit basis. Places are either provided under contract with the local authority, in which case they are public subsidised, or provided for parents/employers on a private basis. Some places in subsidized day care are contracted to employers also. In 1996, 825 of the 1,247 day care institutions received public subsidy (SGBO, 1997).

The Stimulative Measure has had a clear effect on levels of provision, increasing the number of child care places. In all, 62,445 full-time places are available for

children in day care centres in 1996 of which 18,339 are places in age-integrated centres. When measured in full-time places, 6.5% of the 0-4-year-olds attend a day care centre, of which nearly 2% attend an age-integrated day care centre. In 1982, less than 1% of the 0-4-year-olds attended day care centres. Places funded by employers made up 28% of total provision in 1996, a rise from 10% in 1989 (Table 6.2). Around one in 30 places were in 1994 occupied by children admitted on social welfare grounds.

Table 6.2.
Day care centres, number and per cent of FTE children (aged 0-4), 1982-1996.

Year	Number of FTE children (0-4)		%	
	Day care centres	Age-integrated day care centres	Day care centres	Age-integrated day care centres
1982	3,921	..	0.44	..
1983	..	..	..	..
1984	5,667	..	0.65	..
1985	..	..	..	..
1986	7,080	..	0.81	..
1987	..	..	..	..
1988	10,074	..	1.11	..
1989	15,840	..	1.74	..
1990	24,452	3,633	2.61	0.39
1991	28,899	6,873	3.05	0.73
1992	30,729	7,650	3.19	0.80
1993	35,934	11,652	3.70	1.20
1994	39,497	13,197	4.02	1.34
1995	42,027	15,876	4.25	1.61
1996	44,106	18,339	4.50	1.87

Source: CBS: Kindercentra (annual publication). SGBO (1998): Personal communication.
Note: 1 enrolled child = 0.6 FTE child.

Waiting lists have been reduced with the explosion in the number of places but expansion has also created an increasing demand for places so that 17,402 children are still waiting for a place compared to 26,525 in 1990. Full take up of places, however, has not been reached as only 83.7% of capacity is used (SGBO, 1997), partly because most children attend only a few days a week; 38% of children use day care centres for 1 or 2 days, 22% for 3-4 days and 40% for 5 days a week (SCP, 1996). Average attendance hours are 17.9 hours a week

(VWS, 1994). The majority of children attending are of Dutch origin but among children from ethnic minorities Surinamese and Antillean children are significantly predominant, whereas Turkish and Moroccan children are under-represented. Due to relatively high fees most children come from higher income groups; only 15% of children from low income groups make use of day care (SCP, 1996).

Fees

Levels of fees are set by local authorities although the government provides advice on the scale of parental contributions. Around half the local authorities apply government guidelines when setting fees. Parents pay fees according to income and number and age of their attending children. For day care in general – including other forms of day care – parental fees vary for one child aged under 4 from between NLG 97 monthly to NLG 1,176 for full-time day care, depending on income. Part-time fees are approximately 23% of a full-time place. Fees are reduced for second and subsequent children and depend on age, therefore day care for children aged 0-4 is more expensive than for those aged 4-13. For an APW couple with two children under 4 in full-time day care, fees would amount to NLG 1,003 for the first child and NLG 300 for the second (SGBO, 1997). On average, fees paid by parents cover 42.1% of total costs for day care. However, parents making use of subsidized day care contribute 37.3% of costs, or around NLG 6,000 per place per year while parents using employer-provided place pay around 50% of costs, around NLG 9,000. Parents without employer sponsoring pay the full prize, NLG 18,000 yearly (SGBO, 1997).

Standards

In most local authorities, day care centres must apply for a licence in order to operate but in some authorities this may only apply to centres which receive public subsidies. Until 1995, local guidelines applied to group sizes, the number of staff members per child group, building, furnishment and indoor and outdoor-space but now the day care centres are to take primary responsibility for standards and should set up a system of quality assurance during the next 5 years as part of The Childcare Quality Requirement (Temporary Measures) Decree. It is believed that competition, market forces and a strong position of consumers will enable the parents to sort the bad from the good. Until this is in place, local government will regulate some aspects of minimum standards in regards to size of groups and ratio of staff to children.

Earlier guidelines from the Association of Dutch Municipalities recommended a maximum of 8 children in groups for 0-1 year olds, 10 children in groups with 1-2 year olds, 12 children in groups for 2-3 year olds and 16 children for groups of 3-4-year-olds. For groups with children aged over 4, there should be a maximum of 20 children. For age-integrated groups, there should be no more than 12

children and only 3 of these should be younger than 1 year old (Jansen-Voss & Pot, 1994).

Staff members consist of paid and often highly qualified employees. Qualification levels of staff are by collective labour agreements and the minimum qualification is at secondary vocational level (Jansen-Voss & Pot, 1994). 95% of employed staff members have received training or hold qualifications (SGBO, 1997). In day care centres, the group *Leidster* receives a two year of post-18 training or 2-3 years of post-16 training. Students who have not finished their courses may be employed as *juniorleidsters*. Centres are supervised by a *Hoofd*, who has a four-year post-18-training; for larger centres an extra year of management training is required. Umbrella organisations are normally headed by a *directrice/directeur* with at least a four-year post-18 training, plus further training in management or a university degree in Psychology, Pedagogy or Management.

The Association of Dutch Municipalities recommends 1:4 children under 1 year old, 1:5 children aged 1-2, 1:6 for children aged between 2 and 3; and 1:8 for children aged over 3 years (Janssen-Voss and Pot, 1994). In 1996, there were 7,521 FTE paid staff members in day care centres, working on average 26 hours a week, or 1:6.7 children in a full-time place. In addition to this, the equivalent of 220 full-time volunteers and 1,070 full-time trainees worked in day care centres, in all 1:39 children in a full-time place (SGBO, 1997 and own calculations). Activities reflect the age of the children and much time is spent on sleeeping, washing and eating.

Regulation

Some local authorities carry out inspections of day care centres and mainly those that receive public subsidies. Inspections are carried our by the local Health Services and local Fire Department. In some cases, inspections are only theoretical, 13% of municipalities in 1996 planned to inspect the units but did not do so. In 71% of municipalities, regular inspections are carried out, usually once a year (SGBO, 1997).

Workplace day care (Bedrijfscréche)

Apart from funding places in private day care centres some workplaces provide day care facilities for employees in the work-place and mainly for younger children; only very few provide for school age children (Pot, 1996). It is mainly large companies which provide such facilities for employees. Employers determine admission criteria and set fee levels. After the introduction of the Stimulative Measure, the number of places levelled off, but in recent years the number of places has grown again. Around 5,000 children attend work-place day care centres, an increase of 400 since 1989. As in other forms of day care, most

children attend part-time, but attendance hours are higher than in day care centres out with work-places, 20.2 hours per week (VWS, 1994). Fees are negotiated between parents and employers and there is no public regulation of premises.

Family day care (Gastouderopvang)

Provision of family day care was introduced for the first time in the 1970s mainly to support single parents and from the mid-1980s family day care received public funding for the first time. Today, it is used by working parents on an individual basis as well as by employers for their employees. It is organised around a local agency, *gastouderbureau*, which keeps a list of local family day carers, the *gastouder*, and arranges contact between parents/employers and the family day carer. Some family day carers do work independently of the bureaus, these are known as *particular gastouder*. The bureau offers advice, support, training and administrative service but do not employ family day carers as such. The bureaus are run on both non-profit and for-profit basis and some are run by parents. They are open throughout the year during office hours. Family day carers arrange hours with the parents and care for children aged 0-12.

Table 6.3.
Family day care, number and per cent of FTE children (aged 0-4) 1989-1996.

Year	Number of FTE children (0-4)	% of the children (0-4)
1989	0,960	0.11
1990	1,920	0.20
1991	3,920	0.41
1992	7,440	0.77
1993	9,120	0.94
1994	9,753	0.99
1995	11,140	1.13

Source: CBS: Kindercentra (annual publication)
Note: 1 enrolled child = 0.8 FTE child.

Coverage

The family day care system has witnessed an equally drastic expansion in the number of places since the introduction of the Stimulative Measure. In 1996, 15,200 children were cared for by a family day carer or 11,100 when measured

in full-time places, an increase of more than 10,000 since 1989. In all, 1.13% of children in 1996 were in family day care, as measured in full-time places, compared to 0,11 in 1989 (Table 6.3).

The Stimulative Measure was to increase the number of places bought by employers but this has not been achieved as expected although the family day care system offers a very flexible form of day care. However, 2,154 places were reserved by employers for employees in 1996 compared to only 32 places in 1989 (Table 6.3). 69% of places were funded under the Stimulative Measure in 1996 (SGBO, 1997). Waiting lists are much lower than for day care centres, 880 children are currently waiting for a place with a family day carer (Ibid). On average, children attend part-time, 14.6 hours per week (VWS, 1994).

Fees

The family day carer is regarded as semi-employed, neither employed by an agency nor being self-employed. Fees are most often negotiated individually between parents and family day carers. On average, parents pay NLG 3-5 per hour. The family day carer negotiates terms with the parents on sick pay, minimum wage levels and holiday leave and pay. Public funding via the Stimulative Measure is for the agencies organising family day care to pay staff wages until 1996 when municipalities took on responsibility for public funding. Due to the grey area surrounding their employment position, family day carers are not covered by the social security system and are not entitled to social benefits.

Standards

Bureaus organise training courses but the family day carers are not obliged to have training; there are no national standards neither for family day carers who are working with bureaus nor for those working independently. However, it is recommended that there should be no more than 4 children per family day carer, including the carer's own children (Pot, 1995). At the bureau, staff members should at least have received a secondary vocational level of training.

Registration and inspection

Family day carers working with bureaus are registered, but there is no assessment of their ability to care for children. Inspection is almost non-existent, except for the inspection carried out by the bureaus themselves. Bureaus are required to be licensed.

Playgroups (Peuterspeelzalen)

The earliest playgroups were set up by mothers themselves in the mid-1960s because of dissatisfaction about the lack of opportunities for children to meet other children and the lack of free and safe play areas. During the 1980s, the number of playgroups came to a halt. However, they continued serving an

important function in integrating children and parents from ethnic minorities, and like English playgroups, were educating parents in good parenting skills. However, in contrast to English playgroups, Dutch playgroups have never competed with nursery schools, but rather have been set up as parallel provision. The objective of playgroups is still mainly to provide children with an organised social and broadly developmental experience but they are now more focused on their role as an intermediary setting between day care and education for pre-school children. In Dutch playgroups, children are taught how to cope with other children and adults and to develop skills and prepare for school. Daily activities involve a group gathering, a snack, structured play or reading, followed by free play and maybe a rest period for sleep. Children normally attend when they reach the age of 2-3, although a few 1½-year-old children also attend. Provision is part-time and playgroups are usually open 3 days a week from 2-4 hours a day during school term time. Children attend on average twice a week for two or three hours a day in groups of around 12-14 children (NIZW, 1998; Jansen-Voss & Pot, 1994).

Provision and coverage

Playgroups are funded, owned and managed by private non-profit-making organisations, sometimes situated in a school as a special service for parents and to attract pupils, and sometimes playgroups are organised by a community centre, or may be part of a larger umbrella organisation which also administers other forms of day care (Jansen-Voss & Pot, 1994). By 1995, there were 3,900 establishments and in 1996, 79,300 full-time places were available, for 8% of the 0-4-year-olds (Table 6.4). The introduction of the Stimulative Measure in 1990 does not appear to have lowered demand for playgroup provision.

Fees

Playgroups are heavily dependent on parental fees, although some receive state funding through local authorities. Playgroups do not receive funding from the Stimulative Measure as they are not regarded as day care provision but other public subsidies cover approximately 38% of costs, while parental fees cover 56% and fund-raising 6% (Pot, 1993). Parental contributions are usually fixed at between NLG 4 to 11 per session and may occasionally depend on parents' income (NIZW, 1998).

Standards

Staff employed in playgroups mainly consist of a *peuterspelzaalleidster* who has a two or three years of post-16 training. Heading the playgroup, the *hoofdleidster* has a four-year post-18 training. In community-based playgroups, a *peuterwerk-ster* with a 2-3-year post-16 training may be employed. Parents – and mainly mothers – also assist in playgroups as do trainees or other voluntary helpers. Recommended staff:-children ratio is 2 adults per group of 18 children where one of the two are required to have qualifications. In 1995, there were 16.2 full-time

children per 1 full-time staff member (Table 6.4). Activities are in contrast to the nurseries focused more on play than on care, and may include paint, paper and glue and games.

Table 6.4.
Number and proportion (%) of FTE children (aged 0-4) in playgroups and FTE children per 1 FTE staff, 1982-1995.

Year	Number of FTE children (0-4)	% of the children (0-4)	Staff ratio
1982	50,050	5.64	..
1983	..	..	..
1984	53,803	6.14	..
1985	..	..	..
1986	53,008	6.05	..
1987	..	..	..
1988	55,072	6.09	..
1989	65,600	7.19	..
1990	69,520	7.42	..
1991	78,400	8.28	..
1992	76,400	7.94	..
1993	79,000	8.13	..
1994	80,253	8.17	..
1995	79,332	8.02	16.22

Source: CBS: Kindercentra (annual publication).
Note: 1 enrolled child = 0.4 FTE child.

Regulation

There is no regulation of private, non-subsidised services at national level; however, a few local authorities carry out inspection.

6.6.6. Day care for children outside the home – the education system

Primary education (Basisschool)

Compulsory school starts at age 5 but since 1985 nursery schools for 4-6-year-olds have been integrated with the primary school in order to provide a more integrated educational approach. Most children therefore attend primary school from the age of 4. All children can be admitted, to which school depends on parental choice. In general, public schools apply catchment area criteria in order to ensure an efficient spread of pupils but private schools have no such rule. School hours are from 8:30 a.m. to 12 noon and 1:15-3:15 p.m. but from 8:30 to 12 noon on Wednesdays. Term time lasts from 1 August to 31 July. During lunch hours, schools can arrange day care if parents request this. Provision will usually be on school premises. Parents together with volunteers look after the children

during lunch hours, sometimes assisted by a teacher. In recent years, some schools in the western part of the Netherlands have chosen to offer contentious time tables with only a short lunch break instead (Eurydice, 1998; Pot, 1996).

Provision and coverage

Primary schooling is provided by public and private schools, some 65% of primary schools are of private educational system and most often Protestant or Catholic and more rarely of Muslim or Hindu denomination; non-denominational schools are mainly based on a specific educational principle, e.g. Steiner.

Table 6.5.
Nursery education, number and per cent of FTE children (aged 0-4), and according to provider, 1982-1996.

Year	Number of FTE children (0-4)	% of the children (0-4)	%	
			Public	Private
1982	94,076	10.59	31.71	68.29
1983	92,640	10.49	31.59	68.41
1984	95,240	10.87	31.47	68.53
1985	98,886	11.31	31.55	68.45
1986	96,093	10.96	31.35	68.65
1987	92,326	10.39	31.27	68.73
1988	94,867	10.49	31.25	68.75
1989	97,275	10.66	31.19	68.81
1990	100,627	10.74	31.31	68.69
1991	101,296	10.69	31.38	68.62
1992	100,858	10.48	31.50	68.50
1993	101,955	10.49	31.60	68.40
1994	106,762	10.87	31.68	68.32
1995	108,168	10.94	31.76	68.24
1996	107,157	10.92	31.87	68.13

Source: CBS: Personal communication.
Note: 1 enrolled child = 0.55 FTE child

Around 110,000 full-time places were available in 1996. The proportion of 4-year-olds in primary school is nearly all of them, 98%. For primary school children in general, an equal proportion of children attend the public, Protestant and Catholic schools, around 1/3 of children in each form of schooling while the remaining

children attend other private schools (Table 6.5). Most primary schools offer lunch hour provision (90%) and around 30% of children make use of this (Pot, 1996).

Fees

Most primary schooling is free of charge being financed by the Ministry of Education. A few schools charge parental contribution but such contributions must not constitute an obstacle to admission. If day care is provided during lunch hours, parents are expected to bear the costs, around NLG 1-3 a day.

Standards

According to the Primary Education Act schools can determine their own organisational principles. Most primary schools arrange separate groups of 4-5-years-olds, but mixed groups also occur, e.g. in rural areas. Activities reflect the age of the children, with small group activities for younger children instead of class teaching. The same teacher is responsible for learning all subjects. The groups usually consist of 22 children but with large variations and extremes of 40 per group are no longer an exception. Children attend for a minimum of 4.4 hours and a maximum of 5.5 hours per day. Each school is free to set its own curriculum but according to the Education Inspectorate teaching should be based on play, as well as developmental work and basic skills; subjects should have meaningful content; educational surroundings should encourage exploration and fundamental learning experiences; and there should be as much room as for choices and initiatives on the part of children. It is further specified that subjects must include sensory and physical education, Dutch and English, arithmetics and mathematics, factual subjects, creative activities, self-reliance and health instructions – and this has raised doubt about the suitability of primary schooling for very young children. Children from ethnic minorities may have some teaching in their native language. There is one teacher for each class, containing 22 or more children, with a fur-year post-18 education primary teacher diploma obtained on completion of a primary teacher course, PABO, at a higher professional education institution (Eurydice, 1998).

Parental participation

Parents take part in both decision-making and in the provision of care, e.g. during lunch hours. Every primary school is legally required to set up an advisory council with an equal number of elected staff and parent representatives. Parents may also participate through the parents' council, which advise parents' representatives in the participation council and coordinates parental activities.

Regulation

Inspection is carried out by the Education Inspectorate once a year. Lunch hour care is not regulated.

Daily administration

A municipally employed school principal is responsible for daily administration and management of the primary school. Private schools are managed by a school board.

6.6.7. Public facilitation of private day care

Fiscal subsidies were available to parents up until 1989 in order to partly relieve them of the financial burden of day care. This tax relief for child care was abolished, however, because it did not meet the demand for more child care services. The money saved was instead transferred to the Stimulative Measure to spend on providing more child day care services for employed parents (Hogg & Harker, 1992). In 1991, however, the Supreme Court ruled that employees who do not receive employer subsidies for child care are entitled to a tax deduction. Working parents therefore continued to be compensated up to a maximum of NLG 20,000 a year for child care expenditure exceeding the costs of attending a subsidized service (Pot, 1995).

All employers providing day care at the workplace receive an annual bonus of at least NLG 2,000 per place. In addition, private employers providing workplace day care for their employees may deduct part of the costs from taxable earnings. For employers who instead sponsor day care places in subsidized care a new tax measure was introduced in 1996 which compensates the employer at a rate of 20 of net costs (Pot, 1995). New tax measures have as mentioned earlier also been discussed to favour employer subsidy of places for low income employees.

6.7.
Caring for older people

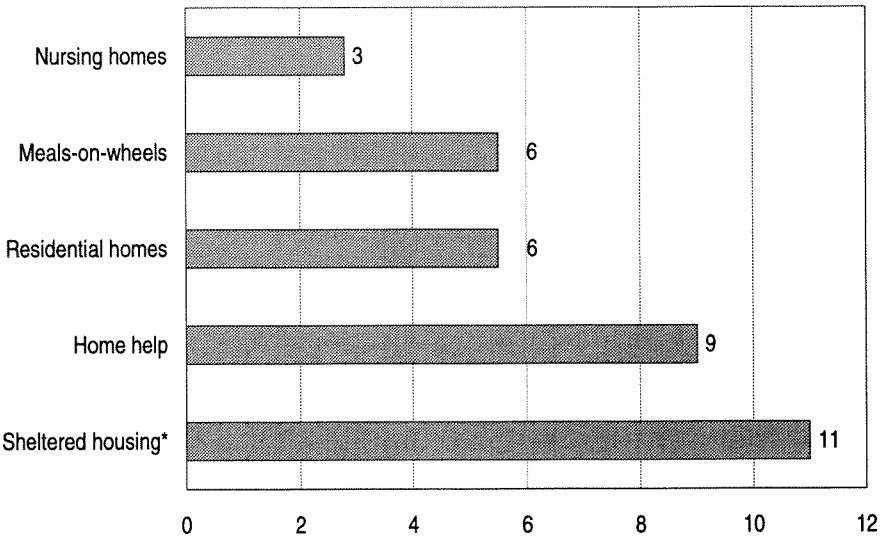
6.7.1. Introduction – Main social services and cash benefits

Care for older people has in the Netherlands undergone great changes during the last decades. As is seen in most other countries, care is today mainly provided in the home as institutional care is more and more substituted with domiciliary care. Previously, the service and health care systems in the Netherlands were split into two separate systems, providing domiciliary care such as home help, home care and residential care within the social system and nursing home care provided within the health system.

The aim is today to apply a functional approach in care provision, instead of a facility oriented approach, and the care system is geared to this through the cooperative arrangement between the social and health care system. The help and care provided by the *Home Help*, which for some older people who live in their own home is an important source of help, is thus often integrated with home nursing. Also, while institutional care was previously divided into two, *Nursing Homes* and *Residential Homes*, according to the facilities and care provided, these are today catering for the same needs and the old distinction is fading, especially since the residential homes are to be financed through the care

insurance payments (AWBZ) also (Figure 6.9). Today, provision include auxiliary care services, such as *Short-term Care, Meals on Wheels, Alarm Services, Day Centres* and different forms of *Housing for Older People.*

Figure 6.9.
Use of main social services, older people (65+) as a percentage of the age group, 1996.



Source: CBS: Kosten en financiering van de gezondheidszorg 1997. VWS (1998): Personal communication. CBS: Statistiek van de bejaardenoorden 1996.
Note: * Data from 1994.

New initiatives include the introduction of various cash benefits. Compensation for informal carers has improved with the introduction of the *Career Leave* and the *Emergency Leave*, but perhaps more important is the new *Personal Budget*, which a certain proportin of the dependent among the older people can use for purchasing private for-profit or non-profit care, or for compensating informal carers.

6.7.2. General principles for care services for older people

The Netherlands like most other countries has pursued a policy of de-institutionalisation for a number of years. Here, the policy is couched in terms of substitution which refers to the objective of replacing the use of one facility –

intramural care – by another – extramural care – while retaining the quality of the services offered. Previously, even hale and hearty older people were likely to move into institutional care. Today, service provision for older people is intended to consist primarily of domiciliary and auxiliary help, while institutional care is mainly for very frail older people. The policy of substitution should serve two purposes, firstly this should facilitate the wish of the user. Secondly, it should produce a more efficient and cost-conscious service provision by avoiding unnecessary use of services. The Government has thus recognised that the substitution policy will result in lowering public expenditures as non-institutional care is believed to provide a cheaper alternative (Ministry of Health, Welfare and Sport, 1990).

Since the publication of the Dekker report in 1987, the objective has thus been to develop more flexible, efficient and cost-conscious services. The policy of substitution belongs to this approach, as is also the search for more integral working methods. This entails blurring the boundaries between professional approaches, so that coordination of medical and social care can be developed and tasks divided. Inspired by British experiments, provision of services should furthermore be less standardized and more tailored to individual need. Also, delivery of services should move away from a facility oriented to a functional approach, i.e. be described in terms of functions, not in terms of which organisation delivers the service. Recently, to achieve this, most of the traditional residential homes have been converted into care and accommodation complexes which are to serve as half-way houses.

Much attention has also been given to the development of quality in service provision and to give the social services a human face, working for equality in relationships and conservation of privacy between care-giver and carer (Baar et al., 1993). Client empowerment is at the top of the present Minister's list of action and older people are encouraged to take part in policy formulation. Since January 1998, services have been further integrated and moved towards a client oriented approach as screening for and providing information about welfare, housing and care services have been merged into one body giving older people a unified access to all services. Attention has also been paid to what has been conceived as a dependency problem – that people and society in general expect too much from the state rather than accepting individual responsibility. Resources in the informal sector have therefore been brought into focus, as have the resources of older people themselves. Partly due also to the tendency to withdraw from the labour market at an early age, policies for older people are aimed at the group aged 55 years and over. Older people are to be encouraged to take responsibility for their own situation as well as taking part in society. Policies for older people

therefore further incorporate the strengthening of integration, independence and participation which needs an integrated approach and one that sees policies for older people as part of general policy making. Various ministries therefore are responsible for formulation of policies for older people as well as the Minister for Social Affairs, including Ministers for areas such as Education, Health, Employment and Housing are also involved.

6.7.3. The need for care services

The integrated approach has facilitated a raising of the poor housing standards which for many older people has been a contributory factor in the decision of move into institutional care. The quality of rented housing for older people is still, however, lower than average. In addition to poor housing quality, the general shortage of housing following the Second World War likewise encouraged older people to move into old people's homes in order to give space to younger families, but older people today remain in their own houses which are mainly owner occupied apartments or houses.

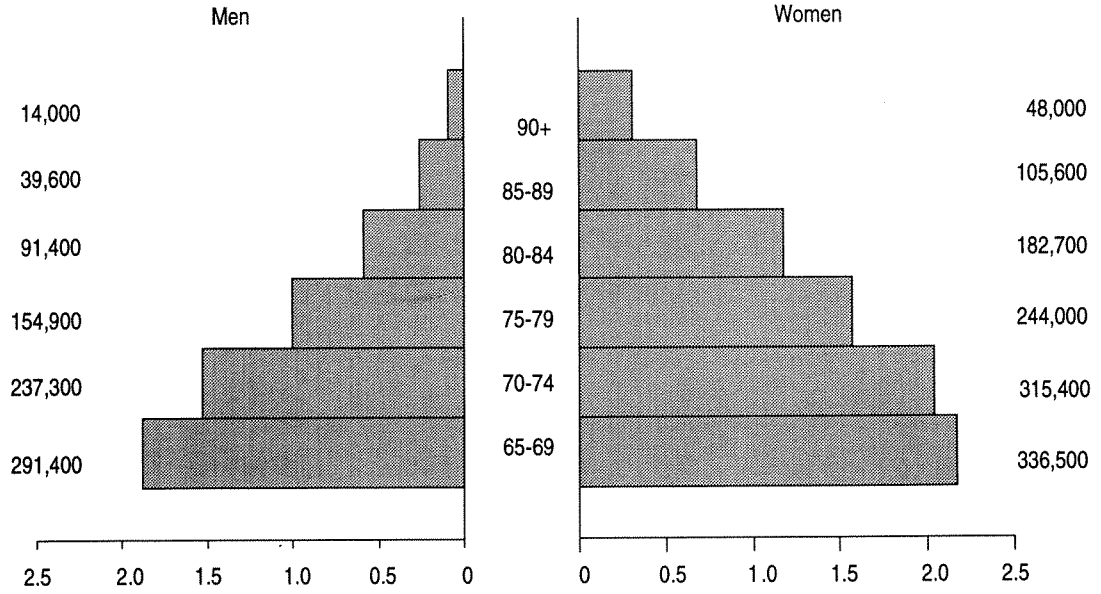
Nearly half of the older people live in one person households, and of these most are women (80%) mainly because women live longer than men. Today's women live 80.3 years on average which is an increase of 10 years since 1970. Men's life expectancy has increased by 4 years since 1970 but is still lower than women's today, at 74.7 years (Eurostat, 1997a; Council of Europe, 1997). Women in general also constitute the majority of older people 65+ (60%) and this increases according to age; women make up seven in ten of those aged 80+ (Figure 6.10).

Older men are much more likely to be married than older women (80% compared to 50%) due to women's longer life expectancy, and more women (35%) than men (9%) are widowed (Timmermans, 1997). Today, two in five live with spouse or partner but in the coming years especially more men will be living alone. The proportion of older men living on their own is expected to increase from one in five men over 65 years to one in three in 2035 while the proportion of women living alone is expected to increase less dramatically (Baar et al, 1993).

One of the reasons for future increases, especially among single men, is the proportional increase of men to women. Life expectancy for men is expected to increase more than for women. But the number of women will continue to outstrip men so that in 2020 there will be 114 women per 100 men aged 65-79 and 199 women per 100 men aged 80+. With increasing life expectancies and falling fertility rates since the mid-1960s, the population of older people in general will constitute a larger proportion of the population in the near future. By 2020 the

proportion of those aged 65+ is projected to constitute 18.9% compared to 12.9% in 1996 while the 80+ will have increased to 4.2%, from the 3.1% today (Figure 6.11). As a proportion of the working age population – people from 15 to 64 years – older people in the Netherlands are thus projected to constitute 29% in 2020, compared to only 20% in 1997 (Eurostat, 1997a; Council of Europe, 1997).

Figure 6.10.
Age pyramid of the older people (65+) as a percentage of the population, 1996.



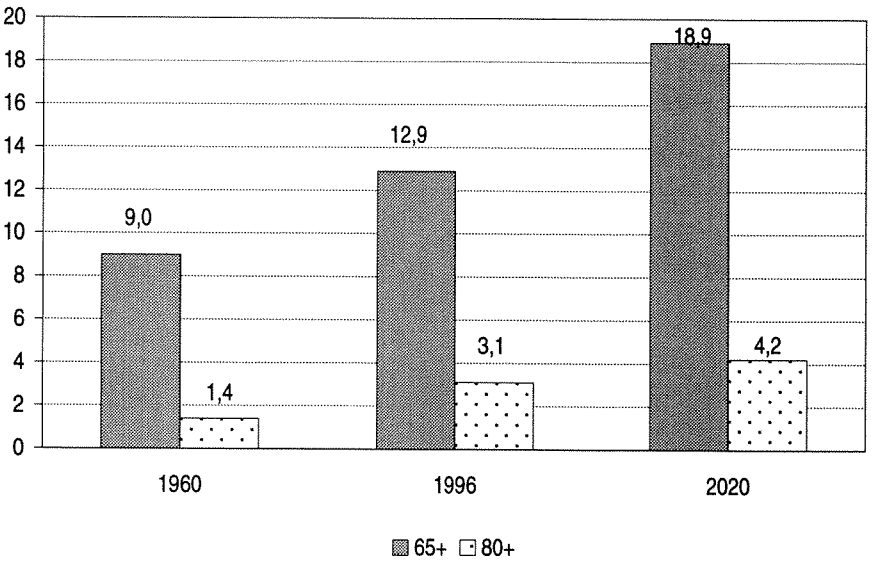
Note: EUROSTAT: Demographic statistics 1997.

The process of double ageing – meaning that the oldest in the population live longer and in number increase faster than the total number of older people – is going to be less pronounced than seen in other countries. The proportion of the 65-74-year-olds will increase slightly by 2020 as a proportion of the total older population, whereas the 75-84-year-olds will decrease. The proportion of older people aged 85+ has gone up since 1982 but by 2020 this age group will constitute the same proportion among the old as today.

Even so the rise in number of older people is expected to increase the need for care and assistance as older people are expected to become more frail with age. Today, nearly half (43%) of the 65-79-year-olds and more than half (58%) of the 75+ have slight or moderate disabilities while one in ten (8%) of the 65-79-year-olds and one in four (23%) of the 75+ suffer from severe disabilities. In regards

to be able to carry out daily tasks, of those living independently, nearly one in five (17%) of the 65+ have slight problems in performing personal care and one in three (35%) have slight problems performing daily household chores (Timmermans, 1997). Based on the increase in the number of older people, projections for the future need for home help and care are thus that this will increase by 25% by 2005 (STG, 1994).

Figure 6.11.
Older people (65+ and 80+) as a percentage of the population, 1960-2020.



Note: EUROSTAT: Demographic statistics 1997.

Informal care has usually taken a great deal of the care load but with increasing number of women in the work force, the traditional sources of informal care may be less available. In all, 59.2% of women are active on the labour market today, however a great deal (68.5%) work part-time. The informal care taker potential is thus higher compared to countries where women on the labour market tend to work full-time but Dutch women's full-time ratio is increasing also. Most men are active on the labour market (79.9%), and although the Netherlands has one of the highest part-time ratios for men, also here most work full-time (73%).

Informal care has been further rendered difficult due to the changing household patterns. Older people tend to live on their own today and the traditional multi-generational family is on the return. The proportion of older people 65+ living with children or others has thus declined from 12.3% in 1979 to 6% today. Two in five (39%) among the old 65+ live with spouse or partner while nearly half (45%) live on their own. Most do, however, have family members – of the 65+ around one in five have children and/or grandchildren – and most older people with children live not far away from them and keep in contact with them, over the telephone or in person. Of those who have children, as many as 85% live within 1 hour's distance of at least one of their offspring, and 90% have contact once a week (Timmermans, 1997).

6.7.4. Domiciliary care

Home help (Gezinsverzorging)

Needs may, however, exceed what informal carers can provide, especially when the policy is to enable older people to stay in their own home. With the policy to substitute intramural with extramural care the home help service has accordingly gained an important function in helping people in their homes. The formal objective behind home help is to offer help with domestic and caring tasks in order for people to be able to live as independently as possible. Home helps have traditionally offered also social-psychological support to individuals and families in distress so the domestic and care services are occasionally supplemented by help of a more personal and advising nature. The service and the staff that performs the service are strictly divided according to the tasks carried out; some home helps specialize in supporting households with complex physiological problems, others perform care and domestic services. The highly professional function coupled with governmental budget limits on home help resulted as mentioned earlier in 1973 in a creation of a new – and cheaper – distinctive position of unqualified home helps, Alpha-helpers, who only perform household functions. Budgetary limits and increasing need for services after the substitution policy was implemented have also led to a more integrated approach between care and domestic work. Much of the home help service is today carried out as team work between the different functional distinctions (Baar et al, 1993).

Admission

Access to services is universal; all residents in the Netherlands who need help of a domestic nature related to an illness, recovery, old age, or to whom bereavement, psychological or relational problems are leading to or are expected to lead to disruption of independency can receive help through the home help (Kwekkeboom, 1991). Since January 1998, assessment for care and domestic help is most often also carried out using the concept of single point of access, by regional assessment teams who thus assess for both home care, nursing homes

and residential homes. Clients can here receive information and be screened for the need for care for all types of services. The assessment team in the new screening process consists of representatives from the insurers and a representative of the older people including a watchdog position filled out by a GP. There is no formal referral needed and potential clients can themselves make contact to the assessment team; or can make contact through their GP, the hospital or nursing home.

Provision

Most home help services are provided by non-profit home help organisations which have been set up as foundations, originally based on the pillarised system. Nowadays, however, the organisations adhere less to ideological principles. These organisations have a regional basis but are also organised at national level in umbrella organisations. In 1990, the umbrella organisations for home nursing and home help merged into the National Association for Home Care (LVT), as stated, in order to reduce overheads, to ensure that appropriate expertise is provided at the right time and to reduce overlaps between the services. A second umbrella organisation for home care covering private for-profit as well as regular non-profit organisations is the Branch-Organisation Home Care the Netherlands (BTN). Both umbrella organisations are recognized by the Ministry of Health, Welfare and Sport and may receive money from the AWBZ. Most of this money, however, goes to non-profit providers. With the integration of the home care and home help functions the number of organisations has declined at regional level – from more than 300 organisations, there are now 118 home help and care organisations. Of these, 53 are integrated home care organisations, 59 are home help organisations and 12 are separate cross associations regional providing home nursing (Weekers & Pijl, 1998).

Although the non-profit providers are many in number in reality there is little choice for the user as to the provider; however the emergence of for-profit providers may change this. These have recently started to provide help and care – mainly for wealthy people or for people who are far down the waiting lists for regular help. The one big organisation providing services nationally on a for-profit basis, the Network Home Care the Netherlands (NTN) also receive funding from the AWBZ. In 1997, a sum of money was set aside to stimulate the new for-profit providers, around 12.5% of the domiciliary care budget; the for-profit organisations must compete for financing which is distributed to regional linking offices (Ibid). Nursing homes have also started to enter the home help market – some nursing homes now provide services for older people in their homes with funding from the AWBZ; often in cooperation with home help and home care organisations.

The home helpers are employed by the providing home help organisation except for Alpha helpers where the client is the direct employer. This is therefore formally organised outside the home help organisations but most home help organisations act as intermediaries between recipient and Alpha helper (Kerkstra, 1996).

Coverage

The number of older people receiving home help services has increased by 65,500 since 1983, as has the proportion of older people provided with home help service – from 7,7% in 1983 to 9,5% in 1996 (Table 6.6). A substantial shift in the user types has, however, taken place since the substitution policy was introduced. Increasing demand for services as more older people live on their own and postponing admission to nursing homes have enforced the targeting of services. It is mainly the oldest group among older people who receives services; one in five (18%) among the 80+ receive home help services compared to less than one in twenty (4.2%) of the 65-69-year-olds; less than one in ten (7.7%) of older people aged 70-74 years and slightly more than one in ten (11%) among the 75-79-year-olds (CBS, 1997).

Table 6.6.
Home help, number and per cent of recipients (65+), 1982-1996.

Year	Number of recipients (65+)	Proportion (%)
1983	130,000	7.70
1984	..	..
1985	133,200	7.70
1986	..	..
1987	..	..
1988	141,200	7.60
1989	149,300	7.95
1990	160,700	8.37
1991	168,100	8.69
1992	185,800	9.48
1993	..	..
1994	..	..
1995	185,479	9.12
1996	195,561	9.49

Source: CBS: Maandbericht gezondheidsstatistiek (monthly publication). CBS: Vademecum gezondheidsstatistiek (annual publication). VWS (1998): Personal communication.

Domiciliary care is now offered mainly when someone in the household suffers from severe disabilities and mainly for older people living on their own – 15% of single households aged 65+ receive services compared to 5.4% of two person households; more women therefore receive home help services than men (10.8% compared to 6.5%) as they live longer and are thus more often single (CBS, 1997). Most home help is awarded to older people without little financial means whereas high income groups are likely to be referred to private services.

Providers currently operate with limited budgets and home help services are only provided within budgetary constraints. Home help can very rarely be initiated at the day as care needs have been established (Weekers & Pijl, 1998). Some home help providers also have waiting lists for care assessment; in 1992, 15% reported such lists. The average waiting period for assessment was 12 days and more than 12,500 persons already assessed for care were waiting for their service. The average waiting period was 45 days for home help and 90 days for Alpha help (Kerkstra, 1996).

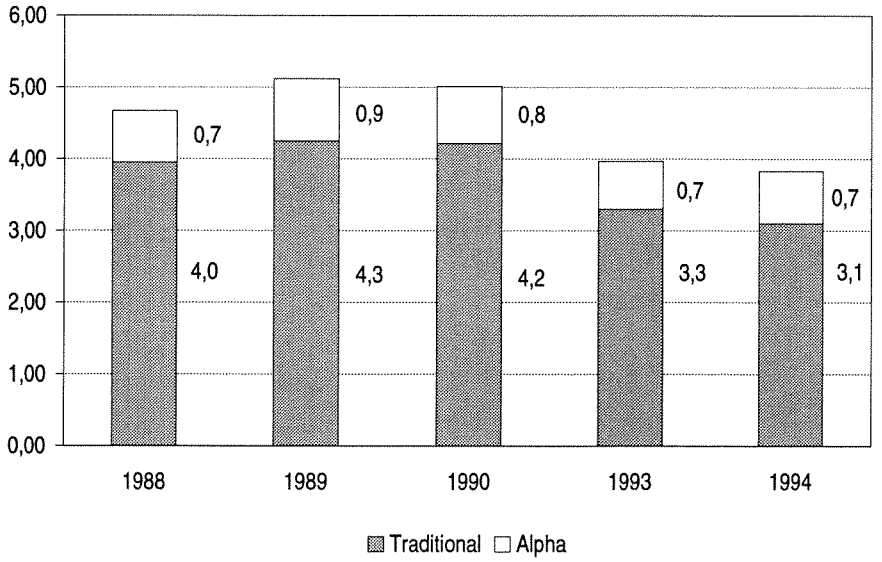
The number of visits have increased as users have become more frail; from on average 8.9 home visits per client in 1985 to 15.2 in 1992 (van der Linden & van Dam, 1996). Previously, help was offered once a day during weekdays. Provision of help is today less standardized as help is offered perhaps several times a day and also outside normal business hours, during evenings and weekends (European Commission, 1998a). A client is entitled to receive a maximum of 4 hours of help daily for an unlimited period. The average number of weekly home help hours has, however, remained stable (Figure 6.12). By 1994, a user of home help on average received 3.8 weekly hours[2)] of which 0,7 hours was Alpha help and the rest traditional home help (Ministry of Health, Welfare and Sport, 1998 and own calculations). Since then, many older people have, however, reduced the number of hours they receive help as fees were increased in 1994.

In addition to the regular home help services being increasingly targeted at the old and frail clients, the increase in fees made more older people use the Alpha help who provide domiciliary help. Alpha help, however, supplies help with domestic tasks, not personal care. In 1980, 1.2% of older people over 65 years used the Alpha help rising to 3.9% in 1985, and then falling slightly to 3% in 1990 (Baar et al., 1993). The amount of Alpha care is limited to 12 hours a week; above this number of hours the Alpha helper would have to pay social security contributions. The service is carried out by an assistant who calls in once or twice

2) Hours for all recipients, including those under 65 years.

a week for a period of 3 hours each time to do domestic work. It is mainly older people who make use of the service.

Figure 6.12.
Home help, distribution of average weekly hours per recipient* per week according to type of home help, 1988-1994.



Source: VWS (1998): Personal communication.
Note: * All age groups.

Fees

With the transition to the insurance scheme approximately 90% of costs should now be borne by AWBZ (Baar et al., 1993). In 1995, user fees covered 10% of expenditure. Maximum hourly rates are NLG 10 which again must not exceed a certain amount per week. This weekly amount depends on net household income and household composition, varying from NLG 5-250 weekly. A single older person with an annual APW wage of NLG 16,293 would thus pay NLG 5 per week as a maximum. The providers of home help reimburse the difference between the actual help received and the maximum prescribed co-payment, from the budget they receive from the AWBZ. In 1994, new rates of co-payment were introduced and this resulted in increases in fees for most recipients. As fees are also based on the number of hours received, the oldest among the old using most home help accordingly pay more. In 1981, older people 65-74 years on average paid NLG 18 per week whereas those 75+ paid NLG 26 per week per

household. By 1994 this had increased to NLG 29,60 and NLG 52 respectively (Timmermans, 1997 and own calculations). Recipients of Alpha help service pay NLG 14.60 per hour, with maximum payment similar to the ones applied for home help (Kerkstra, 1996).

Standards

Provision of home help is now far more flexible and may be delivered 24 hours a day. Staff are divided according to the tasks that they carry out and consist of specialized home carers (*gespecialiseerde gezinsverzorgenden*) who support households with special multiple and complex psychosocial problems; home carers (*gezinsverzorgenden*) who do some housekeeping and provide personal care – so far as this is not done by members of the household themselves – provide hygiene and personal care and also support with psychological problems. These also often work in teams with nurses and qualified home helps. Qualified home carers (*gediplomeerd gezinshelpenden*) also do housekeeping and some personal caring tasks if the members of the household are unable to do this themselves, such as bathing and toileting; and also provide general and family support like shopping, accompanying for walks, and do administrative support such as filling in forms. Unqualified home helps (*ongediplomeerd helpenden*) are only allowed to do domestic care. They usually work alone, operating from their own home. Finally, there are Alpha helpers (*alpha-helpenden*) who carry out the same tasks as unqualified home help but who are formally employed by the recipient of service. Most Alpha helpers are middle-aged women returning to the labour market (Kerkstra, 1996).

Home helps without formal qualifications make up the majority of carers (77%). Those with a qualification either have a two-year or intermediate vocational training (MDGO-vz) or a two-year training (OVDB) comprising one day a week together with practical work of at least 16 hours a week. Qualified home carers have obtained either a three-year intermediate vocational training (MDGO-vz) or a two-year or part-time training (OVDB) one day a week of study together with practical work of at least 16 hours a week. Finally, specialized home carers have in addition to the above received a specific two-year part-time training. Most work part-time and except for Alpha helpers they are paid on a monthly basis at rates depending on length of experience. Of the 68,000 FTE staff members working within domiciliary care in 1995, the majority consisted of the qualified home carers, in addition to 36,833 FTE Alpha helpers, which gives a staff ratio of 28 home helps per 100 recipients when including recipients under 65+.

Regulation

Inspection of home help is carried out by staff members of the home help association itself. Frequencies are varying and often depend on whether the client has filled a complaint.

6.7.5. Public support for the purchase of private care

Personal Budget (Persoonsgebonden budget)

At the beginning of the 1990s, no care allowances were available for informal carers who were looking after elderly family members although a few collective agreements did refer to the problem. However, in 1991 experimental care allowances were introduced by the Ministry of Welfare, Health and Sports. The experiment was supported by organisations for disabled people – and is as such not intended for older people only – mainly in order to improve the freedom of choice for care dependent people (Weekers & Pijl, 1998).

Following a positive evaluation of the experimental scheme, a national scheme was introduced in 1995, the Personal Budget *(Persoonsgebonden budget).* This entitles a person who has been assessed as in need of domestic and/or nursing care to a care allowance which is used for the purchase of care and assistance. The need for assistance must be expected to last for more than 3 months and the recipient must live independently in hs or her own home. A certain number of hours are allocated whereafter the older people can choose between care in kind or cash. Every ½ year, a re-assessment must be carried through. The assessment of need is carried out at the same time as assessment for care in kind, through the one stop offices set up in every local authority and this includes exploration of available informal care. Originally, care provided by spouses and partners was not eligible for Personal Budget but from 1 January 1997, Personal Budget has also been available for this group. Provision is intended to top-up informal care but is also intended to relieve some of the informal care burden (Ibid).

Only a fixed amount (3-5%) of the regional home care budget is available for Personal Budget and if this amount has been spent the recipient is placed on a waiting list and in the meanwhile provided with care in kind. The client was initially awarded the full amount of Personal Budget but a broker system has been established to circumvent fraud and only a small amount is now paid directly to the client.

The client must now also sign up as a member of the Social Insurance Bank *(Sociale Verzekeringsbank)* when awarded Personal Budget. The bank takes care of administrative issues such as taxation and pays the premiums to the care provider for the Personal Budget holder. Contact with care providers is through intermediate offices which hold files of private care workers and who act as intermediaties for a fee, but the Personal Budget recipient is the one employer of the care worker (Ibid).

Provision

In the first year, around 2,000 people applied for the Personal Budget and 75% of applications were granted; with this figure rising to 6,000 by the end of 1996. By the end of 1998, 7,500 persons receive a Personal Budget (Weekers, 1998). However, it is not known how many of these are older people. If there are many applications for the allowance, a client may only receive the allowance for a part of the year and the rest of the year receive care in kind instead. Around half the budget holders were given the allowance to purchase domestic help, 20% to purchase personal care and 30% to buy nursing help. The services were mainly purchased from a private provider (40%) or from one of the regular care organisations (34%) while 12% used the allowance for informal care. In the initial phase after the introduction of the allowance, the budget holder was free to decide how to spend the full amount. Most (89%) used the allowance to buy assistance and care, but 1% spent the allowance in other ways and the rest spent the money on care as well as in other ways (Ibid).

Amount

With the establishment of the broker function only a fixed amount of NLG 2,400 per year may be freely spent. The maximum amount awarded is determined by the multiplication of the assessed hours for care and the tariffs for different home care sectors. In 1998, these are NLG 70 per hour for home nursing, NLG 37.50-55 per hour for home help and NLG 25 for Alpha help. The average amount granted is NLG 1,440 per month. The budget holder must pay a fee as would be the case for care in kind and this is often deducted from the allowance. The average fee is NLG 1,700 per year and is calculated using the same rules as for home help (Ibid).

6.7.6. Auxiliary care

Local authorities are responsible for auxiliary care provided under the so-called Additional Services Policy, often through subsidies to the Foundations on Welfare of the Elderly. These Foundations take care of organising fr example meals-on-wheels, alarm systems, day centres, support for informal care givers, etc. Foundations often co-operate with the local residential homes, who can provide the kitchen for cooking the meals or a central receiving-station for the alarm system. Older people may be asked to pay a fee for the use of services. These services are open for people living in the neighbourhood, too (Kwekkeboom, 1998).

Meals-on-wheels (Maaltijdverstrekking)

Most local authorities thus have a scheme for meals-on-wheels, often run from nursing homes or residential homes. In 1996, more than 100,000 older people (6%) living in their own home used meals-on-wheels. 2/3 had the meal delivered to their own home, while 1/3 had lunch at a residential or nursing home or day

centre. Most of those who had meals-on-wheels used the service daily while those who lunched at a care home or community centre usually oly had lunch there a few times a week. The average cost of a meal is rather high, at NLG 8,6 or 9.3% of an average monthly net household income (Timmermans, 1996).

Day centre (Dienstencentra)

Day centres are also part of the auxiliary services where older people can meet, the purpose being to encourage self-reliance and social integration of older people in the community. Centres are often located in nursing homes or residential homes and provide various activities such as outings, social activities, creative work, etc. Older people are provided with transport to the centre, and services normally also include supervision and counselling of family members, neighbours and others. By 1990, there were 340 centres with 1,794 places; less than 1% of those aged 65+ made use of these (Baar et al., 1993). Co-payment for participating in activities in day centres is NLG 2,50 per hour plus an income related fee.

Short-term stay (Dagbehandeling)

Short-term stay is a recently introduced service available in nursing homes. Short-term stays serve as temporary admission in case the partner falls ill, after a hospital admission or as respite care (Schrijvers et al., 1996). By 1996, most nursing homes provided day care, with 4,108 places available. A short-term stay in a residential or nursing home costs NLG 210 monthly (CBS; 1997). The service may come under the AWBZ in 2001 when the residential homes are transferred to the AWBZ (Kwekkeboom, 1998).

Transport (Aangepast vervoer)

Equally important for older people who live alone is help with transportation to their GP, the day centre or to visit the family. Since 1994, local authorities have been responsible for arranging transportation services under the Act on Services for Disabled people, often provided in cooperation with one of the Foundations. In the same year, transport services were provided in over 150,000 cases. Half of the individual services were for those aged 65+ and 2/3 of the special collective transport service was provided to older people. Reimbursement for taxi fares and to relatives who provide transport is also available, and 4% of older people used these (Timmermans, 1997).

6.7.8. Institutional care

Nursing homes and residential homes (Verpleeghuizen and Verzorgingshuizen)

Institutional care has traditionally been divided into two categories, nursing homes and residential homes, according to the facilities and care provided. Nursing homes were originally seen as a less costly alternative to hospital care, by providing long-term intensive care for older people with high levels of need, whereas residential homes mainly provided accommodation and some services. However, since 1977, when national admission and selection criteria were introduced, only high-need older people are admitted to residential homes also. With admission criteria getting more strict, the old distinction between the two forms of institutional care is therefore becoming blurred. Residents in both kinds of homes are getting older and their needs and requirements are becoming more similar (Pijl, 1993). With the policy to substitute institutional for domiciliary care, the homes have also gained a new role and most provide more flexible forms of services today, such as night admission, weekend and short-term stays, crisis intervention and consultative services from the nursing home physician (Kerkstra, 1996).

Admission

Admission to the homes primarily depends on the individual need for care and medical attention. The same referral body that deals with requests for home help, the regional assesment team, assess the need for institutional care. The team consists of representatives from the insurers and a representative of the old including a watchdog position filled out by a GP. As is the case for home help assessment, there is no formal referral needed and the older person or the family can themselves initiate the first contact to referral team; or they can make contact through the GP, the hospital or nursing home. A home visit may be included in the assessment if this is part of local policy. If the older person is considered in need for institutional care a place is allocated when available. Older people may use homes which are not in the neighbourhood of where they live but instead move into a home nearer their family. Partners can also be admitted to the home without needing care themselves – if a place is available and for payment of the full costs as the AWBZ does not cover costs unless there is a care need established.

Provision and coverage

The Netherlands have had a reputedly high proportion of older people in institutional care since the 1960s, and especially within residential care where practically anyone who applied was admitted. Since 1977, however, a 7% norm has applied to the institutional care, meaning that the number of places must not amount to more than 7% of the number of older people in the area.

For the residential homes, the stricter admission criteria and a less positive image of the homes have evoked a decrease in the number of residents. In 1982, there were 8 places per 100 people 65+ in residential homes and this has been falling ever since; by 1996, the number had dropped to 5.5 per 100 people (Table 6.6). Since the residential homes became part of the AWBZ in 1993, the policy has been to convert 60% of these homes into nursing homes while the rest should function as care and accommodation complexes where occupants should live independently and be provided with home help, meals and transport like other older people living on their own (Timmermans, 1997).

With the convertion of residential homes, the capacity for older people requiring nursing care has on the other hand increased. The capacity in beds and the number of homes increased sharply from the 1970s to the 1980s, mainly as a result of the encouragement of institutional psycho-geriatric care by the central government. In 1982, there were 46,500 beds available, or beds for 2.8 per 100 older people 65+. In 1996, the number of beds had risen by 13,000, but as the number of older people has increased the same proportion of 65+ are accommodating in nursing homes today (Table 6.7). Residents may require long-term care (50% of residents), or may predominantly use rehabilitative services (40%), while fewer suffer mainly from terminal illness (5%) or require special services such as physical therapy (5%). Most of the homes provide separate wards for combined needs of somatic and psycho-geriatric nature, and vary greatly in size, from caring for 5 persons to 522 older persons (Meijer, 1998). Generally, however, the intake of residents in nursing homes is increasing, the average permitted number of beds rose by 22% from 1982-1996.

Because of the fall in residential places, the total number of older people in institutional care has, however, fallen in absolute terms, from 179,600 older people accommodated either in residential or nursing homes in 1982 to 169,500 in 1995. With a larger older population, the number of older people waiting for a place has increased, by 1996, 7,310 persons were waiting to be admitted. Average waiting period differs according to the need for care; psycho-geriatric patients thus had to wait 15.5 weeks while somatic patients on average waited 5 weeks (Meijer, 1998).

The residents in nursing and residential homes have changed in age composition also; fewer of those aged 65-79 years are admitted, 5% of this age group in 1980 compared to 3% in 1995. Average age is for men 76.5 years and for women 82.1 years (Meijer, 1998). As the average age of residents increases, the proportion of women among the residents has gone up from 67% of residents in 1980 to 79% in 1995 since women live longer (Timmermans, 1997).

Table 6.7.
Institutional care, number and per cent of recipients (65+) and staff (FTE) per 100 resident, 1982-1996.

Year	Number of residents (65+)		%		Staff ratio	
	Residential homes	Nursing homes	Residential homes	Nursing homes	Residential homes	Nursing homes
1982	133,092	46,600	7.98	2.79	38.85	104.99
1983	133,350	47,300	7.90	2.80	39.13	108.12
1984	132,562	46,300	7.76	2.71	39.06	113.47
1985	136,238	48,173	7.88	2.78	38.64	111.11
1986	..	48,649	..	2.72	..	110.75
1987	..	48,526	..	2.66	..	115.47
1988	135,119	49,292	7.27	2.65	39.43	114.85
1989	130,406	49,177	6.95	2.62	40.86	117.24
1990	129,379	49,801	6.74	2.59	41.32	117.14
1991	127,886	50,590	6.61	2.62	42.11	117.99
1992	126,386	51,636	6.45	2.63	42.69	118.66
1993	123,569	52,460	6.22	2.64	41.99	118.99
1994	120,606	53,539	6.01	2.67	41.85	117.27
1995	117,035	54,020	5.76	2.66	45.33	119.45
1996	112,581	56,930	5.46	2.76	46.63	..

Source: CBS: Statistiek van de bejaardenoorden (annual publication). CBS: Vademecum gezondheidsstatistiek Nederland (annual publication). CBS: Intramurale gezondheidszorg (annual publication).

Provision

Most of the nursing homes are run by non-profit associations divided along the lines of the pillarisation principle with 5% owned and run by municipalities. 40% of the residential homes are owned by housing corporations, also non-profit. Private for-profit provision has until so far not gained ground; recently, however, a for-profit nursing home was set up.

Fees

For a number of years, there has been a financial incentive for an older person to wait until he/she needed care of a more medical kind in a nursing home where fees were lower. The transfer of the residential homes to the AWBZ has changed this and fees for nursing homes and residential homes will be harmonized. The previous capital assessment for residence in residential homes has been abolished accordingly.

Nursing homes are principally covered by the AWBZ, but in the early 1980s fees were introduced, most costs are, however, still covered by the insurance. In residential homes, residents are, until the transfer to the AWBZ in 2001, individually responsible for the payment of services. The residents in residential homes thus pay a fixed portion of costs and a means-tested portion. As for the means-tested part, older people with incomes lower than the fees charged have to pay their entire income except for a sum of NLG 400 monthly which can be spent as pocket money. The local authority will make up the difference from social assistance. Any private savings of over NLG 10,000 must be spent before the local authority can top up the fees. Around 90% of older people need the local authority to supplement their fees. The means-tested fee must not exceed NLG 2,200 for an unmarried person and 1,100 for a married person per month. The fixed portion is NLG 210 for an unmarried resident and NLG 105 for a married resident per month. The average fee is NLG 900 per month and people are on average left with NLG 1,255 per month to spend on themselves (Timmermans, 1997). In 1996, total fees made up 24.3% of total expenditure, 10.5% in nursing homes and 38.8% in residential homes; this, however, includes contributions for day care activities (Ministry of Health, Welfare and Sport, 1998 and own calculations).

Standard

Although homes must comply with the operating regulations set down by the Ministry of Housing, Special Planning and Environment, the provinces and the four major cities are free to set their own regulations.

Standards of residential homes were previously relatively high, which is reflected in the fact that even healthy older people moved in during the 1970s. However, very little modernization of homes has taken place since and some are therefore somewhat outdated today. Most homes do, however, provide a variety of facilities and residents very seldom have to share rooms with non-relatives. 72% of residents have one room available, and 27% have two, 88% have cooking facilities and 18% a regular kitchen. 88% have telephone in residence rooms and 98% have an alarm system (Timmermans, 1997).

In nursing homes, facilities are less evident; one in five have their own room while one in four (27%) of the residents share a room with one other person, one in three (35%) share with 2-3 people and another one in five (19%) with 4 or more people. 7% of residents have their own telephone, and 96% are connected to an alarm system (Ibid). Although fewer older people today see residential homes as an alternative to independent living, the preferences for these homes reflect differences in standards; 48% of those aged 75 preferred to move into a residential home while only 21% preferred to live in a nursing home (Ibid). Homes

are, however, increasingly directed towards frail elderly people and residential homes in particular are no longer intended for older people who are able to take care of themselves in their own homes. Because of long waiting lists, residential homes in fact take care of a number of people would should be cared for in a nursing home.

Although the homes increasingly serve the same category of residents, staff ratios in nursing homes reflect the focus on medical needs. By 1995, there were 64,529 FTE employees working in nursing homes which corresponds to staff of 119 per 100 residents. From the rate of staff which has increased from 39 per 100 residents in 1982 to 47 per 100 residents in 1996, or 52,491 FTE (CBS, 1997) (Table 6.7), it is clear that the residents' need for care has become more intensive in the residential homes. Beyond the nursing home physicians, staff in nursing homes mainly consist of level A nurses, with general nursing education, and level B, with a two-year specific nursing training. Sometimes untrained nurses' aides are called in, especially in periods of insufficient staff-levels, which are occurring more often due to insufficient financial means. In addition, volunteers often provide social care and arrange activities (Meijer, 1998).

Regulation

Homes are inspected by provincial Home-for-the-Elderly Inspectorates who supervise the standards. This is organised by the AWBZ. The inspectors are intended to work together with the Health Care Inspectorate and to pass on monitoring to them by 2002 at the latest. All homes must be registered.

6.7.9. Housing for older people

Construction of special housing for older people began at a relatively late stage. Most of housing is therefore relatively new but already makes up 4% of total housing stock. Around 11% of older people thus live in some form of adapted dwelling. Especially the number of ***sheltered housing (Aanleunwoningen)*** has increased lately. These are often established in conjunction with a nursing or residential home and are intended for self-reliant older people who have access to the facilities and services provided by the home. The introduction of a subsidy scheme which enables the nursing homes to provide care for older people living independently has helped the furthering of such care provision. Several hundreds of local neigbourhood projects have been initiated and many thousands of older people use the scheme. While most older people live in independent housing (66%), sheltered housing thus make up 15% of the housing stock for older people, with 48,194 dwellings (Timmermans, 1997).

Service flats (Woon-zorgcomplexen) make up 11% of the housing stock. These are either rented or purchased dwellings, with domestic help for example from a

warden and access to communal facilities. Often the standard is quite luxurious and give residents access to a common garden, a restaurant, a common room, etc.

Most housing for the old is provided by non-profit housing associations which are under license from the central government. However, the government has started selling of municipal housing but so far, the profit-making sector is only little involved in housing for the old (Tester, 1996).

6.7.10. Support for informal care

Leave for care of a sick relative/Emergency leave (Calamiteitenverlof)

There is no statutory scheme for leave for care of a sick relative but this form of leave is beginning to appear in collective agreements. The introduction of the emergency leave may, however, also allow carers to take shorter breaks from work. The emergency leave does neither entitle the employee to any specific amount of days off nor wage compensation; this must be negotiated with the employer. In some collective agreements, employees receive their normal wage during the emergency leave. The use of the leave is not registered but normally between 2-3% of employees use the leave during the year.

Career leave (Loopbaanonderbreking)

Also the introduction of the career leave of 2-6 months gives employees the possibility to take a leave for educational or caring reasons. The benefit is related to last earnings but makes up a maximum of NLG 960 a month which is lower than the national assistance of NLG 1,200 monthly. The benefit is taxable but exempt of social security premiums and is paid out of the unemployment fund, as part of job stimulative measure and government subsidies.

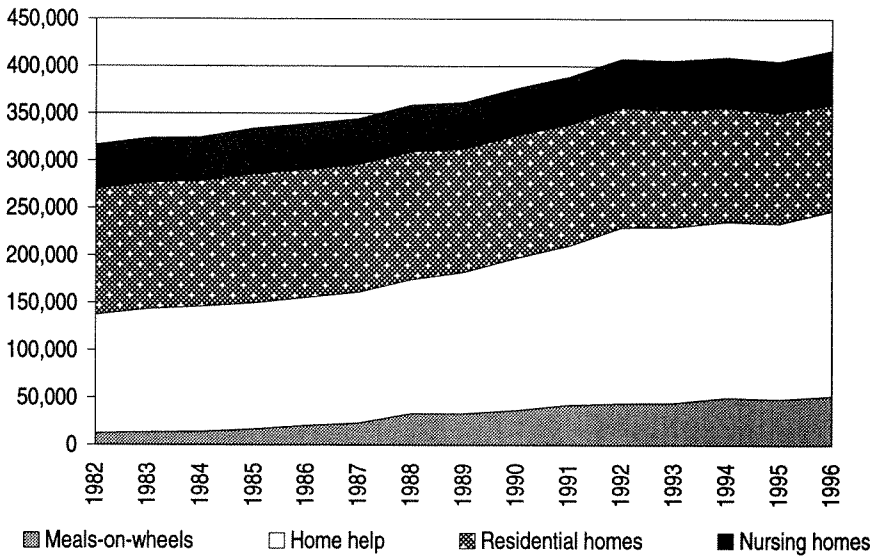
6.8.
Development and changes 1982-1996

Dutch provision of services shows a steady expansion since the early 1980s, reflecting the development of the public welfare provision which has taken place later in the Netherlands than in the other six countries.

The Netherlands experienced fiscal problems in the early 1980s and mainly responded by cutting benefits, tighten eligibility criteria and introduce cost-containment especially in the provision for older people. Here, the rising costs for health care in particular led to the introduction of restricted budgets and efficiency improvements. The home help services alone were cut by NLG 23 m in 1994, in the same year fees increased for most recipients. A cheaper service for the

provision of cleaning was introduced, the Alpha help, and measures were taken to stimulate competition between providers. At the same time, long-term care and domiciliary care services are now part of the health insurance AWBZ, partly to avoid poverty problems among older people. Also in the Netherlands, home help is now targeted on the very frail, and in particular those who live alone and cannot rely on family members or spouse. The number of recipients of home help has, however, increased (Figure 6.13) and by 1996, 9.5% of the 65+ received home help. The number of older people residing in institutional care homes has traditionally been very high in the Netherlands, and although the de-institutionalisation policies has led to a reduction in the number of residents in residential homes, the number of older people living in nursing homes has in fact increased slightly. Another expansion of services is the number of people using meals-on-wheels.

Figure 6.13.
Development in the number of recipients and residents of the main social care benefits for older people (65+), 1982-1996.

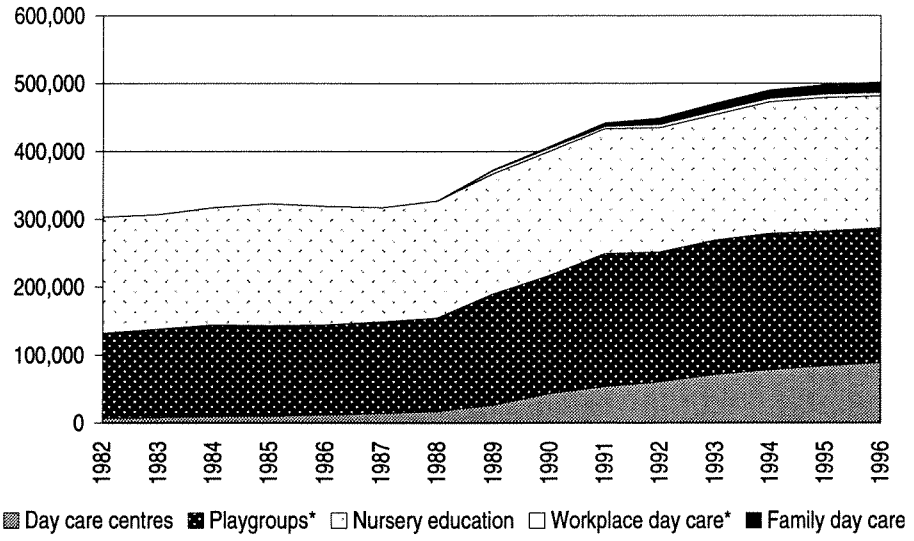


CBS: Statistiek van de bejaardenoorden (annual publication).
CBS: Vademecum gezondheidsstatistiek Nederland (annual publication).
CBS: Intramurale gezondheidszorg (annual publication).

Expansion is also the main word characterising the development within day care services for children (Figure 6.14). The Stimulative Measure has lead to an

expansion in all forms of day care, in particular the day care centres. Of the 0-4-year-olds children, as many as 6.5% are now in a day care centre; in 1982, the proportion was less than 1% in comparison. Playgroup provision has increased also, and although provision is part-time, the playgroups cover a great proportion of the need for day care. Characteristic for both forms of day care is that children mainly attend 2-3 days a week, whereas they stay at home with one of the parents the other days. The number of day care centres run by employers has increased also, as has the number of places sponsored by employers which now totals 47% of all places. At the same time, parents' leave rights have improved, in both length of leave and in compensation rates. For the 4-year-olds in particular, most are cared for in the nursery education in the primary school; nearly all 4 year olds attend nursery education. This form for day care is free, whereas parental fees in day care centres are very high.

Figure 6.14.
Development in the number of enrolled children (aged 0-4) of the main social care benefits for children, 1982-1996.



CBS: Kindercentra (annual publication)
CBS: Personal Communication.
* Data for 1995 is repeated for 1996.

Box 6.2.
Utrecht, the Netherlands

1. Introduction
Utrecht is situated east of the Hague and is a historical city which roots back to 48 AD, when the first settlement took place. Utrecht is the fourth biggest city of the Netherlands with its 23,3951 inhabitants. In 1997, the number of children aged 0-4 made up 5.8% (13,454) of the total population in Utrecht, whereas the number of older people aged 75 and above constitutes 16.5% (14,077).

The City Council of Utrecht has 45 members who are elected for a period of four years. The mayor, together with eight Aldermen have the responsibility of executing, coordinating and oversee the decisions taken by the City Council. In March 1998, a Social Democratic majority was reelected in Utrecht.

2. Children
The financing of child care and the care for older people differs, as the municipality is far more involved in child care. Financing of child care is principally divided between parents, the municipality and enterprises, where each party pays approximately 1/3. In 1995, the budget for day care for children was NLG 10.5 m.

In general, there are three types of child care in Utrecht; playgroups, child care centres and family day carers. Additionally, Utrecht has started a pilot project, where the family day carers take care of children in the homes of the children and provide additional services, such as shopping, etc. It is not compulsory for the different child care providers to be registered, but the municipality and the organisations mediating day care for employers only make use of the registered child care institutions, which reduce the scope of non-registered institutions.

The child care is more coordinated than the care for older people, however, there are still features of a fragmented system, and often more than one non-profit organisation is involved in the provision of child care. In general, the municipality (the district in practice) or a non-profit organisation provide day care. The municipality provides 40% of child care places and 60% of the child care places are provided by non-profit organisations. Some of the places provided by an organisation are paid by the municipality, while the municipality sometimes contracts the organisations to provide day care places.

A child care place has a fixed price of NLG 19,500 which is the standard price when selling and buying child care places. Parental fees are income related.

Visit to the child care institution "De Kikker"
De Kikker is situated in the periphery of Utrecht, near the University. The child care centre originally belonged to the University, but the private, non-profit organisation, SKOBI, now owns and runs the child care centre. De Kikker is situated in an old farm, which has been restored and expanded. There is a nice green lawn in front of the building with climbing frames and sandpits. The children have free access and view to the lawn through big glass doors.

De Kikker provides day care for 84 children, and 45 places are bought by the University for scientific personnel, students and single parents. Children are in the age group ranging from two months to four years. Most children only use the institution for three days per week. There are 20 staff members working at De Kikker.

Each room in De Kikker is quite large, around 80 square metres, with a bathroom, a sleeping room with bunk beds and a tea kitchen connected. The rooms are light and there is a lot of space available for the children to play.

3. Older people

The municipality is no longer involved in the care for elder care services, as the AWBZ has taken over the financing of all care for older people. The provision is going to be centralised in a few big organisations and the financing will be regulated by one fund – the AWBZ. Financing of care for older people is therefore mainly financed by the ABWZ plus co-payment from the user. The total care budget in Utrecht Province for older people 75+ was NLG 651 m in 1998.

Although the role of the municipality is thus limited, an attempt is made to fulfil the need for institutional care while waiting lists for home help are more acceptable. At the same time, political measures emphasise that older people stay in their own homes as long as possible. Traditionally, institutional care has been divided into residential and nursing homes. Residential homes are now, as in the rest of the Netherlands, adapted to meet the needs for the very frail also. With the de-institutionalisation policy more pressure is currently on provision of domestic care and help in the older persons' own homes. Older people may also get a choice between the Personal Budget and services in kind; only 94 persons in Utrecht and its surroundings receive the Personal Budget.

The organisation of services is decentralised in eight districts (Wijken). General policy is to strengthen the independence of the districts, although economic responsibility still is placed at the central level of the municipality. Districts are amongst other in charge of assessment of local needs.

Services like nursing homes and residential homes are organised within the AWBZ and the different organisations that provide the services are mainly non-profit organisations and have no connection to the municipality. Informal care also plays a considerable part in the provision of elder care.

The involvement of the municipality in the elder care is restricted to the provision of centres where older people can participate in different social activities. Centres also arrange delivery of meals on wheels, alarm systems and organise the provision of domiciliary care.

Visit to the elder care organisations KABU

KABU is a Catholic, non-profit organisation, a so-called Stichtung. The organisation has a capacity of 565 places in three nursing homes and 770 places in residential homes, however, by the year 2000 this capacity will be differently divided. The organisation will have a capacity of 410 nursing home places and the remaining places will be divided into residential and nursing care.

The administration of KABU is placed at the Titus Brandsma institution, which is situated in an old building from the 1970s. The institution houses 90 separate, sheltered apartments and a residential home with 235 beds. The sheltered apartments are for people who prefer to live in a safe environment, but not necessarily need help. A typical apartment consists of two or three rooms and the older person pay approximately NLG 700 per month. The residential home is for older people who have a more profound need for care. Here, rooms typically consist of 20m^2 single rooms with a toilet and a tea kitchen.

The average age in the residential home is quite high – 86-87 years old, as no new residents have moved in for a long time. The building is going to be torn down in few years. The staff rate is 1:2,5. The institution is typical for the outdated residential homes in being very big and reminding of a hospital. In the basement, a day centre is situated. This is run by another provider organisation, however, the residents of Titus Brandsma can use the day centre if they are interested.

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CHAPTER 7

England

Box 7.1.
General characteristics of England[1)]

- The nearly 49 million people in England inhabit a land mass of 130,500 square kilometres. Around one third of the population lives in metropolitan areas. The country is divided into 171 local authorities with no regional tier of government. Around 3.3 mill in the whole UK or 6% of population belong to an ethnic minority group, mainly of Indian origin.

- Service industries provide the bulk of employment, 70.5%. One quarter (27.5%) of the labour force is engaged in production industries, and 2% in agriculture, fishing and mining industries. The UK unemployment rate was 8.2% in 1996, with a higher rate for men (9.7%) than for women (6.3%).

- Social expenditure accounts for 28.1% of GDP. Social services are financed through specific central government grants, municipal income revenue and client fees.

- Pensionable age is 65 years for men and 60 years for women. Entitlement to a full basic retirement pension depends on contributions having been made to the National Insurance scheme, but virtually all older people receive the basic retirement pension, of £61.15 a week. An Average Production Worker (APW) income for single pensioners with maximum coverage retiring at the age of 65 years is £6,602 yearly and £10,673 yearly for a pensioner couple. An AWP income for a family with two children would amount to £19,152 when including family allowances.

- In England, 16% of the population are aged over 65. The ageing of the population represents a threefold increase since the beginning of the century. But this growth has now slowed and the proportion of older people in the total population in the next 10 years is expected to remain at the same level as today. Life expectancy has increased from 68.1 years for men in 1960 to 74.2 and from 74.0 for women to 79.4 today. England experienced the same babyboom in the 1960s as other European countries, with nearly 3 children born per woman. Today, the fertility rate is among the lowest in Europe, 1.7, with children aged 1 to 4 years constituting 6.41% of the population.

1) As social services in Great Britain are organised in three regional areas, covering England, Scotland and Wales, this study focuses on England only. English data have been used when available, although for some areas only figures from the UK or Great Britain have been available.

7.1.
Introduction

Social services in England, or personal social services as they are usually called, have been through major changes in recent years which have affected both care services for older people and day care for children. Traditionally, public support for parents with children has been low due to the general view that young children are better cared for in the family – except during war times when women were needed in the labour market. Public day care for young children is therefore provided exclusively for families in need, whereas pre-school arrangements are made within the educational system on a universal basis for children from the age of three. Many women therefore choose to work part-time or leave the labour market for shorter or longer spells when they have children. Parents of children aged 4 years have, however, recently been guaranteed a place for their pre-school child in the education system. Public support for older people has mainly been provided in their own homes under the auspices of community care. The changes in social services have not affected this – but have led to the former dominance of public services being replaced by a mixed welfare approach of services increasingly provided by the independent sector, i.e. the voluntary and the for-profit making private sector. At the same time, much attention has focussed on the informal sector, and the potential economic value it holds. Care in the community, or as it is sometimes re-phrased, care *by* the community, has for many years been regarded as the optimal care solution for older people. Welfare schemes supporting informal carers has increased in number, both in terms of financial support and practical assistance, although in volume these are still marginal. The traditional source of informal care, women outside the labour market, is however becoming depleted as more and more women take up paid work.

7.2.
A history of care

The legacy of the several political thinkers who have formed the British welfare state is still apparent in the structure of the social system today. Scholars like the Webbs, Titmuss, Marshall and Beveridge to name but a few, have all been influential in propounding the ideas of universalism and public intervention, which have underlined the delivery of social services for older people and children, at least up until the end of the 1970s.

From poor laws to pension rights

The first main public response to the need for support and care is, however, found in the Poor Law of 1834. This Act confirmed the public obligation to provide for the poor, the older people and the disabled, which had already been

established in the 17th century Elizabethan poor laws. Under the old laws, parishes were obliged to provide accommodation in work houses for those unable to look after themselves. However, the industrial revolution and the subsequent urbanization had contributed to the erosion of traditional family networks, and the existing support arrangements soon proved insufficient. Under the 1834 poor law, 'deserving' older people who could no longer support themselves could receive outdoor relief, a cash benefit allowing them to remain in their own homes, whereas the so-called 'undeserving' poor were still to be provided for in work houses under harsh conditions.

The concentration of work in factories and the rise in the number of women working outside the home also led to public concern about how children were cared for in the meantime. As a response, the first day nursery was set up in 1850 by a charitable organization. In the same year, the Education Act of 1850 established an obligation on the parishes to organize elementary schools, where children aged 2-5 years could attend for a number of hours during the day. By 1900, 43% of 3 year olds were attending an elementary school. Only a few years later, however, a general change in attitude as to how young children should be cared for meant an end to public funding for these schools and the number of young children in the school system subsequently dropped to around 17% (Cohen, 1988). For older people, the first Old Age Pension Act in 1908 reinforced the idea that able bodied older people should remain in their own homes. The pension was, however, only available to citizens who had not previously been supported under the poor law. Outdoor relief and work houses under the poor law therefore remained the last resort for a number of older people in the years to come (OECD, 1996).

The war years

Experience of two world wars and the great depression changed the general view of welfare underlining the need for universal public intervention. The number of women in paid employment grew during both wars and this again made it imperative to provide day care for young children. In 1918, local authorities were empowered by law both to provide day nurseries and assist voluntary organizations in setting up day nurseries. Nurseries for munition workers were specially supported, with up to 75% of expenditure paid by central government. But the real expansion in the number of day nurseries took place during WWII, when the number of nurseries grew from 14 to 1,345 in just three years, providing for over 62,000 children in public day nurseries or three times as many as today (Cohen, 1988).

Major changes during the war years included the publication of the Beveridge Commission Report in 1942. The Commission set out the basic plan for a

national cash benefit system which has more or less survived until today, providing minimum, means-tested benefits 'from the cradle to the grave'. The principles were incorporated amongst others in the 1948 National Assistance Act. Here, the newly established National Health Service System (NHS) was obliged to provide for older people needing medical care, with local authorities providing residential homes for frail older people without private means. In many cases, local authorities continued using the old work houses for residential care and this contributed to the deterrent perception of public old age support. In 1948, local authorities were given powers to provide domiciliary care for older people and although provision was initially scarce and mainly arranged through the voluntary sector, the notion of care in the community slowly came to shape the 1950s policies for the older people. It was, however, not until 1962 that local authorities were permitted to provide meal services, and an obligation to provide home help for frail older people was not established until 1968 (Parker, 1995).

Calling in informal resources

In 1971, Attendance Allowance was introduced for people who were dependant on care in the home to pay for care services. This was followed by the introduction of Invalid Care Allowance in 1975 for carers who were unable to take up paid work due to caring obligations. During these years, informal care from the family, relatives and friends more and more came to be recognized as an important source of care. The notion of community care became more generally accepted and from being a policy which mainly aimed at de-institutionalisation, community care increasingly came to mean care by the community:

"Whatever level of public expenditure proves practicable, and however it is distributed, the primary sources of support and care are informal and voluntary. These spring from the personal ties of kinship, friendship and neighbourhood. They are irreplaceable. It is the role of public authorities to sustain and, where necessary, develop – but never to displace – such support and care. Care ***in*** *the community must increasingly mean care* ***by*** *the community".*

(Department of Health and Social Security, 1981, quoted in Finch, 1992.)

Revival of the private responsibility for caring for the children

The previously institution-based care for children also changed during these years. At the end of the war, there was no longer the same need for female labour and dismantling of the nurseries began, supported by popular theories that younger children were at risk of severe psychological damage if they were not cared for by their mother at home. Instead, the Education Act of 1944 obliged local authorities to provide nursery education for 3 and 4 year olds on a part-time basis. The private provision of family day care expanded as a consequence of the closure of the day nurseries, and in 1948 registration and regulation of private nurseries and family day carers were introduced. By the mid-1960s, the previous

massive provision of public day nurseries had been cut down to only a third of before. Underlining the changing concept of public responsibility for children's day care, the Plowden report in 1967 re-established the idea that nursery education should only be part-time in order not to separate children from their mothers for longer periods. A year later, a decisive health circular established that day care was principally a private responsibility by recommending that nursery education was to be provided mainly on social grounds and for those single parents who had no option other than to work (Cohen, 1988).

Structural changes and economic constraints

During the 1970s, the social services were also influenced by several structural changes which included administrative reorganisation as well as economic constraints. The administrative changes concerned a major re-organization of local authorities. This promoted a more unified administrative process; firstly in 1970 by the creation of independent Social Service Departments which gathered the previously fragmented social services in one department. Following this, the Local Government Act in 1972 abolished the country boroughs and reduced the number of administrative units.

A turning point in general for the expansion of public welfare was the 1974 oil crisis which created, as in most other Western European countries, an impetus for evaluating welfare provision and rising levels of expenditure. Fuelled by the Conservative victory in 1979, the new-right criticism of public monopolization of welfare led to severe restrictions on local authority welfare spending, and from then on efforts were made to strengthen the role of the private and voluntary sectors and of informal care. Firstly, care provided by family members was ideologically supported through various programs, such as the 'Helping the Community to Care' (Walker, 1993). The second element was financing for the use of private residential and nursing homes by older people through the social security system. This led to a dramatic increase in the number of people in care in private residential and nursing homes and created what was later termed 'a perverse effect' in a public investigation report as it facilitated open-ended funding of residential care and thus worked against the policy of community care. This report, published in 1988 by the Griffith commission, recommended firstly, that purchasing and provision of services should be split; secondly, the introduction of local care managers who would be responsible for the assessment of need, co-ordination of services and allocation of funding; and thirdly, that local authorities should in general be given much more control over the allocation of funding.

More local and mixed provider responsibility

Except for the latter, the ideas came to be embodied in the 1989 White Paper 'Caring for People - Community Care in the Next Decade and Beyond' (Challis & Traske, 1994). The government now expected local authorities to move social

services away from a supply-led to a needs-led system and to make use of services from voluntary and private providers, insofar as this represented a cost-effective choice. The role of the local authorities should change from being providers to being 'enablers'. Recognizing the importance of informal care, the White Paper recommended that carers should receive more support and that domiciliary care was strengthened. With the subsequent NHS and Community Care Act in 1990, the changes meant that funding for domiciliary and residential services was placed entirely with local authorities, whereas before the NHS was partly responsible. In 1993, a joint health and social services development programme completed the transition of responsibility for funding of community care to local authorities. With this, local authorities were required to improve collaboration with health and housing authorities and to increase involvement of service users. The latter group now increasingly includes carers, as the burden of care has for long been documented as being both physically and financially heavy for large numbers of informal carers. The recognition of carers has culminated in the 1996 Carers (Recognition and Services) Act which entitles carers to an assessment of their own need when the person they care for is assessed.

Increasing provision for children within the educational system

Compared to the major amendments within community care, day care for children has been less exposed to changes during the 1980s. Innovations include strengthening of private financing of benefits with the 1989 introduction of an employer financed Statutory Maternity Pay, and an expansion in the number of play groups for pre-school children – offering provision on one or two days a week for children accompanied by a parent. However, the overall strategy of providing day nurseries only for children with social or health problems has continued, and the 1989 Children Act mainly re-established local authorities' duty to provide services within the welfare system for children in need, and strengthened the regulatory role of the local authorities.

Yet, the 1990s saw an incipient opening for the provision of day care on a more universal basis, although within the educational system. During her years in opposition, Margaret Thatcher had been one of those in favour of provision of nursery education free for charge to all 3 and 4 year olds. In 1994, her successor, John Major could announce the introduction of pre-school vouchers for nursery education for all 4-year-olds to be implemented in 1997. Parents would be entitled to a £1,000 yearly voucher, exchangeable for 3 terms of education. However, the change of government in 1997 meant an end to the experiment with the voucher system. The new Labour government adhered to the criticism that the voucher system was incapable of meeting the need for day care and abolished the system. Instead, the new government has proposed to establish

partnerships for reconciling work and family life. This new integration of work and family is, however, also supposed to strengthen the role of the father, and encourages local educational authorities to engage in partnerships with the voluntary and private sector in the planning of new pre-school places. As a replacement for the voucher system, the government has announced that by September 1998 all 4-year-olds will be guaranteed a place in infant schools or primary schools, free of charge. This entitlement is to be expanded to 3-year-olds in time. For the time being, 25 so-called early excellence centres will be established as models of good practice for present and future providers. To give lone parents an incentive to work, a New Deal for Lone Parents is also being launched in July 1998, coming into operation from April 1998. Lone parents will be helped by £200 m for childcare costs, and a special £25 m has been set aside for lone parents with children aged under 5.

Setting the scene for the next decade

The outcome of the latest initiatives since the new Government took office is still too early to predict. But the wide-ranging number of changes which the British social service system has been through in the 1980s and 1990s has left a service system which is geared to taking advantage of the mixed economy. Changes in the managerial division of responsibility and the development of quasi-markets has created a new culture of participation and relationship. Today, the private and voluntary sectors no longer perform on the boundary of the welfare state but work as an integrated part in service delivery, becoming more and more bound to local authorities through contracts of delivery. Likewise, carers are seen as an integrated part of community care. The joining of forces stretches to the previously very separate social, educational and health services, where collaboration and joint planning between different administrative and professional departments is advocated in order to achieve what is termed 'seamless service'. The latest re-organization of local authorities, which started in 1996, reflects the wish to create more user-friendly services in decentralizing large departments into smaller unitary authorities servicing smaller parts of the population. Again, services for older people are more needs-led than before, which has subsequently resulted in a targeting of resources for the worst off, and public day care for children is still reserved for children in need. Individual responsibility for welfare has been emphasized in the last 20 years – and again underlined by the new government. Parents are supposed to negotiate their rights to care leaves and fringe benefits on the labour market, and during the previous government take-up of private care insurances was often on the agenda. Shortly before the election the then Health Secretary stressed that "*the principal responsibility for meeting the costs of social care has rightly rested with the individual since 1948. We are determined to help people achieve this*". Whether the new government is likely to take the same stand is for the future to tell. The new government has most

recently responded by publishing a Green Paper which underlines private responsibility and also by establishing an advisory commission which is to look into the problems of funding long-term care for older people in the future.

7.3.
Financing

7.3.1. Social expenditure

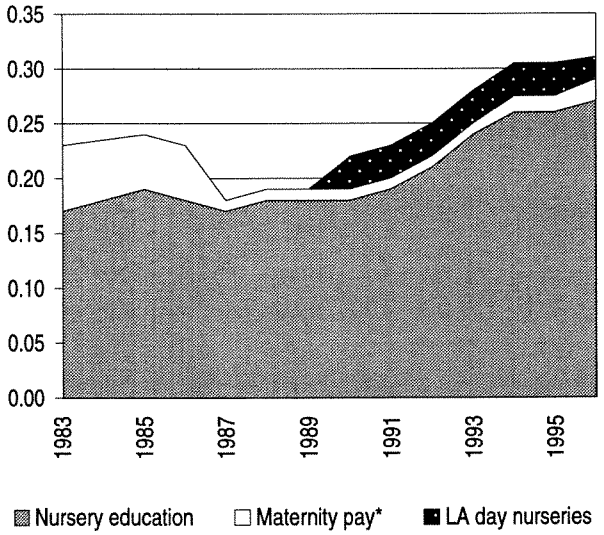
Overall, England has experienced a relative economic growth in the years from the early 1980s. Except from a decrease of GDP in the early 1990s, the rate of GDP has been positive and the growth rate was especially high in the mid-1980s, with figures around 4% growth every year (ONS, 1997). Unemployment has fallen from a peak of nearly 3 million at the end of 1992 to slightly over 2 million or around 8.2 % of the workforce. Social expenditure as a proportion of GDP in 1994 made up 28.1% in 1994[2)] (Eurostat, 1996).

Expenditure on social services for children has increased similarly with GDP increases, from a total amount of £129 m in 1983 for children's day care such as day nurseries and play groups to £139 m in 1995 in fixed 1990 prices. The main increase in costs has, however, taken place in nursery education. Here, costs amounted to £494 m in 1982 compared to £1,121 m in 1995 in 1990 fixed prices (Figure 7.1). In all, current expenditure on social services and cash benefits for children amounted to £2,056 m in 1995 in current prices of which 2/3s went to nursery education and one fourth for maternity benefits, with day care making up the remaining expenditure (Figure 7.2).

For older people, the majority of social expenditure in 1995 went towards the cash benefits, to Income Support, mainly used to finance accommodation of older people in for-profit-making residential care, and to Attendance Allowance. Institutional care in all amounted to 16% of expenditure while domiciliary care such as home help and day centres made up one tenth of expenditure (Figure 7.3). When these amounts are compared against the increase in GDP, the greatest increase in expenditure since the beginning of the 1980s is found within institutional homes, which mainly cover the costs borne by local authorities for the use of independent residential care. This amount has risen from £17 m in 1989 to £1,034 m in 1995 in 1990 fixed prices, or to nearly twice as much as local authority residential care. Costs for Income Support have also risen proportionally more than other benefits, however dropping again since 1992 (Figure 7.4).

2) Figures from UK.

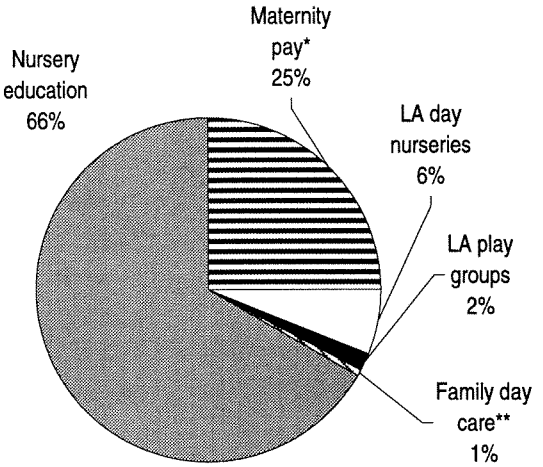
Figure 7.1.
Development of the net-expenditure as a percentage of GDP, 1983-1995. Main social services and cash benefits for children (aged 0-4).



Source: DoH: Personal Social services: Current and capital expenditure in England 1995-96. Statistical bulletin 1997/16. DoH: Personal Social Services: A Historical Profile of Reported Current and Capital Expenditure 1983-84 to 1993-94 in England. DSS: Social Security Statistics 1997. DSS: The governments expenditure plans (annual publication). DfEE (1998): Personal communication.

Note: ** Expenditures as share of GDP for United Kingdom. * Gross expenditures as share of GDP. Maternity pay: Sum of Statutory Maternity Pay and Social Funds Maternity Payments. Net-expenditure for nursery education is an estimation based on average expenditures per pupil in total primary education multiplied with the number of children in nursery education. The figures for playgroups and family day care are too small to be illustrated.

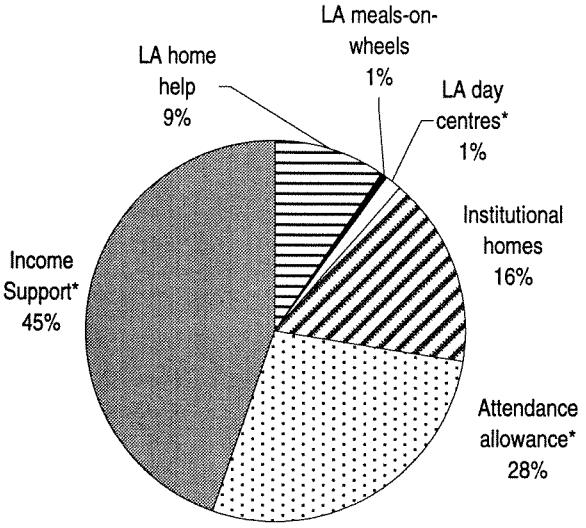
Figure 7.2.
Division of the net-expenditures 1995. Main social services and cash benefits for children (aged 0-4).



Sources: DoH: Personal social services: Current and capital expenditure in England 1995-96. Statistical bulletin 1997/16. DSS: Social Security Statistics 1997. DfEE (1998): Personal communication.

Note: * Gross expenditures for Great Britain. ** Data for 1993. Net-expenditure for nursery education is an estimation based on average expenditures per pupil in primary education multiplied with the number of children in nursery education. Maternity pay is the sum of Statutory Maternity Pay and Maternity Allowance.

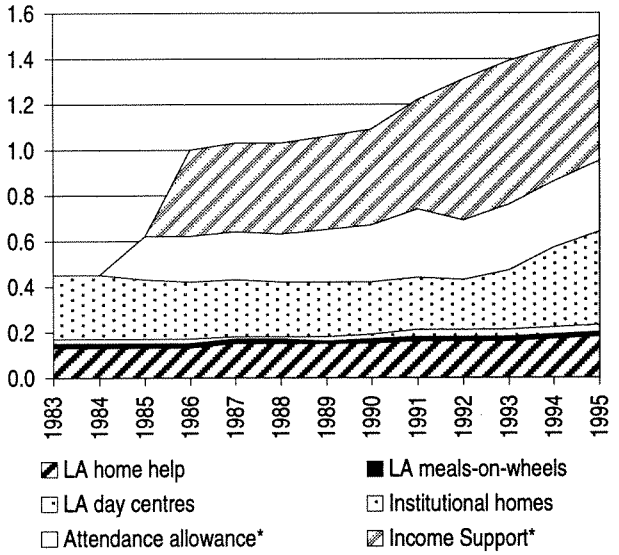
Figure 7.3.
Division of the net-expenditures 1995. Main social services and cash benefits for older people (65+).



Source: DoH: Personal social services: Current and capital expenditure in England 1995-96. Statistical bulletin 1997/16. DSS: Social Security Statistics 1997.

Note: * Data for 1994. Income support is only for older people (65+).

Figure 7.4.
Development of the net-expenditure as a percentage of GDP, 1983-1995. Main social services and cash benefits for older people (65+).



Source: DoH: Personal social services: Current and capital expenditure in England 1995-96. Statistical bulletin 1997/16. DoH: Personal Social Services: A Historical Profile of Reported Current and Capital Expenditure 1983-84 to 1993-94 in England. DSS: Social Security Statistics 1997. DSS: The governments expenditure plans (annual publication).

Note: * Gross expenditures as share of GDP for United Kingdom. Institutional homes is the sum of independent nursing homes, independent and LA residential care homes.

7.3.2. Division of financial responsibility between state and local authorities

The funding of social services is divided between central and local government, whereas cash benefits such as the Maternity Pay, the Attendance Allowance and Invalid Care Allowance are funded through the social insurance system to which both employers and employees contribute (Table 7.1).

The main funding for social services comes from central government grants, supplemented by local taxes. Local authorities have historically been free to set the level of local taxes, a property tax known as the rates. But since the late

1970s, with the new cost-efficiency ethos, there has been an increasing conflict over the levels of local spending and today, central government sets the spending limit for each local authority. Due to demographic changes and the re-organization of health and social services, spending on social services has, however, been allowed to increase by a few percentage points every year and the new Labour government has relaxed the revenue control slightly.

Table 7.1.
Sources of financing and gross expenditures (m GBP), 1996. Main social services and cash benefits for older people (aged 65+) and children (aged 0-4).

	Year	Gross expenditures (m GBP)	Sources of financing (%)				
			State	Local authorities	Employers	Insured	Clients
Children (aged 0-4)							
Statutory Maternity Pay*	1996	472	..	..	..	..	..
Maternity Allowance*	1996	34	..	..	..	..	..
Social Funds Maternity Payments*	1996	22	..	..	..	..	..
LA day nurseries	1995	132	..	93.94	..	..	6.06
LA play groups	1995	36	..	97.75	..	..	2.25
Family day care	1993	12	..	98.31	..	..	1.69
Nursery education**	1996	1,382	..	100.00	..	..	..
Older people (65+)							
LA home help	1995	897	..	91.58	..	..	8.42
LA meals-on-wheels	1995	89	..	57.30	..	..	42.70
LA day centres	1995	149	..	93.96	..	..	6.04
Independent nursing home	1995	566	..	..	..	..	31.45
LA residential care home	1995	818					28.73
Independent residential care home	1995	672	..	62.05	..	..	37.95
Attendance allowance*	1996	2,421	..	..	..	..	..
Income Support*	1996	3,739	..	..	..	..	..
Invalid Care Allowance*	1995	617	..	..	..	..	..

Source: DoH: Personal social services: Current and capital expenditure in England 1995-96. Statistical bulletin 1997/16. DSS: Social Security Statistics 1997. DfEE (1998): Personal communication.)

Note: * Expenditures for Great Britain. ** Net-expenditures for United Kingdom. Net-expenditures for nursery education is an estimation based on expenditures per pupil in primary education multiplied with the number of children in nursery education. Invalid Care Allowance includes expenditures for younger disabled people.

Funding of social services from central government takes several forms: firstly, there is a general *Revenue Support Grant* from the central government which is calculated according to a standard spending assessment, taking into account the demographic factors and local service policies. Secondly, *specific central government grants* are set up to support particular services or functions, e.g. for training of staff. Such grants represented around 1.6% of total Personal Social Services expenditure in 1993. In regards to older people, a third funding form comes from a new 4 year *Special Transitional Grant for Community Care* which was introduced in 1993 as part of the changes in the community care system. Local authorities are now responsible for funding the care costs of people on low incomes in residential and nursing homes provided by the private and voluntary sectors. Previously, this came under the centrally funded social security system but was changed in order to create a local savings incentive. The sums involved are substantial, £1,568 m in 1995/96. Payment is conditional in that 85% must be spent in the independent sector and on local authorities working closely with the NHS. The grant will be available until 1998 where after local authorities are to finance community care themselves. Finally, funding of the expansion in early years education for the coming years will come from the Revenue Support Grant and a *specific grant under the Nursery Education and Grant Maintained Schools Act 1996.* The latter is an annual £1,100 flat-rate payment for each child attending five sessions of nursery education per week, and is given according to provision. If provision is expanded, funding is likewise expanded.

Central government grants are supplemented by locally raised revenue from the *Council Tax* which replaced the Poll Tax in 1993. Only around 15% of local authority income comes from the Council Tax, the remainder is funded from the above mentioned central government grants and from unified business rates. Local authorities decide their own expenditure priorities but there are benchmarks for local taxes set by the Department of Environment.

7.3.3. Employer and employee contributions

Public social services are wholly funded by central and local government, whereas a number of care-related cash benefits are financed by employers and employees. Employer contributions for care-related cash benefits mainly provide funding of the Statutory Maternity Pay where employers are responsible for both funding and payment. However, the amount is later reimbursed through reduced payments to the PAYE payment and National Insurance Contributions (NIC). The reimbursement rate is presently at 92% for large companies and 105,5% for small companies. Employees also pay via contributions to the NIC. Payments are income-related and increase with income.

Cash benefits which are non-contributory, i.e. not financed through contributions from either employers or employees, such as Income Support, are financed from money voted by Parliament from general taxation, which is paid into the so-called Consolidated Fund.

7.3.4. User fees

Fees and charges for social services constitute the third important source of funding besides central and local government funding. Local authorities are not obliged to charge for the use of services and can decide whether and how to treat users' income and capital when calculating liability for charges. Local authorities are, however, obliged to follow guidelines in not charging unreasonable fees. Also, local authorities must review their charges if the user has difficulties paying, and services must not be withdrawn in the event of non-payment. Government guidelines also specify that there should be no service charges for recipients of Income Support or other cash assistance benefits.

There are no national guidelines on what parents should pay for day nurseries in the welfare system. Most children in public day care under the welfare system are regarded as being in risk and fees are often waived. The revenue from fees for day nurseries is therefore low, 6% of total expenditure in 1995 (Table 7.1). Nursery schools and other services provided within the education system are free of charge except for small amounts for meals whereas fees apply in reception classes (Department of Health, 1996). In the private day care sector, fees are relatively high.

Residents in residential or nursing homes pay according to income leaving an amount for personal expenses. Older people without means in residential or nursing homes are supported through the Income Support system or the local authority and thus pay no fees. Fees paid by older people in institutional care covered around 1/3 of total costs in 1995, whereas older people contributed 8.5% of the total costs for home help and home care and 6% of costs for day care centres. Fees were highest in meals-on-wheels where older people contributed 43% of total costs. In all, charges paid by older people for the use of services covered 1/5 of total expenditure (Department of Health, 1996).

By law, children have no responsibility for older parents. But the Acts on provision of nursing and residential home care allow the local authority to consider if help is otherwise available. Whether this includes also the financial position of close family members is less clear. But in some cases, family members are held liable for the debt of an older person, e.g. where rent arrears accrue. Changes in the Income Support scheme have also led to some pressure on family members.

Previously, Income Support could be used to fully fund a place in independent sector homes. Today, in most cases older people themselves must pay more for a place if they do not want to use the home provided by the local authority. Family members can choose to top-up the amount which is offered by the local authority and this may put pressure on the family if they cannot find a vacancy within this amount (Age Concern, 1995).

7.3.5. Funding of voluntary and private for-profit service delivery

As a result of the changes in community care, voluntary organisations as well as private for-profit organisations increasingly engage in contracts with local authorities for delivery of services. Grants from central and local government make up approximately 40% of voluntary sector incomes (Salamon and Anheier, 1996). Many voluntary organisations have charitable status, which confers certain tax advantages. Some voluntary and private for-profit services are also indirectly financed through the social security system, e.g. people living in residential or nursing homes provided by the voluntary and private sector may be receiving Income Support which covers the costs. Contracts normally involve either block grants where a fixed amount is set off every year for provision or spot purchase where the transfer of money is related to a specific amount of services.

7.3.6. Private insurance

There has been some talk about the benefits of private insurances and several enquiries have been conducted. The previous Conservative government proposed to set up partnerships between the state and commercial insurance companies but only around 10,000 long-term insurance policies were sold by 1995. The new Labour government has not yet given their view on how to finance long-term care in the future, but has recently responded by setting up a Royal Commission to look into the matter.

7.3.7. Fiscal subsidies

Before 1988, three small tax allowances recognised the needs of the informal carers: A Resident House Keeper Allowance, claimed by 1/4 m. tax payers, the Dependant Relatives Allowance and the Son or Daughter Services Allowance with around 1.25 m claimants. These have now been abolished (Glendinning, Schunk & McLaughlin, 1997).

The new Government has recently announced a new *Childcare Tax Credit* to come into operation from October 1999 which will cover some of the costs for child care. The already installed *Working Parent Families Tax Credit* may apply also for the child care costs.

7.4.
Provision

7.4.1. Public provision

Public provision of day care for children is scarce for small children while more widespread for older children. Children admitted to public day care are mainly children at risk and the great bulk of day care is provided mainly as nursery education for 3 to 5-year-olds by education authorities – or in the private sector.

For older people, public sector service provision consists of residential care in local authority homes, and help in the home provided as home care or home help. As a result of policy to encourage a mixed market, public sector provision is however getting smaller. This is especially apparent in residential homes where the number of older people living in private and voluntary homes has exploded in recent years. This is, however, mainly a consequence of social security payments which were linked to institutional care.

However, overall the role of the state has changed to enabling others to provide services, and the many contracts made with the private and voluntary sectors confirm the public sector's increasing role as a regulator and funder of services, rather than a direct provider.

7.4.2. Informal care

Informal care provided to older people by family members, relatives, neighbours and social networks has traditionally been comprehensive in scope and this is not getting smaller with the political support and expectations. A survey in 1990 mapping informal caring showed that over 3 m people were caring for either parents or parent-in-laws, and nearly 1 m were caring for a spouse (GHS, 1990). The fiscal value of the contribution made by informal care is obviously high – valued at £32,500 m a year compared to public sector spending of £6,336 m (Glendinning, Schunk & McLaughlin, 1997).

Informal carers are not only impressive in number and value but also in importance compared to public provision. When asked who provides help with domestic or personal care a later survey confirmed that older people mainly receive help from their spouse or their children, whereas fewer older people received public assistance. This is in line with the Griffith Report from 1988 which recommended that publicly provided care should only represent a small proportion of total social care and that the future role of the state should be to support and reinforce informal care rather than replace it (Gostick et al, 1997). Some carers report that their help is 'means-tested in kind' before the local authority provide domestic care and potential carers must often prove that they

are unable to provide support. With the introduction of the Carers (Recognition and Services) Act in 1995, the situation of the carers has, however, been highlighted as the carer's own situation is now also taken into consideration when awarding services. Informal carers can receive advice and support from the Carers National Association which is also active in lobbying.

Informal day care for children is the most common day care arrangement. Around 1/3 of children are cared for by the parent, another 1/3 by grandmother/grandfather and 1 in 10 are looked after by other relatives (OPCS, 1994). Informal care is also one of the most preferred day care solutions – most employed mothers say that they would prefer their child to be looked after by a relative or the husband while they are at work (Scott & Brook, 1997). Some children are looked after by friends or neighbours. The arrangement is often paid – nearly half of mothers of children who were looked after by friends and neighbours report that they pay for this help (OPSC, 1994).

7.4.3. Voluntary provision

There is a long tradition of volunteering in England, partly because of the relatively highly secularised society, where the church plays only a minor role. Local authorities are by law obliged to make arrangements for provision, either by providing services itself or by paying others to provide, and local authorities increasingly make use of provision from the voluntary sector.

The most established of the voluntary sector provision areas is residential and nursing homes for older people. One in five places are now provided by the voluntary sector and this is increasing since a frequently used policy is to transfer local authority homes to the voluntary sector. Voluntary organisations also provide domiciliary care, such as day centres, lunch clubs and transport to and from these facilities. Other important contributions from the voluntary organisations are self-help groups, e.g. the growing number of groups for carers which are members of the Carers National Association (Baldock, 1994). Services are often operated on behalf of, or in partnership with the local authority. Previously, voluntary organisations received grants from national and local government. Today, many voluntary organisations operate on the basis of a block contract with the local authority instead. Voluntary organisations may thus have assumed new significance but they are still sustained by public sector financing.

7.4.4. Private for-profit provision

Considering the strong ideological support for private for-profit services the expansion of these services is an expected development. However, at present most provision is operated mainly via quasi-markets of welfare in the sense that

providers are usually sustained by public sector finances – both through direct payments and tax subsidies.

The most impressive expansion has been in the for-profit delivery of residential and nursing homes where changes in the social security system in 1979 allowing for social security funding to finance the use of for-profit services. The number of for-profit residential home places grew in accordance by 57% between 1980 and 1991 and there was almost a four-fold increase in the number of private nursing home places. By 1988, the private sector had replaced local authorities as the largest provider in the residential sector and today 70% of residential homes are provided by the for-profit sector (Gostick, Davies, Lawson & Salter, 1997). Private provision is apparent also within domiciliary care albeit on a lesser scale; one in five providers run a for-profit business in home help and almost all meals-on-wheels services are contracted out to the for-profit services. This development has been helped along amongst other by the introduction of the Caring for People who Live at Home initiative which supports for-profit as well as non-profit provision. The United Kingdom Homecare Association (UKHCA) is the national representative association for independent providers of home-care.

Most day care for children is also provided by a for-profit agent, 88% of day nurseries and a number of playgrounds are run as for-profit businesses mainly without local authority financing and most family day carers are self-employed. For-profit provision has also gained from the increase in workplace care where employers subsidize a number of day care places for children of the employees. Finally, a number of pre-school children are in independent schools which are run on a for-profit basis without financing from local education authorities.

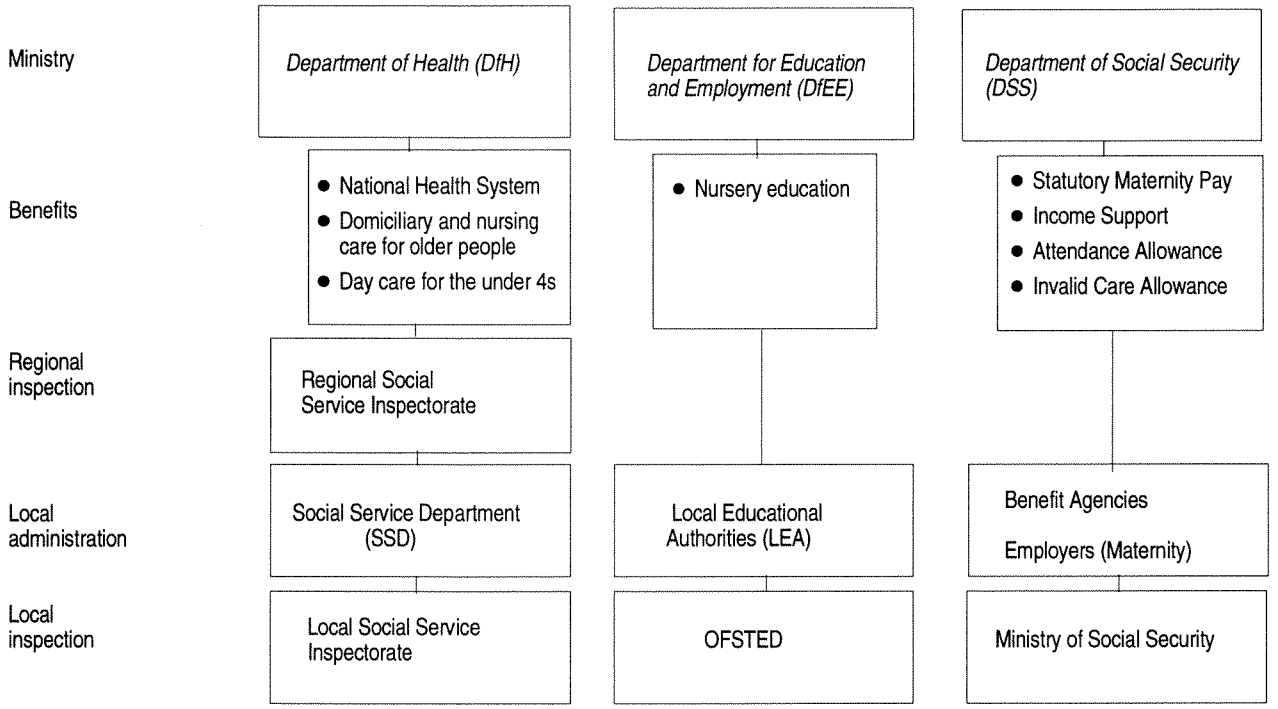
7.5.
Organisation

7.5.1. Central government bodies

The ministry of primary importance for domestic care, residential and nursing homes for older people and day care for children in public day nurseries, play groups and family day carers is the *Department of Health*. The minister, the Health Secretary, is responsible for promoting legislation within which local Social Service Departments operate, whereas power over spending allocations lies with the local authority. The Department has no responsibility for general financing of local authorities as this is the responsibility of the *Department of Environment and the Treasury*. However, the *Social Services Inspectorate* (SSI) is part of the Department of Health and carries out the regulation and inspection of social services in the different regions. Health services such as hospital and community

health services also come under the auspices of the Department of Health. In comparison to the social services, the Department exercises more direct control over the health services in appointing members to local health authorities and in allocating resources.

Figure 7.5.
Organisational structure.



Nursery education for 3 and 4-year-olds is the responsibility of the *Department for Education and Employment* which determines the national aims and formulates policies, commissions research, sets minimum standards of provision and monitors the quality and costs effectiveness of provision.

The *Department of Social Security* is responsible for the various cash transfers, including maternity benefits and allowances paid to informal carers. The Department comprises a central Headquarter which develops and monitors policy, provides corporate management, legal, statistical and analytical services to the Department, and 5 Next Steps Agencies, including the Benefits Agency, which are responsible for payment of benefits.

7.5.2. Regional bodies

There is no regional tier of government in England. The Social Services Inspectorate under the Department of Health is, however, organised on a regional level. Also, 8 Regional Executive offices manages the NHS in the area and oversee purchasing.

7.5.3. Local bodies

Local Authorities (LA) have since 1974 been organised as a two-tier system with a county council and several district councils, covering only one county. However, local authorities are presently under re-organisation putting smaller, unitary or all-purpose authorities in its place. This will add 20 new councils to the present number, with a total of 171 county councils by April 1998 (Bransbury, 1997). Policy making in local authorities is the responsibility of elected numbers of Committees, covering personal social services or education. As part of the re-organisation, the *Social Service Departments* (SSD), which are responsible for social services, have in many local authorities been set up as smaller unitary councils, serving fewer people. Apart from planning and allocation of resources, the Social Service Department in each local authority is also obliged to prepare annual plans for the development of services which are consistent with national policy objectives. Social Service Departments are responsible for the provision of services for older people and children but can contract-out direct delivery to others, including the voluntary and private, for-profit sectors. Local authorities must adhere to the minimum requirements set out in the legislation on standards in services and can in principle set stricter standards. But these may be contested in court by providers and local authorities have in some cases been forced to re-turn to the minimum standards, e.g. in child:staff ratios in child care.

Services for children under the Department of Education are provided by *Local Educational Authorities (LEA).* The LEAs set the budget and allocate funds, provide school places and monitor the facilities and the quality of education. The LEAs have the power to provide additional places if this is considered necessary. Cost management of schools is most often delegated to individual schools except for nursery schools where the LEA is responsible for the budget. Services for children were previously sharply divided between LEA and LA provision but recently there have been moves towards integration of these services. In some local authorities, responsibility for day care thus lies with the education department or with the newly installed independent children's department. From April 1998, provision for 4-year-olds has been taken away from Social Service Departments and now comes under the authority of LEAs. LEAs have recently been made responsible for formulating an early years development plan (EYDP) which demonstrates how places will be provided in the education system for 4-

year-olds. This means that regulation is also the responsibility of the LEAs and this may lead to a focus which is more directed towards educational outcomes than was the case when regulation came under the Social Service Departments.

Provision of *health care* is the responsibility of the NHS but the distinction between health and social services is rather blurred as many local health and social service authorities work together as joint planning teams.

Local administration of cash benefits is by *Benefit Agencies (BA)* which are responsible for the handling of applications and payment of benefits.

7.6.
Children

7.6.1. Introduction – Main services and cash benefits

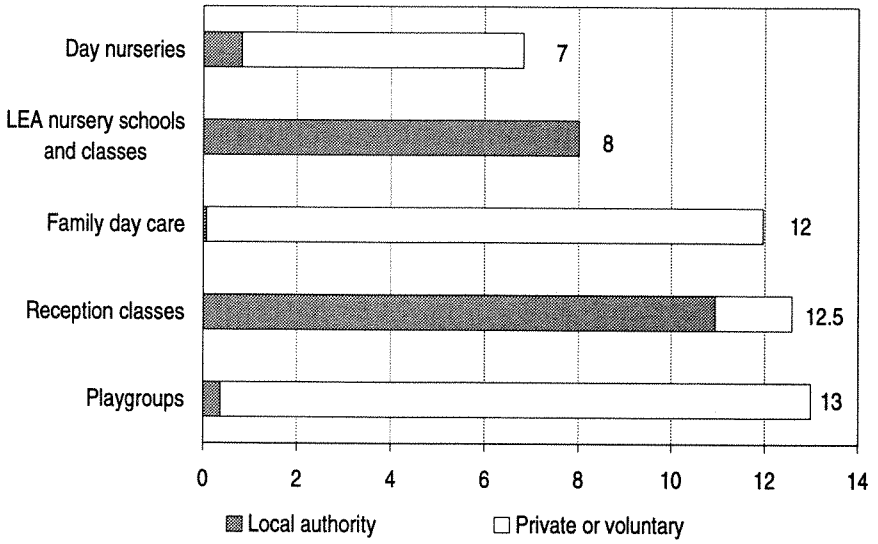
A working mother who has recently given birth can in England make use of her right to be absent from work for up to 29 weeks during which she can receive Maternity benefit for a maximum of 18 weeks. Fathers have no statutory right to be absent from work or to receive compensation for lost earnings during absence – although some fathers gain certain rights through contractual agreements.

Services for children in England are divided into two systems: A welfare system under the Department of Health and an education system under the Department of Education and Employment.

In the welfare system, the main public provision of day care for children aged under 3 is the *Day nurseries* provided mainly for children who are considered to be in need. Parents who need day care for their children because of employment or education obligations use private day care arrangements such as *Child minders, nannies* or *private day nurseries.* For those children who are cared at home, either by a parent, family member or child minder, part-time *Play groups* offer a setting where the children can engage in play activities with other children and where parents can learn more about children's development. In some rural areas, *Play buses and Toy libraries* accommodate toys and equipment for play groups and child minders. Some employers cater for employees with children by setting up *Work-place nurseries* or by *financing a day care place in a private nursery* Although still few in number, these arrangements are popular and the new government has advocated the further involvement of employers along with trade unions, local authorities and parents to solve the problem of lack of day care.

Within the education system, children aged between 3 and 4 are provided with nursery education, either in *Nursery schools* or *Nursery classes*. Some 2 year olds are also admitted. Most children attend as part-timers and provision is only during school terms. *Reception classes* admit 3 and 4 year olds into the school system and provide care under conditions which resemble primary school. Provision is mainly full-time for 40 week sessions (Figure 7.6).

Figure 7.6.
Day care arrangements, enrolled children (aged 0-4) as a percentage of the age-group and by provider, 1996.



Source: DSS: Social Security Statistics 1997. DOH: Children's Day Care Facilities 1996; DfEE: Pupils under 5 years in each LEA authority in England 1996. Statistical Bulletin; DfEE: Pupils under 5 years in independent schools in England 1996. Statistical Bulletin.
Note: Data (recipients and demographics) on cash benefits are for Great Britain.

Nevertheless, the most common care arrangement for children in England is the care provided at by the *mother* or by *grand-parents, friends of the parents, neighbours and relatives.*

7.6.2. General principles for child care

Caring for children in England has traditionally been treated as a private matter for parents, and perhaps employers, to arrange. Government policies today acknowledge the need for women to stay at home after giving birth but prior to EEC membership in 1975 a working woman was not guaranteed the right to take

leave, or to return to work, nor any compensation for loss of income. These rights are now incorporated in current legislation.

Day care for children is provided within two separate systems, the welfare system and the educational system, and the underlying principles for admission, curriculum and fees differs greatly from one system to another. Within the welfare system, local authorities are obliged to provide appropriate day care for children aged under 6 who are in need and not yet attending school. The needs criteria previously included handicapped children, children of sick or handicapped parents and children of single working parents. Currently, local authorities are increasingly focussing on children who are 'at risk'. Many children in local authority day nurseries are therefore in care because they are considered to be seriously behind in their development, others have been exposed to family violence, sexual or other kinds of abuse, live in poor housing or suffer from ill health. These children are to be supported but the aim behind the provision of public day nurseries also includes educating parents in good child-rearing.

Local authorities also have powers, but no obligations, to provide day care for children who are not considered to be in need, but for children aged under 3 it is generally recommended that they be cared for in a home like setting. Many women therefore leave the labour market for shorter or longer periods when they give birth or work part-time. Public responsibility for day care for the under 3s mainly involves the obligation to regulate and inspect voluntary and private day care providers. Under the New Child Care Act, local authorities have the power to provide facilities such as training advice, guidance and counselling to people working in a day care setting. Local authorities are also under a duty to review the full range of services in their area every 3 years and provide information about these services. Lone parents have been targeted as a special group to be helped to find day care to enable them to take up work. Under the New Deal for Lone Parents implemented in April 1998, back-to-work help including how to find childcare is to be offered to those lone parents who join the scheme. For the great majority of children, however, day care provision depends on parental purchasing power within a largely unsubsidised private market of provision. Working parents who need care for their young children must make use of private solutions, such as family day carers or private day nurseries provided by voluntary organisations, for-profit organisations or employers.

Within the education system, some 2-year-olds and a greater number of 3- and 4-year-olds attend nursery schools and nursery classes. In contrast to the services provided under the welfare system, the nursery education provided for children under the Department of Education and Employment is aimed at all

children. Admittance is thus dependant on age, not social need. Most nursery education is however part-time. The tradition of partial provision dates back to the influential 1967 Plowden report which recommended that nursery education should only be part-time because of the perceived psychological damage of allowing children to be separated from their mothers for longer periods.

In addition to nursery classes and schools, local education authorities can enrol children in reception classes in primary schools in the year following their fourth birthday. Some 3-year-olds are also admitted. Most reception classes provide full-time care but this does not cover normal working hours. The now-abolished voucher scheme intended to provide for all 4-year-olds in reception classes by financing part of the costs, with parents bearing the remainder. The new government has followed up a 1987 election promise and announced that part-time early years education in nursery schools and classes, reception classes and primary schools should be available for all four-year-olds by September 1998, later extended to include 3-year-olds also. This will give parents 2½ hours pre-school education for five days a week during term time. A number of related benefits are expected from this National Childcare Strategy, such as moving a number of beneficiaries of cash benefits into work, tackling social exclusion, and supporting quality of services. This initiative reflects the need for a national child care strategy, which has been on the public agenda for a decade and has been supported by e.g. the Equal Opportunities Commission, the Trade Union Confederation and the Confederation of British Industry.

Local educational authorities are now supposed to cooperate with other agents in developing Early Years Development Plans for the provision of services in each local area. The rational underpinning the new government's plans is thus the presumption that the problem of child care must be dealt with in partnerships involving not only the public, but also employers, parents, health authorities and the independent sector. But as the provision of schooling for 3- and 4-years-olds under the new system will remain mainly part-time, the problem of finding day care persists for those parents who are both working.

As costs are to be borne by local education authorities, take-up also by parents with lower incomes should be favoured. In this sense, expansion follows the principle of providing free services in the education system. In contrast, services within the welfare system are means-tested, although most fees are waived.

7.6.3. The need for day care

More and more children in England are brought up by working mothers. The traditional family pattern of breadwinner father and homemaker mother has been

challenged by the number of women who have entered the labour market since the 1960s and especially during the 1980s. In spring 1996, 71% of women aged 16+ years were active in the labour market compared to 85% of all men in the same age group. However, full-time employment among English women[3] is relatively low, with 40% of women working part-time, while 8% of men work part-time (Eurostat, 1997). Fewer are currently registered as unemployed with unemployment rates at their lowest in 5 years, at a rate of 9.7% for men and 6.3% for women in 1996.

Finding day care for children is a particular problem for those parents who both work full-time. Of all couples with children, this is around one third (32%) whereas another one third of families are headed by a full time worker while the other parent is working part-time (31%) (ONS, 1996). For those who work full-time, work takes up more time than previously. Working full-time means that on average men work 45.8 hours a week and women work 40.6 hours, an increase of 1 hour for both sexes over the last 12 years (ONS, 1997).

Working mothers entering the labour market represent most of the increase in the female participation rate, and especially among women with children aged under 5. Here, employment has grown by 77% since the early 1980s compared to a 9% growth rate for mothers with children aged between 11 and 15 (Brannen et al, 1994). Also significant is that half of the growth in employment for mothers is in full-time work. Among mothers with children aged 0-4 nearly one in five now work full-time (ONS, 1997). However, many mothers of young children arrange their working hours in order to take care of their children. One in three work part-time and nearly half are not in paid work. When asked why they are not in work, 43% of women gave care for children as the reason (ONS, 1997).

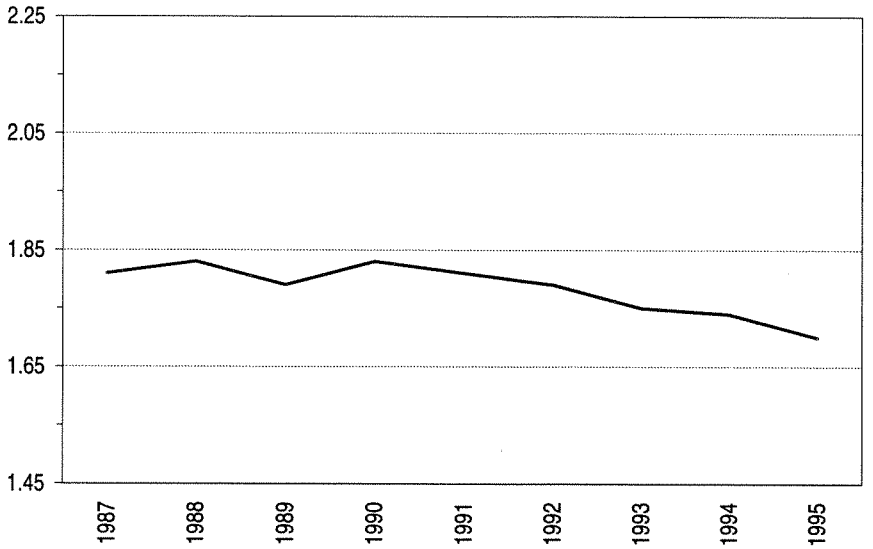
Pressure on day care has slowed down slightly as fewer children are born today than previously. In the babyboom years of the mid-1940s and mid-1960s, the fertility rate increased, peaking at 2.95 in 1964, and then fell by over 40% to a low point of 1.69 in 1977 – influenced by factors such as the number of women taking up higher education and entering the labour market, and better access to contraceptives. From the late 1970s, fertility rates increased slightly and then fell again to 1.70 in 1995[4] (Figure 7.7). The proportion of children under 5 years has therefore remained around the 6% of total population.

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3) Figures from United Kingdom.

4) UK figure.

Figure 7.7.
Total fertility rate, 1987-1995.



Source: EUROSTAT: Demographic Statistics 1994 & 1997.
Note: Data for United Kingdom.

The number of families with 3 or more children has obviously declined, from two in five families in the early 1970s to one in three in 1995-96. Today, most families with children have 2 children (46%) and one in five (22%) of families with children have only 1 child (ONS, 1997).

Single parents represent 20% of all families with children, and of these nine out of ten are single mothers. The main factor behind the high number of single parents is the high rate of marriage breakdown. The divorce rate has now dropped slightly but still remains among the highest in Europe. 45% of marriages end in divorce compared to an average of 30% in Europe. (ONS, 1997). One of the underlying reasons for expanding pre-school provision has been major concern about the increase in single mothers, and especially those relying on welfare benefits. Obviously, the lack of affordable day care can be one of the main hurdles to taking up work for this group of parents. In a survey, 44% of non-employed single mothers thus said that they would return to work if child care was available. And most single parents of pre-school children who had been successful in finding day care, made use of informal arrangements, such as grandmothers (Bradshaw & Millar, 1994).

In general, the availability of informal day care arrangements seems to be one of the main determinants of whether to work or not. Whether due to the inadequacy of the present day care system or not, most parents seem to prefer their child to be cared for by family members. A survey of 5,000 British households showed that most employed mothers would prefer their child to be looked after by a relative or the husband while they were at work, while four out of five non-employed mothers said they stayed at home because they did not have access to exactly this form of care (Scottt & Brook , 1997). When parents choose public day care for their children it is thus often because of a lack of informal care, and less likely to be for reasons of stimulation or education. Other solutions for care are also often popular; in a recent survey 50% of parents said that they would like to have child care vouchers and one third would like to have child care available at their workplace (Daycare Trust, 1997a).

7.6.4. Public cash benefits supporting child care in the home

Women giving birth are in England entitled by law to a 40 weeks absence from work, 11 weeks before birth and 29 weeks after birth, which is the longest in the EU countries including Sweden and Finland. Part of the leave is without compensation for loss of earnings and the female employee is not credited with pension credits during the absence.

Maternity benefit (Statutory Maternity Pay, SMP)

Employed women who pay Class 1 contributions to National Insurance are covered by Statutory Maternity Pay. This means all employees with an average gross weekly wage of £60, or around 60% of female employees. Entitlement to the benefit depends on a minimum of 26 weeks employment with the same employer prior to the 15th week before birth. The claimant must fulfil certain conditions: She is required to give the employer reasonable notice and she must not to be employed elsewhere. Furthermore, she must be expecting to give birth within 11 weeks or to have just given birth.

The replacement rate of SMP is 90% of the mothers average wage for 6 weeks, after which she receives the flat-rate benefit for the remaining 12 weeks. The flat-rate benefit is paid at a rate of £55.70 per week in 1997, or 36% of an APW income for a woman working part-time.

Thus the benefit covers up to 18 weeks and can be claimed 11 weeks before the expected date of birth at the earliest and 6 weeks after the birth at the latest. The benefit period after birth giving, therefore, varies from 6-12 weeks. None of the time can be taken by the father. SMP is treated as taxable income, and is administered and paid by employers. The number of recipients has only in-

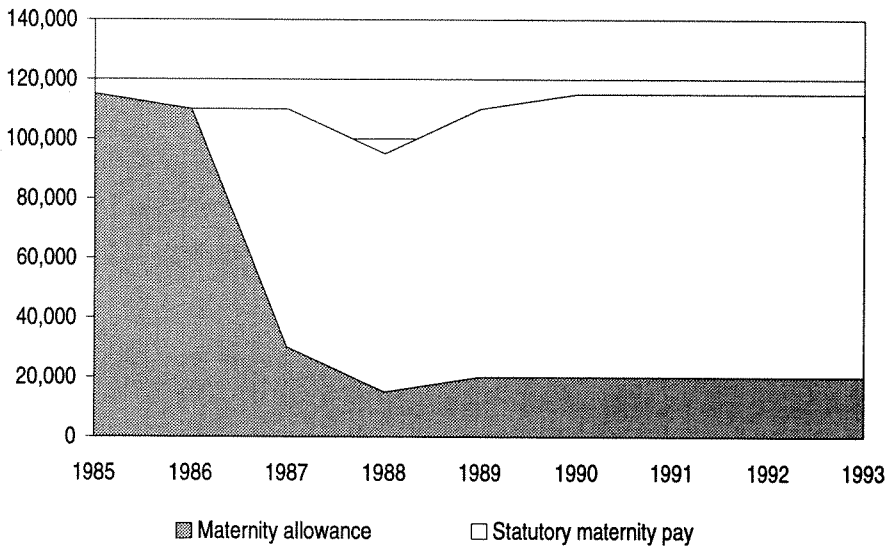
creased slightly since the mid-1980s, with around 95,000 recipients in 1993 for the whole of Great Britain (Figure 7.8).

Supplementary maternity benefit (Maternity Allowance, MA)

Women who either do not meet the employment criteria for SMP or who are self-employed, can receive the MA instead for the 18 weeks. This only covers women who had made contributions to National Insurance for a minimum period. The amount depends on employment status at the 15th week before the expected week of confinement. Employees who are in employment during the qualifying week receive the higher rate of MA. Self-employed and those not employed in the qualifying week receive the lower amount.

The higher rate was £55.70 per week in 1997, with £48.35 for self-employed and unemployed women. MA is financed through general budget and is taxable. Should MA be insufficient, the mother can apply for Income Support or Family Credit if she has more than one child and her spouse/ partner works for more than 16 hours a week. The number or recipients of MA has declined drastically from over 100,000 in 1982 to 20,000 in 1993 (Figure 7.8).

Figure 7.8.
Cash benefits for maternity leave, number of recipients, 1985-1993.



Source: DSS: Social Security Statistics 1997. DSS: The Governments Expenditure Plans (annual publication).
Note: Data for Great Britain.

Parental leave

As a result of Britain signing the EU social charter, Britain is committed to adopt the Parental Leave Directive by late 1999 the latest. Parents will in future be entitled to unpaid parental leave of up to a minimum 3 months after birth. The leave should be granted on a non-transferable basis, to promote equal opportunities between men and women. Employees using such leave should be protected against dismissal on the grounds of an application for, or the take of, leave and should be guaranteed the right to return to the same job, or to an equivalent job consistent with their job contract. The Government has proposed that the contract of employment should continue during parental leave, so that normal terms and conditions of employment would continue. The Department of Social Security is presently reviewing maternity pay arrangements and considering how social security arrangements will be affected by parental leave.

Contractual agreements

Some employees are guaranteed better rights to maternity benefits through labour market agreements, Occupational Maternity Pay (OMP). Additional maternity provision is widespread in the public sector in the form of shorter service requirements to qualify for leave, access to contractual benefits while on leave and provision for adoptive mothers and fathers. There is no statutory system of leave to care for a sick child but many workplaces offer family leave or flexible working hours, e.g. employees in the civil service and in a number of local authorities are allowed 52 weeks of leave. A survey carried out by the Department for Education and Employment found that 17% of employers provided (usually unpaid) career breaks for employees to care for children but only 1% of mothers and 1% of fathers reported using them (Department of Education and Employment, 1996). For fathers in particular, the Trade Union Confederation (TUC) has drawn up guidelines for 10 days paid paternity leave and most employed fathers have access to special leave which can encompass paternity leave. The DfEE survey mentioned above showed that paternity leave was provided by 24% of employers and that most fathers made use of the leave, which averaged around 4 days (Ibid).

7.6.5. Public and private provision of day care under the welfare system

Under the ***welfare system***, local government provides day nurseries for children in need and otherwise facilitates provision in independent day nurseries, play groups and with child minders.

Day nurseries

Admission

Local authority (LA) day nurseries provide care under the welfare system for

children who are considered to be in need. Local authorities have a statutory duty to provide a level and range of services appropriate to children's need but local authorities have discretion to determine what this level of provision should be and when a child should be regarded as being in need. Children needing care because of their parents' employment, education or training are not admitted on grounds of need. Local authorities are empowered to provide services for these children but are not obliged to do so. Almost all services for this group are left to private, non-subsidised services which reflects the notion that finding day care for children of employed parents is the private responsibility of the parents.

Independent day nurseries therefore make up the bulk of day nursery provision. These are set up by voluntary organisations, community groups as co-operative enterprises, private for-profit companies, employers in the public or private sectors and by Government Departments for their workforce. Independent day nurseries do not operate with the same admission criteria as LA day nurseries and their criteria include the individual child's social and psychological need, the parents' employment situation but first and foremost the ability to pay.

Coverage and provision

Children admitted to day nurseries are usually aged between 0-5, although nurseries take a few children aged under 12. The age spread of children is mainly from 1-4 years. Most children start to attend day nurseries when they are aged 2½. Not all children attend the full five days a week, 2 out of five attend for less than 5 days a week (OPCS, 1994).

Provision of day care in nurseries has been greatly increasing for a number of years, especially within the independent sector. Local authorities are not under the same requirement to privatise day care for children as they are with care for older people. However, the financial problems which local authorities have experienced alongside increasing central control over budgets, have led to a closure of many LA day nurseries and increasing use of independent day nurseries. The number of places provided within the independent day nurseries has thus expanded from nearly one in two of total provision to more than four in five from 1982 to 1996. The number of total premises has more than trebled from 1,408 in 1982 to 5,800 in 1996. Places in day nurseries have increased dramatically and today there are nearly 180,000 full-time places. The proportion of places per 100 children has thus increased from less than 2 places per 100 children aged 0-4 years in 1982 to nearly 6 per 100 children in 1996 (Table 7.2).

Table 7.2.
Day nurseries, number and per cent of FTE children (aged 0-4) according to age and provider, and children (FTE) per 1 staff (FTE), 1982-1996.

Year	Number of children (FTE)		%		Staff ratio
		% of children aged 0-4	Local authorities	Independent	
1982	51,049	1.77	57.09	42.91	3.36
1983	51,255	1.74	55.86	44.14	3.19
1984	52,801	1.79	54.68	45.32	3.22
1985	54,890	1.85	52.66	47.34	3.13
1986	57,659	1.92	50.16	49.84	3.10
1987	60,653	1.99	47.48	52.52	3.12
1988	66,237	2.14	43.71	56.29	3.09
1989	75,378	2.39	38.19	61.81	3.11
1990	87,451	2.74	31.99	68.01	3.20
1991	106,068	3.28	25.49	74.51	3.33
1992	116,700	3.58	20.39	79.61	3.12
1993	133,800	4.12	15.99	84.01	4.19
1994	147,600	4.56	15.11	84.89	4.19
1995	161,600	5.04	12.93	87.07	4.07
1996	178,300	5.67	11.16	88.84	..

Source: DoH: Children's Day Care Facilities (annual publication).
Note: 1 enrolled child = 0.77 FTE child. Staff ratio is for LA day nurseries.

Fees

Financing of LA welfare services is by local authorities who determine the level of fees. There are no national guidelines on what parents should pay for day care in the welfare system, although government recommendations do state that there should be no charges for parents in receipt of certain benefits, e.g. Income Support or Family Credit. Most fees are thus waived but for those parents who do pay, costs amount to around £0.50 an hour (OPCS, 1994). In 1995, fees made up 6% of total expenditure. Local authorities are also able to help with the costs of transport to the day nursery. Low income families who receive means-tested benefit to supplement their earnings can receive a subsidy which partly covers their costs when using day care services for their children. Costs of up to £100 a week can be disregarded when means-testing the family income, representing a real value of £45 a week. Take-up of the child care disregard is, however, low – only 23,000 out of 150,000 eligible women have claimed it.

Fees for independent day nurseries are between £55-£160 per week depending on the age of the child. Average hourly cost is £1.30 (Ibid). Parents receiving

means-tested benefits are also entitled to the child care disregard when making use of independent day care.

Standards

Day nurseries in contrast to pre-school education emphasize their function as guardians and care providers who are concerned with the children's well-being and not their educational development. Activities can include creative art-work, singing and listening to music, messy play with sand and water, playing outdoors and problem-solving. However, the Children Act recommends that 3 and 4-year-olds are offered experiences which are comparable in quality with those offered to children attending schools and formal learning activities may be provided, especially in private nurseries. Around half the children are also offered educational activities, such as learning the alphabet (OPCS, 1994).

Some local authority day nurseries provide day care throughout working hours, usually from 7.30 a.m. to 6.00 p.m. all year long, others provide sessional care. Independently provided day care is most often full-time and all year round.

Staff numbers should vary according to the age and number of the children, with 1 adult per 3 children aged 0-2, 1 adult per 4 children aged 2-3, and 1 adult per 8 children aged 4-5. The staff ratio in LA day nurseries has dropped from 3.4 places per member of staff in 1982 to 4.1 in 1996 (Table 7.2). Staffing here mainly consists of nursery nurses who have a National Vocational Qualification at level 2/3, which is a two-year post-16 training course. In independent day nurseries, at least 50% of staff must have this level of education (National Children Bureau, 1996).

The Children Act 1989 recommends that there should be no more than 26 children in each self-contained unit. On average, there are 19 children in a nursery group. Half the LA day nurseries provide for children in groups of less than 15 children, whereas in independent day nurseries this is the case in one out of three (OPCS, 1994). According to the Children Act 1989 the size of premises should vary with the age of the children, providing more space for the younger children. For each child aged 0-2 there should thus be 3.7 square metres of space, for children aged 2-3 2.8 square metres and for children aged 3-5 2.3 square metres. Independent day nurseries must also comply with the standards imposed by the Children Act 1989 on the number of children, staff, safety regulations, size of premises and record-keeping.

Regulation

Day nurseries are overseen by the Children Act Inspectors under the Social Service Departments. Local authorities are obliged to inspect the facilities annually and to review the range of services provided every 3 years. Facilities

which are attended by 4 year olds must be visited and regulated by OFSTED, the inspection unit under the Department of Education.

Waiting lists

There is no national record of waiting lists for private day nurseries but a survey of parents using day nurseries found that about 3/4 of the children were able to start immediately and did not have to wait for a place, 1/3 had to wait an average of 23 weeks and a few waited for 1 year or more (OPCS, 1994).

Playgroups

Admission

Playgroups offer care during school terms for 2-5 part-time sessions a week, either morning or afternoon during school term. Children attending should be aged between 3 and 5 years but some 2½ year olds are admitted to special parent and toddler groups if they are accompanied by a parent. The aim of playgroups is to give children an opportunity to engage in play activities through which they can learn skills appropriate to their stage of development in company with other children and adults. Any child whose parents can pay the fees is entitled to admission. Many include children with special needs but these are often catered for more specifically in special *opportunity playgroups* which have links with medical staff. The parents are involved in all aspects of daily management and operation and some playgroups only admit children whose parents are willing to help at the playgroup on a rota basis.

Coverage and provision

Only a small proportion of playgroups are run by the local authority. Nearly all the places are in playgroups run by non-profit making community or church groups, committees of parents or individually run on a commercial basis. The number of these independent playgroups increased by more than 2,000 between 1982 and 1991 with a similar increase of 14,000 in the number of full-time places. Since then the number of facilities has declined to the current 16,500. LA playgroups have gone down in number to 70 premises in 1996.

The number of children as measured in full-time provision has steadily increased since the early 1980's but with a decline setting in from the early 1990's. The most recent decline from 1994 has been partly caused by a shift in demand in favour of nursery education places (Table 7.3). In all, LA and independent playgroups offered a total of nearly 220,000 full-time places in 1996. Of these, only 700 were provided by the LA. In all there were 7 full-time places available per 100 children aged 0-4 years.

Table 7.3.
Playgroups, number and per cent of FTE children (aged 0-4) according to age and provider and children (FTE) per 1 staff (FTE), 1982-1996.

Year	Number of children (FTE)		%		Staff ratio
		% of children aged 0-4	Local authorities	Independent	
1982	205,884	7.13	0.73	99.27	9.33
1983	213,384	7.25	0.80	99.20	9.37
1984	216,764	7.34	0.75	99.25	9.89
1985	225,370	7.58	0.78	99.22	10.46
1986	227,095	7.56	0.76	99.24	11.32
1987	228,105	7.50	0.81	99.19	10.71
1988	225,333	7.27	0.78	99.22	10.88
1989	224,027	7.10	0.67	99.33	8.49
1990	229,274	7.19	0.61	99.39	9.08
1991	235,852	7.28	0.54	99.46	11.19
1992	228,085	6.99	0.39	99.61	8.63
1993	218,350	6.73	0.40	99.60	7.86
1994	226,600	7.00	0.56	99.44	7.07
1995	226,160	7.06	0.56	99.44	7.76
1996	219,120	6.97	0.35	99.65	..

Source: DoH: Children's Day Care Facilities (annual publication).
Note: 1 enrolled child = 0.55 FTE child. The staff ratio is for LA playgroups.

Nearly all children attend as part-timers; 80% thus attend mornings, 10% in afternoons and 10% either one or the other. Most children attend 2 days a week only (OPCS, 1994). The actual use is therefore higher than the full-time places. In all, 82,000 playgroup sessions were run each week in 1996, representing 4.20 sessions per 100 children aged between 2-4 and 1 weekly session available per child aged 2-4 in 1996 (Department of Health, 1997a).

Standards

Activities in play groups are similar to day nurseries in that they allow children to participate in creative work, play with sand and water, take part in outdoor play and practice problem solving. Activities should be based on the theory that children learn through play. Most children are also offered educational activities of some sort, such as being introduced to books and reading. Playgroups normally start between 9.00 and 10.00 a.m. and sessions run until 1 p.m. Afternoon sessions start at 1.00 through to 3.00 or 4.00 p.m. An increasing number of playgroups are open longer and are taking younger children in response to demand. Most playgroups thus run 5 weekly sessions.

On average, there are 24 children per playgroup, a slight increase since 1995. Most playgroups employ one or two trained members of staff who work with parents helping on a rota basis. The number of full-time places per full-time staff member declined from 9.3 places in 1982 to 7.8 places per member of staff in 1996 due to the implementation of the Children Act 1989. This law recommends a minimum ratio of 1:8 staff (including parents to children). Most playgroup leaders are trained by the Pre-school Learning Alliance and many also hold teaching and nursery care qualifications. At least half the staff team should hold a relevant qualification.

Fees

LA playgroups are financed through the welfare system. Independent playgroups are financed through parents' fees and premises may be provided by the local authority. Some independent play groups may also receive local authority grants. Most playgroups also undertake fund raising activities. Parents pay fees for the use of playgroups. Hourly costs average £0.50 in LA playgroups and £0.80 in those provided by the private for-profit sector. Many playgroups offer places free of charge to children with special needs, paid for either by the playgroup or the Social Services Department.

Regulation

Playgroups are part of the range of services which local authorities must include in their 3-year plans. Both LA and independent playgroups must conform to national and local authority standards and be registered and inspected by the Social Services Inspectorate once every year.

Family day carers (Child minders)

Admission

Family day carers, or child minders as they are called in England, are mainly self-employed women who provide care for children in their own home. Some child minders are employed by Social Services Departments to provide for children in need. Around a third work part-time. Public policy is that next to parents and family members, child minders provide one of the most suitable care forms for younger children in that care is provided in a homelike setting. Some local authorities offer training or lend toys to family day carers but the arrangement is basically private and negotiated between parents and child minder, who must, however, register with the local authority. The main admission criterion is the parents' ability to pay. Most child minders take children aged from a few weeks old to 5 and some take children up to 8 years. Due to the principle of part-time provision in the nursery education, many child minders perform an invaluable service in taking children from one service to another, e.g. to and from play-groups or nursery school.

Coverage and provision

The number of registered child minders has doubled in the last 15 years which partly reflects a real increase, and is partly due to changes in registration standards. Most child minders are self-employed but a few are subsidised or salaried by Social Services Departments. Their number has fluctuated over the years and currently they make up less than 1% of all child minders, caring for 2,300 children. Places have more than trebled in the same period. Places make up twice the number of places in day nurseries and child minders are thus the most substantial care form for children aged under 5. Currently, nearly 12 out of 100 children are cared for by a child minder compared to 3.4 in 100 children in 1982 (Table 7.4).

Table 7.4.
Family day care, number and per cent of FTE children (aged 0-4) according to age and provider and children (FTE) per 1 staff (FTE), 1982-1996.

Year	Number of children (FTE)		%		Staff ratio
		% of children aged 0-4	Local authorities	Independent	
1982	98,495	3.41	2.41	97.59	2.23
1983	106,429	3.62	2.05	97.95	2.22
1984	116,331	3.94	1.93	98.07	2.19
1985	126,847	4.27	0.94	99.06	2.17
1986	137,732	4.59	1.12	98.88	2.15
1987	150,643	4.95	1.19	98.81	2.18
1988	163,700	5.28	1.01	98.99	2.19
1989	186,356	5.91	1.04	98.96	2.22
1990	205,567	6.45	0.92	99.08	2.21
1991	233,258	7.20	0.78	99.22	2.20
1992	254,300	7.79	0.87	99.13	2.33
1993	300,800	9.27	1.56	98.44	3.45
1994	357,500	11.05	0.59	99.41	3.72
1995	373,600	11.66	0.51	99.49	3.85
1996	376,200	11.96	0.61	99.39	3.67

Source: DoH: Children's Day Care Facilities (annual publication).
Note: 1 enrolled child = 1 FTE child. The staff ratio is for LA and independent family day care.

Fees

Most child minding is based on contractual agreements between parents and child minder and fees therefore vary. The only subsidised costs are where the local authority use child minders for children considered to be in need where fees

are subsequently often waived. Most child minders are paid £1.30 an hour (OPCS, 1994).

Standards

Child minders provide full day care from 8.00 a.m. to 6.00 p.m. but most child minders take children part-time if the parents wish this. Care is provided all through the year, except for public holidays and a summer holiday of 2 weeks. Child minders should care for no more than 3 children aged under 5, including their own children. If the child minder also cares for school children she can take as many as 6 children, so long as no more than 3 children are aged under 5. Average number of children per child minder has increased since 1982, to 3.7 in 1996 (Table 7.4). A child minder can employ an assistant and take in extra children with the same adult:child ratios applying (National Childrens' Bureau, 1995).

When registering a child minder, the LA must consider whether she is fit to provide care. This includes previous experience of looking after children; the ability to provide warm and consistent care; knowledge of and a positive attitude to multi-cultural and racial issues; commitment and ability to treat children as individuals and with equal concern; physical health, mental stability, integrity and flexibility; and a qualification or training in childcare, early education or other relevant caring activities. In some local authorities, child minders are required to sign a declaration concerning equal opportunities and/or physical punishment. Local authorities are under a general rule obliged to provide training, advice, guidance and counselling to anyone caring for children or accompanying them whilst they are in day care which includes child minders. However, there are no formal training requirements, although some local authorities require attendance at a course of preparatory training and child minders can now gain a National Vocational Qualification (NVQ) in Child Care and Education. Child minders rarely get paid during sick leave and only 34% have a paid holiday (Daycare Trust, 1997c).

Regulation

All child minders caring for children more than 2 hours a day for payment must be approved by the local authority as being a person 'fit to care' according to the above criteria. New child minders must be registered and are subject to an annual inspection. The child minder is notified in advance of the visit and pays a fee of £12.50 to the local authority both to apply for registration and for annual inspection. Child minding is included in the review of day care which every local authority must carry out every year, on the extent to which services of child minders are available as part of the provision provided by other than local authorities.

Family centres

A number of day nurseries work with the whole family rather than provide day care for children only. These are known as family centres. The term covers self-help centres which have evolved from voluntary play groups, centres provided by local educational authorities, voluntary sector facilities with a community focus, Social Service department centres and publically funded therapeutic centres. By 1996, approximately 510 such centres were providing for children and their families (Department of Health, 1997a).

Nannies and mother's helps

Some children are cared for by a nanny or a mother's help. Nannies usually have a child care qualification. Nannies may live with the employer or separately. Some may be shared between families. Nannies are exempt from registration if they look after the children of one or two families but must be registered by the SSD if they care for 3 children or more. The average hourly wage is £1.65. Mother's helps usually do housework as well as child minding. They mainly live separately and rarely have child care qualifications. The salary is often lower than that of nannies, at £1.40 per hour on average. In a survey of child care provision, only 1.5% of children were cared for by a nanny or a mothers' help (OPCS, 1994).

Parent and toddler groups

Voluntary organizations and community groups often arrange for mothers with children to meet with other parents and children. They typically meet in community or church halls for up to two hours, one afternoon a week. There is usually an organiser who arranges the sessions and organises fund raising. Parents pay fees towards rent and refreshment. Some groups in bigger city areas offer care and play opportunities in parks, such as the One O'Clock groups in the parks of London.

Play buses, toy libraries

Play buses are special buses converted to accommodate toys and equipment for small playgroups or parent and toddler groups. They mainly operate in rural areas or inner city areas where there are no permanent or registered services. Toy libraries lend toys and play equipment. They were originally set up for parents of children with special needs, but are increasingly available for child minders and playgroups also. They are run by parents, local Health or Social Services Departments.

Workplace care

Some employers set up day nurseries for their employees to use. This is not, however, favoured by the tax system as employers' subsidies to nurseries are

assessed as taxable benefits to higher paid employees earning more than £8,500. Employees using work place facilities thus pay on average an extra £700-£1,000 in tax. Work place facilities are not widespread; in 1990, 3% of employers provided some form of child care service while 2% were offering child care allowances.

In 1995, there were approximately 561 employer-sponsored day nurseries. One fourth were provided by universities, one fifth by hospitals while one in six public or semi-public providers were government departments and local authorities. Banks provided 14% of total employer-sponsored day care and the retail industry 5%, while in 2% the provider was unknown. In all, 9,424 children were in employer-sponsored day care, less than 1% of children under 5 years. One out of every 3 places was allocated to an under 2 year old. These types of arrangements are particularly widespread in London and South East England (Working for Childcare, 1995).

Another recent development, pioneered by the Childminding-in Business! Ltd, is the establishment by employers of a Childminding Network in which family day carers offer places to local employers. The family day carer is provided with training and they are linked together for mutual support and assistance in the event of illness.

7.6.6. Public and private provision of day care under the education system

Within the ***education*** system local education authorities (LEA) provide pre-school education for children under the statutory school age of 5 years. This includes nursery education in nursery schools or classes for the 2-4-year-olds and reception classes in primary schools mainly for the 4-year-olds. Independent schools also provide for some 3 and 4-year-olds in reception classes. From September 1998, all children aged 4 years should be guaranteed a place in nursery education or reception classes.

Nursery schools and nursery classes

The law does not oblige the LEA to make educational provision for children aged under 5 generally available. However, the LEA has a duty to ensure that appropriate provision is made for children aged between 2 and 5 who are identified as having special needs, although this may not be LEA provision. The aim is to further children's emotional, social, physical and cognitive development, complementing the learning that takes place in the home. It is not intended to provide care for choldren of working parents.

Admission

Admission to LEA nursery schools and nursery classes is governed by criteria defined by each school on their basis of local admission policies. The criteria may include the child's educational and psychological needs, where he or she lives and whether there are siblings attending the school. Services are provided by the Department of Education and Employment and the independant sector and are mainly for 3-4 year olds, although some 2 year olds are also admitted.

Nursery classes and nursery schools are in principle organised as different systems. The two systems care for the same age groups and have the same regulations but whereas nursery classes are in facilities which are part of the primary schooling system, nursery schools are separate schools and have their own legal identity and head teacher. They have different staff ratios - higher in nursery schools – and another difference is that 2 year olds are sometimes admitted to nursery schools.

Coverage and provision

Although nursery school and classes are the responsibility of the LEA, children can be enrolled in private schools. A survey showed that of the children attending nursery schools in 1994, 45% were in publicly provided schools and the rest in private provision. This may change once the guarantee to provide places for all 4-year-olds is introduced in September 1998. Private nursery schools have agreed to take a number of 4-year-olds on payment of £1,100 per year which will be covered by the LEAs. In nursery classes, the rate of children in publically provided nursing classes is much higher, with 85% of children attending nursery classes run by the LEA.

Often children attend less than the whole week. From the early 1980s, the change in the number of full-timers became apparent and currently nine out of ten children use nursery classes only on a part-time basis. In nursery schools, children more often attend full-time - 30% attend both morning and afternoon and the rest attend mainly mornings.

Nursery school provision is however relatively low, less than 1% of the 0-4 years in full-time places, more or less the same level as in 1982. Full-time provision in nursery classes is relatively higher, 3.2% of children in 1982, rising to 4,5% in 1996 (Tables 7.5 and 7.6).

Table 7.5.
LEA nursery schools, number and per cent of FTE children (aged 0-4) according to age and children (FTE) per 1 staff (FTE), 1982-1996.

Year	Number of children (FTE)	% of children aged 0-4	Staff ratio
1982	26,271	0.91	16.82
1983	26,192	0.89	16.81
1984	25,914	0.88	16.71
1985	25,873	0.87	16.47
1986	25,735	0.86	16.42
1987	25,688	0.84	16.44
1988	25,678	0.83	16.24
1989	25,750	0.82	16.30
1990	26,119	0.82	16.23
1991	26,211	0.81	16.01
1992	26,104	0.80	15.99
1993	26,354	0.81	16.04
1994	25,845	0.80	16.37
1995	25,800	0.81	16.33
1996	25,459	0.81	16.03

Source: DfEE: Pupils under 5 years in each LEA authority in England. Statistical bulletin (annual publication).
Note: 1 enrolled full-time child = 0.83 FTE child.1 enrolled part-time child = 0.42 FTE child.

Table 7.6.
LEA nursery classes, number and per cent of FTE children (aged 0-4) according to age, 1982-1996.

Year	Number of children (FTE)	%
1982	91,814	3.18
1983	96,331	3.27
1984	100,481	3.40
1985	103,770	3.49
1986	105,920	3.53
1987	107,357	3.53
1988	110,873	3.58
1989	114,749	3.64
1990	118,741	3.72
1991	123,012	3.80
1992	..	..
1993	131,705	4.06
1994	134,809	4.17
1995	138,735	4.33
1996	142,726	4.54

Source: DfEE: Pupils under 5 years in each LEA authority in England. Statistical bulletin (annual publication).
Note: 1 enrolled full-time child = 0.83 FTE child. 1 enrolled part-time child = 0.42 FTE child.

Waiting lists

Most children are able to start nursery education when their parents wish them to. Around 2/3 of nursery class and nursery school attenders thus started when their parents wanted, for the remaining third the average waiting time was 24 weeks for nursery schools and 26 weeks for nursery classes but nearly one out of three in this group had to wait for a least a year to be admitted (OPCS, 1996).

Standards

Both LEA and independent nursery schools and nursery classes are normally open five days a week from 9.00-11.30 and 1.30-3.00 during term time and closed during school holidays. Each session lasts 2½ hours. Full-time children may have lunch at the premises.

Children may be divided into groups according to age. The Children Act 1989 recommends a minimum of two adults per 20 children in nursery schools and two adults per 26 children in nursery classes, one being a qualified teacher and the other a qualified nursery assistant.

In nursery schools, average group size is 22 children but this may differ whether it is a public or private provider. On average there are 27 children in nursery schools run by the LEA and 17 children in nursery schools run by private agents. The average number of children in nursery classes, private as well as public, is slightly higher, 24 children, with on average 25 children in LEA nursery classes and 12 in private nursery classes.

Staff mainly consist of nursery teachers and nursery nurses. To qualify as a nursery teacher a degree is required, whereas nursery nurses must hold the National Vocational Qualification level 2/3 which is a two-year post-16 training course.

There are no specific regulations for a nursery curriculum except that at least 12 hours of suitable activities must be provided during every half day session on which a school or class meets (Eurydice, 1995). The management and staff of each institution therefore jointly determine the programme of activities. Children will most often be introduced to words, books and science but not through formal teaching. Children are also encouraged to participate in creative artwork, messy play, music and dance. In private nursery schools there may be more emphasis on a formal educational approach. Nursery schools undertake educational activities and problem solving a little more often than nursery classes. Most children are taken on outings, do sporting activities or play outside (OPCS, 1994).

Fees

General funding for nursery schools and nursery classes is subsidized by central and local government. No fees are charged although parents pay for meals.

Daily administration

Nursery classes are usually managed as part of primary schools by a governing body that includes parents. Parents of nursery class children are sometimes involved in class room activities and fund raising. Nursery schools are not required to have a governing body, although some LEAs do establish them and have places for elected parent representatives.

Regulation

Inspection of LEA premises is carried out by OFSTED, a regulatory body under the Department of Education and Employment every four years. Registered Nursery Inspectors inspect private and voluntary providers of early education premises.

Reception classes

By law, children must begin in school in the term following their fifth birthday and LEAs are not obliged to provide for children under this age. However, many LEAs admit children into reception classes in the year following their fourth birthday. Sometimes children aged 3 are also admitted. Any child in the school catchment area is eligible to be admitted. The LEA together with the school decides the policy for admission of under 5s. Policies thus vary and whereas some children are admitted as 'rising fives' in the term they reach the age of five, other schools have only a once-yearly admission. Independent schools also admit under 5s. Here, the main admission criterion is the ability to pay.

Coverage and delivery

Most children in reception classes are in schools maintained by the LEA. Only a small proportion of children are in independent schools, 4% of the 3 and 4 year olds compared to the 25% of this age group attending public reception classes. But 80% of the new places created to fulfil the guarantee of places for all 4-year-olds from September 1998 are in reception classes and primary schools and this will undoubtedly stimulate independent sector provision.

The number of places for children aged 3 and 4 in LEA reception classes has increased by 150,000 full-time places since 1982. The increase has taken place mainly in full-time care, where places increased by 44% and today most children are in full-time places, 91% in all in 1996.

The expansion of the number of children in LEA maintained reception classes has mainly taken place among 4-year-olds. More than 340,000 children among the 4 years olds attend reception classes in 1996, an increase of 72% since 1982. In comparison, only 1,416 among the 3 year olds attended reception classes in 1996, more or less the same number as in 1982. A number of reasons have led to the increase among the 4 year olds, such as falling primary schools

rolls in the early 1980s, but also because it is a less expensive day care provision than nursery schools due to lower staff ratios (National Childrens Bureau, 1996).

In 1982, nearly 8 out of 100 children aged 0-4 years attended reception classes, when measured in full-time places. By 1996, the number had gone up to 12 out of 100 children (Table 7.7).

Table 7.7.
Reception classes, number and per cent of FTE children (aged 0-4) according to age and provider, 1982-1996.

Year	Number of children (FTE)	% of children aged 0-4	% Local authorities	Independent
1982	219,967	7.61	88.28	11.72
1983	226,403	7.69	89.19	10.81
1984	254,044	8.60	89.94	10.06
1985	263,447	8.86	89.69	10.31
1986	255,131	8.50	88.86	11.14
1987	261,539	8.59	88.58	11.42
1988	269,648	8.70	88.18	11.82
1989	275,971	8.75	87.50	12.50
1990	294,897	9.25	87.74	12.26
1991	309,549	9.56	87.93	12.07
1992	..	..	..	..
1993	342,395	10.55	88.46	11.54
1994	353,723	10.93	88.65	11.35
1995	370,818	11.57	88.67	11.33
1996	369,468	11.74	89.16	10.84

Source: DfEE: Pupils under 5 years in each LEA authority in England. Statistical Bulletin (annual publication). DfEE: Pupils under 5 years in independent schools in England. Statistical bulletin (annual publication).
Note: 1 enrolled full-time child = 1 FTE child. 1 enrolled part-time child = 0.5 FTE child.

Fees

In maintained schools, the LEA covers the costs with funding from central government. Parents must pay for meals and for the school uniform. Some parents are involved in fundraising for extra school equipment. Independent schools charge fees for providing education, varying from £400 to more than £800 a term (OPCS, 1994).

Standards

School hours are generally from 9.00 to 15.30 with a supervised lunch time break and classes are open during school terms, 40 weeks a year. Part-timers attend for three hours a day in the morning or afternoon.

Deregulation of space requirements in 1996 has resulted in more crowded classrooms. Today, group sizes are on average 26 children, somewhat lower in independent schools with 17 children per group compared to 27 in maintained schools (OPCS, 1994).

Staff consist of primary teachers with a Qualified Teacher Status (QTS) which is usually gained through a four-year post-18 degree course. Staff may also consist of teaching assistants or nursery nurses with NNEB/NVQ level 3 training. Regulations governing standards of adult per children are less favourable compared to the ones applied in nursery schools and nursery classes as there is no official recommended ratio of staff to children. One adult per 20 or 30 children is the normal standard, not including other adults in the classroom such as paid helpers and parent volunteers. This has created some debate whether this is suitable for the increasing participation of 4-year-olds and also for 3-year-olds. The curriculum has mainly been directed at achieving 'desirable outcomes' whereby children should achieve a certain educational outcome. The intake of younger children from September 1998 has led to criticism that this curriculum may be ill-suited for younger children.

Regulation

In maintained schools inspection is carried out by OFSTED, the inspection unit under the Department of Education and Employment, on a four year cycle. In independent schools, Her Majesty's Inspectorate of Schools visits at intervals of between 5 and 7 years.

7.6.7. Public facilitation of private or informal day care

Abolition of voucher scheme

The voucher scheme for the use of independent nursery education was to have been implemented in 1997. The scheme covered children aged 4 whose parents were to be given a voucher which would be exchangeable for a half day of day care. The voucher would allow access to institutions such as LA schools, private nursery schools, play groups, LA day nurseries and child minders who formed themselves into a group. Parents would be able to top up the value of the voucher in private establishments but not in state schools. Due to criticism of the inadequacy of the scheme, the new Labour government chose to abolish it and replace it with the guarantee for an early years education place for all 4-year-olds.

Child care disregard

In October 1994, a Child Care Disregard (CCD) was introduced for recipients of Family Credit, Disability Working Allowance, Housing Benefit and Council Tax Benefit. CCD was implemented in order to improve work incentive. Rules allow

certain formal child care costs up to a maximum of £60 a week per family to be offset against net earnings in the calculations of these benefits. From Summer 1998, this amount has been raised to £100 a week for families with two children under 12 years. Lone parents are the main beneficiary of CCD although married couples can qualify under certain conditions. Students and trainees cannot claim CCD. There were 706,420 recipients on Family Credit but only 27,060 of these families received CCD in 1996. The average award was £18.71 a week (Daycare Trust, 1997b). In 1999, the disregard will be replaced by the following tax allowances.

Tax allowances

A tax concession is available for single parents; not for the specific use of day care but to compensate for meeting the expenses of having children as a sole provider. For two-parent families there are presently no tax concessions available for the costs of day care, except for a tax relief for employees who pay for a place in workplace nurseries, but only if the employer is wholly or partly financing the facility.

However, the Blair Government has recently announced a new *Childcare Tax Credit* to come into operation from October 1999. The credit will cover 70% of the first £100 of childcare costs up to a limit of £100 for families with one child, if parents earn less than £14,000 annually. Parents with two children in childcare who earn less than £17,000 will be able to recoup 70% of the first £150 of costs. In comparison, the AWP income for a family with two children was £19,152 in 1996.

For parents in employment, the *Working Parent Families Tax Credit* may apply. This covers also middle-income families, including parents with one child earning up to £22,000 and those with two children earning as much as £30,000 a year. For example: a couple earning £450 a week with two children could receive £45 a week. This includes both single parents and couples. Both must be working: single parents for 16 hours a week at least and paying for the care of a child aged under 11. Couples must also both be working 16 hours a week or more. Both tax allowances will come into operation in 1999 and will replace the Child Care Disregard system.

Family Credit deduction

When applying for Family Credit, low income families can deduct a maximum of £70 per week which can be used for purchase of regulated day care facilities.

Home Responsibilities Protection (HRP)

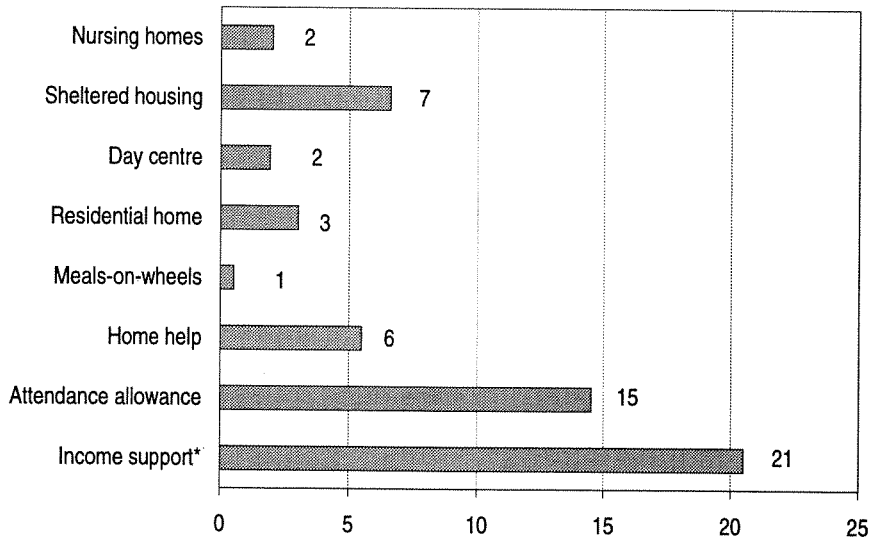
Parents who stay at home to take care of their children may lose out in not being able to contribute to a pension scheme. The HRP scheme is intended to alleviate the situation for this group of parents. It helps protect people's rights to state pension if they take time away from work to stay at home to look after children – or care for someone who is ill or disabled. Recipients of Child Benefit and Income Support get HRP automatically.

7.7. Older people

7.7.1. Introduction – Main social services and care cash benefits for older people

With the encouragement to contract-out services to the independent sector, services for older people are increasingly provided by voluntary and private agencies under contract with local authorities. This includes domiciliary services where the *Home help* is the most important source of care. Home help services are mainly provided to frail and very old people who need help with personal care but help is also given with domestic tasks. Most older people also receive *care from a spouse, children or other relatives.* Informal care is supported by different care allowances, such as *Invalid Care Allowance* which compensates the carer for loss of income and *Home Responsibility Protection*, which protects the carer's pension rights. A number of older people receive *Attendance Allowance* which can be used to pay informal carers also. Institutional care is provided by the public sector, the private for-profit sector and the voluntary sector. Two forms of residential services exist: *Nursing homes* and *Residential care homes*, with the former serving as a medical alternative to hospital care. Almost all nursing homes are in the private or voluntary sector, whereas a greater number of residential homes are run by local authorities. Despite the policy of enabling older people to remain in their own homes, institutional care has been the fastest growing sector in the last decade due to public subsidies to private, for-profit residential care providers. As an alternative to residential care, *Sheltered housing* offers older people an opportunity to live in specially designed accommodation. Where housing is poor different *Improvement grants and loans* may help older people to remain in their own homes (Figure 7.9).

Figure 7.9.
Use of main social services, older people (65+) as a percentage of age-group, 1996.



Source: DOH, Community Care Statistics: Day and Domiciliary Personal Social Services for Adults 1996. Statistical bulletin. Residential accommodation statistics: Personal social services - residential care homes and supported residents in England 1996. Statistical bulletin. DoH (1998): Personal communication. Social Security Statistics 1997.

Note: * Only for old people. Data (recipients and population) for cash benefits are for Great Britain.

7.7.2. Main objectives of care policies for older people

For the last 40 years, community care has been the main policy objective underpinning care of older people. Community care does not, however, only mean providing domestic care in the home of the older person; more and more the term has come to include residential and nursing home care also, but not long-stay care in hospitals. Furthermore, the meaning of community care has changed away from the sense that services are provided directly by the public sector. Moving from care in the community to care by the community, policies have promoted an increasing role for the non-statutory sectors, i.e. the voluntary or for-profit sectors and the family. The latest reforms of the community care programmes, have strengthened this emphasis through the focus on efficiency in resource use. Local authorities should act as enablers and should make use "whenever possible of services from voluntary,'not-for-profit' and private providers insofar as this represents a cost effective care choice" (Department of Health, 1989a). The responsibility for funding residential and nursing care now lies with local authorities and 85% of the funding from the Department of Social Security

must be spent on the independent sector. Private and voluntary residential home places and home help services have accordingly exploded in number, often delivering on a contractual basis. The NHS and Community Care Act 1989 also aimed to achieve better quality of care. Instead of being provider-led, services should reflect users' needs and become needs-led services. To improve quality, changes in policies have included the introduction of a more efficient registration system and inspection of both publicly and independently provided services. The reforms also recognise that informal carers should not bear the full care burden so that the local authorities must 'ensure that service providers make practical support for carers a high priority' (Department of Health, 1989a). This now includes an entitlement for carers to be needs assessed in their own right when the person they care for is assessed. As expressed in the preceding White Paper, policies for older people should further normalisation, independence and greater user involvement in the following ways:

- 'to enable people *to live as normal a life* in their own homes or in a homely environment in the local community';
- 'to provide the right amount of care and support *to help people achieve maximum possible independence* and, by acquiring or re-acquiring basic living skills, help them to *achieve their full potential*';
- 'to give people a *greater individual say* in how they live their lives and the services they need to help them to do so.' (Department of Health, 1989a).

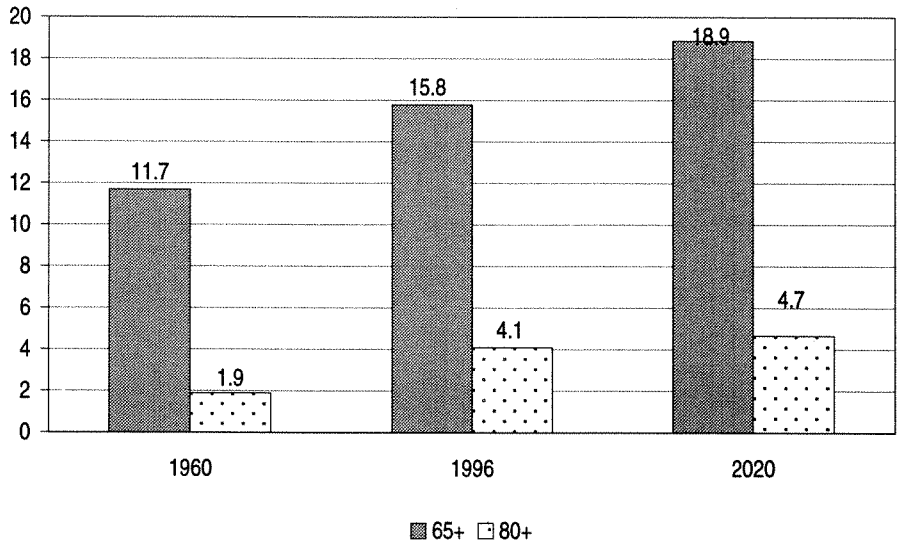
Concern over lack of integration between services means that health and social services must be developed, purchased and commissioned jointly. As the principal guarantee of a common approach, care managers have responsibility for assessing need and designing individual care packages. Services should be allocated according to need and are in many cases allocated also on the availability of informal help, financially as well as practically. However, allocation of resources increasingly focuses on the very old with the greatest needs. Concern over the shortage of resources and the huge variation in local supply has therefore been voiced. Local authorities must now produce annual community care plans and community care charters for the development of community care within their areas against which their performance and standards can be monitored and assessed.

7.7.3. The need for care services

The need for community care is rising as the population grows older and the older population becomes larger. Compared to other countries, England has however experienced a relatively slow process of ageing. From constituting 12%

of the total population in 1960, people aged over 65 in 1996 made up 16%, or nearly 10 m The very old aged 80 or over represent 2 m or 4.1% of the whole population. Life expectancy has increased over the years partly because of improved living standards and currently stands at 74.2 years for men and 79.4 years for women. In the next 20 years, the proportion of older people will show only a small increase and older people aged 65 and over compared to the rest of the population will be around one fifth in 2020 (Figure 7.10).

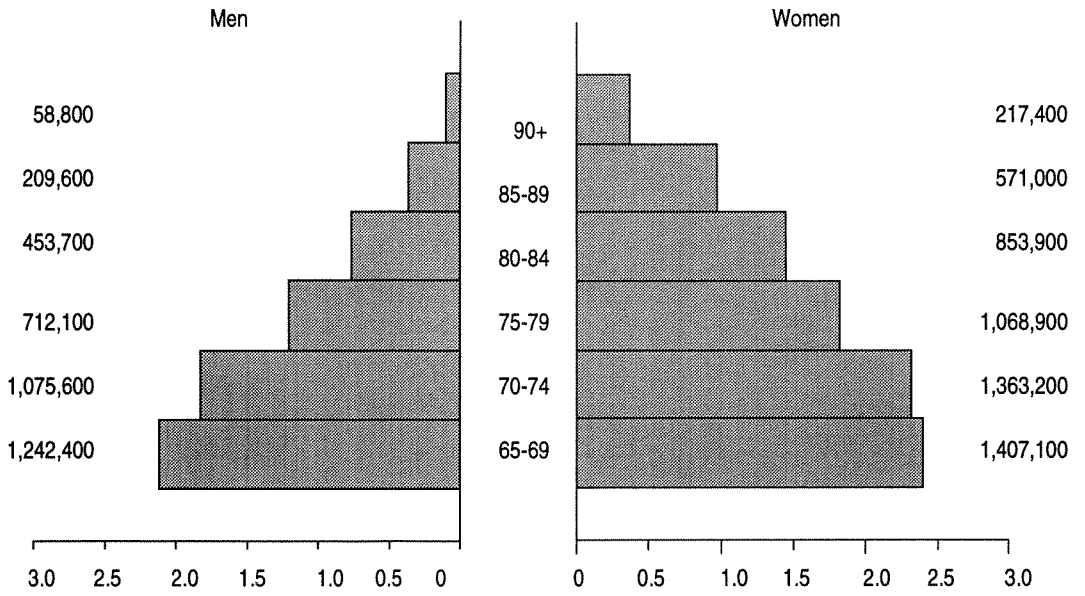
Figure 7.10.
Older people (65+) as a percentage of the population, 1960-2020.



Source: ONS (1998): Personal communication. EUROSTAT (1997): Demographic statistics 1997.
Note: Data for 1960 and 2020 is for the United Kingdom.

Women make up most of the older population. Of those aged 65 and over, 59% are women and this percentage increases with age, so that among those aged over 80 nearly 70% are women (Figure 7.11). Women tend to live alone more than men, mainly because of their higher average age. Whereas slightly over 3% of older men aged over pensionable age live alone, as many as 12% of women in this group live alone. Some older people live with their children, slightly more men than women, with 7.8% of men aged over 65 and 6.5% of women living with their children (ONS, 1997, and own calculations).

Figure 7.11.
Age pyramid of the older people (65+) as a percentage of the population, 1996, England.



Source: ONS (1998): Personal communication.

A number of older people are therefore looked after by their children living with them; other older people live on their own but still receive help from family members. In general, more older people receive help from informal sources than via public support (Table 7.8). In the latest survey of carers in UK it was estimated that 5% of adults look after parents, and as many as 1.7 m are involved in care for more than 20 hours a week (ONS, 1998b). The contact with family members is thus high, and one in five older people say that they are in contact with family members every day, whereas nearly half are in contact with them once a week or more. Another one in five say that they are in contact with their family once or twice a month or less (Andersson, 1993).

Table 7.8.
Who provides help with domestic and personal care for older people (65+), sources of help in per cent , 1991.

Provider	Tasks	
	Domestic	Personal care
Spouse	28	34
Child	45	40
Other relatives	19	14
Friends or neighbours	15	13
NHS or personal social services/Home help	23	15
No-one	1	8
Other	16	7

Source: Derived from GHS, 1991.
Note: Base: UK=883. Some older people are helped by more than one helper and percentages may add to more than 100. Provision of help with locomotive and self-care tasks (getting around, out of bed, washing, feeding, dressing, etc.) Survey from United Kingdom.

Availability of informal care is, however, at least partly dependent on the strength of family ties. High divorce rates, coupled with an increasing number of women in paid employment and a lower fertility rate challenges the potential reliance on children and spouses for care and support in old age. The majority of informal carers are women, although a number of men also provide help for older people, especially spouses. Nearly 40% of women in employment work part-time and this obviously facilitates informal care. Many women are, however, in a situation where they may have responsibility for young children or grandchildren also. Female carers tend to be aged between 45-64, which is also the age group which often has caring responsibilities for both children and older people and they are often referred to as the 'the sandwich generation'. The informal care pool[5)] in England is the lowest among the 7 countries in this study with 1.22 women aged between 45 and 69 per person aged 70 years or over. Next to children, spouses are the most important source of help, but divorce rates are likely to increase for future older people if the pattern which is predominant today persists. Care provided by spouses may thus be a less reliant source of help in the future.

The need for care is often related to age and to the degree of frailty; more of the younger than older elderly population are thus able to perform household tasks and look after themselves. A survey among 65-year-olds showed that around one

5) Women 45-69 as proportion of population 70+.

in ten had problems getting out, walking down the road and/or using stairs, whereas between 1 and 2% experienced problems with moving around indoors. One in twenty had problems washing all over or getting dressed and 1% were unable to feed themselves. However, household tasks are often a greater challenge, and one in five older people reported that they were unable to go shopping on their own and one in ten could not hoover by themselves. In all, 7% of those aged 65 and over reported that they were unable to do at least one self-locomotive or self-care task, whereas this increased to 23% of those aged 75 or older (GHS, 1991). Recent General Household Survey data does, however, suggest that there has been a decrease in the proportion requiring help with locomotive, self-care or most aspects of domestic work (ONS, 1998b).

Besides the ability to perform tasks in the home and disability levels, housing situation is often amongst the factors which determine the need for care and whether an older person can remain in his or her own home. However, older people are in general more likely to live in housing without amenities such as central heating and an indoor toilet. Although 75-year-olds and over only make up 10% of all households, they occupy nearly a third of dwellings without these amenities, and 16% of unfit dwellings (McGlone, 1992).

7.7.4. Domiciliary care

Home help

Local authorities may provide or arrange the provision of domiciliary help in order to allow people to continue living in their own home as independently as possible, and the help provided in the home by a home help or care attendant is one of the most important sources of care for many older people. From being primarily a service for maternity care, home help nowadays mainly caters for older people, with 87% of home help provision going to this group. A home help may carry out domestic tasks such as cleaning, cooking and washing; personal tasks like dressing, washing and feeding clients; or social duties such as talking, assisting in social contacts, or assisting with shopping or recreation. In many local authorities the home help has been redesignated as 'home care services', thus putting emphasis on personal care. Day and night attendants are also available, either through Social Service Departments or voluntary organisations such as Crossroads, for those needing special attention because they have just come out of hospital or to provide relief for carers.

Assessment

Local authorities must make an assessment of need for care if so requested by an older person or carers. Assessment for social services would usually be undertaken by a social worker while an assessment for health would usually be made by their doctor, the General Practitioner, or if the older person is in a

hospital, by hospital staff. When assessing, older people's health, their ability to do self-locomotive, self-care and household tasks are examined. Assessments should take into account the preferences of the older person and the carer, and must review the possibility of remaining in the home. The NHS and Community Care Act states that assessment must be needs-led. The final allocation of resources and the decision as to who should provide the services lies with the Home Care Team or a care manager, who determines the right package of care. Since 1990, local authorities have been obliged to arrange annual health checks for people aged over 75 and the need for home help or other services is assessed as part of the visit. The availability of informal care may determine whether an older person is awarded home help services but the recent Carers (Recognition) Act should ensure that the assessment takes into account whether the carer needs assistance also. A recent House of Lords ruling has determined that local authorities may take into account an older person's financial means when assessing the need for home help services. Wealthy older people may thus be denied public services and be referred to private providers instead where admission depends on the ability to pay.

Provision

Home help services may be provided directly by local authorities or by an independent agency under contract, either in the voluntary or private sector. Provision has changed from being nearly entirely publicly provided to include more private for-profit services which are delivered under contract with the municipality. Such provision has increased from 1.6% of recipients of home help in 1992 to 19% in 1996. Voluntary provision has risen slightly less, from less than 1% of provision in 1992 to 3.5% in 1996 (Table 7.9). However, the LA still provides the bulk of services. The changes reflect the statutory requirement to spend a minimum of 85% of the transfer grant in the independent sector.

Private for-profit services which are not contracted to the LA do not form part of public statistics. Surveys do, however, estimate that such services are used by 4% of those aged over 65 years. Older people pay for these services privately without any compensation from the LA. Very few make use of both LA and private for-profit home help services (GHS, 1991).

Table 7.9.
Home help, number and per cent of recipients (65+) according to age and provider and staff (FTE) per 100 recipient, 1992-1996.

Year	Number of house-holds (65+)	%		Local authority	Voluntary	Private	Staff ratio
		65+	85+				
1992	476,400	6.22	18.69	97.96	0.40	1.64	12
1993	462,900	6.02	18.19	96.59	0.91	2.51	12
1994	479,800	6.23	19.24	89.41	2.17	8.42	12
1995	452,300	5.85	18.36	82.60	2.76	14.64	13
1996	427,800	5.52	16.91	77.14	3.55	19.31	..

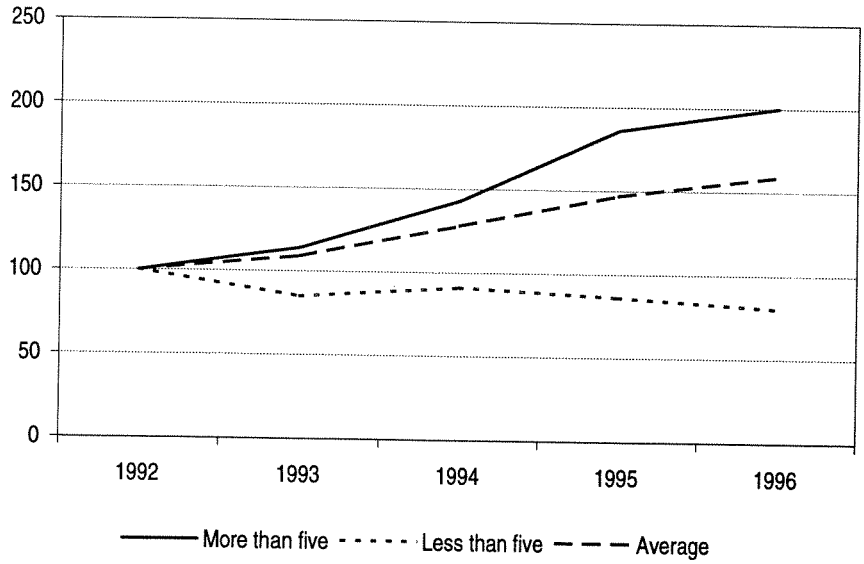
Source: DoH: Community Care Statistics: Day and Domiciliary Personal Social Services for Adults 1996. Statistical bulletin. DoH: Local Authority Social Services Statistics – Staff of Local Authority Social Services Departments 1992 & 1995, England.

Coverage

Overall, fewer older people currently receive services, and home help services are increasingly reserved for the very old. The number of households aged 65 and over receiving services has declined from 476,400 households in 1992 to 427,800 households in 1996 (Department of Health, 1997b). Among these aged 85 and over, one in six receive home help services, a decline from nearly one in five in 1992. The service level has fallen less sharply among 75-84 age group where nearly 9% in 1992 received the service compared to 7.5% today. Among those aged 65-74, provision has declined from 3% of the age group to 2.5%. In all, 5,5% of the 65+ received home help services in 1996 compared to 6.2% in 1992. Dissatisfaction amongst users is obviously higher among the younger older people; in a 1992 survey one in four of those aged 65-74 compared to one in ten of those aged 75 and over said that they needed a home help service which they were not getting (OPCS, 1992).

The changes in the intensity of provision also clearly show that services are targeted towards a certain group of users. The needs assessment to determine who should receive help has been tightened in many municipalities and some have withdrawn shopping and cleaning from the services provided (Phelps 1997). Instead, more home help is provided, concentrating on personal care for the frail older people. Contact hours have increased from 1.7 m hours in 1992 to 2.5 m hours in 1996 (Department of Health, 1997b). The distribution of hours reveals that more households receive 5 hours or more a week while the proportion of households receiving less than 5 hours has declined (Figure 7.12). With the number of households receiving services falling and the number of contact hours increasing, the average number of weekly hours per household has increased from 3.2 in 1992 to 5 in 1996 (Department of Health, 1997b).

Figure 7.12.
Home help, distribution of weekly hours among recipients (65+), 1992-1996.



Source: DoH: Community Care Statistics: Day and Domiciliary Personal Social Services for Adults 1996. Statistical bulletin.

Fees

There is no national level of charges, and whether or not to charge for services is at the discretion of local authorities. In the near future, there will be issued a guidance on factors to take into account when means-testing. In the absence of any national framework for determining charges, there is wide local variation in charges. Most local authorities do apply charges, either as flat-rate payments or according to means, often using different charging bands. If an older person has problems paying the charge the Social Service Department must consider the charges and reduce or waive them. But local authorities are not required to take specific account of the costs of the service. A survey of charging principles found that cleaning and other domestic services were charged more often than previously and that there was a move away from no charges and flat rating to means testing. Also, welfare benefits such as Attendance Allowance for carers were increasingly treated as income to be drawn on for payment for charges (Balloch, 1994).

The proportion of spending on home help services recouped from user charges has risen steadily in the last 15 years. Many local authorities have reacted to fiscal pressure by imposing charges, and in the 1980s this was done particularly in Labour constituencies (Bennington & Davies, 1993). But within the last years

there has been a dramatic growth in both the number of local authorities imposing charges as well as in the level of charges (Phelps, 1997). Fees as a proportion of total expenditure have remained at 7% in the period 1986-94 but has increased to 8.4% in 1995. Average weekly fee has gone up from £11.70 to £24,70 (Department of Health, 1997c); some of this increase is, however, explained by the targeting of resources. Most recipients today receive more hours than previously.

Standards

By 1995, there were nearly 57,000 full-time equivalent home help and care attendants, an increase of more than 7,000 from 1982. The ratio of staff per 100 recipients has been the same since 1992, at 13 in 1995 (Table 7.9). Territorial differences are widespread not only between urban and rural areas but also based on political complexion. Variations in the number of home helps in the London boroughs, which traditionally have been Labour constituencies are thus three times as many as in others (Walker & Warren, 1996). Training is not a strict requirement but approximately half the staff have received some form of limited training (Age Concern, 1997). The introduction of National Vocational Qualifications for care workers may gradually increase the amount of training received.

Regulation

Local authorities may at any time inspect the premises in which community care services are provided, whether directly or under arrangements made with another person. There is no registration or inspection of private providers of domiciliary care.

Daily administration

Home help are organised into home care teams which operate from a central office. Normally a Senior home help would be in charge of daily planning and operation.

Meals-on-wheels

For those older people who cannot manage to do shopping or cooking themselves, meals are provided in the home or in lunch clubs which are often located in a day centre. Most meals are provided by the LA, but voluntary organisations, such as the 'Women's Royal Voluntary Service' and the Red Cross, provide 35% of meals while 10% are provided by the private sector. A small number of meals are delivered via the National Health Services. The number of people receiving meals is around 1/4 million. Most older people receiving the service receive meals once or twice a week. On average, meals were provided for 5 in every 1,000 people aged over 65 (Department of Health, 1997b). Only 8% of meals are served at weekends. Nearly half the users are aged between 75-84, whereas one in five of those aged 65-74 make use of meals services and one in three of those

aged 85 or over. Fees in 1995 covered 43% of total expenditure (Department of Health, 1997c).

Day centres

Besides being an important focal point for social and leisure activities, day centres provide meals and facilities such as laundries. Transport to the centre is often provided by ambulance or minibus. Day centres are located within community-based social services day centres or in residential homes, and are mainly run by local authorities or voluntary organisations, e.g. Age Concern. 2/3s of places for people aged over 65 are in centres run by the LA, whereas the voluntary sector provides 31% and the private sector only 3% of all places (Department of Health, 1997b). Some centres are organised as mobile centres, servicing those living in more remote areas. Many centres provide respite care and short-time relief for relatives and others caring for an older person. A little more than 150,000 older people used day centres in 1996. Most use the day centre for two week days from morning to 3 or 4 o' clock and the centres are not open at weekends. Of the total expenditure in 1995 fees covered 6% (Department of Health, 1997c).

Sheltered housing

Since the 1960s government policy has been to encourage the building of sheltered housing units for older people, the objective being to reduce the likelihood of entry into residential care and to release large properties for families (McGlone, 1992). Sheltered housing units are provided by the local authority Housing Department or a private or voluntary housing association. The units usually consist of independent flats or small houses with some communal facilities and a resident warden. Sheltered housing operated by housing associations, but not by LAs, can apply for registration under the 1984 Registered Homes Act which gives low income tenants the right to apply for social security board and lodging payment to help pay the costs. Up to the 1980s, an increasing number of sheltered housing units were built but since then the number of completions has begun to fall. Waiting lists reflect this: over 1/4 m people in England in 1987 were waiting for a place in sheltered housing (McGlone, 1992). By 1995, more than 500,00 sheltered housing dwellings were available, although not all were servicing older people. Approximately 10% of older people were accommodated in sheltered housing, of which 4% lived in sheltered housing with a warden. Some granny annexes are available too, mainly as self-contained homes next to a family home. Hostels and group living may also accommodate older people; in these a housekeeper often provides main meals (Tinker, 1997).

Free help-lines

Telephone help lines are operated by some local authorities and voluntary groups, e.g. Help the Aged's Senior Line sponsored by British Gas, which provides a free national information service on care issues for older people, their relatives, and carers.

Adaptation to the home

In order to facilitate older people remaining in their own home for as long as possible different schemes have been set up to improve housing standards. These include improvement grants and care and repair schemes, provided by local authorities or housing associations. Housing can also be adapted to the needs of older people by installing handrails, chairlifts on stairs and grips by the bath. Care and Repair Ltd is the national coordinating body for private agency services which offer advice on adaptions and improvements. They receive 70% of their funding from central government (Tinker, 1997).

Transport

Many local authorities provide free or subsidized transportation. 'Dial-a-ride schemes and community buses operate in many areas and some voluntary organisations like Help the Aged operate services for older people using specially adapted minibuses.

Care attendance and sitting services

Relief for carers has become an increasingly common service but there are no national data on the number or use of services. Most referrals come from local authorities with services run by voluntary organisations such as Crossroads' Care Attendant Scheme.

Respite residential care

Short-term in residential and nursing homes or hospitals are provided by local authorities and the National Health Service as part of the community care strategy. 4% of older residents in residential and nursing home care were in short-term care in 1996 (Department of Health, 1997e). Costs are born by the older person or more often, the carer, whether this is a spouse or family member It is not possible to claim help towards the housing costs of a respite stay in a home.

7.7.5. Institutional care

For people who are too frail to live independently, residential care in a residential home or nursing home may be the likely alternative. Under the NHS and Community Care Act 1990, local authorities have a duty to provide accommoda

tion or to see that it is provided for people in need because of age, illness and disability. In residential care homes, accommodation, meals and personal care are provided for people who cannot manage at home. Nursing homes provide accommodation, meals and nursing care for older people who need a high level of attention because they can no longer live at home, but do not need to be in hospital.

Assessment

Local authorities are empowered to assess people and to provide funds for care in residential and nursing homes whether these are provided by the local authority or the independent sector. Assessments for institutional care must be needs-led and care management must determine the right package of care. However, the older person must be allowed to exercise as much choice as possible as to the home they enter. Local authorities have developed multi-disciplinary assessment procedures with participation of medical staff as well as social workers in deciding on admission to their own residential homes. The assessment for placement in a home, however, varies by the sector within which the home is provided. People entering independent nursing or residential homes are only assessed if they apply for financial support to cover fees. If an older person – or a relative – is capable of paying the fees without public support, their admission to independent homes depends on whether there are vacancies and the view of the person running the home.

Provision

Residential homes are provided by the public sector, the private for-profit and the voluntary sector. Local authorities are allowed to make arrangements for provision with any voluntary organisation or private individual managing a residential or nursing home. Nursing homes are predominantly provided by the independent sector, although a few homes are provided by the NHS.

Despite the policy of independent living for as long as possible, institutional care has been the fastest growing sector in England in the last decade due to public subsidies for voluntary and private, for-profit residential and nursing homes. In 1980, new social security regulations meant that older people entering a residential or nursing home in the independent sector qualified for social security benefits which covered the fees. This created what was later called a 'perverse incentive' for local authorities to admit older people to institutional care instead of providing domiciliary care, and contributed to a sharp increase in private residential care. By 1992, social security expenditure for people in residential and nursing care homes had risen to £3,739 m, from £941 m in 1982 (Department of Social Security, 1997) and 60% of older people in private for-profit or voluntary residential homes were financed by social security income support compared to

14% in 1979 and 36% in the mid-1980s (Gostick, Davies, Lawson & Salter, 1997).

Part of the growth in independently provided residential care was, however, also a reflection of an increase in the number of very old people, reductions in long-stay hospital provision and strict control over local expenditure (McGlone, 1992). Analysis using post-hoc assessment procedures indicate that only 7% could be categorised as not needing the care (OECD, 1996). After the changes in 1993, there was no longer the same incentive for local authorities to admit older people to the independently provided homes as an alternative to providing domiciliary care. Local authorities are now given responsibility for funding and commissioning all domiciliary and institutional care. Through transfer grants, central government has transferred to local authorities the resources which would otherwise have been spent on social security support for residents in the independent sector. However, local authorities are still encouraged to contract-out the provision of services, and they are required to spend at least 85% of the transfer grant in the independent sector. Today, more than 70% of residential homes are provided within the private sector, whereas local authority and voluntary provision each make up 1 in 6 residential homes. Residential homes numbered in all 10,826 in 1996. Private nursing homes amounted to 5,883, when including the small number of private hospitals and clinics.

Coverage

In residential homes, the number of residents in the private sector has thus exploded during the last two decades, increasing from 36,000 residents to 140,000 between 1982 and 1996. But whereas the voluntary sector has also increased, there has been a gradual decline in local authority provision to less than half the previous level of provision. In total, provision today covers 29 in 1,000 older people over 65 years in 1996, compared to 23 in 1982 (Table 7.10). Among the 85+, 136 in 1000 older people live in residential homes.

The number of residents in private nursing homes has increased nearly as much as the number of residents in residential homes although the number of residents is smaller. Since 1985, the number of residents in private nursing homes has increased by 27%, covering from 4.8 per 1000 older people in the population to 17.2 in 1996 (Table 7.11). Among the 85+, 71 on 1000 live in nursing homes.

Table 7.10.
Residential care homes, number and per cent of residents according to age and provider and staff (FTE) per 100 residents, 1982-1996. (65+) 1982-1996.

Year	Number of residents (65+)	%					Staff ratio
		65+	85+	Local authorities	Voluntary	Private	
1982	165,675	2.33	..	58.75	18.69	22.56	58
1983	172,208	2.43	..	56.46	18.32	25.21	61
1984	180,676	2.56	..	53.47	17.56	28.97	63
1985	193,487	2.68	..	49.69	16.04	34.27	65
1986	204,382	2.79	..	47.34	14.74	37.92	66
1987	209,800	2.83	..	44.84	13.50	41.66	70
1988	219,174	2.93	..	42.67	13.06	44.28	72
1989	232,584	2.99	15.49	39.18	12.26	48.57	74
1990	235,856	3.05	15.46	36.87	12.23	50.90	79
1991	235,234	3.02	15.10	34.01	11.04	54.95	83
1992	230,860	2.98	14.74	30.43	12.58	56.98	92
1993	227,205	2.90	14.07	27.33	13.65	59.02	69
1994	228,266	2.93	14.26	24.73	14.82	60.45	73
1995	225,624	2.89	13.89	23.07	15.15	61.78	73
1996	226,329	2.86	13.64	21.75	14.87	63.38	..

Source: DoH: Residential accommodation for older people and for younger physically handicapped people, 1990, table A & B. Detailed statistics. DoH: Residential accommodation statistics: Personal social services – residential care homes and supported residents in England, 1996, table E17. Detailed statistics. DoH: Local Authority Social Services Statistics - Staff of Local Authority Social Services Departments 1992 & 1995, England.

Note: Data for 1982-90 includes younger disabled people. Residential homes covers homes registered as residential homes under the Registration Homes Act 1984 (including those dually registered as care homes and nursing homes) and homes which are residential homes but which are exempt from registration, e.g. Royal Charter Homes.

As was seen in the provision of home help services, over the years institutional care has become increasingly concentrated on the very old. Of residents in residential homes, those aged 85 and over constitute the majority (55%), an increase of 8% since 1989. The proportion of those aged 65-74 has remained around 9-10% whereas the proportion of those aged 75-84 has decreased from 40% to the present 34%. Of the residents in nursing homes, nearly half of residents are 85 years old or older.

Table 7.11.
Private nursing facilities, number and per cent of residents (65+) according to age, 1985-1996.

Year	Number of residents (65+)	%	
		65+	85+
1985	33,869	0.48	..
1986	41,570	0.59	..
1987	..	..	..
1988	57,007	0.79	..
1989	73,601	1.00	..
1990	89,616	1.21	..
1991	108,979	1.46	..
1992	113,839	1.51	..
1993	144,325	1.90	..
1994	148,459	1.72	7.14
1995	155,412	1.75	7.22
1996	159,217	1.72	7.09

Source: DoH (1998): Personal communication.
Note: Number of residents is the number of beds in registered private hospitals, homes and clinics with intended use for older people (65+). The age-distribution is only for older people in private nursing homes.

Fees

A number of older people are supported by the local authority, i.e. they are considered to be in need of residential care but lack the means to finance a place themselves. Up until the changes in financing in 1993, the number of supported residents in residential homes was slowly declining from 112,000 residents in 1982 to 68,700 in 1993. The decline was caused by the number of older people who were claiming Income Support to pay all or part of their fees instead of being financially supported by local authorities. Since local authorities have taken over responsibility for funding residential care for older people without sufficient means, the number has nearly doubled to 112,300, but this increase also reflects the number of older people who are no longer funded via the social security system.

When the older person is considered to be able to pay fees, different charges apply, depending on whether they entered the home before or after the changes introduced on 1 April 1993. Firstly, those who were already living in a voluntary or private home before this date have so-called 'preserved rights' to higher rates of the Income Support (IS) to meet fees. The amount of IS will be either the level of fees or a set maximum amount whichever is the lower and a personal expenses allowance of £13.35 per week. The maximum amount paid over the IS

rate depends on the type of disability experienced by the claimant and where the home is located. For older people in homes outside London the maximum fee covered by IS is £197 a week for residential homes, and this is increased to £231 for homes in London. A maximum of £334 for London nursing homes and £295 for nursing homes outside London is payable. Fees above this amount must be covered by the residents themselves or alternatively by family members. In 1994, it was estimated that 11,760 residents out of a total of 208,480 received Income Support which was lower than the fees charged (Age Concern, 1995).

If fees are paid entirely by older people or their families and resources run out, the local authority can step in to help with funding over and above the preserved Income Support level only if no other residential home place is available at IS rates. Local authorities cannot help the older person to remain in the same home; care can only be arranged in another residential home, which is cheaper. However, under the Social Security Benefits and Contribution Act 1992, the government can monitor the charges being negotiated by local authorities under the system since 1 April 1993 and may introduce local variations in levels of Income Support where costs are shown to be higher than IS rates allow (Age Concern, 1995).

Secondly, those who already lived in a LA home and those who first moved to any type of residential or nursing home after 1993 come under the new system of charging. Residents in LA homes and new residents in independent nursing homes may be eligible for the standard amount of IS if they have £8,000 or less in savings. On top of this, they can receive a special residential allowance in recognition of housing costs. Social Services Department will then look at total income and capital, including IS or other Social Security benefits. Residents in LA homes and new residents in voluntary and private homes may then, after a means test have their fees met by the local authority. Local authorities have been allocated a transfer grant to meet these extra costs. The fees should represent the full costs to the authority of its provision. If relatives want to contribute to a more expensive home than the one chosen by the local authorities they are able to do so. In general, when an older person is means-tested, any capital under £3,000 is ignored and where there is between £3,000 and £8,000 this leads to a reduction in the amount paid by the local authority. The older person must have £13.35 left per week for personal expenses. If capital exceeds £8,000 the older person is not eligible for local authority funding.

The principle of 'liable relatives' applies for residents under both the old and the new system. If a married resident in a home receives funding from the local authority, their spouse can be asked to contribute to costs. The local authority

can assess a married couple according to their joint resources but cannot force a spouse to pay, nor refuse or delay the provision of services. Unmarried couples and other relatives have no liability.

Owner occupied housing is regarded as a resource for payment of private residential and nursing home fees, and the local authority can regard the value of the house as a capital asset when means-testing. The property is ignored, however, if a spouse or close relative lives in the house (Tinker, 1997). This principle has been accused of disqualifying many thousands of people from public support help and for encouraging a 'spend-down effect'. Previously, people in homes receiving occupational pensions had this amount deducted in the means test which in many cases caused problems, e.g. for the spouse who may be dependant on the pension for income. From April 1996, new rules have been applied so that 50% of the pension is now disregarded in the means-testing but only if the resident will leave at least half the pension to the wife/husband.

Fees for LA residential homes covered 29% of the gross expenditure in 1995[6] and 38% in independent residential homes (Department of Health, 1996). In independent nursing homes, fees made up 32% in 1995, with average weekly cost at £337. In residential homes average costs amount to £242 a week.

Approximately 28% of residents in independent sector care homes pay for their care mainly from private income or capital for their care. 71% of residents in residential homes were supported by the LA (Department of Health, 1997e).

Standards

By far the majority of residents in nursing and residential homes have their own room; 75% of places are in single rooms, 23% in double rooms, and 2% share a room with more than one other person. Local authority and voluntary homes are of a better standard in providing single rooms. Here, 83% of places are in single rooms compared to 72% in private homes (Department of Health, 1997e). By 1995, 38,380 full-time equivalent members of staff, a ratio 73 employees per 100 residents, were employed within the field of local authority residential provision for older people. The majority of these were employed as care staff and support staff.

Regulation

Local authorities are required to establish units to register and inspect both their own and independent residential homes accommodating more than four people. For homes with less than four people, more simplified rules of registration apply.

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6) Includes fees from younger physically disabled.

Inspection should be carried out twice a year and one of the visits must be unannounced (Tinker, 1997). Inspection units must be independent of the day-to-day management of the home. Nursing homes are now also required to be registered. Under the Registered Homes Act 1984, regulation and inspection of nursing homes in both the private and voluntary sectors are wholly delegated to health authorities who must provide written guidelines for prospective owners, register new nursing homes and inspect nursing homes twice a year. Inspection is carried out by Registration Officers. Private individuals offering board and lodging for one or more older persons must register with the relevant Social Services Department.

7.7.6. Cash benefits for help with care and independent living paid to the older person

A number of cash benefits are available for older people who depend on help with personal care or help to carry out daily activities. Benefits are intended to relieve some of the extra expenses or intended to be an income-supplement for carers and cared-for.

Attendance Allowance

Older people aged 65 and over who need help with personal care can apply for Attendance Allowance. It is a non-contributory tax-free benefit which is not income related. The benefit is normally not included when means testing, e.g. for Income Support, except for people in residential and nursing homes. The older person must have been in need of help for a period of 6 months, except for those who suffer from a terminal illness. The benefit is paid to the older person who may be entitled to the benefit even if she/he is not receiving informal care from relatives or other family members. The aim of the benefit when it was introduced in 1971 was to meet the general extra costs associated with disability, but there is a growing assumption that the benefit should be used for purchasing services (Glendinning, Schunk, & McLaughlin, 1997). Attendance Allowance can be used for purchasing private care or for paying fees for LA domiciliary services. Assessment is normally carried out by social workers and in most cases does not involve a medical examination. The allowance is taken fully into account when topping up fees for residential care and nursing homes for Income Support purposes. The benefit is given at two rates, a higher rate of £49.50 a week if the older person needs help both night and day, and a lower rate of £33.10 a week if help is needed either during the day or the night. The number of recipients has increased from 202,000 (3% of the 65+) in 1982, to 1,142,000 in 1996 (15%) (Table 7.12).

Income Support

Before 1 April 1993, many older people received Income Support (IS) to finance their residence in independent homes. As mentioned above, from this date those already resident in independent homes have 'preserved rights' to a higher level of IS, whereas new residents and residents in LA homes are entitled to the standard benefit only. The increase in the number of recipients reflects the changes made to social security regulations in 1980 which enabled more older people to meet the fees for private residential and nursing care through IS and its predecessor, Supplementary Benefit. Since then, the system has been changed and in 1993 local authorities took over responsibility for funding older people in residential care. Today, more than 1.5 m older people receive IS, mainly as funding for residential care (20,5% of the 65+) compared to 1.8 m in 1985 (25%) (Table 7.12).

Table 7.12.
Care allowances for older people (65+), number and per cent of recipients of 1982-1996.

Year	Number		%	
	Attendance allo-wance	Income support*	Attendance allo-wance	Income support*
1982	202,000	..	2.84	..
1983	..	..	..	..
1984	..	..	..	..
1985	555,000	1,805,000	7.69	25.03
1986	605,000	1,930,000	8.25	26.33
1987	670,000	1,950,000	9.03	26.27
1988	730,000	1,815,000	9.75	24.24
1989	795,000	1,780,000	10.53	23.58
1990	890,000	1,705,000	11.73	22.48
1991	975,000	1,575,000	12.78	20.64
1992	660,000	1,643,000	8.61	21.44
1993	700,000	1,736,000	9.10	22.58
1994	952,000	1,765,000	12.36	22.92
1995	1,051,000	1,781,000	13.59	23.04
1996	1,142,000	1,588,000	14.73	20.48

Source: DSS: Social Security Statistics 1997. DSS: The Governments Expenditure Plans (annual publication).
Note: Number of recipients are for Great Britain. Proportion is calculated on demographics for England. * Only for older people.

Independent Living Fund

Another benefit is the provisional Independent Living Fund (ILF) which provides help for severely disabled people of all ages to purchase personal care or domestic care in order to remain in their own home. This measure was introduced to balance out the income loss which some residents in residential care might have suffered after the changes in Income Support. Entitlement to the benefit depends partly on income and partly on the extent of physical disability. The older person must receive Attendance Allowance and be unable to carry out household work or normal personal care tasks without extensive help. The fund was closed to new applicants in 1990 but payments are still made to applicants from before then. In 1996, payments averaged £125 a week, ranging from £31 to £448. In 1997, there were just over 12,000 beneficiaries, including the under 65's.

Residential Allowance

All residents of independent homes taking up residence after 1 April 1993 are able to claim residential allowance in respect of housing costs as part of Income Support. The allowance is not available to people in local authority homes. This creates an incentive for local authorities to place people in independent homes, as this costs less than operating LA homes.

Social fund

Different payments are available through the Social Fund to enable older people to return or stay in their own home. Payment is mainly made for special or emergency needs. Two types of payments are available as a right for older people - the *assistance in meeting funeral expenses* and *cold weather payments for the costs of heating*. Other discretionary payments that older people can receive are community care grants, crisis loans and budgeting loans. The *community care grant* is intended for people who are leaving institutional care, e.g. hospital care, or residential or nursing homes. The grant can be used to buy furniture, a washing machine, or to pay for removal expenses. The older person must receive Income Support (IS) in order to be entitled to Social Fund payments. A carer can also apply to the Social Fund for a community care grant if she/he is moving house to look after an older person who has just left institutional care and is a recipient of IS. Recipients of IS may also receive a *Crisis loan* which is paid in an emergency, or a *Budgeting loan* which is intended to spread the cost of large one off payments. Both loans must be repaid.

7.7.7. Cash benefits paid to the carer to support for informal care

Family leave

As a result of Britain signing the EU social charter, Britain is committed to adopt the Family Leave Directive by late 1999 the latest. Workers should be entitled to take time of work for urgent family reasons in cases of sickness or accident. Employees using such leave should be protected against dismissal on the grounds of an application for or the take of leave and should be guaranteed the right to return to the same job, or to an equivalent job consistent with their job contract. The employer is not committed to pay wages during the leave.

Invalid Care Allowance

The main cash benefit paid directly to carers is Invalid Care Allowance (ICA). When introduced in 1976, it was intended to replace income lost or foregone from giving up or being unable to resume work because of caring tasks. Up until 1986, married women were excluded from the assumption that their caring involved a forfeit of earnings but this was ruled illegal by the European court. ICA is payable to people of working age who are caring for a severely disabled person. Carers are entitled to ICA if the older person they care for is receiving Attendance Allowance; if they are aged over 16 but under 65 years when claiming; if they are spending at least 35 hours a week as a carer; if they are earning no more than £50 a week after deduction of allowable expenses (which excludes part-timers); and if they are not in full-time education. The rate of benefit is higher if the carer has dependents and lower if the carer receives any other benefit. ICA is taxable (£37,35 a week in 1997), ensures National Insurance credits and can be paid during shorter breaks from caring, e.g. during holidays or if the person being cared for is admitted to hospital. An added premium for carers already receiving ICA was introduced in 1990 in order to compensate carers for their loss of the higher rate of means tested benefits. The premium is paid for up to 8 weeks after care has ceased. ICA recipients are not entitled to unemployment benefits after this period. The premium is intended to balance out income loss due to performing care tasks and is paid at a rate of £13.35 per week in 1997.

The number of recipients of Invalid Care Allowance – which covers all age groups including those aged under 65 – has increased sharply, from 8,000 in 1982 to more than 361,000 in 1997 (Table 7.13).

Table 7.13.
Invalid care allowance, number of recipients (all age-groups) 1985-1996.

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Number of recipients	10,000	25,000	80,000	100,000	115,000	136,000	167,000	199,000	240,000	285,000	339,000	361,000

Source: DSS: Social Security Statistics 1997; DSS: The Governments Expenditure Plans (annual publication).
Note: Data for Great Britain.

Home Responsibilities Protection

A special arrangement is in place for people to protect their right to Basic Retirement Pension if they take time away from work to look after older people (or children). For people who receive benefits because of sickness or disability, their carers can receive Home Responsibilities Protection in order that they can retain their right to basic pension. For entitlement the carer must be engaged for at least 35 hours a week in caring for someone who has received a minimum of 48 weeks of Attendance Allowance or other benefits.

7.8.
Development and changes 1982-1996

With more emphasis on cost-efficiency English care services and cash benefits have changed since the early 1980's, especially in relation to the role played by private providers and informal carers. Private provision of services has gained weight and a number of cash benefits are used in order to subsidize informal and private provision of care.

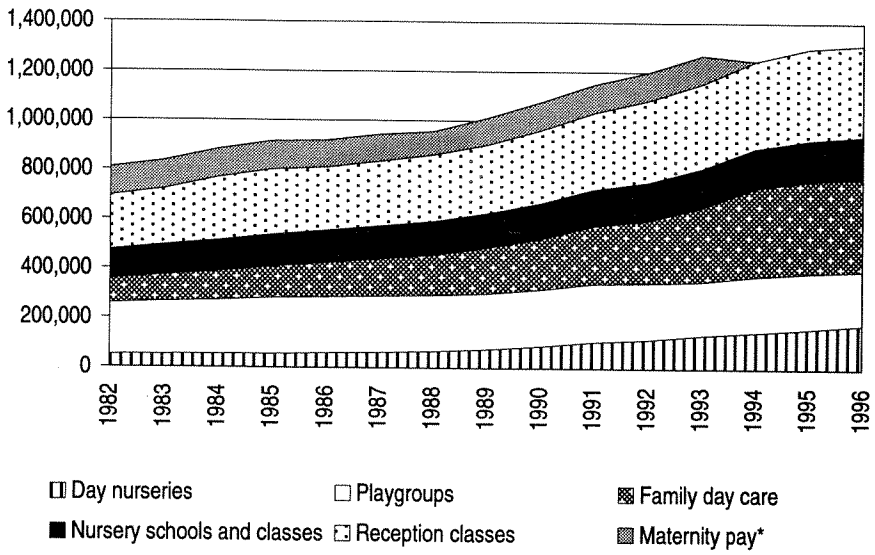
Looking at the changes in provision of services for children within the welfare system there has been a decrease in the local authority run provision of day care. The number of day nurseries run by local authorities has thus declined, and today 89% are provided by independent providers, predominantly profit-making. The increase in full-time places, from 1.7% of aged 0-4 years in 1982 to 6% in 1996, has therefore mainly taken place in independent provision. (Figure 7.13) The growth in private day nurseries has most likely been the effect of the increase in female employment in the mid-1980s and onward. Private provision has also increased in family day care, especially from 1988 and again from 1991, which partly can be explained by changes in registration procedures. Today, there are full-time places for 12% of children aged 0-4 years. The part-time playgroups have not increased in number of full-time places; around 7% of children attend playgroups when measured in full-time places, and these are today under some

pressure from the early years education program. Playgroups have always been mainly independently provided. Work place day care so far only make up a small proportion of overall day care, and there are less than 1% full-time places available for children aged 0-4 years. All places are within the independent sector, and mainly the profit-making. One of the consequences of the growing private provision is that parental fees increase as share of costs. A place in a private day nursery may cost from £55-160 a week. New initiatives have, however, been taken to reduce parental payment. Two new tax measures have been introduced to enable also low-income parents to use private day care provision.

Within the education system the increase in private provision is less apparent, but this may change with the early years' education program which has mainly found places for 4 year olds in private provision. The nursery schools and classes for 3 and 4 year olds have increased provision slightly, from 4% in 1982 to 4.5% in 1996. Around half of these are provided by independent schools under contract with the local educational authority. Reception classes for 4 year olds have increased even more, one in four of 4 year olds today attend reception classes when measured as share of children aged 0-4 years; an increase from 7.5% in 1982 to 12% in 1996 (Figure 7.13). Reception classes are mainly provided by the local educational authorities. Cash benefits are paid less attention in England than in other countries, mainly because there are no statutory paternity leave and parental leave. The number of recipients of the two main statutory maternity pay benefits has remained at the same level since the 1982. Some parents are, however, ensured the right to take further leave as part of occupational agreements while receiving their wage.

For older people, the main changes have been the increase in the number of recipients of cash benefits. Especially the number of recipients of Income Support has grown, mainly for financing the use of private residential and nursing homes by older people (Figure 7.14). By 1992, three in five older people living in private or voluntary residential home were financed over the Income Support. As a result, the number of older people living in private residential and nursing homes increased from the early 1980s. The local authorities have now taken over the budget for the domiciliary and institutional care, but 85% of the budget must be spent within the private sector which has therefore continued to grow as share of total provision. Today, 30 in 1000 older people live in a residential home, of which 50% are private profit-making, compared to 23 in 1000 in 1982. The number of residents in private nursing homes has increased also, from 4.7 in 1000 older people in 1985 to 20.5 in 1996.

Figure 7.13.
Development in the number of recipients and enrolled children (aged 0-4), 1982-1996. Main social services and cash benefits for children.

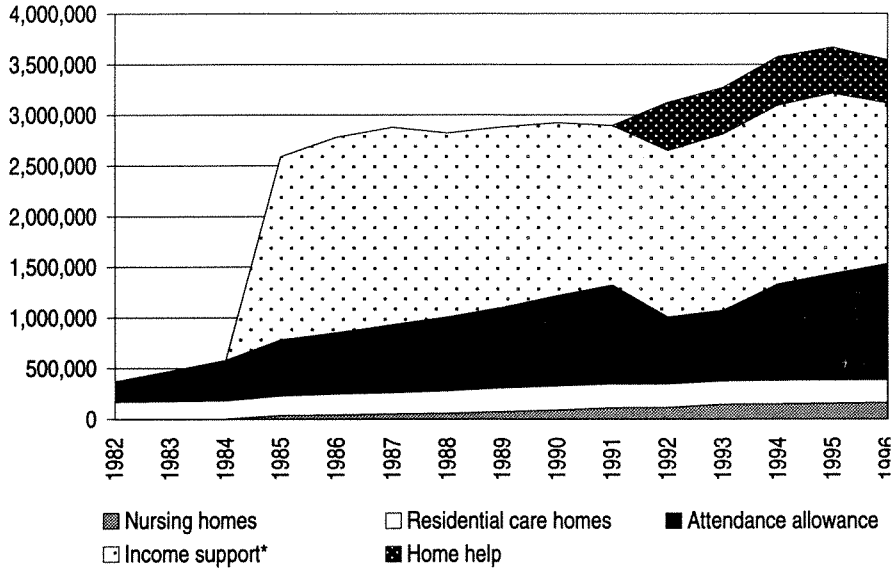


Source: DSS: Social Security Statistics 1997. DSS: The Governments Expenditure Plans (annual publication). DoH: Children's Day Care Facilities (annual publication). DfEE: Pupils under 5 years in each LEA authority in England. Statistical Bulletin (annual publication). DfEE: Pupils under 5 years in independent schools in England. Statistical bulletin (annual publication).
Note: Absolute figures.

From the early 1980s to early 1990s the number of older people receiving Attendance Allowance increased also, with an increase again from 1993/93. More than one in six older persons receive Attendance Allowance today, compared to one in thirty in the early 1980s. The amount is increasingly used for payment of informal care and domiciliary services and is included when means testing for home help services.

Data on home help is not available for the 1980s but the share of older people receiving home help services has gone down slightly since 1992, underlining the increasing role played by informal carers. Today 5.5% receive home help services. (Figure 7.14) During these few years private provision has, however, increased dramatically, from making up 2% of total provision in 1992 to 19% today. Voluntary providers provide 3.5% of services. Also, the service is today targeted on the most frail among the old and average hours have therefore gone up from 3.5 to 5 hours per week.

Figure 7.14.
Development in the number of recipients and residents, 1982-1996. Main social services and cash benefits for older people (65+)



Sources: DoH: Community Care Statistics: Day and Domiciliary Personal Social Services for Adults, England. Statistical bulletin (annual publication). DoH: Residential accommodation statistics: Personal social services - residential care homes and supported residents, England. Statistical bulletin (annual publication). DoH: Residential accommodation: Detailed statistics on residential care homes and local authority supported residents, England (annual publication). DSS: The Governments Expenditure Plans (annual publication). DoH (1998): Personal communication.

Box 7.2.
Southampton, England.

1. Introduction
Southampton is situated in the South of England and has 207,099 inhabitants, where 4.9% belong to an ethnic minority. The number of inhabitants above 65 accounts for 15.8% (32,688 inhabitants), and 6.4% (13,267) of the inhabitants are under the age of five.

In April this year, Southampton went from a local authority with no responsibility for Personal Social Services to a Unitary Authority with an increased budget of £36 million to ensure the provision of Personal Social Services. Thus, Southampton City Council has been in a period of transformation, re-developing the organisation and prioritisation of social services. The total budget of the Social Services Department in Southampton is £36 m, where the main part of the resources are earmarked for older people in need. The expenditure of social services for older people in Southampton is £14 m which constitutes approx. one third of the total budget of Social Services. The unemployment rate for males is 14.2% which is a little above the national average. The unemployment rate for women is 6.9%, which is equal to the national average rate. The total unemployment rate in Southampton is 11.1%.

2. Children
In general terms, the policy of child care is for children in need. The City Council provides and ensures care for those children who are considered to be in need. Child care is mainly provided by the private or voluntary sector, where parents have to pay full price, which naturally limits the availability for low income parents. The limited care facilities are reflected in the amount of women who are neither in employment or are seeking work, which in Southampton for couple families is 48% and for female lone parents it is 68%. The main facilities available in Southampton are nursery schools and classes, receptions classes, play groups, child minders and day nurseries.

The city council's expenditure of child care consists mainly of the running costs of the family centres offering therapy and consultation for socially deprived families, rather than actual day care. None of the family centres provide child care for working parents' children. However, the centres have an important function of providing information to parents about what kind of child care is available.

All kinds of day care facilities are to be registered by the local authority, which regulates standards in both the private and voluntary day care sector, including child minding. In practice, the task is carried out by the family centres, which have the responsibility of register and control the day care sector.

Visits to the Fledging Day Nursery
Fledging Day Nursery is situated in a residential neighbourhood. It is a private for-profit day nursery, which is attended by 40 children in the age from five months up to five years. Fledging Day Nursery has a contract with Midland Bank which buys half of the day care places. The bank pays the full price of the places and it then organises pay with its employees afterwards. The opening hours of the day nursery are from 8 o´clock in the morning to 8 o´clock in the evening.

When arriving at the premisses there were no children to see and somehow the nursery seemed empty. As the nursery was just started up, the facilities were very new and this partly explained the general atmosphere, but the organisation of the day nursery also seemed formal, perhaps because it was mainly catering for employers. There were no children in the entrance as all the doors were closed in order to ensure that children stayed in their groups. There were four age groups (a baby group, a toddler group, a tweenies group and a pre-school group). The house consisted of six rooms in two levels. Each room was organised according to age group or to functions of eating or teaching. Most of the toys available for the children were made of plastic, there were only few creations made by the children themselves, and decorations were placed too high for the children to see them. The outdoor facilities were limited but were used when the weather allowed it. A room with toilet facilities were available next to the group rooms. Changing of nappies mainly took place on the floor as this was easiest for the staff members. All staff members had a formal education and were required to wear uniform - a blue apron with the name of the nursery printed on it.

3. Older people

The overall aim of the care policy for older people in Southampton is to ensure that older people can stay in their own home as long as possible. This means that only older persons in need with no possibilities to stay at home are placed in institutional care. In general, services are provided by the voluntary/private sector which provides approx. 60% of the services for older people.

The main provision of institutional care in Southampton is carried out by the private sector, as the Local Authority only runs 7 out of 102 different kinds of institutional care. In total, 4.1% of the older people above 65 years are living in residential care. The City Council also plays a considerable role in providing sheltered housing schemes for 3,678 persons above the age of 60. All nursing homes are run by the private sector and in total there are 105 places available. The older persons, who attend a nursing home, are offered continuous medical care and due to the high fees for a place in a nursing home, only a limited number of older people make use of this offer.

A relative big part of the older people in Southampton receive some kind of care or help in their homes, personal as well as domestic care. The policy of caring for older people in their own homes means that the intensive share of care has increased. The Executive Director of Social Services illustrated this by saying that some years ago the older people received help 2-3 times per week, now they receive help 2-3 times per day. In total, 2,047 persons (6.2%) above the age of 65 receive some kind of home help or domiciliary care, where 877 persons, or 43% receive care provided by the city council. Other services include day centres and meals-on-wheels.

When a person is in need of care or help s/he has to address a care manager, who will then assess the need for care. The care managers are placed in three main centres in Southampton. The charging of services is dependent on the income of the older person and which services the older person receives. For a range of services, the Local Authority charges the older person for the services according to six "Charging bands". The charging bands are used for setting the user fee non-residential services (care at home/personal assistance, day care services, sitting services). But a max. monthly amount applies regardless of income.

Visits to the Day Centre "Age Concern" and the Residential Home "Birch Lawn"

The Day Centre Age Concern is independent, but belongs to the national Age Concern group, which is one of the biggest elder care organisations in England. The day centre is open five days a week from 9.00 a.m. to 15.30 p.m. During the week, there are two days for older people with mental problems, two days for frail older people and one day for a mixed ability group. In total, 115 older people make use of the facilities during the week. Staff consist of trained and paid staff (12 persons) as well as voluntary staff (21 persons). Older people pay an income related user fee for attending the day care centre. The minimum fee is the cost of a meal which is £1.65 and the maximum is £6.60. The older people are charged per day they attend. Various activities take place in the centre such as painting, playing cards, quizzing etc. At the day of the visit, the users were busy painting and playing quiz games, all in a very open and friendly atmosphere.

Birch Lawn is a residential home organised by the City Council. There are four places for respite care and 27 long stay residents. In total, there are five full time employees and 30 part-time employees. The building has been restored recently, so it presents itself almost like a hotel, with nicely decorated rooms. The aim of the restoration was to create a bench marking residential home for the rest of the residential homes privately, as well as publicly provided. The building is in two floors and rooms are single rooms where it is allowed to bring own furniture. Each room is around 12-15 m^2 and as carpets or painting was going to be changed as a part of the restoration, the older people themselves were allowed to decide the colour. Some of the residents were rather agile, while others seemed very frail. In an annex to the building the daycentre had its premises. The day centre is organised by a voluntary organisation and is part of the residential home. But the two institutions cooperate as the residents from the residential home join the daycentre, when a special arrangement is set up and in return, the day centre can use the dining hall in the residential home when hosting big arrangements.

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CHAPTER 8

France

Box 8.1.
General characteristics of France

- France is divided into 22 regions, 96 départements and 37,000 communes with elected governments at each level. Many of the communes are very small (80% with fewer than 1,000 residents) and have to co-operate with neighbouring communes and/or the departments. With a population of around 58 million on an area of 543,965 sq km France is the largest country in Western Europe and one of the less densely populated (106 persons per sq km). However there are great differences between the more densely populated regions in the north and the less populated south-west of France.
- 26% of employment is in industry, 69% in services and 5% in agriculture. Activity rates in 1996 were 76% for men and 62% for women. 30% of the employed women were working part time. Unemployment has since the beginning of the 1980s been fluctuating between 9% and 12% and was 12.4% in 1996. For women it was 4.4%.
- Around 30% of GDP is spent on social protection. 75% of this budget comes from employer and employee contributions to the rather fragmented system of social security insurances.
- France was one of the first countries in Europe to experience the aging of the population. 15,2% of the population is 65 years of age or more and this proportion is expected to increase to almost 21% by the year 2020. The total fertility rate was 1.7 in 1994.

8.1.
Introduction

The French social welfare system shares most of the characteristics with what might be called a corporatist type of welfare state. The welfare system *(la protection sociale),* which has been developed since the Second World War, is mainly based on a system of social insurance schemes *(la sécurité sociale).* Most benefits are earnings related and conditional upon a record of contributions. Funding is based mainly on contributions paid by the employers and the employees. The system, however, is heavily regulated by the government and an increasing but still minor part is financed by taxes. In addition to the social security system, there is a tax financed system of social assistance and other social and health care activities *(aide sociale).*

It is characteristic of the French social security system that the family is considered to be very important, and the system contains many elements of support for

the family and especially for families with children. This orientation can be traced back to the exceptional demographic history of France. During the demographic transition in the Nineteenth' century France experienced a comparatively low birth rate, and as a consequence the population growth in France fell behind that of other European countries, which experienced a population explosion. This caused severe concern in France about the position of the country and already around the year 1900 the first family and population measures were introduced in France.

Most of the support for families with children takes the form of allowances to parents. Some of these allowances are granted without regard to need, others are means tested based on parental income. Tax relief is also available for families paying income tax. The first two children in a family count as half persons and the third and subsequent children count as one person each when deductions in tax to be paid are calculated. Fiscal help is also offered for domestic help or childcare expenses and for payment of mortgage interest. The comprehensive system of subsidies to parents, however is combined with a relatively wide public provision of day care services for children.

In France policy has aimed at offering a range of measures for care of children and thereby supporting the labour market participation of working mothers. In addition to the direct subsidies to day care institutions a general tax relief is available for the parents to compensate for the costs of day care, and grants are provided for those using self employed and not publicly subsidized family day carers, while social security contributions are covered for those, who as employers are employing a private carer in their own home. Furthermore employment of domestic help is subsidized by tax deductions. The parental leave scheme has also been improved but still the incentives for taking a career break while one's children are under 3 are still small except for low-skilled, unemployed women.

Almost all children attend pre-primary school *(école maternelle)* from the age of 3, and often the école maternelle is provided for the 2 year olds as well. About a third of two year olds attend these nursery schools, which are a part of the educational system. In addition within the welfare system there are a number of types of day care institution available on a full-day all-year round basis.

Care services for old persons dependent on help have been stressed less in France and are still under development, although policy for a number of years has been to improve the situation. Part of the background for this situation is that France still has a very complex system for supporting old dependent persons in need of care with a set of services and financing mechanisms which are not very

coordinated. Care services in the home have been a priority since the early 1980s, but varies greatly between regions. Subsidies for home help are in general means tested, but employment policies have lately improved the possibilities for hiring domestic help by offering tax deductions for those who pay income taxes.

8.2.
A history of care

The French insurance based social security system has developed gradually during the twentieth century. After the Second World War a number of social principles were set up for the social welfare system. Among these principles is that the system should be able to insure the standards for individuals and their families, which are necessary for their development, and to guarantee to everyone, especially children, mothers and elderly employees: protection of health, means of subsistence, and rest and leisure time. Also persons unable to work are entitled to a suitable means of subsistence.

The system consist of a number of schemes which cover diverse social risks. It is organized into a number of so called *régimes* of which the *régime general* is the most important including as it does almost two thirds of the working population and all types of risks. It is divided into three sectors: 1) health and sickness insurance - benefits for sickness, maternity, invalidity, injury and occupational diseases. Also nursing care in the home is granted by this scheme. 2) old age pensions including other benefits for the elderly in need. 3) family benefits. Unemployment insurance is organised in a separate scheme. Finally there is a social assistance scheme administered by local authorities, which covers those in need of help without access to social insurance.

All these insurance schemes are financed mainly by insurance contributions on a pay as you go basis. The Scheme of family benefits, however, is solely financed through employer contributions and entitlement is not tied to a record of employment or contributions excepting the parental leave allowance.

Until the 1970s French social policy was oriented towards expansion and improvements. Since 1974, however, the deficit of the *sécurité sociale* has been a major preoccupation of the government (Palier, 1997) and a number of reforms have aimed at decreasing expenditures and increasing revenues. User charges in health care have been raised, the level of family benefits have not been raised etc. Also the mainly contribution-based funding of the welfare system has been supplemented with more tax financing. In 1989 a *contribution sociale généralisée*

was introduced earmarked to fund non-contributory welfare programs. It is a proportional tax on all kinds of income including capital revenues and welfare benefits. In 1993 it was levied at 2.4% of all income.

Traditionally the care of small children and the frail elderly has been the responsibility of the family. Child care services including the the pree-school programs were initially seen as services for poor and vulnerable children. In the late Eighteenth century the first charitable institutions were established. During the Nineteenth century these institutions expanded throughout France and the idea of pre-school education began to form in France. The term 'nursery school' came gradually to replace the older one of 'asylum', and as early as 1835, a decree ordered primary school inspectors to visit asylums as well as schools. Ministerial recommendations encouraged basic religious teaching, elementary reading techniques, mental arithmetic and writing, edifying songs, needlework and all manner of handicrafts. The Schools Law of 1881 provided that nursery schools were places of education, and an educational curriculum was adopted in 1887. In 1921 the teachers in nursery schools became the same as those in elementary schools and their teaching hours became identical. However, the major growth in the number of children attending the *École Maternelle* took place after World War II and especially since 1955. The legislative framework of the present pre-school was enacted in 1976. By now all children aged 2-5 years are guaranteed a right to a place in pre-school. However, for the 2 year olds, if there are still not enough places, priority is given to children from disadvantaged families.

Also creches for poor children were established already in the Eighteenth century, with the primary aim of protecting against contagious diseases. While the pre-schools expanded, the creches for the infant children remained linked to the original health care orientation. First in 1971 a legislation was enacted, which provided an increase in the funding for creches. In 1982 an early childhood policy was declared, which stressed the aim of ensuring the necessary number of places in day care services and pre-schools. In 1988 a system of child care contracts between the regional family allowance funds *Caisses dállocations familiale* and the local welfare authorities was established in order to stimulate the expansion of day care facilities and the quality of these facilities. The *CAF's* by these contracts co-fund the day care institutions.

In 1977, an allowance *AFEAMA* was introduced to support families making use of a family day carer, who then had to be approved and supervised by the local social welfare authorities. The *assistantes maternelle agrée* has been increasingly successful, and the allowance was raised in 1994.

Parents employing a child minder in their own home may since 1986 receive a subsidy *AGED* to pay the social security contributions for the employed person.

Although the number of places in day care has expanded considerably and almost one third of all children aged 0-2 years are cared for during the day at publicly funded facilities the need for day care facilities have still not been met.

Until the 1960s there were not really any specific policies for the care of old people. However some charitable associations developed home help/care services financed by social assistance from the *départements* and from sickness insurance schemes. Benefits were granted for care provided by doctors and medical auxiliaries in order to avoid the hospitalisation of elderly persons who were not acutely ill. In 1960 the Commission for the Study of the Problems of Old Age, was created. It was chaired by one of the founders of social security after World War II P. Laroque. The Laroque report proposed a replacement of the old *hospices* - large old peoples institutions, which were set up by the *départments* - with a range of more flexible services, which should support the independence of elderly people and maintain them in their own homes as long as possible.

In 1967 the old age insurance system was separated from the sickness insurance system, and home help from then on was financed by the old age scheme apart from the help granted by the social assistance scheme. Until 1981 the home nursing service was a small self-employed service. In 1982 the service was regulated, and since then the number of services attached to the general hospitals or local associations have increased under agreement with the health insurance schemes.

The social services legislation of 1975 abolished the old *hospices,* which were gradually adapted into retirement homes. At the same time the general hospitals were limited to provide acute care and instead a separate category of long-stay wards was created for long term care associated with the general hospitals. Furthermore standards were set for retirement homes (and for sheltered housing institutions) to set up medical sections, and thereby assume the function of a nursing home.

In 1991, a commission set up by the National Assembly recommended a new and improved dependency allowance administered by the social insurance scheme but financed by taxation. One of the aims was to find a more simple system of financing the services for dependent old people. The proposal was rejected on grounds of the cost to the public finances. However in 1995 an

experimental dependency allowance was introduced in 12 *départements,* which in 1997 was followed by a new specific dependency allowance. The new *PSD,* however, is part of the social assistance system and accordingly is means tested and recoverable from donations and inheritance. But it is stated in the new act that it is introduced while awaiting a new provision to further the autonomy of older dependent persons (Pijl, 1998). This might in due time be as part of the social security insurance system.

8.3.
Financing

8.3.1. Social expenditure

France has experienced a rather strong growth economically and has developed into a post industrial society with a large proportion of employment in the service sector. However growth rates have stagnated in the 1990's and were even negative in 1993. Also unemployment rates have been somewhat high during the 1990s - around 12% since 1993.

Social welfare expenditures totalled 2,313 billion FR in 1994, up from 821 billion FR in 1981, and represented around 30% of GDP as against 26% in 1981. Financing the social protection system presents problems today because of rapidly rising expenditures. The aging of the population means that expenditures on retirement and health care are increasing, while the age structure and the rise in unemployment have led to a decline in contributions. In France contributions from salaries have been the most important basis for providing social protection, although the proportion of state subsidies is rising. A generalized social contribution, introduced in 1991, integrates a proportion of tax revenue levied on income from all sources, including unearned income, with contributions deducted from salaries. Also other changes are under consideration. One of these is an extension of private insurance in the retirement and health sectors.

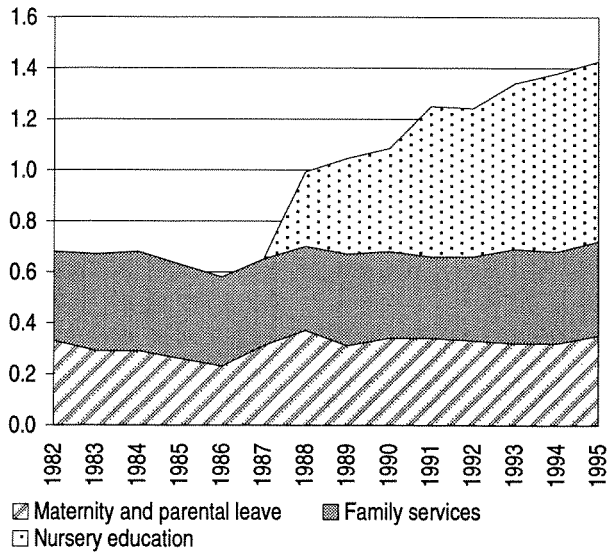
In December 1995, the government introduced a comprehensive reform - the Juppe-plan - including an extension to income other than wages as a basis for financing social protection and a plan for a progressive merger of all specific social schemes into one system. In 1996 a special tax *(Remboursement de la dette sociale - RDS)* was introduced in order to pay down the deficit of the social security system.

About 75% of the total revenue for social protection comes from contributions paid by employers and employees. About two thirds of these contributions are paid by the employers. But the trend since the beginning of the 1980s has been,

that an increasing part is paid by the employees. The remaining budget is covered by public means through general taxation or by special taxes earmarked for social protection (8%).

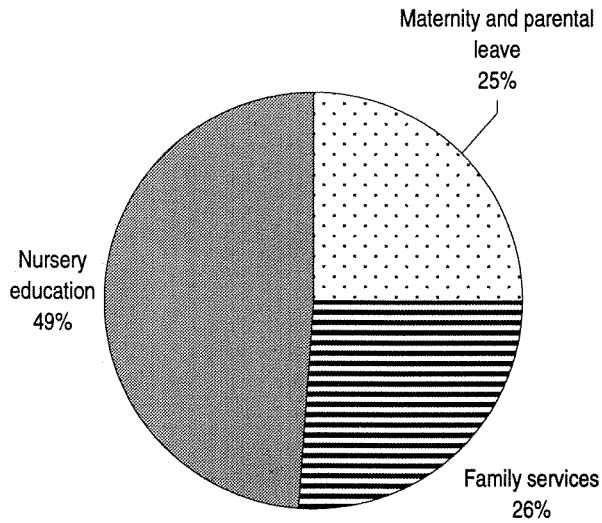
Expenditures on family services as a percentage of GDP has been fairly stable since the beginning of the 1980s. About two thirds of these expenditures are direct subsidies for formal day care. In 1982 they amounted to 0.35% of GDP. In 1995 the proportion was 0.37%. Expenditures on all family cash benefits have decreased from 2.61% of GDP in 1982 to 2.23% in 1995. The decrease has mainly been in general allowances to families with children, whereas expenditures on day care has increased. The possibilities for getting financial support for day care to children in family day care or in the home been especially improved. Expenditures on maternity and parental leave only increased a little between 1982 (0.33% of GDP) and 1995 (0.35%). However the scheme for parental leave benefits have been improved lately.

Figure 8.1.
Development in the net-expenditures of the main social services and cash benefits for children (aged 0-5) as a percentage of GDP, 1982-1995.



Source: OECD: Social expenditures database 1998.
MENRT-DEP: Repères et références statistiques sur les enseignements et la formation (annual publication 1988-1995).
Note: Data is not available for nursery education for the period 1982-1987.

Figure 8.2.
Division of the net-expenditures into main social services and cash benefits for children (aged 0-5), 1995.



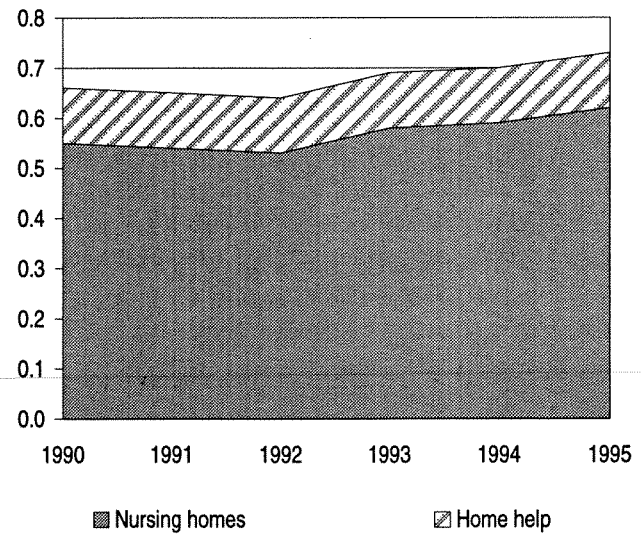
Source: OECD: Social expenditures database 1998.
MENRT-DEP: Repères et références statistiques sur les enseignements et la formation 1996.

Expenditures on nursery schools financed under the educational system have to be taken into consideration as almost all children aged 3-5 years attend an *École maternelle*. Expenditures on nursery education increased from 0.29% of GDP in 1988 to 0.70% in 1995, and so make up a substantial part of the total expenses for day care for children.

Figure 8.2, however, underestimates the expenditure for day care under the social welfare sector as expenditures on support for families making use of a family day carer or employing a child minder in the home, are not included.

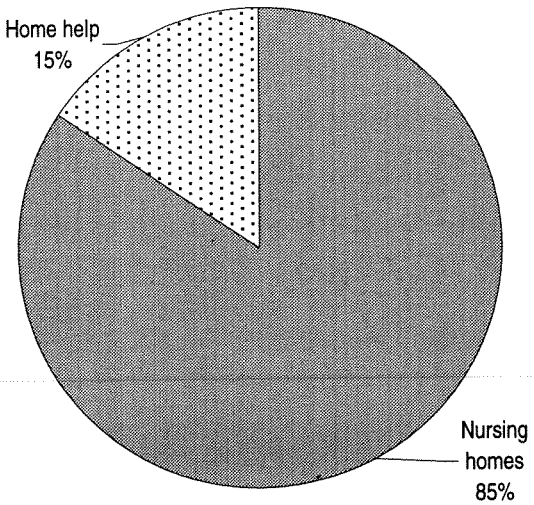
Expenditures on services for long term care and help for old people and the handicapped have increased from about 0.65% of GDP in 1982 to about 0.78% in 1995 according to the OECD social expenditure database. The major part of the expenditures are on support to residents in retirement homes or sheltered accommodation, whereas expenditures on home help services only account for 15% of the total expenses in 1995. Expenditures on home nursing however are not taken into consideration here, as they are granted by the health insurance schemes.

Figure 8.3.
Development in net-expenditures* on the main social services for older people (65+) as a percentage of GDP, 1982-1995.



Source: OECD: Social expenditures database 1998.
Note: * Data from 1982-1989 is for the 'Régime général'. Data from 1990-1995 is for all 'régimes'

Figure 8.4.
Division of the net-expenditures into the main social services for older people (65+), 1995.



Source: OECD: Social expenditures database 1998.

8.3.2. Division of financial responsibility

France has a very complicated and partly overlapping system of provisions for meeting the costs of maintenance and care for old people, involving all the main insurance schemes, local and central governments and private obligations under family law (OECD, 1996).

The health insurance system covers medical costs without regard to income, but the users are subject to a co-payment - the *ticket modérateur.* However the health insurance only covers the medical component of long term care. There is a maximum rate for the medical component in a long-stay ward associated with a hospital and a lower rate for costs in the medical section of a retirement home. The board and lodging part of the costs is to be met by the resident themself or the family, unless they qualify for social assistance. These costs vary considerably.

Home nursing services are reimbursed by the health insurance scheme at a fixed price.

Pensioners can get help from their pension scheme with the costs for home care services or residential care. Most grants are for domestic help, and are granted based on a means test, which however is less restrictive than that for social assistance. Over half of all assistance granted for home help in France comes from pension schemes. Pension schemes may also finance part of the costs of home improvement, which is mainly financed by local governments with a central government refund.

The family allowance system is responsible for the most important housing allowance scheme, which is payable based on a means test to people living in their own home, in a retirement home or in sheltered housing, as is the financing of the board and lodging costs for persons with low incomes.

Social assistance is funded from the budgets for *Aide Sociale,* which is the responsibility of the *départements.* The social assistance scheme includes a minimum income scheme for older people, which tops up low incomes. It also pays the charges for home help services or for board and lodging costs for persons qualifying for social assistance. Also the compensatory allowance which can be made to disabled elderly people to help them pay for a care person and the new specific dependency allowance are paid by the social assistance scheme.

All the social assistance payments are subject to the *obligation allimentaire,* except since 1977 the subsidies for home help. This obligation is a legal requirement for families (children and adult grandchildren) to meet the living costs of their elderly relatives if they can. The obligation is not enforced if the relative already has an old person living in his/her household. Also the estate of the recipient can be obliged to refund the assistance after death.

This diversity of sources for funding of care for the elderly makes it necessary for the old person and their family to consider a wide range of funding possibilities in order to assemble an 'income and costs package" (OECD, 1996).

The situation is less complicated when it comes to day care for children. All family allowances for families with children are paid out by the *Caisse d'allocations familiale (CAF).* Employees do not pay contributions to this scheme of family allowances, instead family allocations are mainly financed by the employers. Their contributions have since 1990, been set on the basis of all wages and salaries paid. The national family allowance association *Caisse nationale d'allocations familiale (CNAF)* administers the contributions together with the proceeds from the generalized social contributions and state subsidies.

The *CAF's* also co-fund many of the day care services, which mainly are the responsibility of the local welfare authorities. The parents contribute with a fee, which is usually calculated on the basis of a formula set up by the *CNAF*, which takes the number of children and the family income into consideration. In 1993 the fees of the parents covered 28% of the costs in creches (*collective* and *familiale*). The *CAF's* paid 23% of the costs.

The *École Maternelle* is part of the education system and is free of charge for parents. The communes are responsible for nursery and elementary schools and are in charge of building, re-building, extending, repairing on a large scale, equipping and operating schools. The State is responsible for pedagogical expenditure: the initial equipment in material for the national curricula aimed at introducing new technology, the supply of specialised material vital for the renewal of courses, school textbooks, the maintenance of equipment purchased by the State, etc. and for staff expenditure (recruiting, management and remuneration). The communes are refunded according to the number of pupils in each establishment. In addition they get a general support for the operation of schools according to the resources of the communes concerned.

8.4.
Provision of services

Home help services are usually provided by private non-profit associations or in some cases by services set up by the CCAS's the communal centres for social action.

Home nursing services were until 1981 an entirely private service provided by self employed nurses. In 1981 regulations were made for the *service de soins infirmiers à domicile - SSID.* These are run in connection with hospitals or as local non-profit associations under agreements with the health insurance schemes.

Other services such as meals-on-wheels alarm systems or subsidised restaurants are supplied by local government - the CCAS - or by private non-profit associations.

Sheltered accommodation and retirement homes are provided by local authorities (the commune or the département) or by private non-profit associations or for profit agencies.

Long stay wards connected to hospitals are provided by public authorities or by private non-profit associations.

The provision of **Day care facilities** is the responsibility of the local social authorities, which run the majority of the services. Private non-profit associations also manage some institutions.

The ***École Maternelle*** is part of the education system and the vast majority of schools are public.

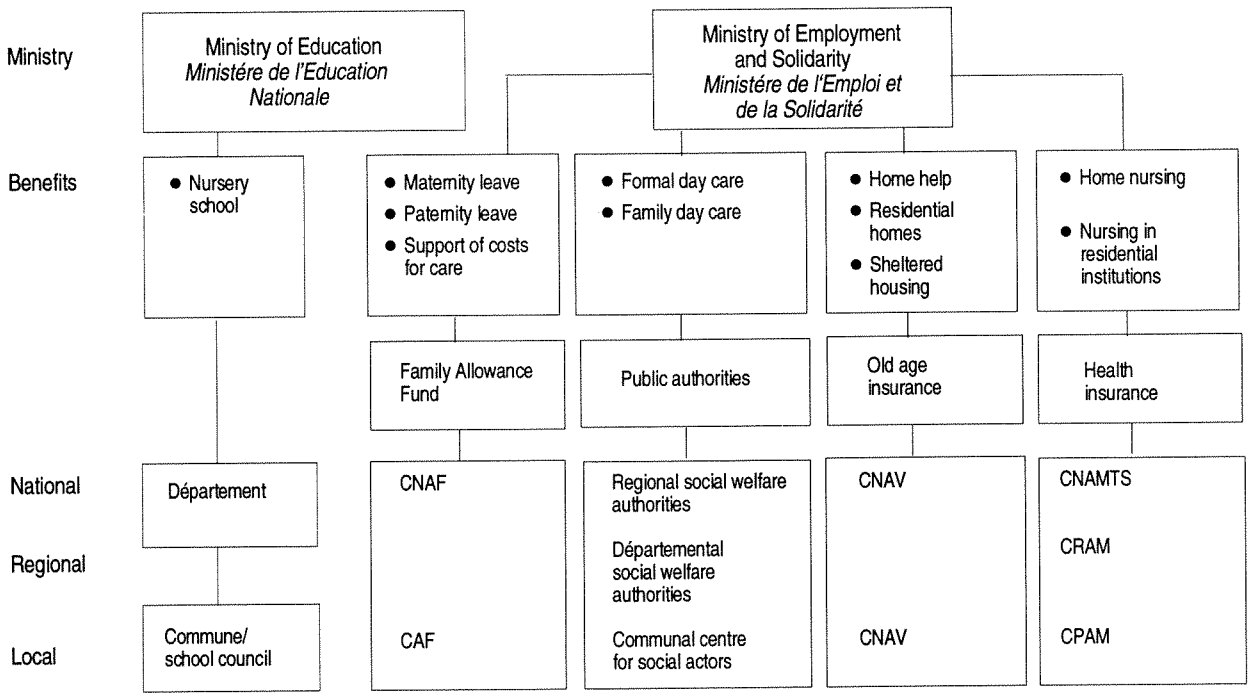
8.5.
Organisation

8.5.1. Central government bodies

The Ministry of Employment and Solidarity is responsible at the central government level for the system of social protection (including social insurance, the social assistance schemes and the social services) and for the health care sector. The government determines, in detail, the framework for the social welfare system or the system of social protection as it is called in France. This is carried out through legislation such as the *Code de la securité sociale,* the *Code de la santé publique* and the *Code de la famille et de l'aide sociale.* The central

government also has a role in supporting the local development of services. As revenues from taxes are increasingly used for the financing of the system the central government plays an ever larger role in financing social protection.

Figure 8.5
Organisational diagram



8.5.2. Regional bodies

In France the tradition for centuries has been a very centralised administration which concentrated decision making in Paris. The real power in local affairs was in the hands of the *préfet,* a state employee who ran the affairs of the *département.* Since the beginning of the 1980s, however, a decentralisation process has been taking place, which has facilitated the local development and coordination of social services. In 1982 elected bodies at the level of the *region*, the *département* and the *commune* became responsible for many services and for the spending of local resources. Since the decentralisation of 1982 the *départements (Les directions départementales de Affaires sanitaire et sociale - DDASS)* have played an important role in providing and paying out benefits and services under the Family and Social Assistance Act *(Code de la Famille et de l'aide sociale -*

CFAS). For old people the most important services, which are supported under this act are means tested benefits for home help, meal services and residential care.

The *départements* share some of the responsibilities within the health care and social sector with the regions - *les directions régionales des Affaires sanitaire et sociale DRASS.*

8.5.3. Local bodies

Direct contacts with citizens takes place at the local Communal Centres of Social Action *(Centre communaux d'action sociale - CCAS).* They are, among other tasks, responsible for setting up and running social and medico-social institutions and creating structures, which facilitate co-ordination between different partners in the social and medical sectors. They also play a role in the allocation of cash and kind social benefits as they submit the applications to the *départements* for decision. Local authorities are also responsible for insuring that the provision of social and health care services are available in the local area. The precise division of responsibilities between the *département* level and the commune, however, depends upon the size and means of the commune.

Day care services within the welfare system are the responsibility of the local authorities. In addition the elected authorities *(Conseil Général)* at the regional level of the *Départements* plays a role as responsible for approving private services and providing some subsidies. Also the regional family allowance funds *Caisse d'Allocation Familiale - CAF's* and their national organisation *Caisse Nationale d'Allocation Familiale - CNAF* play a role by subsidising services in general and stimulating the development of day care services through *contrats enfance* - that is co-finance agreements with local authorities to support the provision of services for children under school-age.

8.5.4. The social protection system

The administration of the insurance based social security is organised into a great number of schemes, which are regulated by the central government but operate within this framework as independent bodies. In all there are 144 different schemes. A set of basic compulsory schemes *(régimes)* is supplemented with a number of complementary *régimes*, which improve the level of coverage and sometimes are compulsory. The most important scheme is the *régime général* which covers those employed in industry and trade. It is the largest scheme as it covers 2/3 of the population in work and is considered a model for the other schemes. The *régime général* is divided into three sectors: 1) health insurance including maternity, 2) old age pensions and 3) family benefits.

All the schemes are administered by funds *(Caisses)* at national, regional and local level. Within the *régime général* the CNAMTS *(Caisse Nationale d'Assurance Maladie Travailleurs Salariés)* is the national organisation responsible for the health sector system. At the regional level there are 16 CRAMs *(Caisse Regionale d'Assurance Maladie)* and at the local level 133 CPAM's *(Caisses Primaire d'Assurances Maladie)* which pays out benefits from the scheme. The CNAVTS *(Caisse Nationale d'Assurance Vieillese des Travailleurs Salariés)* is responsible for the management of pensions plans and has some other responsibilities for example granting home help benefits. The CNAF *(Caisse Nationale d'Allocations Familiale)* is responsible for the management of the 25 different kinds of family benefits and plays a role in provision of day care services. The benefits are delivered at the local level by 125 CAF's *(Caisse d'Allocations Familiale)*. A central agency for the three *Caisses* is in charge of the budget for the *régime général*, and at the local level 105 URSSAF's *(Union Locales de Recouvrement des Cotisations)* are responsible for collecting the social contributions.

8.6.
Caring for children

8.6.1. Introduction - Main services and cash benefits

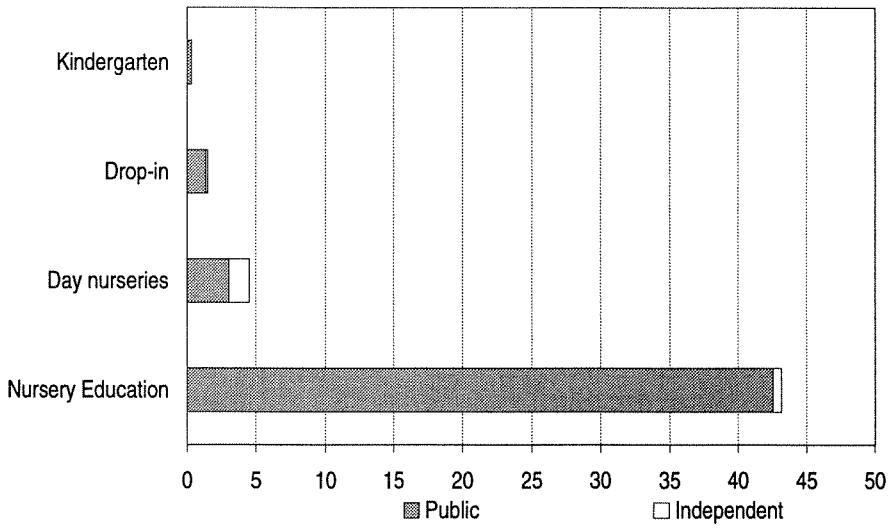
In France there are two separate systems of publicly funded day care services for children under 6. Compulsory schooling starts at 6 years. One system is aimed at small children aged 0-36 months under the social welfare administration and the other under the educational system is aimed at children aged 2 years and above.

Within the welfare system there are a number of types of day care institutions available on a full-day all-year basis. The day care centres are managed either by the local authorities or by private organisations. Two out of three creches for the 0-3 years olds are managed by the local authorities. Most of the kindergartens *(jardins d'enfants)* are managed by private organisations.

Most children start pre-primary school *(école maternelle)* at the age of 3, but often the *école maternelle* provides for the 2 year old as well. About a third a the 2 year olds attend nursery school and almos all children aged 3-5 years. The *école maternelle* is part of the educational system and is the responsibility of the Ministry of Education. They are free of charge, whereas parents' fees cover about 28% of the cost of daycare institutions within the social welfare sector.

Private non-subsidised services are mainly provided by family day carers or by carers working in the home. Both are indirectly subsidised through tax relief for parents costs by payments covering social security contributions for the carers.

Figure 8.6.
Day care arrangements, enrolled children (aged 0-5) as a percentage of the age-group, 1996.



Source: SESI: Annuaire des statistiques sanitaires et sociales 1997. MENRT-DEP: Repères et références statistiques sur les enseignements et la formation 1996.

There is also a potentially long parental leave, up to 3 years, but the allowance paid out is rather low and only given where there are at least two children in the family. The scheme has been improved and take up is rising but still quite low.

France combines relatively high public expenditures that directly subsidize public services with a comprehensive system of direct subsidies for parents. All parents have a general tax relief, grants are provided for families using family day carers, and the family allowance funds cover social security contributions, which the parents have to pay as employers if they employ a family day carer or a private day carer in their own home.

8.6.2. General principles for child care

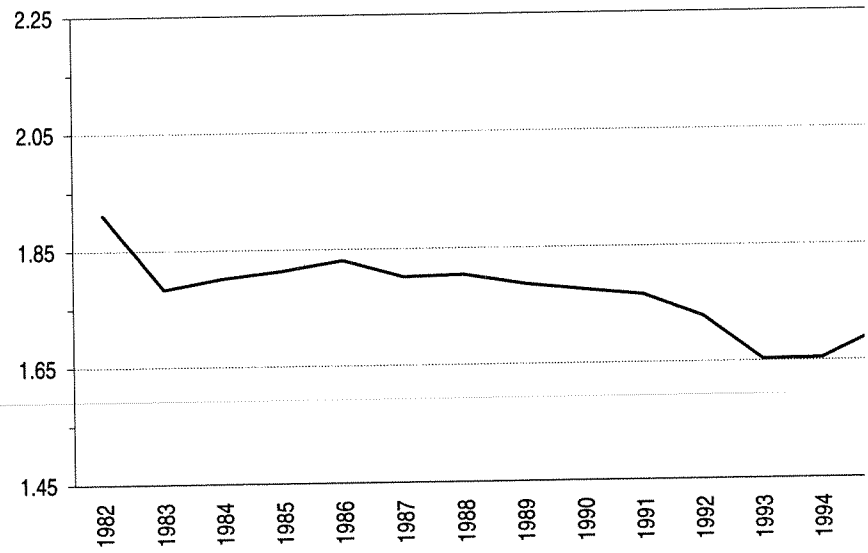
Family policy has traditionally been a very high priority in France for pronatalist reasons. Families with children and especially families with many children have been subsidised by general family benefits and by tax reductions.

In France policy has been to offer a range of measures for care of children and thereby support the labour market participation of the working mothers. In addition to the direct subsidies to day care institutions a general tax relief is available to the parents to compensate for the cost of day care, and grants are provided for those using self-employed and not publicly subsidized family day carers, while social security contributions are covered for those, who as employers are employing a private carer in their own home. In recent years furthermore employment of domestic help has been heavily subsidized by tax deductions. The parental leave scheme has also been improved but still the incentives for taking a career break while the children are under 3 years of age are small except for low-skilled unemployed women.

Uniquely in the EU the employers in France contribute to the costs of services by compulsory contributions to The Family Allowance Funds - CAF's. They pay about a quarter of the total cost for services in the social welfare system, and play a very active role in stimulating the growth of local services.

Services in the welfare system and the educational systems have different functions. Schools in principle do not offer care but education.

Figure 8.7.
Total fertility rate, 1982-1995.



Source: INSEE: La situation démographique en 1995.

The entrance of the 2 year old children into the *école maternelle* has not been met with universal approval. Both childhood specialists and parents have been

critical. But free entry to nursery school does provide a solution for families that must have a full day of care for their children, and many families make use of it for this reason.

8.6.3. The need for day care

In France, a relatively large proportion of women are economically active. The proportion of all women of working age (15-64) in the labour market has increased from 58% in 1985 to 62% in 1996. However unemployment rates for women have been somewhat higher than for men. In 1996 unemployment among women was 14.7% and 10.6% for men (EC, 1997). Employment rate for women in working age was around 53% in 1996. 30% of the employed women were working part time. As mentioned above the family in France has been given a high priority based on population policy reasons. As part of this policy a system of rather generous family allowances has been combined with an increasing provision of day care possibilities, which has facilitated the labour market participation of women. From the age of 3 almost all children attend nursery school and the possibilities for care outside school hours are increasing. With an increasing proportion of women wanting to keep up their working life even when they have small children, there is some pressure on day care facilities for children under 3. But increasingly 2 year old children are attending nursery school, the number of places in *crèche collective* and - *familiale* is growing, and the possibility of employing a child minder in ones own home has improved. However, the parental leave has also been improved and an increasing number of women may choose to stay at home until the children are 3 years old, especially low skilled women.

The total fertility rate has decreased a little from around 1.9 in 1982 to 1.65 in 1994 and 1.7 in 1995, but still the rate in France is higher than in most central and southern European countries.

8.6.4. Child care in the home

Maternity leave (Congé de maternité)

Women insured for at least 10 months by contributions paid to the sickness insurance scheme for 1200 hours of work in the previous year are entitled to maternity benefits in the form of 6 weeks before and 10 weeks after birth - in all 16 weeks (26 weeks for 3rd and subsequent child + extra for multiple births). Payments are 100% of the basic daily wage with a maximum of 351.91 francs a day (1996). Many collective agreements provide for women with higher salaries to receive full pay while on maternity leave. During the first year after birth, employed women who breast-feed are entitled to two 30 minute breaks per day from their employment.

Paternity leave (Congé de trois jours pour naissance)
The father has a right to a short paternity leave of 3 days, to be taken within 15 days before or after the birth with full salary paid by the employer. Some will have more days according to agreements.

Parental leave (Congé parental d'éducation)
In France there is a right to parental leave during the first 3 years of the child's life. The leave can be taken by either parent, shared or alternated. Parents taking leave can work part time. The leave is unpaid, but for the second and subsequent child a qualifying parent can receive a parental allowance *(Allocation Parentale d'Education -APE).* The condition is that the recipient has been economically active in 2 of the preceding 5 years. Periods spent on maternity leave, unemployment or in education are qualify as activity. For the third and subsequent child the requirement is 2 years of activity within the last 10 years.

Regular statistical information on the overall use of parental leave in France is unavailable. A 1992 survey estimated that parental leave was taken in about 10% of dual income households with children under 3 years of age, and that 99% of the parents taking leave were women. Around 50% of the parents taking leave had three or more children, when taking leave also qualified them for an APE payment. The length of leave taken varied with occupational status. Those employed in better paid jobs were less likely to take the full three years. Less than 15% were taking leave part time (EU, 1994).

The non means tested benefit was introduced in 1985. However, in 1994 the benefit scheme was improved considerably. The allowance was extended to parents with two children, for children born since July 1995. Previously the *APE* was only paid to parents with three children or more. And until 1. January 1995 employers with fewer than 100 employees could refuse to allow parental leave if they considered that the leave would prejudice production. Under the new Family Law of 1994 all employees with one year's seniority have a right to take parental leave and to return to the same or a similar job. Also training can be undertaken during leave. People who have taken career breaks of at least five years to care for at least two children are eligible for professional re-training. Furthermore it is now possible to take part time leave and receive a reduced benefit. A Family may receive two part time benefits.

In 1996, the allowance was 2,964 FR a month for recipients on leave full-time, 1,960 FR if the recipient worked part time (less than 50% of full time i.e. less than 19.5 hours a week), and FR 1,480 if working hours were between 50% and 80% of full time hours. The allowance is not taxed. The enlargement of the

scheme has led to a considerable increase in the number of families receiving the *APE*. In 1991 174,000 families received the *APE* allowance. In 1996 it was 343,000 families. 99% of the claimants were women and only 15% received a reduced benefit because of part time work. Part of the background for the increase may be high unemployment in combination with the strong incentives to withdraw from the labour market especially for low-skilled women registered as unemployed. (Fagnani & Strobel, 1998).

Leave for family reasons (Congé pour maladie d'un enfant)

From January 1995 on employed parents were entitled to 3 days leave a year to care for a sick child under 16. This is increased to 5 days if there is a child less than 12 months old or there are three or more children in the family. If there is a child with a serious illness or handicap the parent is entitled to work part time for up to 6 months - renewable for another 6 months. The leave is unpaid unless the employee is covered by collective agreements, which provide for payments.

According to collective agreements all women and all divorced or widowed men in the public sector are allowed 12 days leave a year to care for a sick child, and a substantial amount of agreements in the private sector make a similar provision - sometimes for men and women, sometimes for women only.

Home child care allowance
(AGED - Allocation de garde d'enfant à domicile)

This allowance was introduced in 1987 to cover social security contributions where parents employ a person to mind their children under 6 years of age at home (before 1995 only if children were younger than 3 years). From 1995 the scheme was also improved; the amount now covers the total contributions to be paid by the employer and the employed with a minimum salary *(SMIC)*. In 1997 the amount was 4,279 FR per month, which is paid directly by the *CAF* to the *URSSAF*, which is the agency that collects social security contributions. Half of the amount is granted if the child is 3-5 years old. Furthermore, since 1995 families that claim *AGED* can also make use of the fiscal benefits aimed at increasing domestic employment, and so may deduct in income to be taxed 50% of the cost of employing a person to care for the child/children at home (salary and costs not covered by the *AGED*) up to a maximum of FR 90,000 a year in 1996, bringing the maximum income-tax reduction to FR 45,000 a year. The value of this, however, varies with income. In 1994 14.7 million households were subject to income taxation - only 10% of them paid at least 45,000 FR in taxes per year (Fagnani & Strobel, 1998).

These improvements have led to a rise in the number of families receiving *AGED,* from 25,000 in 1994 to 67,000 in 1997. Expenditures on the family sector rose 73% from 1995 to the amount of FR 1,619 million in 1996.

The improvements have been severely criticized by the audit office in France because the combination of the *AGED* and the tax reduction for domestic employment means that local authorities may cover as much as 70% of the total costs of employment, including 50% of the net salary (Fagnani & Strobel, 1998).

8.6.5. Child day care outside the home

In France there are two separate systems of publicly funded day care services for children under 6 years. Almost all children aged 3-6 years are in pre-primary school *(École maternelle),* which is the responsibility of the Ministry of Education, although local authorities are responsible for non-teaching staff, lunch and supervision during the break in the middle of the day. Compulsory schooling starts at 6 years. Also children aged 2 years may attend the *École maternelle*, which during term time is open between 08.30 and 16.30 but usually closed on Wednesdays. The children can stay during the two hours lunch-break if the local authority provides lunch and supervision.

The other system is the responsibility of the Ministry of Social Affairs, Health and Towns and of local authorities. In addition the *départemental* family allowance funds *(Caisse d'Allocations Familiale - CAF's),* and their national organisation *(Caisse Nationale d'Allocations Familiale - CNAF)* subsidise services and stimulate development through *contrats enfance* programmes with local authorities to support the expansion of services for children under 6 years. Within the social welfare system there are several types of day care centre and one organised family day care system.

Crèche collective for children 0-36 months, open on a full-day, all year basis.

Crèche parentale for children 0-36 months, open on a full-day, all year basis, managed by an association of parents, who may also work in the centre alongside qualified workers.

Crèche familiale organised family day care for children 0-36 months.

Halte-garderie for children from 0 to 6 years, but mainly used by children under 3 years. Opening hours vary according to local needs, sometimes offering regular part time care and sometimes only opening on certain days.

Jardin d'enfants - kindergartens - are not very common. Open for children aged 0-6 years on a full-day all-year basis.

Garderie périscolaire school based service for children attending *école maternelle* outside school-hours. Closed during school holidays.

Centre de Loisirs sans Hérbergement - CLSH for school-age children under and over 6 years outside school-hours on an all-days and all-year basis. They are located in a school or outside and usually open from 8:00 .am. to 6:00 p.m. or 7:00 p.m.

Besides the centres there are family day carers ***- assistante maternelle*** - who may be employed by the local authorities in a *crèche familiale* or may be self employed. They are mainly for children aged 0-6 years, but also for older children outside school hours.

Day care services are indirectly subsidised through tax deductions for parents' costs and other payments. Families, where both parents are working, enjoy a tax reduction of maximum FR 3,750 per year.

École maternelle

The *école maternelle* is part of the educational system and in 1986 a government circular emphasised, that the purpose of the *école maternelle* is not to provide care, but to introduce children to school, to socialise them and for them to learn. They are funded by the Ministry of Education and parents do not pay any fees. Local authorities, however, are responsible for providing lunch and supervision during the break in the middle of the day.

The école maternelle is open during term-time and for the same hours as primary school, that is from 8:30 a.m. to 4:30 p.m. every weekday except Wednesday, when schools are closed in the afternoon. In addition the schools are open Saturday morning.

Coverage

Almost all children in France aged 3-5 years attend the *école maternelle.* The provisions for the 0-2 year old children is less extensive covering 11-12% of the age group. Most schools provide care arrangements before and after school hours as well as during lunch hours, with a hot meal served. Apart from the traditional closing of schools on Wednesday afternoon and during the vacation periods, almost all children are looked after on a full time basis from the age of 3 years. The children in France spend a lot of time outside the family home.

Staff

The staff in the *école maternelle* have a 5 year higher education as an *Institutrice/instituteur.* She/he may be assisted by an *Agent Spécialisé des Écoles Maternelles (ASEM),* who has no initial training, but must acquire a *Certificat d'Aptitude Professionnel petite enfance* through one year of work experience in an approved institution and some courses.

Table 8.1
Nursery education, number and% of FTE children according to provider, 1982-1996.

Year	Number of FTE children		%			
		% of the children aged 0-5	0-2	3-5	Public	Private
1982	1,567,388	35.19	..	..	98.16	1.84
1983	1,604,019	35.40	..	..	98.16	1.84
1984	1,644,218	36.27	..	..	98.12	1.88
1985	1,671,076	36.71	10.43	99.99	98.15	1.85
1986	1,663,186	36.46	11.24	96.70	98.17	1.83
1987	1,658,844	36.58	11.91	97.31	98.19	1.81
1988	1,653,893	36.77	12.12	98.36	98.17	1.83
1989	1,675,794	37.37	11.89	98.73	98.15	1.85
1990	1,687,800	37.55	11.93	98.89	98.10	1.90
1991	1,689,714	37.41	11.55	99.34	98.07	1.93
1992	1,681,101	37.05	11.61	99.52	98.10	1.90
1993	1,675,486	37.22	11.84	99.90	98.24	1.76
1994	1,659,990	37.36	11.90	99.63	98.35	1.65
1995	..	..	11.73	99.24	..	..
1996	1,633,950	37.56	11.49	98.11	98.53	1.47

Source: MENRT-DEP: Repères et références statistiques sur les enseignements et la formation (annual publication).
Note: 1 enrolled child = 0.87 FTE child.

Standards

In 1993/94 the staff-child ratio was on average 1 *institutrice* for 27 children. The *institutrice* may be assisted by an assistant *Agent Spécialisé des Écoles Maternelles (ASEM),* who are in every school but not necessarily in every group.
The *école maternelle* for the 2 year olds is sometimes criticised for not always being suited to the needs of very young children (EU, 1996), that is for not always having satisfactory facilities for rest and sleep and for having too many children in each group.

Day care centres

Day care services *(creches)* under the welfare system for children aged 0-2 are mainly for children with parents in work. Parental employment is the main criteria for admission. In addition children at risk may be given priority depending on the

local authority. Parents not in work may make use of the *haltes garderies* for some hours during the week, where the parent may do shopping or other activities.

Funding and costs

The publicly funded day care services are funded by the local authorities and the CAF's. Parents payments are based on a formula set by the CNAF, which takes family income and the number of children into consideration. In 1993 the parents contribution amounted to 28% of the total cost of *crèches (collective and familiale)* and 23% of the costs of the *haltes garderies*, local authorities contributed 34 and 47% respectively and CAF's 23 and 22%, (EU, 1996).

Coverage

At the end of 1993 there were 118,500 places in *crèches collective*, 8,200 places in *crèches parentale* and 65,000 places in *crèches familiale.* That is all together 191,700 places for 0-2 years old children. In addition there were 60,000 places in *haltes garderies* that are shared by an estimated average of 5 children or more, so that about 325,000 children benefitted from this. The number of places for the 0-3 years old children in these institutions and the 250,000 places in *école maternelle* for 2 year olds all together adds up to about 23% of the total age group.

Table 8.2.
Day nursery, number and% of FTE children according to provider, 1983-1996.

Year	Number of FTE children	% of the children aged 0-5	%	
			Public	Independent
1983	118,974	2.63	66.15	33.85
1984	126,231	2.78	65.68	34.32
1985	..	..	..	..
1986	130,700	2.87	64.50	35.50
1987	140,400	3.10	64.74	35.26
1988	148,900	3.31	64.27	35.73
1989	156,878	3.50	63.57	36.43
1990	165,991	3.69	64.50	35.50
1991	173,854	3.85	64.63	35.37
1992	181,884	4.01	63.69	36.31
1993	188,100	4.18	64.97	35.03
1994	192,200	4.33	66.02	33.98
1995	192,062	4.38	66.19	33.81
1996	196,889	4.53	67.99	32.01

Source: SESI: Annuaire des statistiques sanitaires et sociales (annual publication).
Note: 1 enrolled child = 1 FTE child.

Most of the 3-6 year old children are in the *école maternelle*, but a further 11,800 places for this age group are in kindergartens *(jardins d'énfants)*.

Also in the *Centre de Loisirs sans Hérbergement- CLSH's* there are places for the 3-6 years old children attending the *école maternelle*. In 1993 there were 278,000 places.

Staff

There are a number of different qualifications for the staff in the day care institutions: a *puéricultrice* has a 4 year higher education as a medical nurse. The director of a *crèche collective or familiale* must be a *éducatrice* or *puéricultrice*.

Table 8.3.
Drop-in institutions, number and% of FTE children according to provider, 1987-1996.

Year	Number of FTE children	% of the children aged 0-5	%	
			Public	Independent
1987	14,076	0.31	93.72	6.28
1988	14,552	0.32	92.06	7.94
1989	16,018	0.36	90.87	9.13
1990	17,193	0.38	89.81	10.19
1991	17,972	0.40	89.70	10.30
1992	18,955	0.42	89.98	10.02
1993	19,856	0.44	90.41	9.59
1994	20,434	0.46	90.68	9.32
1995	21,515	0.49	90.34	9.66
1996	21,981	0.51	90.32	9.68

Source: SESI: Annuaire des statistiques sanitaires et sociales (annual publication).
Note: 1 enrolled child = 0.33 FTE child.

Standards

In day care centres the staff-child ratio is 1 adult to 5 children who do not yet walk and 1 adult to 8 older children below 3 years. Half of the staff must be *auxiliare de puéricultrice* and there must be at least one *educatrice de jeunes enfants.*

In a *garderie périscolaire* there must be 1 adult for every 10 children aged 2-6 years, but not any requirements for education or training.

Family day care

Family day care is provided by public authorities in the *crèche familiale* or by self employed family day carers. It is made use of by 0-3 year olds on a full day basis and by older children after school hours.

Crèche familiale

The organised family day care *(crèche familiale)* was introduced as a general scheme in 1971 in order to meet the need for day care places outside the Paris area, but the first organised family day care scheme was established in 1959. The director of the *crèche familiale* employ day carers *(assistante maternelle)*, provide training for them, places the children, makes visits once a week and provides toys for the children. The children are cared for in the home of the day carer, but the day carer is employed in the centrally organised institution. There is on average 30 family day carers per crèche familiale.

In a *crèche familiale* there has to be one *assistante maternelle* for every 3 children. The director must be an *éducatrice* or *puéricultrice*.

There are no requirements for the initial training level of an *assistante maternelle*, but since 1992 it has been compulsory to do a minimum of 60 hours approved training during the first 5 years, of which 20 hours must be done during the first two years.

66,000 children under 3 years of age were cared for under the organised family day care schemes in 1994. The number of places almost doubled between 1981 and 1993.

Public authorities fund most of the organised day care schemes. Local authorities contributed to 35% of total costs, *départements* 7% and the regional family allowance funds *(CAF)* contributed 22%. The remaining 34% is paid by the parents, who make an income related payment.

Assistante maternelle agréée - AFEAMA

Private non-subsidised day care services, including family day care, should be approved by public authorities - that is the maternal and infant welfare services *(Protection Maternelle et Infantile - PMI)* of the *Conseil Général* in each *Département*. This approval is given to the day carer (*assistante maternelle agréée)* after inspection of the home in order to secure the health safety and development of the children. The approval is valid for 5 years, but can be withdrawn.

If parents make use of a self employed approved day carer (*assistante maternelle agréée)* they can receive a support *(Aide à la Famille pour l'Emploi d'une*

Assistante Maternelle Agréée -AFEAMA) in addition to the general tax relief for day care expenditures. The *AFEAMA* consists of a financial contribution to the parents and a payment from the CAF to cover the social security contributions for the employed day carer paid by the employer. The payments for coverage of social contributions are paid directly to the *URSSAF* (the body collecting social security contributions). The financial support to the parents amounts to FR 800 a month (1995 and 1996) if the child is under 3 and FR 400 if the child is between 3 and 6. One of the aims of the *AFEAMA* was to get the work of day carers out of the grey economy in addition to the aim of reducing child care costs. The *AFEAMA* has increasingly been successful. In June 1996, 350,000 families were receiving it. The total expenditures for the family sector amounted to FR 7,032 million in 1996.

In 1994 self employed and approved family day carers were estimated to be caring for 340,000 children under 6 years, of which 200,000 were under 3 years of age.

An *assistante maternelle agréée* should have a maximum of 3 children including her own under care.

Support services for the *assistante maternelle agréée* are being developed, partly by funding from the *CAFs,* which in 1994 paid 69% of the costs of these services. The rest was paid by local authorities (22%) and the *départements* (7%) (EU, 1995). The services may be managed by public authorities or by private organisations. They are different but some of them offer advice from a range of types of staff including nurses, social workers, family therapists. They offer training sessions, opportunities for the *assistante maternelle agréée* to meet and for the *assistante maternelle agréée* children to play, arrange excursions etc. In 1994 there were 200 such *relais assistante maternelle* in France, and the goal is to establish 1 *relais* for every 100 *assistante maternelle.*

8.7.
Social services for older people

8.7.1. Introduction - Main social services and care cash benefits

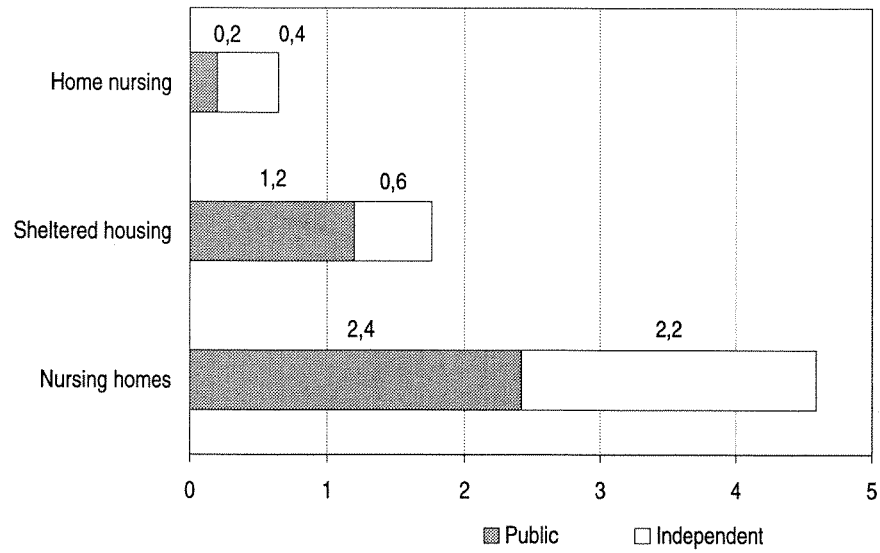
France has a particularly complex system for supporting old persons in need of care with a set of services and financing mechanisms which are still not very coordinated, but offer a variety of services for the elderly in need of help and care. The financing of residential care and home care service is divided between sickness insurance, pension insurance and social assistance funds of the local municipalities for the poor.

Care services in the home have been a priority for both central and local government since the early 1980s. The services, however, still vary greatly from area to area both in components and coverage, and subsidies for home help are only granted to persons with resources below a certain ceiling.

8.7.2. General principles for care services for older people

The costs are divided into a health component covered by health insurance and a social component which is to be covered by ones own means, by means tested subsidies from pension schemes or by social assistance benefits if one qualifies.

Figure 8.8.
Use of main social services for older people aged 65+ as a percentage of the age-group, 1996.



Source: SESI: Annuaire des statistiques sanitaires et sociales 1997.

The sickness insurance covers medical treatment in hospitals and in the home given by nurses and assistant nurses or other para-medical personnel. Practically all citizens are covered by the basic sickness insurance, which pays about 75% of the costs. 83% of the population have a complementary insurance, which covers the rest of the costs.

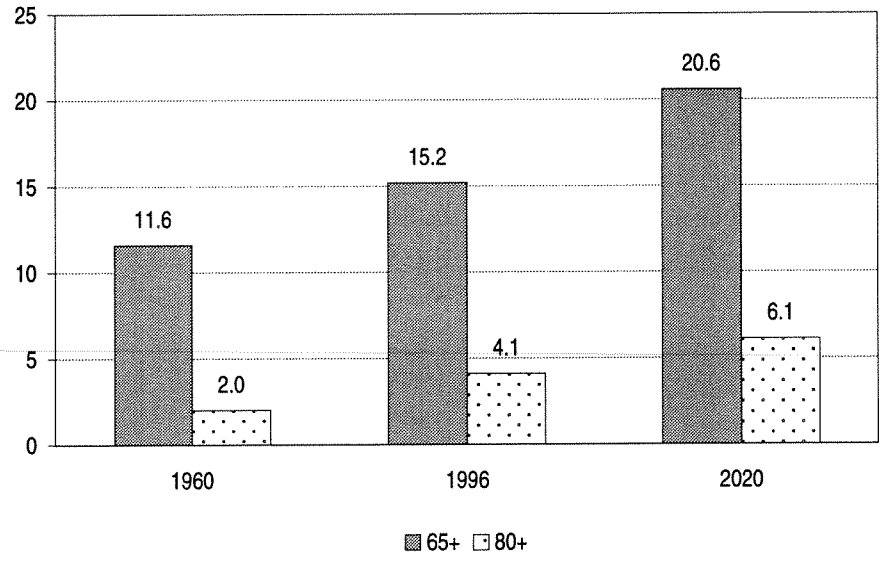
The responsibility for providing continuing help with daily domestic activities beyond medical treatment and nursing is effectively still a family matter in France, and the role of the state is confined to providing a safety net to those

without the sufficient resources and family support. The aim is not to cover the care costs of those with resources above a social assistance level of income. Those below this level have all their costs covered from social assistance budgets with a test of income and assets. In addition some people will have the possibility of getting support for home help from pension funds, but this support is means tested, and only benefits a limited number of dependent persons. However, lately the possibility for employing home helpers has been improved considerably through different job-creation programmes, and this employment policy is most likely going to have a large impact on the provision of home help services in France.

8.7.3. The need for care services

An aging of the population is taking place in France as in other European countries. In 1982 13.5% of the population was 65 years of age or more. This proportion have increased to 15.2% in 1996 and is expected to rise rather sharply to almost 21% by the year 2020. The proportion of very old persons (85 years or more) among the group aged 65+ has increased from about 8% in 1982 to about 13% in 1996. In 2020 the proportion of very old is expected to be around 16% of the total group of persons aged 65 or more.

Figure 8.9.
Older people (65+) as a percentage of the population by age-group, 1960-2020.



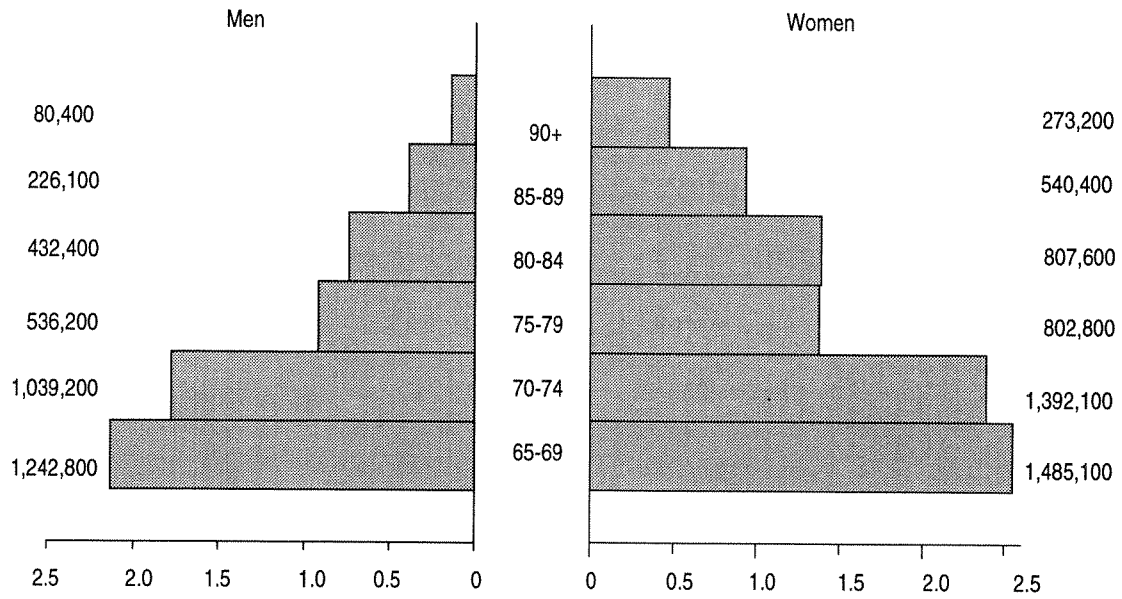
Source: EUROSTAT: Demographic statistics 1997.

8.7.4. Community care

Home help (Aide à domicile/aide ménagère)

Help with domestic tasks for frail elderly persons is effectively still the responsibility of the family and the role of the social welfare system is confined to providing a safety net for those without the sufficient resources and family support. They can receive an allowance for home help through their pension fund subject to a test of family income *majoration pour tierce personne* if the invalidity was diagnosed before the age 60, or they could apply for an allowance from the social assistance system paid by the *département* - the *allocation compensatrice pour tierce personne - ACTP*. The ACTP was meant for handicapped persons, but gradually more and more older persons applied and were found eligible for it. This caused an uncontrolled growth in costs in connection with the aging of the population.

Figure 8.10.
Age pyramid of the older people aged 65+ as a percentage of the population, 1996.



Source: EUROSTAT: Demographic statistics 1997.

For many years an improvement in the provision of home help services and an improvement of the allowances has been debated in France. And improvements have lately come about through the introduction in 1997 of a new dependency allowance *Prestation Specifique Dependance - PSD*, which has been accompa-

nied by changes in organisation and the establishment of standard criteria for assessing eligibility for the care allowance. But employment policies have also had a great impact on the provision of home help services.
Among the measures taken to combat unemployment are various ways of reducing the cost of labour within the domestic and care services - *services de proximité.* Associations in the social sector may be exempted from paying social security contributions. This is also the case for persons aged 70 or above, who employ someone to help them. In fact, all private persons with children or elderly or handicapped persons who hire someone to work in or around the home, can deduct from taxes half of the amount spent on wages up to FR 90,000 a year. However, as the minimum level of income to be taxed is FR 100,000 for couples and FR 60,000 a year for single persons only households with a substantial income are able to profit from this (Pijl, 1998).

Prestation Specifique Dependance - PSD

The new specific dependency allowance *(Prestation Specifique Dependance - PSD)* started up in 1997 following an experimental programme in *12 départements*, which was administrated by the main old-age pensions agency. The new PSD, however, is part of the social assistance system under the competence of the *départements*, and accordingly is means tested and recoverable from donations and inheritance. But it is stated in the new act that it is introduced while awaiting a new provision to further the autonomy of older dependent persons (Pijl, 1998). This might in due time be as part of the social security insurance system.

The PSD is targeted at persons aged 60 and above, who are heavily dependent on help with daily activities. The dependency is assessed by a medico-social team, consisting of a medical doctor and a social worker, who assess the need for care, decide on the level of benefit and elaborate a plan of help for the elderly. The assessment is based on a newly developed national scale of dependency grille AGGIR *(Autonomie, gérontologie, groupes iso-ressources),* according to their ability to manage a range of 17 daily activities without the help of a third person. The scale distinguishes between 6 categories of dependency. Only categories 1, 2 and 3, needing help for essential activities or constant supervision are entitled to the PSD.

A person who wants the allowance must apply to the elected President of the General Council of the *département,* with a certificate from the medico-social team and evidence of financial situation based on tax-papers. The PSD is granted for a limited period after which a new assessment from the medico-social team is required.

The allowance has to be spent on the salaries of employed persons, but a maximum of 10% can be used for other purposes such as technical aids, if this is indicated in the care plan. The money for salaries can be paid out as an employment service cheque to the person receiving PSD or directly to an approved care providing association or by the new device called *chèque autonomie* (see below). In this way the PSD is considered to be a provision in kind. The PSD has a ceiling of FR 4,477 a month in 1998, which will be paid at the maximum level to persons with net income including the PSD of less than FR 10,477 for a single person and FR 14,477 for couples and with the payment declining beyond this level. It will be recovered from any inheritance which exceeds FR 300,000. Persons receiving the PSD remain eligible for home help granted from the social security system (old age insurance).

Home care allowances from old age insurances

Some of the different pension insurance schemes offer home care allowances to members with resources above the social assistance level. Each system freely determines the level of provision, which results in wide diversity. The assessment of need can follow the rules of the public sector. The allowances are means tested with different ceilings, and different amounts granted for subsidy per hour of home help. The maximum hours of help granted in general is 30 hours a month.

Provision

Home care service is provided by public or private agencies. The public provider is usually the local centre for social action CCAS. The private providers are associations, which often belong to one of the four larger national umbrella organisations. Both the public and the private providers can have comprehensive services including both home nursing and home help, or they can be specialised in one type of service provision. In smaller towns there is usually only one provider, either public or private. In bigger cities there might be some competition between different service providers, but in general it is the perception, that there is no competition and so not a home care market in France (Pijl, 1998) .

Both public and private care providers have to be approved and authorised by the prefect of the *département*. Private for-profit firms have been since January 1996 allowed to enter the home care market. So far only a very few examples of this have appeared (Pijl, 1998).

Independent self-employed persons may be approved as service providers. Independent nurses specialise in medical treatment, whereas the associations usually provide the more time consuming personal care activities.

Home helpers employed as part of the employment schemes are often not employed by the associations, as the person in need of help has to be the employer in order to profit from the tax-deduction possibility and the other advantages, which are a part of the employment schemes. The associations in such cases offer a *service mandataire*, whereby the association takes over the formalities of hiring and firing, paying out salary and social contributions, while the user formally remains the employer. In addition the association can provide a replacement during holidays or illness of the home helper. And the association may find a new employment for the home helper if the user is hospitalised or dies. Under the *service mandataire* the employer pays the minimum wage plus a fee to the association of FR 15 per hour. In all the employer pays between FR 50 and FR 60 per hour. The full price for regular home help is about FR 80 per hour (Pijl, 1998).

Another possibility created by the job-creation schemes is to set up an intermediary association *(association intermédiaire),* which helps the unemployed in finding jobs in or around the house, including care for children or dependent old persons. The intermediary association remains the employer, but does not have to pay the social contributions, so that they can offer home help for about FR 60 per hour, and the user still gets the fiscal advantages.

Persons, who employ home help and want to manage the practical problems themselves may use the *cheque emploi service,* which can be bought in banks. This cheque consists of one part, which is used to pay the employee, and a second, which documents the payment, and is sent to the national agency URSSAF, so that they can collect the social security contributions from the bank account of the employer. This document can then be used by the employer to claim the tax-reduction, and serves as evidence for the employed of his social security rights. The *cheque emploi service* thus guarantees a person finding a part-time job in the care sector at least the minimum wage and that contributions are paid to social security insurance (Pijl, 1998). Because of the rather favourable provisions for employing home helpers it is considered, that the grey market employment of home helpers has become uninteresting for the employers as well as for the employees.

Staff

There are no statutory requirements for training for home helpers. The public agencies or private associations employing the home helpers often offer internal training programmes, but they are not officially recognised. Some home helpers get a specific training, subsidised by the Ministry for Solidarity, and get a certificate of aptitude for functions of home help (CAFAD), which, however, does not lead to an increase in wages. They are mostly employed by larger municipalities.

Standards

Home helpers mainly carry out housework, and in a few cases personal care such as dressing and bathing. These types of activities are usually carried out by home nurses and/or assistant nurses.

The quality of the service provided by the regular public agencies or private associations is in general considered to be good, as these agencies offer training and supervision to the employed home helpers, who have good working conditions, due to collective agreements (Pijl, 1998). If the dependent person makes use of the *service mandataire* he can choose the home helper himself, but there is no supervision and guarantee of training. However, it is often the same home helpers, who work partly within the regular agencies and partly with the *service mandataire* -scheme. Home helpers working within the intermediary associations were previously unemployed, and so have very varied qualifications. It may be expected that the intermediary associations offer less expertise, as their main purpose is to create jobs and not the provision of home help (Pijl, 1998).

The number of hours granted has been decreasing. In general the maximum number of hours granted is 30 for single persons and 48 hours for couples.

Coverage

In 1992, it is estimated that in all 522,000 persons aged 65 or more made use of home help services (Lebeaupin, 1996). This corresponds to 6.2% of all persons aged 65 or more. This coverage had increased slowly during the 1980s. In 1982 it was estimated that about 436,000 elderly persons received help from the social services (Rozenkier, 1990). That corresponds to 5.8% of the population aged 65 or more in 1982.

In 1992, the old age receipients together with around 17,000 persons under 65 years of age received around 81 million hours of help. So the average number of hours supplied was 150 hours a year per recipient or 2.88 hours per week on average.

A major part of the benefits granted for home help are granted by the pension insurance schemes. The major national insurance association for salaried workers CNAVTS granted home help benefits to 316,000 persons in 1996. About 100,000 received a benefit from the social assistance scheme.

Home nursing care (SSIAD - service de soins infirmiers à domicile)[1)]

Home nursing care has been covered by sickness insurance since 1981. Before that the home nursing service was a small entirely self-employed service. The sickness insurance covers medical treatment in hospitals, residential homes and

1) Home nursing 'service de soins à domicile' is included in the chapter on France, as this service mostly carries out personal care and light health care.

at home, given by nurses, assistant nurses and other para-medical personnel. Also personal care is in general the responsibility of home nursing separate from home help. Practically all citizens are covered by the basic sickness insurance, which pays about 75% of the costs. In order to discourage over-consumption a co-payment is asked of users *(ticket moderateur)*, but if the person has complementary insurance, the costs are likely to be covered by this. About 83% of the population has joined a complementary insurance.

The principal function is to give nursing and personal care with the objective of preventing, postponing or shortening stays in hospitals.

Table 8.4
Home nursing, number and% of recipients (65+) according to provider and staff per 100 recipient, 1983-1996.

Year	Number of recipients (65+)	%			Staff ratio
		65+	Public	Independent	
1983	19,634	0.27	..	..	..
1984	23,338	0.33	..	..	35.56
1985	26,573	0.38	..	..	..
1986	28,228	0.39	..	..	..
1987	30,382	0.41	..	..	..
1988	34,870	0.46	..	..	..
1989	38,322	0.50	..	..	..
1990	42,761	0.54	..	..	..
1991	42,388	0.53	28.13	71.87	..
1992	47,468	0.58	..	..	..
1993	51,809	0.62	..	..	..
1994	54,470	0.64	..	..	..
1995	55,379	0.64	..	..	..
1996	56,650	0.64	30.72	69.28	17.18

Source: SESI: Annuaire des statistiques sanitaires et sociales (annual publication).

Entitlement

The eligible population is theoretically all persons aged 60 and over for whom nursing care has been prescribed by a doctor. Need in itself, however, does not always guarantee home nursing, as the services are rather scarce in some areas (Henrard et al., 1991).

Provision

Home nursing care can be provided by a public or private body, for example the social service centre of a municipal authority or a nursing centre attached to a hospital, a public or private retirement home or a home help association. Authorisation is given by the prefect of the *département* after advice from the consultative regional board for social and medico-social institutions. A maximum price for daily care is set jointly by the ministers responsible for health and social security.

Coverage

There has been a rapid growth in the capacity of home nursing services, from about 3,000 in 1981 to about 56,000 places in 1996. The number of places in 1996 corresponds to 0.65% of the population aged 65 and over. The average level of dependency of those receiving home nursing is high. Mostly the home nursing carer carries out personal care and light health care. Real nursing duties were only necessary for one person out of six in 1987 (Henrard et al. 1991).

Standards

The number of visits varies, but in 1987 the average number of visits to the least dependent group was 7.6 visits a week and 10.3 visits a week to the most dependent group (Henrard et al., 1991).

Staff

A salaried nurse co-ordinates the activities. The employed nurses can be salaried or private, independent nurses, who have an agreement with the managing body and have paid holidays. In 1984 there were 650 services employing 1,400 salaried nurses and 3,500 care assistants, and with agreements with more than 3,500 independent nurses. The nurses have a three year education which leads to a state diploma. Most of the home nursing activities - especially personal care - are carried out by assistant nurses, who have a practical and theoretical training leading to the *Certificat d'Aptitude aux functions d'Aide et Soignant - C.A.F.A.S.*

8.7.5. Auxiliary care services

Home improvements and adaptations

They are mainly financed by local governments - with a subsidy from the central government, but pension schemes also contribute on a discretionary basis. About 45,000 homes benefit from this annually

Community services

Community services such as meals-on-wheels, alarm systems and subsidised restaurants are supplied by local governments and vary between regions.

8.7.6. Institutional care

The present structure of institutional care dates back to legislation enacted between 1970 and 1977, in which the role of general hospitals was limited to acute care and a separate category of long-stay wards was created within hospitals.

Also conditions were set for retirement homes *maisons de retraite* to set up 'medical sections' *(sections de cure médicale)* and thereby take on the function of nursing homes. In 1975 the old *hospices* - hostels - which were the traditional institutions for poor elderly people - were abolished and replaced with or adapted to retirement homes with medical sections.

Besides residential homes sheltered accommodation is provided in the *logements-foyers.* These provide independent accommodation with supplementary services such as restaurants, alarm systems etc. The aging of residents, however, has led to the sector gradually adapting to increasingly dependent residents.

In addition to the main types of homes mentioned above, there are a number of innovations trying to cross the traditional boundaries between the institutional and home care sectors: *Cantous* are small residential homes accommodating up to 12 persons, who are suffering from dementia in a group living form. *Mapad* are homes offering places to 40-80 elderly people with physical or learning disabilities, and *Marpa* are small homes in rural areas with 7-10 places.

A number of small family hotels and guest houses have developed into special homes for elderly people and are gradually converted to approved residential homes.

Table 8.5
Places in retirement homes and sheltered housing 1986-1996.

	Residential homes:					Sheltered housing:				Other	In all
	Public long stay wards in hospitals	Public	Private non-profit	Private	All	Public	Private non-profit	Private	All		
1986	114,476	99,614	89,647	21,188	324,925	85,930	32,187	2,811	120,928	6,364	452,217
1988	113,563	98,394	90,899	26,268	329,124	92,164	33,632	3,182	128,978	7,142	465,244
1990	108,370	103,233	100,759	40,299	352,661	99,226	39,238	4,014	142,478	8,035	503,174
1992	104,916	108,289	108,262	54,659	376,126	102,365	41,556	4,884	148,805	4,416	529,347
1994	100,994	113,111	115,408	65,119	394,632	105,300	42,960	5,107	153;397	4,109	552,138
1996	98,630	116,202	119,587	72,334	406,753	106,344	43,456	5,903	155,703	3,533	565,989

Source: SESI: Documents Statistique No 259 and No 297. Les Établissements d'herbergement pour personne agées.

Entitlement

A person may get a place in a residential institution if the person is above 65 years of age (60 if the person is unable to work), and not is able to stay at home because of health problems or loneliness.

Coverage

The number of persons in long stay wards associated with hospitals were 77,000 in 1994, and this number had grown by around 9,000 places since 1990, despite the relatively high cost of this form of care. In addition around 30,000 elderly were receiving care in psychiatric wards. Together these forms of care in hospitals cover just over 1% of the elderly aged 65 or above.

The number of places in retirement homes has increased from 325,000 in 1986 to 406,000 in 1996. It is estimated that about 95% of the residents were 65 years of age or more. About 4.4% of the population aged 65 or more were living in a residential home.

The number of places in sheltered housing increased from 121,000 in 1986 to 156,000 in 1996, which amounts to about 1.7% of the population aged 65 years or more were living in sheltered housing in 1996.

All in all 6.1% of the old aged 65 or more in France are living in a residential home or sheltered housing, and including the long-stay wards of hospitals the proportion amounts to around 7%.

Almost half of the places in the residential homes associated with the hospitals are nursing home places. In other publicly owned residential homes the proportion of nursing places is above 40%, but in non-public residential homes only 18%. In sheltered housing only between 3 and 4% are nursing places. In all 24% of all the places in residential homes and sheltered housing had nursing care attached in 1996. As in other European countries the demand for places for very dependent persons is increasing. The proportion of nursing care places has increased from 21% in 1990. The number of nursing care places covers 1.5% of the population aged 65 or more.

The average age of a resident in residential homes or sheltered housing is a little more than 83 years, and three out of four residents are women.

Provision

More than half of the places in residential homes and sheltered housing were provided by the public sector (57%) in 1996. The rest are managed by non-profit associations (29% of the places) and by private companies on a commercial basis (14%). The private commercial sector has expanded their proportion of places from 6% in 1986 to the 14% in 1996, whereas the proportion of places in

the non-profit sector has remained stable. Almost all places in the private for profit sector are in residential homes. There are some regional differences in the provision of places and especially in the south of France the number of places in relation to the number of old persons is below the French average.

Staff

As the number of places occupied by heavily dependant persons are increasing, so the number of full time staff has increased. The number of staff per 100 residents has increased from 30.0 in 1992 to 31.2 in 1992. The increase has taken place in all types of institutions, but mostly in residential homes and long stay wards within the public sector, as the proportion of nursing care places has increased most in these institutions. The staff/resident ratio here was 41 in 1996.

Standards

Gradually more of the places in residential institutions have become rooms with only 1 bed. In 1996 this was the case for 66% of the places in residential institutions within the public sector, for 81% of the places within the private non-profit sector and 60% within the private for profit sector. In long stay wards associated with hospitals the proportion of 1 bed rooms was 56%.

Table 8.6
Full time equivalent staff in residential homes and sheltered housing.

Residential homes:			Sheltered housing:		Other	In all
	Public (incl. long stay wards in hospitals	Private	Public	Private		
Number of full time equivalent staff:						
1992	83,478	54,255	14,050	6,244	1,151	159,178
1994	85,619	60,061	14,894	6,444	1,090	168,078
1996	88,143	65,090	15,722	6,805	918	176,677
Full time equivalent staff per 100 residents:						
1992	38.9	33.3	13.7	13.4	25.9	30.0
1994	40.0	40.0	14.1	13.4	26.5	30.4
1996	41.0	41.0	14.8	13.9	26.0	31.2

Source: SESI: Documents Statistique No 259 and No 297. Les Établissements d'herbergement pour personne agées.

Fees

The residents in sheltered housing pay rent. In residential institutions they are required to pay up to 90% of their income to the payment of board and lodging and the rest may be covered by the means tested social assistance, but the

resident must be allowed to have free use of a monthly minimum. Sums paid out by social assistance can be recovered from his/her estate after the death of the beneficiary. The medical nursing care is financed by health insurance funds.

Persons aged 70 or more may deduct in taxes to be paid 25% of a maximum 15,000 FR a year of the costs of rent or board and lodging. The maximum deduction thus is 3,750 FR.

8.7.7. Support for informal care

Taxpayers who take in a person aged 75 or above have a tax deduction for the benefits in kind that they provide up to a limit of 14,000 FR per elderly person cared for, if the senior citizen does not have their own means above a certain ceiling. Also persons relieved from the *obligation alimentaire* by taking in an elderly relative in need has the tax deduction.

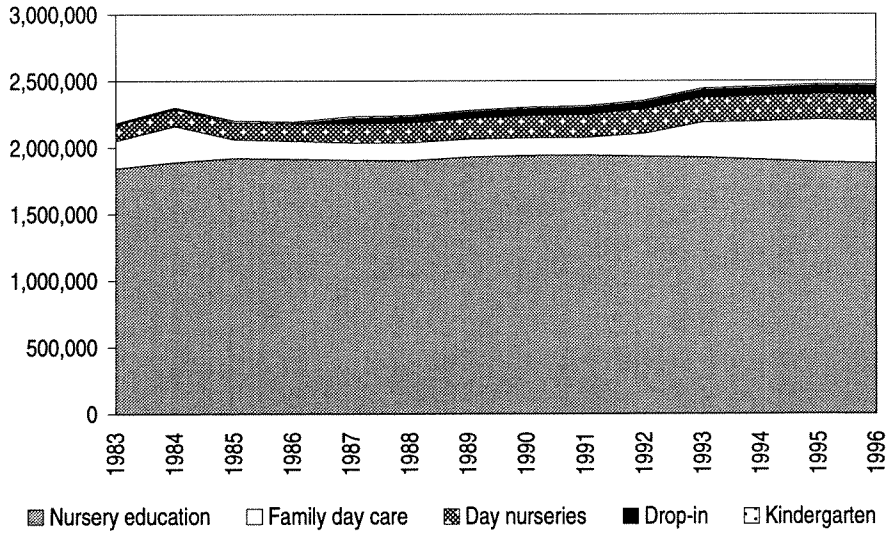
8.8.
Development and changes 1982-1996

The need for day care facilities has put pressure on the provision of day care places although France for many years has had a comparatively high provision. But an increasing proportion of women with children prefer to keep paid work while having children under school age. The number of places both within the educational system and the social welfare system has been extended. From the age of 3 almost all children attend nursery school and the possibilities for care outside school hours have improved. Increasingly the 2 year old children attend nursery school, and the number of places in nurseries *crèche collective* and in organised family day care *crèche familiale* is growing.

In contrast, the parental leave has also been improved and an increasing number of women may choose to stay at home until the children become 3 years of age, especially among low skilled women. Furthermore the possibilities for employing a child minder in ones own home has been improved. In 1987, a home child care allowance *(AGED - Allocation de garde d'enfant à domicile)* was introduced to cover social security contributions where parents employ a person to mind their young child under 3 years of age at home (after 1995 if children are below 6 years). Furthermore since 1995 families that claim *AGED* can also make use of the fiscal benefits aimed at increasing domestic employment, and so may deduct in income to be taxed 50% of the cost of employing a person to care for the child/children at home up to a maximum of FR 90,000 a year in 1996, bringing the maximum income-tax reduction to FR 45,000 a year. These improvements have led to the number of families receiving *AGED* rising from 25,000 in

1994 to 67,000 in 1997. Expenditures in the family sector rose 73% from 1995 to the amount of FR 1,619 m in 1996.

Figure 8.11.
Development in the number of enrolled children (aged 0-5) in the main social services for children, 1983-1996.



Source: SESI: Annuaire des statistiques sanitaires et sociales (annual publication).
MENRT-DEP: Repères et références statistiques sur les enseignements et la formation (annual publication)

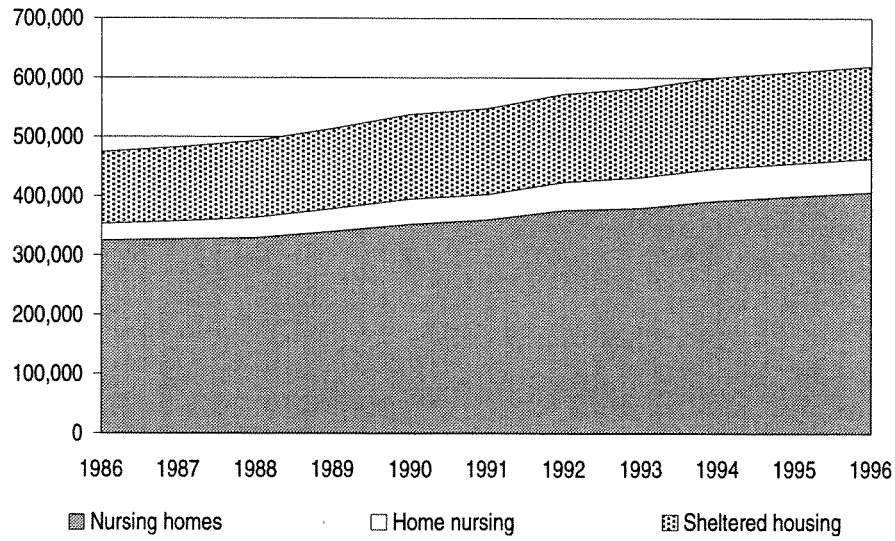
Part of the background for these initiatives is the high level of unemployment in the 1990s, and unemployment rates for women furthermore have been somewhat higher than for men. In 1996 unemployment among women was 14.7%. However, a majority of children are still cared for outside the home at least from the age of 2 and from the age of 3 they all attend the universal nursery school. Also the provision of home help services for elderly persons dependant on help and care has increased, but the rather complex system for supporting the elderly in need of care is still considered to be inadequate to meet the needs. So the responsibility for providing continuing help with daily domestic activities beyond medical treatment and nursing is effectively still a family matter, and the role of the state is confined to providing a safety net to those without the sufficient resources and family support. Persons below a social assistance level of income have their costs covered from social assistance budgets. In addition some people have the possibility of getting support for home help from pension funds, but

also this support is means tested, and only benefits a limited number of dependent persons. However, lately the possibilities for employing domestic help have been improved considerably through deductions in taxes to be paid as mentioned above. This employment policy might have an impact on the provision of home help services in France.

For many years an improvement in the possibilities for supporting dependent elderly staying in their own homes have been debated and a new means tested dependency allowance *Prestation Specifique Dépendance - PSD*, has been introduced, and it has been accompanied by changes in the organisation assessing eligibility and in establishment of a set of standard criteria for assessing eligibility for the care allowance.

Home nursing care has been covered by the health insurance scheme since 1982 and the home nursing services has since been established - sometimes in connection with a hospital or a retirement home. There has since then been a rapid growth in the number of persons receiving home nursing services. The capacity has risen from about 3,000 in 1981 to about 56,000 places in 1996.

Figure 8.12.
Development in the number of recipients of the main social services for older people (65+), 1986-1996.



Source: SESI: Annuaire des statistiques sanitaires et sociales (annual publication).

In 1975 the old *hospices* - hostels - which were the traditional institutions for poor elderly people - were abolished and a process of replacing or adapting to retirement homes with medical sections began. Also sheltered accommodation have increased providing independent accommodation with supplementary services such as restaurants, alarm systems etc. The aging of residents, however, has led to this sector gradually adapting to increasing dependency among the residents. The total number of places has increased slowly and so been following the increasing number of elderly. In all about 7% of the old aged 65 or more in France are living in a residential home or sheltered housing including the long-stay wards of the hospitals.

Box 8.2.
Montpellier, France

1. Introduction
Montpellier is a university city in southwestern France. It is the eight most densely populated city in France with 208,103 inhabitants, including 63,783 students. Children in pre-school age (0-5 years old) constitute 6% of Montpellier's total population and older people aged 65 or more constitute 15%. Montpellier is considered to be a very attractive city to live in, especially due to its location only 6 kilometres from the beaches of Palavas.

There is a high degree of plurality in the social services in Montpellier. The informal care is an important source of care both for the caring of children and for the care of older people. Not only do the family play an important role in the obliged financing of care but also in the provision of care. The formal care is mainly the responsibility of the municipality and voluntary organisations. However, private companies do also have an important say in the running of seven of the 24 nursery homes in the municipality.

2. Children
Montpellier has placed quality of child care in focus within the system of welfare and the educational system during recent years. It is the aim to prepare the children for elementary school, by means of improving the qualifications of the employees. Historically mothers provided child care for their children aged 0 to 2 years. But with the increasing female labour market participation grandparents are by now an important source of child care. The overall responsibility for the provision of child care, both within the welfare system and the educational system is placed with the municipality, which evaluate the need for institutions and number of places.

Besides the informal child care in Montpellier there are several possibilities within the formal day care system, depending on the age of the child. Firstly, parents can receive cash benefits for taking care of their own child until the child is 3 years old. Secondly, the child can be cared for in a day care institution, which not necessarily is public, and thirdly, children aged 3-5 can be signed up in preschool *(école maternelle)*. Places in day care services cover 81% of the age group 3-5 years in Montpellier.

The major part of the formal child care for children aged 0-2 takes place in public institutions (day nurseries, kindergartens, and drop-in institutions). In 1997 Montpellier held 1,591 places, of which the commune run 57%, voluntary organisations 20%, the hospital 11% and the *département* 6%. In all the coverage for children aged 0-2 years was 26,8%.

The other type of formal child care in Montpellier is the preschool *(écoles maternelles)*, which constitutes the far most important child care solution for children aged 3-5, both at local and national level. There is no user payment for children in pre-schools. However, the parents must pay for the meals which are served at lunch.

The need for child care possibilities outside opening hours of the pre-schools is major. However, the supply has not been extended accordingly. The opening hours outside the opening hours of the pre-schools are from 7:30 a.m. to 8:30 a.m. and again in the afternoon from 5:30 p.m. to 6:30 p.m. (le temps péri-scolaire).

Visit to 'Le petit prince de Boutonnet'
The public day nursery 'Le petit prince de Boutonnet' is situated in the periphery of Montpellier. The growth of the city has entailed a need for extending housing in this area. The institution was build in 1996 and reserved for occupationally active parents in this part of the city. The opening hours of the day nursery are from 7.30 a.m. - 6.30 p.m., corresponding with the general opening hours of day nurseries in Montpellier.

The 44 children are divided into sections according to age: the young section (*La petite section*) for children aged 3-12 months and the mid-section (*La moyenne section*) for children aged 13-24 months. The oldest section is for children aged 25-36 months. The capacity is equally divided between the sections. Each section contain a playroom, a mini-kitchen, and a wardrobe and toilets for the children.

When the day nursery has opened up in the morning the children are served breakfast. The breakfast consists mainly of fruit, as the high amount of water prevent dehydration. The children are also served milk and bread. In the morning the children are playing, singing, drawing or other activities - mostly indoors. Around 11 a.m. the children are served lunch, which is prepared by a professional cook. When the children have had lunch they take a nap, and in the afternoon they play. Due to the heat in the summer the day nursery has a special swimming pool connected to one of the nursery sections. Naturally, a very popular play field for the children. The day nursery closes at 6:30 p.m. However, most of the children are picked up late in the afternoon and several of them by a grandparent.

The 'Le petite prince de Boutonnet' has been inspired by the book 'Le petite prince' and its main principle is for the children themselves to explore and experience the world within the limits given by the pedagogues. Generally the pedagogues distinguish between individual and joint activities, as it is quite ok for the child to play by itself, but the pedagogues have the overall responsibility for that the children most of the time participate in joint activities such as playing at the playground or in the play room, drawing or singing.

3. Older people

The overall senior politicy pursued by Montpellier corresponds with the national as well as international policy; of supporting the older people in staying in their own homes as long as possible. Partly because of economic reasons and partly due to the tradition that younger family members take care of the older family members as well as the older family members support the younger by taking care of their children or picking them up in the day care institutions, when the parents are prevented.

It is the perception of the municipality that the need for domiciliary care is covered by the comprehensive supply offered by the voluntary organisations. Thus the senior policy of Montpellier has emphasised institutional care. Institutions which originally was meant for older people with a need for being looked after have now been rebuild to receive frail older people with a need for care. Additionally, the municipality has plans to establish some short-term places for older people in their own home, thus, the relatives can be relieved.

Besides the important informal care of the older people in Montpellier various formal services are offered, partly in own homes and partly in institutions. Additionally there is a range of possibilities for active older people with financial means. The voluntary organisations are running the main part of the domiciliary services, whereas the institutional care is equally divided between public suppliers (the state, county and municipality), voluntary organisations and private companies.

The domiciliary services vary from home help (*aide ménagère*), home care (*soins infirmières á domicile*) and meals on wheels (*portage de repas*) to home visiting service and practical help. It is both the municipality and the voluntary organisations which run these schemes. In 1997 1,760 older people received home help in Montpellier. It corresponds to 5.7% of the older people in Montpellier. There is a tendency that an increasing proportion of the older people receive home help and that the range of home help offered by voluntary organisations is increasing.

In 1997 the supply of nursing home places corresponded to the actual need for care in the municipality. Out of the total capacity of the municipality of 1,820 places, 679 places were for care-demanding older people, 896 for sheltered housing and 245 were at the hospital. In total, it corresponds to that 6% of the older people in Montpellier are in a nursing home.

Visit to the nursing home 'Simone Gillet-Demangel'
This nursing home is an example of adjustment to the new need for care; in 1997 the nursing home was renovated with the aim of using the capacity on older people with a substantial need for care. 'Simone Gillet-Demangel' is situated very beautifully in the periphery of Montpellier.

The nursing home is run by the social welfare office (CCAS). It has room for 82 residents, whereof 62 of the places are for care-demanding older people. The nursing homes is very light and there is a pleasant atmosphere. It was our impression during the visit the residents were having a good time, and we felt that we were almost disturbing the quiet and cosy atmosphere. Besides a nicely decorated dining room there was also a modern rehabilitation centre, where the residents can exercise in a pool or fitness machines The older people live in single rooms on 15 square metres. The rooms are light and they can be decorated with the older people own furniture if wanted. All the rooms have a balcony. Our general impression was that the older people were happy to stay at the nursing home.

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CHAPTER 9

Germany

Box. 9.1.
General characteristics of Germany

- Germany is a federal republic consisting of 16 *Länder*, 5 of which were incorporated in 1990, when the former German Democratic Republic was united with the Federal Republic. Each of the Länder has its own legislation. Local authorities consist of 428 *Kreise* and 14,915 *Gemeinden*, but most bigger cities only have one level, *Kreisfreie Städte.*

- With a population of around 82 million on an area of 356.700 sq km Germany is one of the more densely populated countries in Europe (230 persons per sq km), although there are vast differences across the Länder. Nordrhein-Westfalen has 521 persons per sq km and Mecklenburg-Vorpommern 80 persons per sq km. Germany has had rather large numbers of immigrants for some years and non-national inhabitants make up 8.5% of the population. About 23% of these are from other EU countries, with 28% from Turkey and 18% from the former Yugoslavia.

- A comparatively large proportion of employment is in industry (35%) although this has been decreasing. 62% of employment is in services and 3% in agriculture. Activity rates are 78% for men and 60% for women. About 34% of the employed women are working part time. Unemployment has increased during the 1990s to around 9% in 1996.

- 31% of GDP was in 1994 spent on social expenditure. This proportion has been increasing since the beginning of the 1990s. Most of the costs for long term care of the old are since 1995 financed by the new long-term care insurance scheme. Public expenditures for day care facilities for children and the leave schemes for parents to infant children are financed by taxes.

- Annual disposable income for an APW couple with children was DM 58,823 in 1996, for a single APW pensioner DM 25,094 and for a couple APW pensioners DM 37,641 (Hansen, 1998).

- Life expectancy is 73.3 years for men and 79.8 for women. The ageing of the population means that persons aged 65 years and above in 1996 made up 16% of the population. The total fertility rate was during the 1980s around 1.4 in West Germany and has fluctuated around 1.3 since the beginning of the 1990s in the united Germany. After unification the fertility rate dropped considerably in East. Children aged 0-5 years made up 5.9% of the population in 1996.

9.1.
Introduction

Germany is often characterized as a conservative and corporatist type of welfare state - conservative because the role and responsibilities of the family are stressed in the German welfare state, and corporatist because implementation

of the "social state" is carried out by non-government insurance associations and large associations of independent welfare providing service agencies, within the framework set out by legislation and public authorities.

According to the Constitution, the Federal Republic of Germany is a democratic and social federal state. This principle of the social state is anchored in the Constitution through a series of basic social provisions, among which is the obligation on state authorities to respect and protect human dignity. It is from this principle that the guarantee of a minimum standard of living for all citizens is derived. The obligation of the state to provide special protection for marriage, the family and the motherhood is also specified in the constitution.

The principle of the social state is not solely directed at government. Citizens are expected and obliged to practice individual and collective self-help and social solidarity. One form of collective solidarity is the community of insured workers in the social security insurance associations.

In terms of social policy this means that welfare is governed by the principle of subsidiarity. As defined by the Federal Constitutional Court, subsidiarity means that the community should act first and that the state should intervene only when there is no alternative. If an individual is unable to help him or herself, assistance should be sought first from the family, neighbours, self-help groups and from voluntary welfare organisations. Only as a last resort should the state be called in.

The special position of the family and marriage is institutionalised in the German welfare state in many ways. The tradition of the insurance-based social security system is that it is related to labour market earnings of (male or female) bread-winners. The resulting benefits are to maintain the whole family. Health insurance covers family members also and contribution levels are eased by tax deductions for family obligations.

When it comes to childcare and the older people in need of care, policy has been to support and stimulate as far as possible self help resources stemming first of all from family members, but also from neighbours or others in the local community. German childcare policies have aimed at enabling mothers to stay at home to take care of their children rather than providing day care services, which might facilitate a combination of work and family duties. The number of infant children cared for outside the home in Germany is still very low. Kindergartens are about to be established for all children from the age of three, but the purpose of kindergartens is as much to prepare children for school as it is to

sustain labour market participation of parents. Most kindergarten places are part-time.

Policies for long term care of frail elderly people also reflect belief in family solidarity. Public initiatives to support the provision of professional care have developed slowly, and policies have aimed equally at reinforcing family care. Benefits in kind for professional domestic care in Germany have been developed along-side development of cash benefits if family members provide the care. This has led to the vast majority of benefits paid out for long term care of older people being cash "payment-for-care" benefits, and only small proportions of older people in need of care receive this from professional domestic services.

In accordance with the principle of subsidiarity, the provision of welfare services is left to various non-government and non-profit associations which traditionally have had a strong element of voluntary work. They are organised into six major associations, which co-operate within an umbrella organisation. These associations have become large professional organisations employing more than 1.1 m people in different welfare services.

In October 1990 the former German Democratic Republic was united with the Federal Republic of Germany, and it was agreed that the social legislation and institutional system of the former West Germany would be adopted by the 5 new Federal States (Länder). The integration of a former communist state into the Federal Republic of Germany is a demanding and costly operation, which is hampered by considerable cultural differences between the former East and West German states. In the former East Germany the basic principles for welfare provision were quite different from the principles which have been maintained and developed in West Germany. In the East, a very high female labour market participation was matched by publicly-funded day care facilities with full coverage for children aged 0-6 years, as well as for schoolchildren after school hours. Since re-unification the number of places has been reduced considerably, accompanied by a dramatic decrease in the birth rate, increasing unemployment and the introduction of the parental leave scheme, which had already been developed in West Germany.

9.2.
A history of care

Germany was a pioneer in establishing basic social security insurance systems. Old age pensions, sickness insurance, industrial accident and invalidity insurance schemes were established in the 1880s for workers. Later on the system was

extended to all employed persons, and in 1927 unemployment insurance was introduced as the fourth pillar of the insurance system. This so called Bismarck model of social protection was a state-regulated system based on corporative independent insurance associations with employees and employers sharing the costs and the decision-making powers. Some financial contributions were available from public funds. Administration was taken over by the state during the Nazi-period, but after the war the original system was re-established, with independent insurance associations in the managing role.

In addition, there is a system of state benefits to compensate groups not covered by insurance schemes. This system was established for war victims after the First World War but was later extended to cover victims of crime or social violence.

The third main system is a means-tested social assistance scheme established in its present form in 1961. It is managed by local authorities as a safety net, which is to be used only when there are no other possibilities for support. Social assistance legislation confirms the right of every citizen to maintain a standard of living that allows participation in cultural and social life. Assistance is granted with the aim of enabling those in need to help themselves.
Finally there are a number of benefits referred to as social support *(Soziale Förderung)*. Among such benefits are the Child-raising benefit *(Erziehungsgeld)* for a parent staying at home to take care of a child, and Housing benefit.

Costs caused by acute sickness are covered by health insurance funds, which insure more than 90% of the population. The rest may be covered by private insurance or by social assistance where eligible. Traditionally benefits for long-term care and help, however, were not part of the insurance-based welfare system. In the 1970s benefits from sickness insurance were introduced for care in the home and for home help, but only in the short term in connection with acute medical treatment. Also in residential homes health insurance funds were (and are) only to cover acute treatment and not living costs or personal care and assistance help. Thus in Germany there is a very sharp distinction between costs arising from short term illness and long-term care and assistance with daily activities.

Until recently there were only very limited possibilities for obtaining a financial support to cover the costs of assistance for older people. People in need of care beyond any unpaid help given by family members and others, had to pay for it themselves or apply for social assistance. Social assistance, however, depends on a means test which takes into account income of relatives in direct line. An

increasing number of older people, however, qualified for this kind of social assistance, and an enormous rise in social assistance expenditure started up.

Since the early 1980s various governments, political parties and welfare associations have come up with reform proposals to cover the financial risks of long term care and assistance, but agreement about which model to follow was only achieved very slowly.

One way of easing pressure to provide more care facilities has been to prioritize self help and care in the family rather than professional care and to prioritize community care over residential care. In 1984 social assistance legislation gave community services priority over care in residential institutions. Since 1970 social centres have been established throughout Germany, providing a range of welfare services and they have increasingly provided home care and home help services for older people. Also self-help groups and other citizen initiatives were starting up during the 1970s. This trend may be seen in connection with declining economic growth after 1975, when social expenditure was called into question in Germany as elsewhere. Initiatives to control rising expenditures had already started in 1976, but in 1982, when the Christian Democratic/Liberal government under Helmuth Kohl took office, a major change *(Wende)* in policies was announced, and a number of cut-backs made. However, this period of so-called welfare state crisis in Germany is better described as a period of consolidation rather than as a period of retrenchment (Clasen & Freeman, 1994) partly because the fragmented and corporate structure of the welfare system is not easily changed, partly due to public opinion. The trend, however, was reflected in a renewed interest in self help, which was shared by both left-wing and right-wing parties, albeit for different reasons. The Right stressed "new subsidiarity" and a renewed commitment to the family, whereas the Left stressed a new communitarianism.

Improvement of the system for assistance and care to dependent old people had to wait until a reform of the Health Service Insurance Act in 1988, which came into force in 1991. This introduced benefits for home nursing and home help, although persons in residential homes were not eligible for these benefits. Benefit levels were low, but through this care and assistance were introduced as a new part of the German insurance-based welfare system.

The payment for care option was also introduced. However, not least because care in residential homes were not covered, the debate about better financing of care and assistance for older people in need continued. Residents in these homes, until the introduction of the new health care insurance, were left to apply

for "help for care" under the social assistance legislation, if they were eligible for social assistance.

Even then an increasing number of persons were entitled to this kind of social assistance, and a considerable rise in social assistance expenditure was one of the adverse consequences of this situation. In 1991 40% of the 30 billion DM spent on social assistance was used for long term care (Evers, 1996). About 80% of nursing home residents were dependent on social assistance. Average costs for a place was 4,150 DM a month, which social assistance covered, but residents were left with only a small amount for personal expenses. Costs were lower for home care, and so was the number of older people living at home eligible for social assistance.

In 1991, the Ministry for Families and Older Citizens was asked to focus more on older citizens, and the following year the Ministry launched a four point policy plan for older people (Bundesaltenplan): promotion of self help, support for people in need of care, equalization of older people's living conditions throughout the united Germany, and promotion of international policies for older people (BMFSFJ, 1997).

In April 1994, the German parliament finally passed a legislation introducing a long term social care insurance system *(Die Soziale Pflegeversicherung)*. This is financed on a 'pay-as-you-go' basis, and has to be self-financing. All members of sickness insurance schemes are obliged to pay contributions which are currently 1.7% of gross earnings. Contributions may vary between 1.5% and 2.0%. Employees and employers both make contributions. Employers are compensated by a reduction in paid holidays of one day a year. Members of private insurance schemes are required to insure privately.

The care insurance scheme allows a choice between care in kind *(Sachleistung)*, cash payment *(Geldleistung)* or a combination of both. This may be either at home or in a residential institution. The amount granted in cash payments for care is about half the amount granted for benefits in kind, which are provided through professional service provider, who is paid directly by the insurance fund. By far the most popular is the payment for care option - 76%. An additional 17% opt for the payment for care in combination with some professional services, and only 7% of recipients choose the benefit in kind only.

Day care institutions in Germany have some roots in day-nurseries which were set up by Christian charitable organisations at the beginning of the 19th century to protect children of working mothers or other children at risk. Care facilities for

infant children aged under 3 years have never shaken off their association with provision for families in distress, and provision even now only covers a few per cent of infant children. Instead the use of family day care has expanded since the beginning of the 1970s.

The Kindergartens, however, have established themselves as the main pre-school educational institution, which covers almost all children at least in the 2 years before statutory school age. The reason for this orientation of kindergartens is largely due to the ideas of the German philosopher Friedrich Fröbel (1782-1852) whose conception of the kindergarten was as a pedagogical institution utilizing play and games educationally. These ideas spread not only within Germany but also to many other countries. In Germany the number of children attending kindergartens was about 500,000 in 1910. Kindergartens were mainly run by private non-profit-making welfare organisations. After the First World War the education system was reorganized but kindergarten were not included as part of the school system although this had been discussed. In 1922 regulation of kindergartens was established by the Youth Welfare Act using principles, which to a great extent remain even now. The principle of subsidiarity in particular was underlined. Public authorities are obliged to ensure, that kindergarten places are provided, but are only supposed to manage the institutions themselves if non-government agencies are not able to provide the places. During the National Socialist period the number of kindergartens increased greatly, as many women were working in war production, but after the war two different systems developed in East and West Germany. In the East kindergartens were integrated into the education system as its first level. In the West the pre-Nazi system was restored. Kindergartens remained the responsibility of the Child and Youth Welfare system, emphasis was placed on traditional family policies and kindergarten places were greatly reduced, as they were only supposed to supplement family upbringing where needed.

During the 1960s ideas of mobilizing the educational reserve and the need for compensatory development of disadvantaged groups stimulated a new interest in increasing kindergarten attendance. In 1970 the German Educational Council *(Deutsche Bildungsrat)* proposed to establish kindergartens as the first introductory phase of the education system, but in all länder (except for Bavaria) kindergartens have remained the responsibility of the Child and Youth Welfare system. The number of children attending kindergartens increased rapidly from less than one third of 3-5 year old in 1965 to about 75% in 1975 and 80% in 1986.

Increasing awareness of the problems of reconciling work and family life has also led to a demand for more day care places in Germany. In 1994 it was stressed

that local authorities are obliged to ensure that the necessary places in nurseries and after-school day care are available. In addition it was decided to guarantee a place in kindergarten to all children aged 3-5 years which applies from 1 January 1996, but with an interim implementation period until 1 January 1999. The financial problems in fulfilling this guaranty have in many areas squeezed investments in day care for children aged under 3 year.

Child-rearing allowances *(Erziehungsgeld)* and parental leave *(Erziehungsurlaub)* were introduced in 1986 as part of a "family package", which compensated for some of the cuts in family benefits and tax allowances, which had been made in the years 1982-85. Child-rearing allowance was a flat rate allowance of 600 DM of month, which was the equivalent of a half-time job with a low female wage. In addition it was possible to work up to 19 hours a week and retain benefit. Since 1986 the entitlement period has been extended four times and now stands at two years for payment of the allowance and three years for the leave protection. Working mothers tend to take advantage of the full leave period which may be due to the lack of day care availabilities. The allowance of 600 DM, however, has not been changed since 1986.

9.3.
Financing

9.3.1. Social expenditure

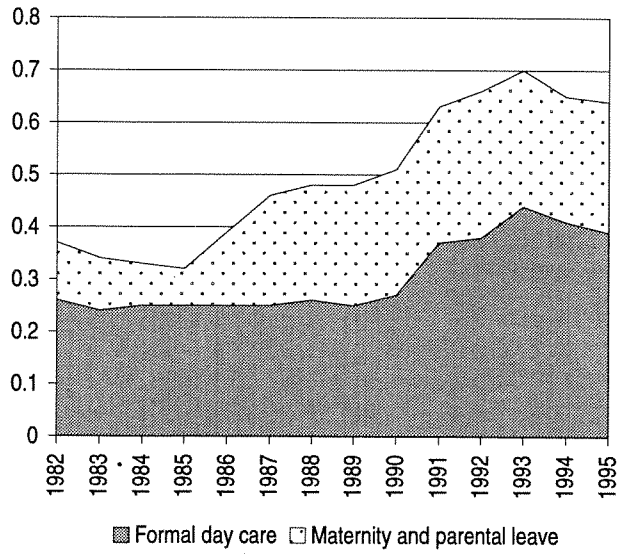
Except for 1993 GDP has increased in West Germany since 1982. In particular, in early 1990s growth rates were high, but then declined rapidly in the following years. West Germany is one of few countries in Europe, where social expenditure as a percentage of GDP has actually been decreasing throughout the period since the early 1980s, from around 26% of GDP in 1982 to around 23% in 1991. However, in the united Germany this proportion has increased during the 1990s from 26% in 1991 to 31% in 1994.

The social budget is the total amount of all types of social expenditure in both cash and kind. In Germany two thirds is spent on monetary transfers. Approximately two thirds of revenue is raised via contributions from employers (37%) and from employees (28%). The remaining third is raised through general taxation.

Expenditures for child care as a proportion of GDP did not increase either in West Germany in the 1980s, except for the introduction of child rearing leave in 1986. The proportion spent on formal child daycare was stable until 1990, and expenditure on maternity benefits decreased substantially throughout the 1980s

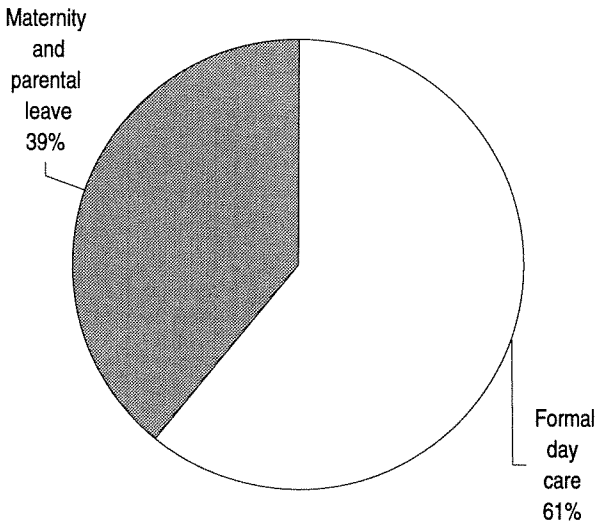
because of a decreasing birth rate and because maternity benefits paid out by the health insurance associations were not updated. Since 1991 expenditure has risen sharply in the united Germany. Expenditures on formal day care has increased because the proportion of children attending day care institutions is higher in East than in West Germany but also because an increasing number of children in the West are attending kindergarten.

Figure 9.1.
Development in the net-expenditures on the main social services and cash benefits for children (aged 0-4) as a percentage of GDP, 1982-1995.



Source: OECD: Social expenditures database 1998.

Figure 9.2.
Division of the net-expenditures into the main social services and cash benefits for children (aged 0-4), 1995.



Source: OECD: Social expenditures database 1998.

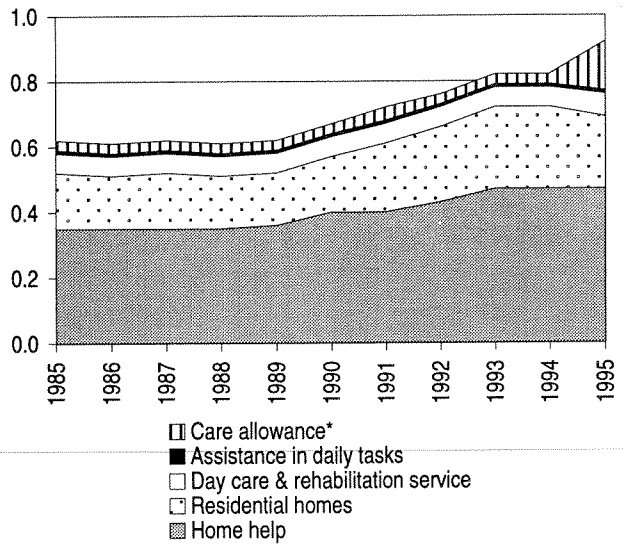
In 1995, social expenditure for child care in the united Germany was divided between formal day care (61%) and leave benefits, which comprised maternity benefit paid by health insurance associations (5%) and child rearing allowance (34%). According to the OECD social expenditure database a total of 13,465 m DM was spent on formal day care and 8,672 m DM on maternity and child rearing leave in 1995. Expenditure on families with children amounted to 0.6% of German GDP.

In addition to expenditure on the social security system, employers were obliged to continue payment of wages during maternity leave. This amounted to 2,757 m

DM in 1995 compared to 1,210 m DM paid out by health insurance associations for maternity benefits.

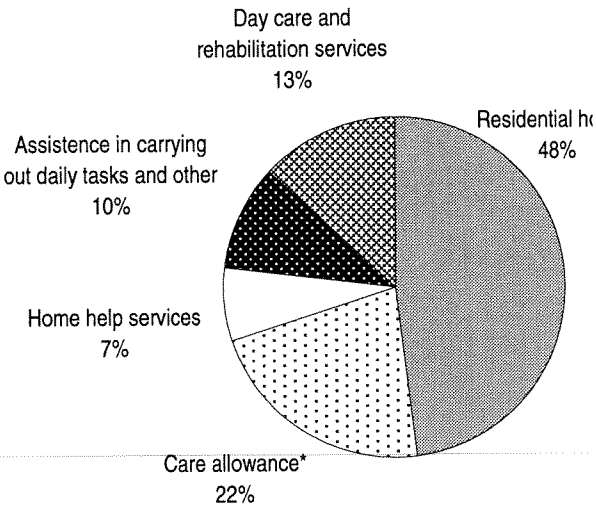
Expenditure on long term care and assistance for older people was mainly granted as means-tested social assistance benefits before the introduction of the new long term care insurance. The majority of assistance benefits have always been paid to those living in residential care institutions. In fixed 1991 prices expenditure for residential care for older people and handicapped people doubled between 1982 and 1995 and increased from 0.16% of GDP in West Germany in 1982 to 0.22% of GDP in the united Germany in 1995 according to the OECD social expenditure database. Also, assistance benefits granted for care and assistance at home as care allowances, whereby the person in need of care may pay a family member or another person, and benefits in kind as payment of home help services, increased throughout the period. But after unification the increase has mainly been in benefits in kind.

Figure 9.3.
Development in the net-expenditures on the main social services and cash benefits for older people (65+) as a percentage of GDP, 1985-1995.



Source: OECD: Social expenditures database 1998.
Note:* Sum of Social Assistance and Long Term Care Insurance from 1995

Figure 9.4.
Division of the net-expenditures into the main social services and cash benefits for older people (65+), 1995.



Source: OECD: Social expenditures database 1998.
Note: * Sum of Social Assistance and Long Term Care Insurance from 1995.

In 1995 almost half of the expenditure for older and handicapped people was for residential care, and the majority of this expenditure was on social assistance benefits, since benefits under the new long term care insurance for residential care only started up in 1996. However, in 1995 care allowances and benefits in kind for home help were granted from the long term care insurance scheme, constituting 22% and 7% respectively of expenditure for older and handicapped people (Figure 9.4). Another 10% was spent on other benefits in kind. Included in other benefits in kind is expenditure for assistance in carrying out daily tasks granted from social assistance, health insurance and other social security schemes. 13% of expenditure was for day care and rehabilitation services for older and handicapped people.

9.3.2. Division of financial responsibility between state and municipalities

About 2/3 of the total social budget is financed by contributions to social security schemes from employers and employees and about 1/3 by general taxation. Employees (insured persons) contribute about 31% and employers about 35%. About half of state expenditure is financed by revenues at federal level and half by revenues at Länder and local authority level.

In general social services such as day care facilities for children and home help services or residential institutions for older people are the responsibility of local authorities, which also have to make general public contributions to the services. Benefits granted under the social assistance scheme are also the responsibility of local authorities. Within each Land, there is a redistribution of income among the local areas, which evens out some local differences in financial burdens and revenue from taxation.

Federal government makes some general contributions to the free non profit-making welfare associations, and these are spent on all services provided by these agencies.

General income-transfer schemes, which are not insurance-based, such as child-raising leave which provide benefit of 600 DM a month for parents taking care of infant children at home, are fully financed by Federal government, although the scheme is administered by the local Youth Welfare Authorities.

Kindergartens are financed by parental fees, subsidies from local authorities, subsidies from the Länder and subsidies from the free service agencies managing the kindergartens. The proportion of finance from these sources varies greatly across Länder and between local municipalities within each of the Länder.

Social centres providing home help and care services for the older people cover a number of different services for different groups in the population, and they are financed from a number of different sources. The care and home help services delivered to the older people are financed from user payments, social insurance benefits, social assistance benefits and general contributions from the Länder and local public authorities. Contributions vary greatly across Länder and between local municipalities within each of the Länder. In addition centres managed by the welfare associations have their own income from general public contributions and from charity donations.

Home nursing in connection with acute medical treatment is financed by benefits from sickness insurance. Long term care and home help are financed through the new social care insurance. Before the introduction of the new scheme these services were mainly funded through benefits from social assistance, and were provided to the increasing number of older people who qualified for social assistance.

9.3.3. Employer and employee contributions

Insurance schemes are mainly financed by employer and employee contributions. The new long-term care insurance is financed on a "pay-as-you-go" basis, and has to operate without public contributions.

9.3.4. User fees

User fees (service charges) make up a substantial proportion of the financing of day care services for children and the care and home help facilities for the older people.

9.3.5. Funding of voluntary work

There is traditionally a considerable number of people working on a voluntary (un-paid) basis within the free welfare agencies. It is estimated that a total of about 1.5 m people work on a voluntary basis within the free welfare organisations, carrying out a wide range of social services. The amount of savings to the public treasury from unpaid voluntary work is thus considerable, and represents a significant proportion of the resources available for the free welfare services. In addition these welfare agencies have income from membership fees, foundations, lotteries, donations from private individuals etc. and from church taxes in the case of churches and confessional associations. However the major part of the income of welfare agencies is from state grants and from service charges, and it is estimated that no more than 10% derives from fundraising, property and subscriptions (Lorenz, 1994).

9.3.6. Private funding and fiscal subsidies

In Germany there are no special tax benefits for informal care in the home, but the financially most important form of tax allowance in Germany is the so called "tax-splitting" of married couples. The combined income of a married couple is treated as if each partner earned exactly half of it. Because of the progressive tax system, this income splitting favours single earner couples or couples with large earning differentials. This serves implicitly to support less than full-time labour market participation of married women, as does the rule that recipients of child rearing benefits are allowed to work up to 19 hours a week without deductions in benefit.

9.4.
Provision of services

9.4.1. Public provision

It is the responsibility of local authorities to ensure, that the needs for day care services for children and services for dependent elderly are met. The local Youth Welfare Office *(Jugendamt)* is responsible for the provision of day care facilities for children, and the local Social Welfare Authority is responsible for services for older people.

However, according to the principle of subsidiarity the non-profit making welfare associations are prioritized over public bodies to provide services for health and social care. These associations are guaranteed independence to define the aims, organisation and implementation of social policy measures, and public bodies traditionally have only been allowed to provide services if the welfare associations are not able to do so. This principle, however, has been diluted a little by the new social care insurance scheme, but the vast majority of services are still provided by the welfare associations. Only in creches for children (mostly children at risk) and in residential homes for elderly are the local public provision of some importance.

The fragmented provision of welfare services means that comprehensive statistics on the provision of services in Germany are difficult to obtain. It is also often noted that the coordination of services and of provision is lacking because of this.

9.4.2. Informal care

The German welfare system presupposes that the family will take care of its frail elderly relatives and its children. This is in line with the guiding principle of subsidiarity. According to this, services should be provided by the individual or

the family, and only when this is not possible should a higher level such as a charity or a public body provide the service. The principle thus stress family obligations, and how individuals and their families can meet needs for care and assistance.

Informal family care is supported by a number of measures. Families with children are supported by general child benefit, and the mother (or father) have the opportunity to take leave from work and receive childraising benefit *(Erziehungsgeld)* until the child reaches 2 years of age. This benefit is paid irrespective of income for the first 6 months, but then becomes income-related. The recipient is allowed to work part time (up to 19 hours) without reduction in benefit. Accordingly the vast majority of children under 3 years of age are taken care of at home. From the age of 3 most children attend kindergartens. There is in Germany guaranteed kindergarten places. Most places are half-time, however.

Also the vast majority of elderly dependent on home help and care are mainly assisted by family members. The family member (or other care-giver) may apply for compensation from the new long-term care insurance scheme *(Pflegegeld)* and in addition have contributions to social security insurances credited.

9.4.3. Voluntary organisations

A major part of social services are provided by free (non-government, non-profit) welfare organisations (charities), which cooperate with local authorities.

There are six major associations of such welfare providers in Germany, *Wohlfahrtsverbände*, which provide welfare services. These organisations have historically developed their field of work and are now large professional organisations which organise and provide services on the basis of financial support mainly from public bodies and insurance funds. The associations cooperating within the umbrella organisation BAG- *Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege* are:

Diakonisches Werk der Ewangelischen Kirche in Deutschland (DW), the Service Agency of the Protestant Church in Germany, was formed in 1957 by amalgamation of organisations associated with the protestant churches. The tradition of social work stretches back to 1848. It has about 268,000 staff members.

Deutscher Caritasverband (DCV), German Caritas Federation founded in 1897 is in terms of services and full-time staff the major welfare organisation employing about 300,000 persons.

Arbeiterwohlfahrt (AW), Workers Welfare Association was founded in 1919 and has its roots in the social democratic worker movement. As well as its social work and services the organisation traditionally sees itself as an organisation which actively supports progressive social policy.

Deutscher Paritätischer Wohlfahrtsverband (DPWV), the German Non-denominal Welfare Association, was founded in 1924 as the The Fifth Welfare Association, bringing together non-denominational and non-party political organisations. Traditionally the association supports the self-help model and works with self-help groups and organisations.

Deutsches Rote Kreuz (DRK) the German Red Cross, formed in 1921 is the largest welfare society. They have about 4.7 m members of whom 340,000 are active.

Zentralwohlfahrtsstelle der Juden (Zwst), the Central Welfare Office of the Jews in Germany, founded in 1917 developed into a large organisation with residential and community services. During the Third Reich it lost most of its facilities, but since reestablishment in 1951 the Agency has concentrated largely on community work and services specially for the elderly, but also for young people and refugees.

All the agencies operate a considerable number of services, facilities, residential homes and schemes. They are mainly financed by public funds but also contribute considerable amounts of their own funds from donations in money and kind. Also voluntary work is still a vital element. The federations related to the churches (DW and DCV) manage a large number of day care institutions for children, whereas the AW and DPWV are the main federations providing care and other services for the elderly.

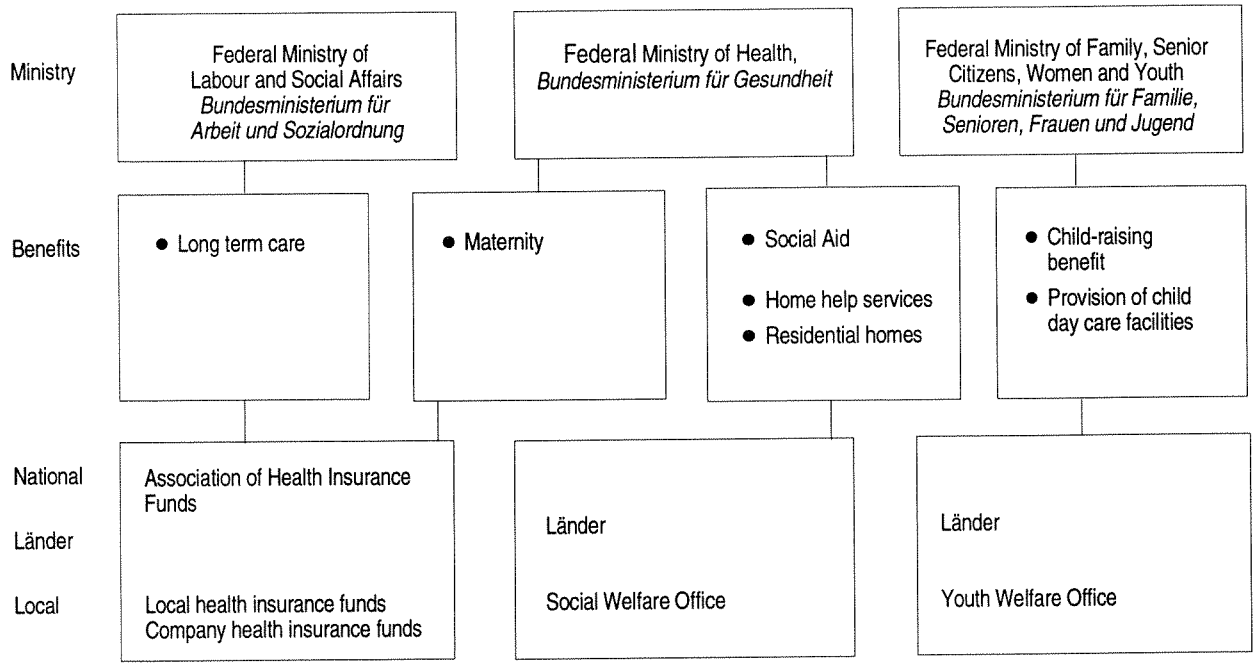
9.4.4. Private profit-making provision

Recent years have seen an increasing number of private agencies which provide services on a commercial basis for elderly in need of care. This may be through private residential homes or private firms offering home help and care. Many of these are single-person bussinesses. Although private service provision on a commercial basis is increasing its proportion of service provision is still very limited.

9.5.
Organisation

The rather segmented institutional structure of the German welfare system reflects the principle of subsidiarity. The federal state in general only guarantee and supervise the aims of the social state leaving implementation to other agencies such as the Länder and local government or to independent insurance funds or to the service-providing welfare associations.

Figure 9.5.
Organisational diagram



At federal level, the social security system since 1970 has been regulated within one comprehensive Social Code *(Sozialgestzbuch)*, which also delimits what is understood by social security in Germany (Pieters, 1990).

The Ministry of Labour and Social Affairs *(Bundesministerium für Arbeit und Sozialordnung)* is at federal level responsible for the social budget, insurance schemes (except the health insurance scheme) and almost all other social security schemes. The Health insurance scheme and maternity benefits, however, come under the Ministry of Health, but long-term care insurance comes under

the Ministry of Labour and Social Affairs. Also the Social Assistance scheme is the responsibility of the Ministry of Health. Child raising benefits are taken care of by the federal Ministry of Family, Senior Citizens, Women and Youth *(Bundesministerium für Familie, Senioren, Frauen und Jugend)*, which also plays a role in providing information, setting up model projects, and elaborating guidelines for care services for children as well as for older people in need of care.

Administration of the large insurance schemes is entrusted to legal persons under public law - the insurance funds. The principle of self-government is applied to social insurance funds, but they are none the less regulated in detail by the *Sozialgestzbuch*, which states that the general assembly has to be composed by representatives elected equally by employers and employees. The general assembly appoints a governing board. Management and accounting of administrative bodies are supervised by the *Bundesversicherungsamt* at federal level and at Länder level usually by the Ministry of Labour and Social Affairs. The new social long-term care insurance scheme is managed as a separate scheme by the sickness insurance funds *Krankenkassen,* which are associated at both Länder and federal level.

Insurance schemes are financed by payments from employers and employees as a percentage of wages or income from work with an upper ceiling. Contributions are supposed to cover expenses in a given year, and thus operate on a "pay-as-you-go" basis. Sickness insurance and social care insurance schemes are to operate without contributions from public money.

All other social security schemes, apart from the insurance schemes, are directly administrated by the Länder, but social assistance is the responsibility of the *landkreise* and the *kreisfreie Städte,* which also have to finance social assistance with only small contributions from the Länder.

The Federal Employment Services *(Bundesantalt für Arbeit)* have a special place as administrator of the general family allowance *kindergeld*, and the Länder may also choose the *Bundesantalt* to administer the parental care benefit *(erziehungsgeld)*, which is fully financed by the Federal level.

The Länder are responsible for the provision of a sufficient infrastructure of service providers for residential and ambulatory care and home help to dependent older people, but according to the principle of subsidiarity the non-profit making welfare agencies are prioritized over public bodies to provide services for health care and social care. These service agencies are guaranteed independence to define aims, organisation and implementation of social policy measures,

and public bodies traditionally have only been allowed to set up services if the welfare associations are not able to provide them. This principle, however, has been diluted a little by the new social care insurance scheme, but the vast majority of services are still provided by the welfare associations. Only in residential homes for the elderly is the local public provision still of some importance. As mentioned above, the Länder are allowed to invest a certain amount in care service providers, and a special aid-package for the renewal and establishment of ambulatory, part-time and residential care institutions in the new Länder is granted for the period 1995 to 2002.

The Social Care Insurance Funds can only make use of those service providers which the Länder association of care insurance funds have made contracts with. In order to stimulate competition between providers, contracts are made with all providers that offer proper care/home help services on a commercial basis. However individual Insurance Funds may make contracts with individuals, who have established themselves as single-enterprises providing home care/home help. Charities and private service providers are to be preferred over public services.

National associations of care insurance funds and service providers are jointly responsible for establishing principles and norms for service quality and for quality control. The Länder associations of care insurance funds can have service providers evaluated by approved evaluators.

Settling of accounts with service providers is coordinated by 18 centres *(Leistungskomplexe),* which have been set up by the social care insurance funds.

All day care facilities for children including family day care (private child minders) are regulated by the Federal Child and Youth Welfare Act *(Kinder und Jugendhilfgesetz)*, of 1991 and its subsequent amendments. This serves as a framework act for day care services, which the Länder have to work within. It is stressed that parents have primary responsibility for the raising and care of their children. Public authorities have to support parents in this. Among ways of supporting is the obligation to ensure that day care facilities are provided in the interests of children. Facilities may be provided by public authorities (*Jugendamt* in *Kreise* and *Städte)*, associations of welfare services, churches or by initiatives of the parents. As the fundamental idea in West Germany has been that children under 3 years of age should be cared for in the family, the majority of care places for infant children are for children with a special need for care outside the family. Local public authorities have managed a large proportion of these facili-

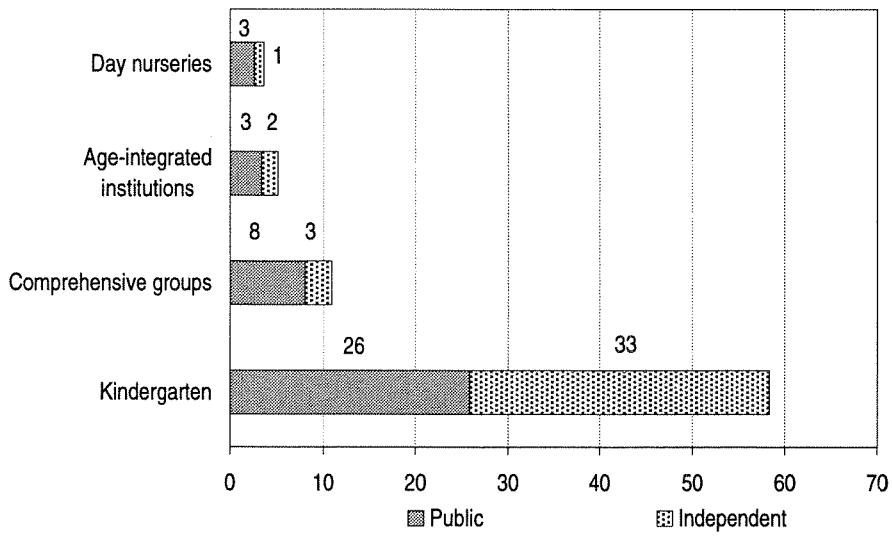
ties. In providing kindergarten places for children aged 3-6 years, however, the independent welfare organisations working within youth welfare plays an important role.

9.6.
Caring for children

9.6.1. Introduction - Main services and cash benefits

Working mothers are entitled to maternity benefit for 8 weeks after giving birth and employers are obliged to pay the difference between the benefit and the salary. For the first 6 months of the child's life almost all families receive the flat rate child-raising benefit of 600 DM a month. The benefit may be paid out until the child is 2 years old, but from the 7th month the benefit is income related and most families receive a reduced benefit. It is allowed to work part-time (up to a maximum of 19 hours a week) without reduction of the benefit.

Figure 9.6.
Day care arrangements, enrolled children (aged 0-4) as a percentage of the age group and according to provider, 1994.



Source: StBA: Sozialleistungen, Fachserie 13, Reihe 6.3 (annual publication)

Publicly-funded daycare services for children under 6 years are provided by the welfare system. The compulsory schooling starts at the age of 6. However, the

provision of services are very different between East and West. In West only very few children under 3 years of age are attending day care services, whereas most of the younger children used to be in creches in the former East Germany. The day care services include some approved family day care, creches for children under 3 years, kindergartens for children aged 3-6 years and examples of aged integrated centres. Many of the centres, however, are not available on a full-time, all-year basis. In East still the level of provision is higher than in West, both concerning creches for the under 3 year olds and all-day kindergartens for children aged 3-6 years.

Private non-subsidised services are mainly provided by family day carers. Low income families may get a subsidy for using family day carers and other private services approved by public authorities.

9.6.2. General principles for child care

Public acceptance of day care services for children under 3 years of age traditionally has been and still is very low. The general preference being that small children should be taken care of by their mothers. This attitude was expressed in a government "Structural Plan for Child Rearing" in 1970 which was stating: "It is the commonly held view that during the first three years of life, a child's development is best furthered if its family provides an understanding and stimulating environment. It is hard to see how children of this age can experience more stimulation outside such a family. For 3-4 year olds, however, this conclusion is no more valid" (Here cited from Pettinger, 1993). In accordance with this view priority in policies has been to improve and enlarge the maternity and parental leave periods and the benefits connected to the leave periods, and the vast majority of children under 3 years of age has been cared for at home.

The low proportion of small children in day care and the public attitudes have tended to stigmatise services for the younger children, as they have an image of providing mostly for problem families. In East Germany, however, the services are viewed much more favourably and the increase in employment of women with small children in West tends to change the attitudes in West as well, but still the number of 0-2 year old children cared for outside the home is very low.

From the age of three, however, policies have been to encourage attendance in kindergartens. Kindergartens are to some extent viewed upon as a preschool facility, preparing children for the school at 6 years of age. So the concept of kindergarten is more addressing socialisation and educational aspects of child rearing than aiming at supporting labour market participation of the mothers. This shows off in opening hours as most kindergartens are half day services. The

importance of the kindergarten, however, is underlined by the guarantee to a place in a kindergarten issued by the federal government.

All day care facilities including family day care are regulated by the Federal Child and Youth Welfare Act *(Kinder und Jugendhilfgesetz)* from 1991 with some later amendments - most recently in 1996. This act stipulates a frame for day care services, which the Länder have to implement themselves. It is stressed in accordance with the constitution that parents have the primary responsibility for raising and care of their children and that public authorities have to support the parents in this. Among the ways of supporting is the obligation to ensure that day care facilities are provided in the interest of the children. The facilities may be provided by public authorities (*Jugendamt* in *Kreise* and *Städte)*, the welfare associations, the churches or by initiatives of the parents.

The federal act states that care in day care facilities shall aim at developing a responsible and social personality and comprises the following three aspects: Care, general development and education *(Betreuung, Bildung und Erziehung des Kindes)* which has to be carried out in close cooperation with the parents.

The legislation of 1991 in accordance with the principle of subsidiarity allowed for care based on parental initiatives alongside professional care service provision. In this the legislation took into account the numerous initiatives and self-help solutions to the day care problem which had developed during the preceding 20 years.

In East Germany before unification, the situation was quite different as the high female employment rate was supported by a very high provision of day care places not only for kindergarten children but also for children under 3 years of age. This still is reflected in public attitudes towards day care outside the home, as the rate of children in day care still is higher in East than in West Germany. But the number of day care places has decreased considerably since unification because of decreasing number of births, high unemployment, rising fees in day care institutions, the introduction of the parental leave and parental benefits for families with children under 3 years and because company based day care facilities are abolished.

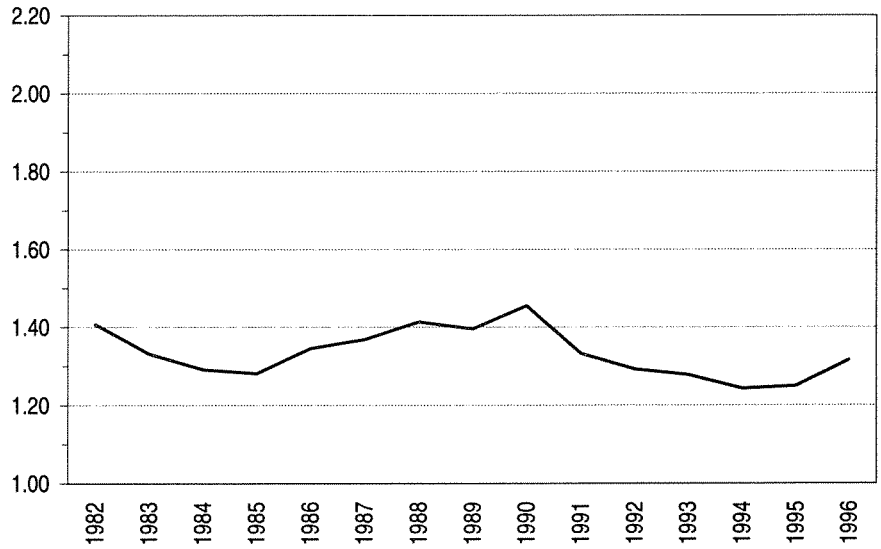
9.6.3. The need for day care

As in most other countries the increasing labour market participation of women has put pressure on day care facilities for the children. However, in West Germany the increase has been rather slow compared to other European countries. In West Germany the activity rate of women in working age in 1985 was 51%. The

rate increased to 55% in 1991 and was in 1995 in all of Germany 57% compared to 75% in Denmark. About 35% of the employed are working part-time. As mentioned above attitudes in general favour care at home for the children under 3 and hereafter for social and educational reasons the child should attend a kindergarten part of the day. Also the shortage of after-school facilities tend to discourage labour market participation of women. It is expected, however, that also in Germany an increasing proportion of women want to keep up working life as it has been the case in other European countries.

Fertility rates have been very low in Germany since the beginning of the 1980s. In 1982 the rate in West Germany was 1.4 and during the 1980s only varied between 1.3 and 1.5. After unification the fertility rate in Germany declined to 1.25 in 1993 and 1994, but apparently has increased slowly since then.

Figure 9.7.
Total fertility rate, 1982-1996.



Source: StBA (1998): Personal communication.

9.6.4. Child care in the home

Maternity benefit (Muttershaftsgeld)

Since 1979 employed mothers have been entitled to a maternity leave and maternity benefits. Maternity leave is a general right for all female employees for 14 weeks starting 6 weeks before the delivery and normally ending 8 weeks

after. In case of multiple or premature births the period after delivery is extended to 12 weeks. Entitled to a maternity benefit during the statutory rest period are women in work, who have been in a statutory health insurance for at least 12 weeks between the 4th and 10th month preceding the birth.

The amount of the tax free benefit is related to previous income with a maximum of 25 DM a day/775 DM a month. However, employers are obliged to make up the difference between the benefit and net income earned if this was higher than the maximum benefit.

The Childraising benefit (Erziehungsgeld)

In order to acknowledge the role of a parent, who is staying at home to take care of the child, the childraising benefit was introduced in 1986. Since 1993 the benefit may be paid out during the first 24 months of the child's life. The benefit is available to either parent and can be split between them or for alternative periods. In 1995 2.5% of the recipients were men. The parent receiving the benefit can work for an employer for up to 19 hours per week.

The benefit is a flat rate benefit of 600 DM a month. It was until 1994 paid out irrespective of income for the first 6 months of the life of the child. Hereafter it is only granted if the family income for married couples does not exceed 100,000 DM a year. From the seventh month the benefit is gradually reduced if the income exceeds 29,400 DM a year until it cease at 100,000 DM a year for couples. For a single parent the limits are somewhat lower.

The amount of 600 DM has not been raised since it was introduced in 1986, and so has lost some of its value. In 1986 it almost matched a half-time wage in low paid female jobs. It is possible to work up to 19 hours a week without reduction in the allowance.

Almost all families with newborn children receive the benefit for the first 6 months. In 1992 15% of all families with small children received the full child-raising benefit after the seventh month, 73% received a reduced benefit and 12% were not entitled at all because of too high family income.

Parents in work have a right to claim unpaid child-raising leave until the child are 3 if the spouse is not at home to take care of the child. It may also be claimed if the spouse is unemployed or under education. During child-raising leave the parent is protected from unwarranted dismissal.

Leave for family reasons (Arbeitsfreistellung wenn Kind krank werden)
From statutory health insurance sickness benefits may be paid out 10 days a year for each child under the age of 12 who has to be cared for at home. For single parents the number is a maximum of 20 days. If more than one child is insured the maximum number of days are 25 and 50 days for single parents.

Labour market agreements
Since the mid 1980s a number of large companies have made company agreements on extended duration of unpaid parental leave. It may be up to 7 years. In general the person on leave is not guaranteed to return to old job, but is secured a re-employment after the leave period. Many companies also offer their employees the opportunity to work part-time during company parental leave and/or offer training and special return programmes.

Tax allowances
There is no special tax law provision which benefits informal care in the home, but the financially most important form of tax allowance in Germany is the so called "tax-splitting" of married couples. Married couples combined income is treated as if each partner earned exactly half of it. Because of the progressive tax system this splitting of the income favours single earner couples or couples with large earnings differentials. It is often criticised because this favour is at the expense of two earner couples and implicitly discourage labour market participation of women.

9.6.5. Child day care outside the home

The provision and coverage of publicly-funded day-care services for children vary greatly across the Länder and even across local municipalities within the Länder. The legal framework is set up at Bundes level, but implementation and funding are responsibilities of Länder governments and local authorities - the *Jugendam* in *Kreis* or *Stadt*.

The situation still is very different in West and East. In the East before reunification there was an almost full coverage of day-care services in a centralised and very structured system with detailed curricula and cognitive objectives. Many of the day care places and most of the places in *Krippen* were company based. Since reunification the number of places has been reduced but basically still meets the demand. The services consist mostly of creches *(Krippen)* for the under 3 years old and all-day kindergartens *(Ganztagskindergarten)* for children aged 3-6 years. Also provision of services for school age children is rather high.

In West the development of day care places in general has been lagging behind demand, but because of the decentralised responsibility the diversity of services is great. The services include publicly supervised and subsidised centres for children under 3 years, centres for children aged 3-6 years and examples of age integrated centres. Most of the centres, however, are not available on a full-time, all-year basis.

The great variety of day care arrangements include the following services (EU, 1996):

Krippe: creches for children aged 0-36 month, usually open from 07:00 a.m. to 4:30 p.m. Many centres are closed for a short period in summer.

Kindergarten: publicly-funded day-care center for children aged 3-6 years. Traditionally opening hours in West were 3-4 hours in the morning and 2 hours in the afternoon, but the trend is towards longer opening hours, either by extending opening hours to all-day or by providing longer hours in the afternoon.

Ganztagskindergarten: all-day publicly-funded day-care institutions for children aged 3-6 years open from 7:00/8:00 a.m. to 4:30 p.m. or 5:00 p.m., where lunch is provided. This type of day-care is most common in East, where opening hours often are longer i.e. from 6:00 to 18:00.

Krippen and *Kindergartens* are the most important types of services, but in addition are a number of other types, which are unevenly common in the different Länder: *Privater Kindergarten* are kindergartens entirely funded by parent fees. They are expensive and not very common. Quite often they are based on a specific pedagogical concept. *Elterninitiative* are day-care centres initiated and managed by the parents and often aged integrated taking children aged 0-6 years. They employ paid staff but parents are also involved in daily activities such as cooking. Opening hours may vary according to the parents needs. *Erweiterte Altersmischung*: kindergartens with extended and mixed age groups. They take in children younger than 3 years and up 7 years. *Kinderhaus*: integrated institution for children aged 0-6 years and sometimes older. Sometimes as old as 14 years. The children are grouped according to age but integrated through common facilities and activities. *Familiengruppen*: family-groups are integrated institutions for children aged 0-6 years and sometimes older - up to 14 years. The children are not grouped according to age. *Spielgruppen/Mutterkindgruppen*: play-groups or mother-child groups for children under 3 years meeting 2-3 times a week in 2-3 hours with a mother present.

Tagesmutter: self employed family day-carer (child minder), mostly for childrer under school-age.

Also for school age children, there are a number of daycare facilities: *Horten* ar institutions providing day-care for school-children. They are separate from schoc and have opening hours outside school-hours from 7:00 a.m. until school begin and again after school to 4:30 p.m. *Betreute Grundschule* are school-base services for children up to 10 years, open until 1:00 p.m. and sometimes provid ing lunch. *Hausaufgabenbetreuung:* Home-work group for up to 10 school chil dren supervised by an adult for 2 hours in the afternoon. They are usually pro vided by private organisations.

For the children under school age the important distinction, irrespective of th type of daycare institution, is between places for the under 3 year old childrer and places in kindergartens for the children 3-5 year old. The Federal Child an Youth Welfare Act *(Kinder- und Jugendhilfegesetz)* passed in 1991 has as on objective to create a coherent funding system for all services for children age 0-6 years. Public funding of kindergartens comes from Länder governments an local authorities. For services for children under 3 years the funding comes eithe from Länder governments or from local authorities (Except for three Länder where the funding is shared).

In 1994, there were in all 46,600 day care institutions in Germany. Hereof 85 creches, 29,757 kindergartens, 3,657 after school institutions, 4,700 institution covering different age groups, 4,675 institutions with mixed age groups an 2,975 with both mixed age groups and separated groups.

Creches (Krippen)

Provision

Local authorities (*Jugendamt* in *Kreise* or *Städte)* are responsible for providing sufficient number of places in day care institutions and in family day care. Ac cording to the principle of subsidiarity they have to prioritise places provided b welfare associations or private provision and only if they are not able to ensur provision are local authorities supposed to establish services. Most day car services are provided by the welfare associations.

In West Germany the number of creches and places for children under 3 year of age has always been and still is very small. Many places are reserved fc children from families with different kind of problems, and creches by this sti have an image of institutions for children at risk. In East Germany, howeve before unification there were places for the majority of the children aged 0- years old, but the number of places were drastically reduced after 1989.

In 1994, it was in all 151,000 places in publicly funded creches in Germany. 104,000 (or 68%) of these in East Germany. In addition there were about 30,000 places in private not publicly funded creches in all of Germany. Most of the places in creches are provided by the public sector, but the number established by welfare associations has increased slowly.

Coverage

In 1990, there were 38,153 places in publicly funded creches *(Krippen)* in West Germany. This constituted a coverage of less than 2% of the age group. In the former East Germany there were places for 3/4 of the age group. The number of places in East were reduced drastically in the first years after reunification, but still in 1991 the number of publicly funded places covered 54% of all children aged 0-2 years.

As only publicly funded places are included in official statistics, information on the proportion of all children attending creches has to be based on survey data. According to such data 4,5% of all children aged 0-2 years were attending a creche in 1996 in West Germany. In East the proportion went down from 42% in 1994 to 33% in 1996. In all this meant that 7.5% of the children 0-2 years of age were attending a creche in 1996.

Fees

Parents contribute to the costs of all publicly funded day care services taking account of family income and number of children. Parents fees are decided by the local authorities irrespective of whether they are managed by one of the welfare associations or by the local authorities. The parents fees vary very much between the local authorities, but on average parents pay between 16% and 20% of the costs. The fee for a *Krippen* - place may vary between 0 and 600 DM a month. Low income families may obtain a subsidy benefit from the local authorities.

Standards

There are not any national standards for staffing, group size etc. for the day care services in Germany. Standards are determined by the Länder. In West Germany staff/child ratios varies for children under 3 years of age from 1 adult to between 5 and 7.5 children. Usually there are at least 2 adults in each group of children, one being a qualified *ErzieherIn* or *KinderpflegerIn* (see under kindergartens), the other a trainee or untrained person. Creches might also employ pediatric nurses *(Säuglingsschwester)*.

Table 9.1.
Places in publicly funded day care institutions available for children aged 0-2 by provider, 1982-95.

	Creches in all		Public		Associations	
	Institutions	Places	Institutions	Places	Institutions	Places
West Germany						
1982	882	26,245	549	19,138	311	6,633
1983	..	..	..	..	..	..
1984	..	..	..	..	..	..
1985	..	..	..	..	..	..
1986	1,028	28,353	642	20,601	360	7,332
1987	..	..	..	..	..	..
1988	..	..	..	..	..	..
1989	..	..	..	..	..	..
1990	..	38,151	..	18,771	..	18,581
1991	..	..	..	..	..	..
1992	..	..	..	..	..	..
1993	..	..	..	..	..	..
1994	..	47,064	..	..	..	..
1995	..	..	..	..	..	..
East Germany						
1991	..	255,280	..	..	..	..
1992	..	..	..	..	..	..
1993	..	..	..	..	..	..
1994	..	103,689	..	..	..	..
1995	..	..	..	..	..	..
All Germany						
1991	..	..	..	..	..	..
1992	..	..	..	..	..	..
1993	..	..	..	..	..	..
1994	..	150,753	..	109,42	..	41,333
1995	..	..	..	..	..	..

Source: StBA, FS 13 Reihe 6.3 (various years)
Bundesministerium für Familie, Senioren, Frauen und Jugend, Statistische Angaben zur Tagesbetreuung von Kindern in der Bundesrepublik Deutschland 28.01.1998.

Table 9.2.
Day nurseries, number and per cent of FTE children (aged 0-4) by provider, 1982-1994.

Year	Number of FTE children	% of the children aged 0-4	% Public	% Independent
1982	26,245	0.87	72.92	27.08
1986	28,353	0.94	72.66	27.34
1990	38,153	1.09	50.25	49,75
1994	144,296	3.41	72.58	27.42

Source: StBA: Sozialleistungen, Fachserie 13, Reihe 6.3 (annual publication).
Note: 1 full-time enrolled child = 1 FTE child. 1 part.time enrolled child = 0.5 FTE child.

Kindergartens (Kindergarten)

Entitlement

Public debate around a new abortion law passed in 1993 had a major effect on the provision of kindergartens, as it at the same time was decided to make the provision of day care facilities for the 3-6 years old children a legal right. This decision have put local authorities in West Germany under considerable pressure and has had the effect that services for children under 3 years and schoolchildren have been cut or not expanded. Also the group size and/or adult-children ratio in kindergartens have been under pressure.

The right to a kindergarten place came into effect 1 January 1996. For the first 3 years it will be applied flexibly, but from 1999 every child will have the right to be admitted to a kindergarten from the age of 3.

Provision

The welfare associations are managing most kindergartens, but many are also established by public authorities. In 1994 the number of places in different kind of institutions available for children aged 3-5 was about 1.4 m in institutions belonging to the welfare associations and about 1.1 m belonging to public authorities. In all it were about 2,472,000 places in Germany.

The number of places in West increased from 1.5 m in 1990 to 1.9 m in 1994 whereas the number in East decreased from 888,000 in 1989 to 552,000 in 1994. This meant in West an increase from 78 to 85 places per 100 children aged 3-5 years. In East there were still 116 places in 1994 for every 100 children in this age group. The reduction of places in East has been matched by the falling birth rate and a lower level of employment for women.

Table 9.3.
Places in publicly funded day care institutions available for children 3-5 by provider, 1982-94.

	Kindergartens in all		Public		Associations	
	Institutions	Places	Institutions	Places	Institutions	Places
West Germany						
1982	22,724	1,334,997	7,088	410,727	15,365	916,306
1983	..	..	..	..	..	..
1984	..	..	..	..	..	..
1985	..	..	..	..	..	..
1986	24,476	1,438,383	7,606	442,013	16,667	990,041
1987	..	..	..	..	..	..
1988	..	..	..	..	..	..
1989	..	..	..	..	..	..
1990	..	1,552,027	..	474,920	..	1,070,898
1991	..	..	..	..	..	..
1992	..	..	..	..	..	..
1993	..	..	..	..	..	..
1994	..	1,918,823	..	..	..	..
1995	..	..	..	..	..	..
East Germany						
1991	..	713,306	..	..	..	..
1992	..	..	..	..	..	..
1993	..	..	..	..	..	..
1994	..	552,865	..	..	..	..
1995	..	..	..	..	..	..
All Germany						
1991	..	..	..	..	..	..
1992	..	..	..	..	..	..
1993	..	..	..	..	..	..
1994	..	2,471,688	..	1,093,073	..	1,378,615
1995	..	..	..	..	..	..

Source: StBA, FS 13 Reihe 6.3 (various years)
Bundesministerium für Familie, Senioren, Frauen und Jugend, Statistische Angaben zur Tagesbetreuung von Kindern in der Bundesrepublik Deutschland 28.01.1998

However, the provision of places available for kindergarten children varied considerable not only between the old West and East, but also between the Länder in West. The numbers of places available were particularly low in the heavily populated Länder of Niedersachsen and Nordrhein-Westfalen, where provision covered less than 75% of the 3-5 year old children. In Baden-Würtenberg there were more than 100 places for every 100 children in this age group (Holzer, 1998).

In the Eastern Länder, almost all kindergarten places are full time places with lunch provided. In West, however, 50% of the places in 1994 were 'morning and afternoon places' with a break during lunch, where parents have to see to the children, 23% of the places were either morning or afternoon places without lunch and only about 17% were full time places with lunch included. Full time places with lunch provided are not common in any of the Länder in West, but in a number of Länder (Baden Würtenberg, Nordrhein-Westfalen, Rheinland-Pfalz und Saarland) most places are 'morning and afternoon' places with a break during lunch hour. In Niedersachen and Schleswig-Holstein are morning or afternoon places without lunch the most common kind of kindergarten places (DJI, 1998).

In order to meet the required guarantee for a kindergarten place 1 January 1999 the Länder in West have enlarged the number of places for kindergarten children. According to their own reporting to the *Deutsches Jugendinstitut* in 1997 most of the Länder were close to a full coverage of places. However, some of the Länder take into account other possibilities for day care of children than kindergarten places. Or they take into account that a considerable proportion of children does not enter a kindergarten before they are 4 years old. To meet the requirements of the guarantee for a kindergarten place, it is sufficient to offer a part-time place of 4 hours. Many of the Länder have declared that they are aiming at establishing a provision of full-time places which meets the demand of the parents, but it is foreseen, that it will take some years further before this demand will be met (DJI, 1998 p. 83).

Coverage

Many of the places available, however, are not exclusively for children aged 3-5 but also for children older or younger than this. Information on the proportion of children 3-5 years old attending kindergartens has to be based on survey data. Such data indicate that the proportion of children attending a kindergarten in 1994 was 59% in West and 89% in East. In all Germany this makes a proportion of 65% of the 3-5 year old. In East the vast majority attend a kindergarten from the age of 3 years (82%), but in West only 29% of the 3 year old children were in kindergartens. Among the 4 year olds the proportion was 70% and among the

5 year olds 82% in West. So most of the children in West were not starting in kindergarten before they are 4 years old. Available statistics do not distinguish between kindergartens with different opening hours. In East, full-day kindergartens are the most common form, but in West only 13-15% are open on a full-day basis.

Table 9.4.
Number and per cent of FTE children (aged 0-4) in kindergartens by provider, 1982-1994.

Year	Number of FTE children		%	
		% of the children aged 0-4	Public	Independent
1982	1,334,997	44.43	39.57	60.43
1986	1,438,383	47.88	39.57	60.43
1990	1,583,622	45.34	37.59	62.41
1994	1,666,192	39.36	44.22	55.78

Source: StBA: Sozialleistungen, Fachserie 13, Reihe 6.3 (annual publication).
Note: full-time enrolled child = 1 FTE child. 1 part-time enrolled child = 0.5 FTE child.

Fees

Parents fees are set by local authorities and vary very much across local authorities, but in average parents pay between 16% and 20% of the costs. The fee may vary between 0 and 240 DM a month for a kindergarten place. Low income families may obtain a subsidy benefit from local social authorities.

There is also an increase in companies participating in public-private partnerships to develop services for young children.

Standards

There are no national standards for staffing, group size etc. for day care services in Germany. Standards are determined by the Länder. In West Germany, the staff/child ratio in kindergartens vary from 1 adult/10 children to 1 adult/14 children. In East the ratio in kindergartens can be 1 adult to 18 children.

Staff

Qualification standards of employed in day care services traditionally have been high in Germany. The qualified staff consists almost entirely of social teachers *(Sozialpädagogen),* nursery-school teachers *(ErzieherIn)* and nursery nurses *(KinderpflegerIn).*

Sozialpädagogen have a 3-4 year post-19 years education. They work in kindergartens and in *horts.* Heads of day care institutions *EinrichtungsleiterIn* usually are *SocialpädagogIn* or *ErzieherIn.*

Erzieherln is a pre-school teacher with 3-5 years post-16 years education. They have traditionally been working in kindergartens and horts, but are increasingly also working in centres for the under 3 year old children.

Kinderpflegerln is a nursery carer with a 3 year post-14 years education. They are working in creches and kindergartens. The number of educated *Kinderpflegerlns* is decreasing.

Family Day Care (Tagesmütter)

In 1973 a women's magazine in West Germany published an article on family day care in Sweden, which started up a model-project of a more organized and supervised provision of family day care. By this local organisations of parents and day carers were established throughout Germany and in 1978 a federal association of organisations for family day carers was established to promote training and to enhance public acceptance of family day care. In some Länder local organisations are supported by the Länder and the federal organisation is supported by the federal government. These organisations have played an important role in developing family day care in Germany, although only one third of all family day carers are members.

Provision

Family day carers are in general self-employed. There are a few projects where family day carers are employed by local authorities. They can choose to seek local authority approval. Subsidies for low income families can only be given if they use an approved family day carer. About half of all family day carers have an approval from local authorities.

Because of the shortage of day cay facilities some employers are subsidising family day carers for use by their employees. Or private firms are funding family day care agencies which help parents to find an appropriate family day care and by supervising the arrangement.

Coverage

Family day care provides care for children in all age groups. Although family day care by the Children and Youth Act is recommended for children under 3, only one third of the children are of this age. The other children are divided between children aged 3-5 years and school children who often make use of family day care outside the opening hours of the kindergarten or the school (EU, 1995).

The number of places at family day carers approved by local authorities increased from 25,735 in 1985 to 43,615 in 1990. The number of not registered day carers is estimated to be about the same.

It is estimated that about 2% of all children under 3 years of age attend an approved family day carer, and another 2% are attending day carers without contact to the authorities.

Fees

The self employed family day carers in general set the price themselves. However, some Länder have regulations specifying maximum and minimum payments for the approved family day carers. These maximum payments vary between 350 DM and 950 DM a month.

Low income families may obtain a subsidy benefit from the local authorities for the use of an approved family day care as for a publicly funded day care centre.

Standards

There is no requirements for formal education or training of family day carers. However, in some Länder local authorities fund training courses for family day carers.

Local authorities, have to supervise the approved family day carers. Approved day carers are not allowed to care for more than 3 children apart from their own children.

There are no regulations or guidelines on working hours and family day carers are themselves responsible for social insurances. In general they have no paid sick leave and holidays have to be negotiated with the parents.

9.7.
Social services for older people in Germany

9.7.1. Introduction - Main social services and care cash benefits

The German welfare system has traditionally presupposed that the family will support older relatives in line with the principle of subsidiarity, and most elderly in need of care and assistance are receiving this from family members. It is estimated that about 10% of the population aged 65 or over are in considerable need of care and assistance. 90% of these people are largely taken care of by a family member, mainly the spouse or a child - and mainly women.

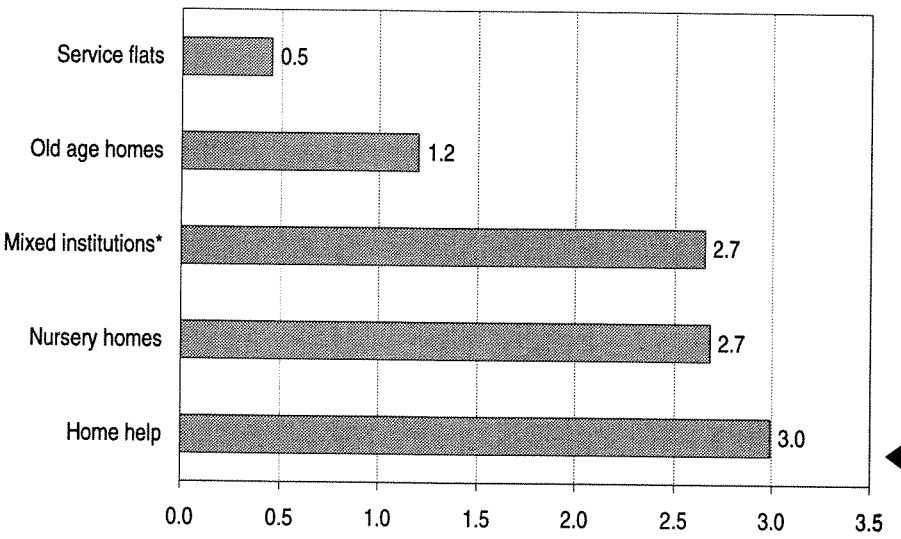
Between 5 and 6% of the population aged 65 or more live in a residential homes. The number of institutions and places have steadily increased, and as in other countries more and more places are occupied by residents dependent on nursing and care. The traditional distinction between different types of institutions such as old age homes (*Altenheime* and *Altenwohnheime*) and nursing institutions (*Pflegeheime*) has increasingly been superseded by institutions offering

different types of places. Currently about two thirds of residents need personal care and assistance.

Home help and home care services have developed since the 1970s but the provision of services is still at a modest level. The number of people making use of a professional domestic service is only vaguely known. It is estimated that about 3% of the population aged 65 or over receive professional home care and about 2% receive help with domestic work from the domestic service agencies.

Other community services include meals on wheels, which an estimated 2% of the persons aged 65 or over receive, stationary meal services, and day care/activity centres.

Figure 9.8.
Use of the main social services for older people (65+) as a percentage of the age-group, 1996.

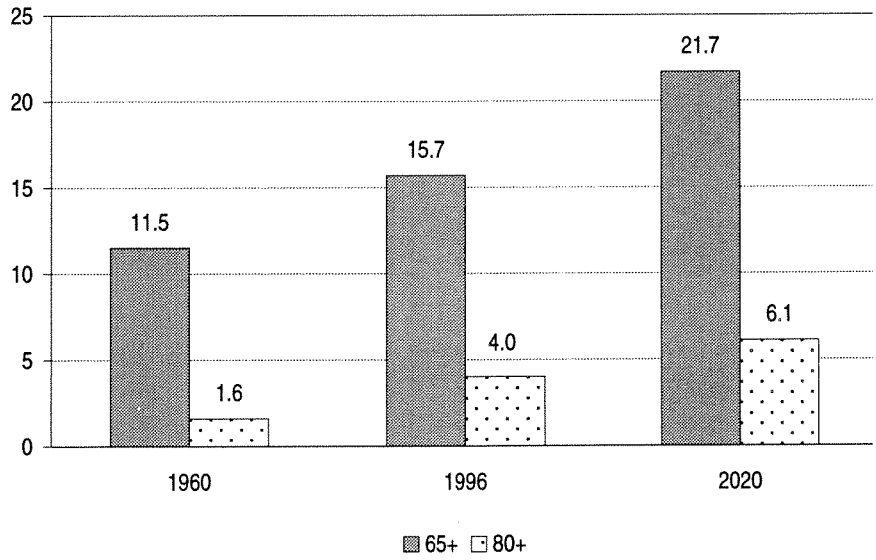


Source: StBA: VII D - P. StBA: Statistical yearbook (annual publication)

Until the new Social Care Insurance scheme was introduced in 1995, there were only very limited possibilities for financial support, which would cover the costs of care and assistance for dependent elderly people. People in need of care beyond the unpaid help from family members and others, had to pay for it themselves or apply for social assistance. The care insurance scheme allows a choice between home care in kind *(Sachleistung)* and a cash payment for care by a

family member or other care person *(Geldleistung)* or a combination of both. The amount granted in cash payments for care is about half the total amount granted for benefits in kind, which is a service provided by a professional agency, which is paid directly by the insurance fund. By far the most receipients receive the payment for care. In first half of 1997 an estimated 6.5% of all aged 65 or over received payment for care from the long term care insurance scheme, about 1.5% received home care in kind and about 2.5% received help to pay for residential care from social care insurance. In all about 9% of the population aged 65 or over received some kind of benefit from the social care insurance scheme. There are finally a few hospices with a very limited number of places for care of terminally ill people in Germany.

Figure 9.9.
Older people (65+) as a percentage of the population according to age-group, 1960-2020.



Source: EUROSTAT: Demographic statistics 1997.

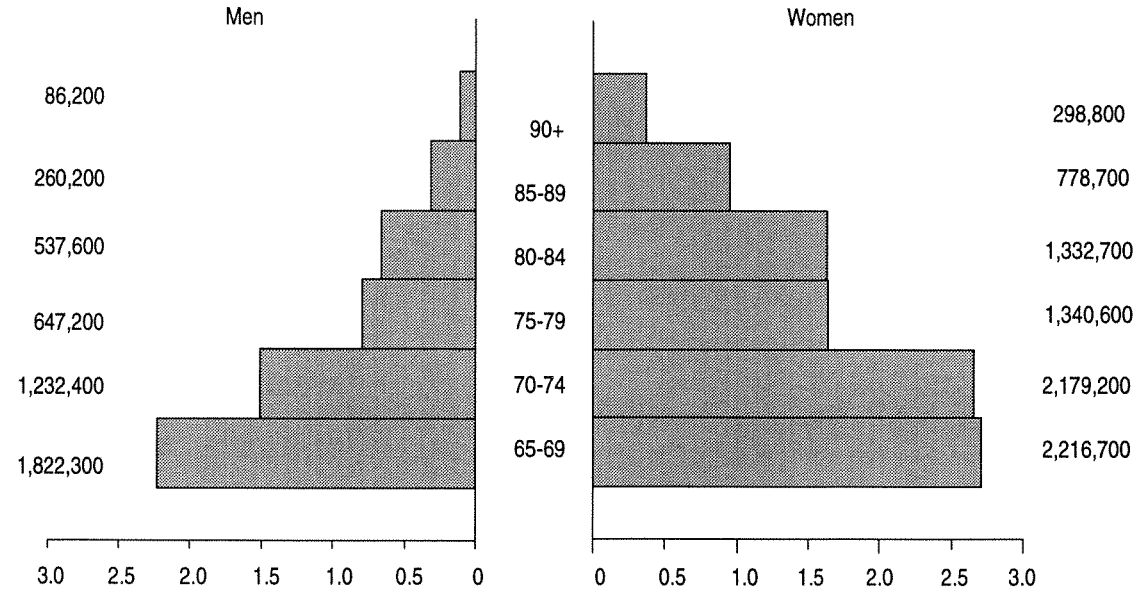
9.7.2. General principles for care services for older people

There is a sharp distinction in Germany between cure and care - between acute illness and long term care dependency. The temporary impairment of health is the responsibility of the health sector and treatment is financed through health insurance, general taxation and payments by the user. Need for long term care,

however, is regarded as a private risk, whether living in a private home or a residential institution. Costs for professional home help and care may be covered by social assistance if the means of the receipient do not exceed the social assistance level. The introduction of Social Care Insurance has changed this situation. Specialised home nursing in connection with acute medical treatment is still covered by health insurance, but personal care *(Grundpflege)* and domestic work *(hauswirtschaftliche Versorgung)* may be covered by the new care insurance scheme. Personal care includes toilet, bathing and health monitoring.

For a number of years policy has been to support self-help and enabling older people to stay in own home for as long as possible. This is in accordance with the general principle of subsidiarity. Also in accordance with the principle of subsidiarity is that outside the family most social care and welfare services are provided by charities, self-organised groups and private business. The most important are the big associations of free welfare services. Local municipalities also provide services. Private providers - including single-person enterprises - are of increasing importance. Private provision has mainly been within the residential care sector but increasingly private providers offer community care services.

Figure 9.10.
Age pyramid of the older people (65+) as a percentage of the total population, 1996.



Source: EUROSTAT: Demographic statistics 1997.

9.7.3. The need for care services

As in other European countries aging of the population is taking place. In 1982, 14.9% of the population in West Germany were aged 65 or over. This proportion increased to 15.7% by 1996 in all Germany and is expected to rise sharply to almost 22% by the year 2020. The proportion of very old people (aged 85 years or over) increased from about 1% of West German population in 1982 to about 2% in 1996. In 2020 the proportion of very old people is expected to be around 2.5%.

German social services for the elderly are still considered to be inadequate to meet demand. A survey carried out in 1991/92 stated that 7.6% of all persons aged 65 or over living in private households were in need of care (Schneekloth et al., 1996). That corresponds to 915,000 persons of which 756,000 persons live in the Western Bundesländer (Alber & Schölkopf, 1998, p. 98). Another 12.5% are in need of help for domestic tasks. These numbers refer only to people living in private households. If those living in residential homes are added, it is estimated, that in 1993 about 1.24 m people aged 65 or over were in considerable need of care. That is about 10% of this age group. Because of women's longer life expectancy the proportion in need of care was 11.5% of women aged 65 or over and 7.4% of men. Need for care increases with age, and among 60-79 year olds the proportions in need of regular care were only about 4% of men and 3% of women. However, among those aged 80 years or over the proportions amount to 19% of men and almost 30% of women including 5.5% of men and 11% of women living in residential homes.
For older people cared for at home, the care provided by family members or neighbours is by far the most important. 90% of those in need of care are helped by such carers, who in about three of four cases are women. 9% of older people in need of care do not receive any help from family, neighbours or others. Those in this group mostly live in one-person households (Schneekloth, 1996).

The potential for care of the 'sandwich generation' of women has been more favourable in Germany in comparison with other countries because the proportion of women aged 45-69 in relation to the number of persons aged 70 or over has been relatively high. Between 1980 and 1990 this proportion increased from 1.3 to 1.5 women for every person aged 70 or over in West Germany. In the East the proportion in 1990 was 1.7 and in Germany in all 1.55. This proportion, however, will decrease in the coming decades and is estimated to be around 1.0 in the year 2030 (Alber and Schölkopf, 1998 table 5.2).

9.7.4. The new social sare insurance scheme
Die Soziale Pflegeversicherung

The New Social Care Insurance covers costs for long term personal care and domestic assistance whether the person in need of care is living in a residential

institution or at home and receive professional, has chosen a payment for care benefit because they know a family member or other person who is able to carry out the care tasks. As the principles for needs assessment are common, whatever method of care giving the scheme described in this section applies to each of the above categories.

1 January 1995 the new long-term care insurance scheme was established as an independent branch, or 'fifth pillar' of the German social insurance system and introduced compulsory private long-term care insurance *(Pflegeversicherung)*. As a result almost everyone in Germany now enjoys the previously non-existent safety net of long-term care insurance. All those covered by statutory health insurance automatically have long-term care insurance too. Also those with private health insurance who are entitled to general hospital care must have private long-term care insurance.

The aims of the new law were:

- to keep people with a care need in their own homes for as long as possible
- to reduce the need for placements in residential care
- to stimulate and activate social networks around those in need of care
- and to make people in need of care independent of social assistance.

The Social Care Insurance Funds grant benefits for care in the home or in residential institutions if the need for care is more than short term (in general a minimum of six months). As far as possible support should aim at helping older people to regain the ability to carry out tasks independently. Prevention and rehabilitation measures to overcome, reduce or prevent an increase in the need for long-term care are given priority over care. Also home care has priority over care at residential institutions.

Care insurance is financed on a 'pay-as-you-go' basis, and has to be self-financing. All members of sickness insurance schemes must pay contributions, which may vary between 1.5% and 2.0%. Currently it is 1.7% of gross earnings. Employees and employers both make contributions. Employers are compensated for this by a reduction in paid holidays of one day. Members of private sickness insurance schemes are required to insure themselves privately. In the first half of 1997 the income of the Social Care Insurance Funds was 15 billion DM, of which about 12 billion came from contributions and about 3 billion from regional funds. Payments made in care benefits amounted to 14.4 billion DM.

Entitlement

Entitlement to benefits from Social Care Insurance Funds depends on previous contributions to the insurance fund. In the first years of the new Social Care Insurance Scheme the entitlement waiting period is to be only gradually extended from one year of contributions between 1996 and 2000 when the requirement will be a minimum of 5 years of insurance contributions within the most recent 10 years. Those who do not yet fulfil this condition will have to wait for benefits until they meet the required period for entitlement.

The Social Care Insurance is statutory for all who are also statutorily insured through Health Insurance Funds *(Krankenkassen)*. The insurance is thus obligatory for most of the population since employees, students, soldiers and pensioners all have to be insured. Those who are voluntarily insured through Sickness Insurance Funds must also be insured in Social Care Insurance Funds *(Pflegekassen)*. Dependent children and spouses are covered by the insurance without contributions if their own income does not exceed 610 DM a month in the old Bundesländer and 520 DM in the new Länder (1996). In 1996 98.6% of the population were insured. 90.2% were insured in the social funds and 8.3% were covered by private care insurance.

Contributions are 1.7% of total income - pensions included. There is, however, a maximum contribution ceiling of - in 1997 - 6,150 DM a month in the old Länder and 5,325 DM a month in the new Länder. Half the contribution are made by employers and the other half by employees. Pensioners proportion the contribution amount with pension insurance funds. For unemployed the contribution is paid by the Federal Employment Services (*Bundesanstalt für Arbeit)*, and for social assistance recipients the contribution is paid by the service providing social assistance payments.

Benefits from Social Care Insurance Funds have to be sought by the person in need of care. The beneficiary is always the person in need of care - to secure his/her independence.

Assessment of need

The need for care is assessed by medical advisors of Health Insurance Funds *(Krankenkassen)*, which are also the assessors of the Social Care Service Insurance Funds *(Pflegekassen)*.

The routine day-to-day activities that are covered include:

1. Personal hygiene: washing, showering, bathing, dental hygiene, hairgrooming, shaving, toileting.
2. Eating: eating, and preparing food so that it is bite-sized and ready to eat.
3. Mobility: getting out of and going to bed, getting dressed and undressed, walking, standing, climbing stairs, leaving and getting back to one's home without assistance

4. Housekeeping: grocery shopping, cooking, housecleaning, dishwashing, changing and washing linen and clothing, heating the home.

The benefits are granted according to three Care-levels of need *(Pflegestufe)*:

Care-level I: considerable need of care *(Erheblich pflegebedürftige)* - need of assistance for at least two daily activities concerning personal care and need for home help services several times a week. The time needed for this has to be at least 90 minutes a day of which at least 45 minutes are needed for personal care.

Care-level II: substantial need of care *(Schwerpflegebedürftige)* - need of assistance for personal care at least three times a day and some home help services with the time needed at least 3 hours daily all together.

Care-level III: most substantial need of care *(Schwerstepflegebedürftige)* - in need of assistance round-the-clock for at least 5 hours a day, of which at least 4 hours are for personal care needs.

A major part of the care provided has traditionally been given by family members, and the new law offers a support for this by introducing a **Payment for Care** *(Pflegegeld)*, if the person in need of care is able to organise in an approved way help from family members or other carers. Payment for care may amount to a maximum of 400 DM a month at Care-level I, 800 DM a month at Care-level II and 1,300 DM at Care-level III. The payment for care is paid for the days care has actually been provided, but also during short term stays in hospital (up to a maximum of 4 weeks a year).

From April 1995, **home help and care** *(Pflegesachleistungen)* from a mobile service agency is available, if professional assistance is required. This is a benefit in kind with a fixed upper ceiling. The benefits may cover up to 750 DM a month at Care-level I, 1,800 DM at Care-level II and 2,800 DM at Care-level III. In special cases of hardship the amount may be increased up to a maximum of 3,750 DM a month. Home help/care from mobile service agencies and Payment for Care may be combined in a way which suits each individual situation.

Partial residential care during day time or at nights is also a possibility if the family or other care persons are able to carry out the care tasks the rest of the time.

Benefits for **residential care** may be up to 2,000 DM a month at Care-level I, 2,500 DM at Care-level II and 2,800 DM at Care-level III. In special cases of hardship the amount can be increased up to a maximum of 3,300 DM a month.

Table 9.5.
Monthly benefits from the social care insurance scheme (Die Soziale Plegeversigherung).

1997-1998	Care-level I	Care-level II	Care-level III
Home care	DM	DM	DM
Home help/-care from professional services *Plegesachleistung*	750	1,800	2,800
Payment for care *Plegegeld*	400	800	1,300
Holiday relief[1)]/year *Pflegevertretung*	400	800	1,300
Short term care/year *Kurzzeitpflege*	2,800	2,800	2,800
Partial residential care *Teinstationäre Tages- und Nachtplege*	750	1,500	2,100
Institutional care	2,000	2,500	2,800

1. By professional relief up to 2,800 DM a year on all levels.

Provision

Social Care Insurance Funds are only to make use of service providers which th Länder association of care insurance funds has made contracts with. In order t stimulate competition between the providers contracts are made with all provider who are able to offer proper care/help services on a commercial basis. However, th individual Insurance Fund may make contracts with individuals who have establishe single-person enterprises for home care/home help services. Charities and privat service providers are to be preferred over public services. The Länder are respons ble for the provision of a sufficient infrastructure of service providers. Altogether th Länder are allowed to grant about 3.6 billion DM a year to investments of car service providers. A special aid-package of 6.4 billion DM is reserved for the renewa and establishment of ambulatory, part time and residential care institutions in th new Länder in the period 1995 to 2002.

The national associations of care insurance funds and service providers are respor sible for establishing principles and norms for service quality and for quality contro The Länder associations of care insurance funds can have the service provide evaluated by an approved evaluator.

Settling of accounts with service providers is coordinated by 18 centres *(Leistungskomplexe)*, which have been set up by the social care insurance funds.

Table 9.6.
Recipients of social care benefits, 1997 first half year.

	Care-level I	%	Care-level II	%	Care-level III	%	Cases of Hardship	%	Total	%
Home care										
Home help/-care from prof. services *Pflegesachleistung*	56.612	8	48.811	7	13.364	5	688	29	119.475	7
Payment for care *Pflegegeld*	460.585	67	398.134	56	100.844	37	-		959.563	57
Combinations	46.687	7	76.256	11	38.941	14	320	13	162.204	10
Holiday relief *Pflegevertretung*	723	0,1	1.695	0,2	919	0,3	-		3.337	0,2
Short term care *Kurzzeitpflege*	1.780	0,3	2.614	0,4	1.157	0,4	-		5.551	0,3
Partial residential care *Teilstationäre Tages- und Nachtpflege*	1.697	0,2	2.414	0,3	809	0,3	-		4.920	0,3
Residential care	118.797	17	180.170	25	116.011	43	1.380	58	416.358	25
Total	686.881	100	710.094	100	272.045	100	2.388	100	1.671.408	100

Source: Bundesministerium für Arbeit und Sozialordnung, Bundesarbeitsblatt 6/1997.
Note: The table include all recipients in all age groups. Some duple counting is included, as persons receiving *pflegegeld* also may receive partial residential care and holiday relief.

Coverage

Almost 1.7 m persons were receiving benefits in 1997 from the Social Care Insurance Funds. Of these approximately 416,000 live in residential homes, and about 1,200,000 are cared for at home by relatives, neighbours or professional care providers. These numbers include recipients in all age groups. 78.5% of all recipi-

ents are aged 65 years or over, but statistics are not available on each age group and type of benefit. In all about 9% of the population aged 65 or over receives some kind of benefit from the scheme.

The vast majority of benefits from social insurance care funds are granted for payment of care benefits. Two of three benefits paid are for payment for care, where the dependent person has a family member or other non-professional carer attending. 10% receive support for payment for care in combination with home help from a professional care service, and 7% receive benefits to cover home help/-care from a care service. 25% of the benefits are paid to people living in residential homes.

9.7.5. Support for informal care

Payment for care (Pflegegeld)

Traditionally dependent elderly to a large degree have relied on care and assistance from family members or sometimes from others in the neighbourhood or elsewhere. The new care insurance scheme supports this provision by providing access to payment for care benefits, and as demonstrated in Table 9.6 the insurance scheme to a large extent is a payment for care scheme.

Entitlement

Payment for Care may be granted to both those living at home and those living in old age homes, in sheltered housing or service flats for elderly if they have an attendant *(Pflegeperson).* Attendants may be family members or a neighbour or other person, who are not working as professional attendants. Payment for Care may be granted in combination with home care/home help from a professional care provider or with partial residential care during day time or at nights if the family or other carers are able to undertake the care tasks for the rest of the time.

Assessment of need

The person receiving Payment for Care is obliged to have the arrangement for care and assistance assessed by a professional care provider at least every 6 months at Care-level I and II and every 3 months at Care-level III. Assessed are both the need for care and the ability of the carer to carry out the care tasks, as well as whether training of the carer is required. The assessment is paid for by the person receiving Payment for Care.

Coverage

In the first half of 1997 about 960,000 people were receiving *Pflegegeld* and 162,000 people a combination of payment for care benefit and benefit in kind i.e. professional home care/home help (table 9.6). Given that about 75% of the recipients of benefits for care in the home are aged 65 years or over, is it estimated that 6.5% of the 65 year old or over receive a payment for care benefit from the social insurance scheme.

Standards

The new care insurance scheme has introduced a number of provisions aiming at stimulating the Payment for Care solution to a requirement for help and care and at improving the situation of carers. Care Insurance Funds are obliged to offer training to carers.

Contributions to be paid by the carer to old age pension schemes are covered by the Payment for Care scheme if the carer work less than 30 hours a week in paid work and carry out care tasks for at least 14 hours a week. Contributions depend on Care-level and on number of hours used for care and assistance. In addition the carers are covered in accidence insurance by the local municipality. The social care insurance funds were in 1996 spending 1.8 billion DM on contributions to old age pensions out of their total expenditures of around 23 billion DM. About 500,000 persons benefit from this. The vast majority being women.

Care relief may be granted to pay either another care person or professional relief for a maximum of up to 4 weeks a year when the carer take holidays or otherwise is unable to carry out the care, if the person has been attending for the last twelve months prior to the leave. In case it is not possible to obtain sufficient care in own home it is possible to receive part-time care in a residential institution which provides day and night care. If this is not enough, you can enter a short-term care facility. In such cases long-term care insurance pays the costs of basic care, social services and treatment in a day and night nursing care facility up to a maximum of DM 750, DM 1,500 or DM 2,100 a month depending upon the level of care required and up to DM 2,800 for a maximum duration of 4 weeks of short-term residential care a year. Payment for care benefits are taxfree.

9.7.5. Community care

Home help and home care

Entitlement

Benefits for payment of home care or home help from a professional provider may be granted from Social Care Insurance Funds to insured persons in need of professional attendance if they fulfill the requirements of time insured.

Assessment of need

Need for care is assessed by the medical advisors of the Health Insurance Funds *(Krankenkassen)*, which are also the carriers of the Social Care Service Insurance Funds *(Pflegekassen)*.

Provision

Choice of service agency is free for the recipient, as long as the provider has an agreement with the Länder-association of care insurance funds. Also single-person enterprises may be chosen as long as this person is not family or a close relative. A number of different types of organisations provide ambulatory care for the elderly. They are in general referred to as Ambulatory Social Nursing and Care Services

(Ambulante Sozialpflegerische Dienste). The services include:

Services for specialised nursing *(Gemeindekrankenpflegestationen)*
Domestic work and family services *(Haus- und Familienpflegestationen)*
Housewife relief services *(Dorfhelferinnenstationen)*
Social centers *(Sozialstationen)*
Mobile home help services *(Mobilen Soziale Hilfsdienste)* providing cleaning, meals-on-wheels and other such services.

Comprehensive and regular statistics on the number of service providers are only available for services run under the auspices of a welfare association. In 1996 these associations were running a total of 6,812 *Ambulante Sozialpflegerische Dienste* employing 65,300 persons full-time or part-time. The services are not specialised on old people but are working with all groups in need of their services. For a number of years the trend has been that more of the different kind of services are offered by more comprehensive social centres. Also the number of mobile home services has increased.

The first *Sozialstation* was established 1970 in Rheinland-Pfalz. Since then they have been established all over (including the new Länder after 1990) except for The state of Bremen, where *Dienstleistungszentren* is providing the services. Social centres are by now the most important community-based care-providing agencies providing home nursing, home care/home help and other services.

3,749 social centres were in 1996 managed by welfare associations. The centres are financed by health insurance for the specialised medical nursing and by the users who are fully or partly covered by care insurance and sometimes by social assistance. The new care insurance scheme benefits are by now the most important source of income of the centres. The financial situation of the centres, however, vary according to practices of Länder and local authorities for subsidising different activities of the centres.

The establishment of social centres in the 1970s was followed by a fast decrease in the number of specialized home nursing services which used to be run by the confessional welfare associations. In 1970 there were 8,700 such specialised home nursing services in West Germany. The number has since fallen to 631 in 1996 in all Germany.

The number of agencies engaged solely in providing domestic work and help has decreased in recent years at the favour of comprehensive social centres, mobile home help services and recently of private service providers.

Table 9.7. Number of domestic care services and employed persons under *Verbänden der freien Wohlfartspflege.*

	Social stations		Home nursing		Domestic work		*Dorfhelferinnen*		Mobile home services		All	
	Number	Employed	Number	Employed	Number	Employed	Number	Employed	Number	Employed	Number	Employed
West Germany												
1983	..	..	..	..	..	..	..	..	..	..	..	..
1984	1,542	14,309	2,248	3,658	729	7,891	412	607	252	1,859	5,183	28,324
1985	..	..	..	..	..	..	..	..	..	..	..	..
1986	..	..	..	..	..	..	..	..	..	..	..	..
1987											5,380	30,525
1989	..	..	..	..	..	..	..	..	..	..	..	..
1990	2,140	21,492	1,585	2,902	871	4,417	463	659	729	4,798	5,788	34,268
1991	..	..	..	..	..	..	..	..	..	..	..	..
1992	..	..	..	..	..	..	..	..	..	..	..	..
1993	2,403	30,344	1,066	3,057	562	5,452	433	927	892	1,813	5,356	41,593
1994	..	..	..	..	..	..	..	..	..	..	..	..
1995	..	..	..	..	..	..	..	..	..	..	..	..
1996	..	..	..	..	..	..	..	..	..	..	..	..
East Germany												
1991												
1992												
1993	666	5,899	6	12	61	972	3	53	158	1,279	894	8,215
1994												
1995												
1996												
All Germany												
1991	..	..	..	..	..	..	..	..	..	..	..	..
1992	..	..	..	..	..	..	..	..	..	..	..	..
1993	3,069	36,243	1,072	3,069	623	6,424	436	980	1,050	3,092	6,250	49,808
1994	..	..	..	..	..	..	..	..	..	..	..	..
1995	..	..	..	..	..	..	..	..	..	..	..	..
1996	3,749	54,656	631	2,315	599	3,812	430	821	1,403	3,696	6,812	65,300
1997	..	..	..	..	..	..	..	..	..	..	..	..

Source: For 1984, 90 and 93 Alber&Schölkopf, 1998. BAGFW: Gesamtstatistik der Freien Wohlfartspflege, 1996.
Note: Employed include full time and part time employed. Domestic work are *Haus und familienpflegestationen.*

Mobile home help services have been increasing in numbers since the beginning of the 1980s. Originally they were staffed largely with young men who had chosen to do community work instead of military service *(Zivildienstleistenden),* and voluntary workers. So the mobile services were able to offer home help at a very modest price. By now these agencies have become more professional and comprehensive service providers which resembles the social centres.

It is not easy to find information about the number of service providers outside the big non-profit welfare associations. In a survey from the mid 1980s 82% of the social centres were managed by one of the major associations. Additional 7% had mixed ownership whereas only 7% were run by municipalities. Statistics on the number of providers will be greatly improved by the new social care insurance scheme, as the services have to be approved by the care insurance funds.

The new social care insurance act has stimulated a further fast growth in home care provision. According to the First Report on the Development of Social Care Insurance *(Erster Bericht über die Entwicklung der Pflegeversicherung)* the number of ambulatory services all in all increased from 4,000 in 1991 to 11,700 in 1997. And the number of partial residential services (day care or night care) and short term care institutions increased from about 100 in 1991 to more than 6,000 in 1997. The strong increase is partly due to establishment of private services on a commercial basis. In some bigger cities they have about half the market. In general, however, the impression is that the home care market hardly is working as a market because receipients of benefits in kind lack the information about alternatives and about quality of the care (Weekers, 1998).

Coverage

The number of receipients of home help and care provided by one of the professional service agencies is only vaguely enlighted. It is estimated that about 3% of the population aged 65 or over receive home care and between 1 and 3% receive home help provided by domestic service agencies (Alber & Schölkopf, 1998, p. 107).

Compared to the proportion of older people living in own home and in need of care mentioned in section 9.7.3 these numbers are rather small. According to the survey carried out in 1992 about 33% of persons in need of care and living at home received help from some type of social community service and 16% of persons in need of home help received some type of help. For persons living in one-person households the proportions were 51% and 25% respectively (Schneekloth, 1996). The proportions of the old age groups are not analysed separately.

The number of persons receiving the benefit in kind of home care/-help from social care insurance has increased rapidly since the introduction of the scheme in 1995

(Table 9.8). In first half of 1997 119,475 persons received this benefit in kind only and another 162,204 persons received the benefit in kind in combination with a cash payment-for-care benefit. Given that about 75% of the recipients are aged 65 years or over the proportion of this group receiving the benefit in kind is 1.5%.

Table 9.8.
Recipients of social care benefits for home help/-care, 1995-1997.

	1995 2. half year	1996 2. half year	1997 1. half year
Home help/-care from prof. services *Pflegesachleistung*	82,790	105,879	119,475
In combination with payment for care *Pflegegeld*	82,923	135,305	162,204
In all	165,713	241,184	281,679
Holiday relief *Pflegevertretung*	10,783	6,805	3,337

Source: Bundesministerium für Arbeit und Sozialordnung, Bundesarbeitsblatt 9/1996, 6/1997, 1/1998.
Note: The table include all recipients in all age groups.

Table 9.9.
Home help, number and per cent of recipients (65+) 1985-1995.

Year	Number of recipients (65+)	%
1985	251,875	2.75
1986	..	..
1987	..	..
1988	..	..
1989	271,000	2.92
1990	..	..
1991	377,500	3.97
1992	398,500	4.14
1993	394,100	4.04
1994	..	..
1995	364,800	3.00

Source: Source: StBA, Personal communication (Social Insurance). Deutscher Bundestag, Drucksache 13/9528.

Staff

Recognized as professional attendants in home nursing are educated nurses *(Krankenschwester)* or old people's nurses *(AltenpflegerIn).* Often the nurses have an additional one-year education as specialised community nurses. Personal care and domestic help is delivered by 'home and family helpers' *(Haus- und Familienpflegehelferln),* who have a variety of short training courses and two years of work experience within the five most recent years. Traditionally the services run by the non-profit associations are staffed with a considerable number of volunteers. Also young men who have chosen to do community work instead of military service are employed *(Zivildienstleistenden).*

A survey carried out in 1991 revealed that of 44,000 persons employed in the ambulatory services 55% had an education. There were 14,200 nurses, 4,500 old people's nurses and 5,400 family carers. Staff with some training were 2,000 *Krankenpflegehelfer/rInnen* and 11,300 qualified through other training and finally 6,500 without training. In addition to the 44,000 were about 4,000 *'Zivis'* working in home care - mostly in the mobile home help services - and another 4,000 working voluntary. The 44,000 persons employed equalled about 27,000 full time employed which gives a rate of 2.8 full-time home carer/home helper per 1,000 people aged 65 or over - or a rate of 1 full-time carer per 28 people in need of care in the home (Alber & Schölkopf, 1998). However, the increase in services after the introduction of the new care insurance scheme is followed by a sharp increase in staff as well. In services managed under welfare associations the number of persons employed in all increased from 50,000 in 1993 to 65,000 in 1996.

Auxiliary care services

Apart from home care and home help services a number of other services is offered aiming at supporting the older people to stay in own home.

Day centres

The first day centres were established in the mid 1970s. In 1996 welfare associations were running 3,313 day centres of which a smaller number are offering personal care and assistance. In 1996 there were 244 such daycare homes offering about 3,000 places. It is estimated that about 90% of the places are occupied by people aged 60 or over. The price for a daily place was around 1,000 DM per month which the users before the introduction of the new care insurance scheme had to pay themselves. The users might receive social assistance - if qualifying - to cover the costs. Local authorities subsidise day centres in order to keep down prices. For the same reason most of the transport to and from the centres is carried out by *Zivildienstleistenden* who provides cheap labour. Since 1995 care insurance cover the costs up to a ceiling.

Table 9.10. Number of auxiliary services for elderly and employed persons under *Verbänden der freien Wohlfartspflege.*

	Day centres			All other special services:		Hereof: Meals-on-wheels		Stationary meals		Other services	
	Number	Employed	Places	Number	Employed	Number	Employed	Number	Employed	Number	Employed
West Germany											
1982	..	..	..	..	..	..	..	..	..	..	..
1983	..	..	..	..	..	..	..	..	..	..	..
1984	1,960	2,018		2,343	3,349	935	1,596	182	365	1,226	1,499
1985											
1986	..	..	..	..	..	..	..	..	..	..	..
1987	..	..	..	..	..	..	..	..	..	..	..
1988	..	..	..	..	..	..	..	..	..	..	..
1989	..	..	..	..	..	..	..	..	..	..	..
1990	2,102	2,058		3,203	6,402	976	1,958	311	473	1,916	3,971
1991	..	..	..	..	..	..	..	..	..	..	..
1992	..	..	..	..	..	..	..	..	..	..	..
1993	2,647	2,407		3,586	6,102	856	1,624	440	470	2,290	4,008
1994	..	..	..	..	..	..	..	..	..	..	..
1995	..	..	..	..	..	..	..	..	..	..	..
1996	..	..	..	..	..	..	..	..	..	..	..
East Germany											
1991	..	..	..	..	..	..	..	..	..	..	..
1992	..	..	..	..	..	..	..	..	..	..	..
1993	569	754		1,519	2,078	648	572	420	451	451	1,055
1994	..	..	..	..	..	..	..	..	..	..	..
1995	..	..	..	..	..	..	..	..	..	..	..
1996	..	..	..	..	..	..	..	..	..	..	..
All Germany											
1991	..	..	..	..	..	..	..	..	..	..	..
1992	..	..	..	..	..	..	..	..	..	..	..
1993	3,216	3,161		5,105	8,180	1,504	2,196	860	921	2,741	5,063
1994	..	..	..	..	..	..	..	..	..	..	..
1995	..	..	..	..	..	..	..	..	..	..	..
1996	3,313	3,800	52,608	5,700	8,209	1,573	2,179	638	848	3,489	5,182
1997	..	..	..	..	..	..	..	..	..	..	..

Source: For 1984, 90 and 93 Alber&Schölkopf, 1998, BAGFW: Gesamtstatistik der Freien Wohlfartspflege, 1996.
Note: Employed include full time and part time employed. Other services are counsel and advice centres, emergency telephone centres etc.

Meals-on-wheels

There were in 1996 in all Germany 1,573 centres delivering meals on wheels under the auspices of the welfare associations. These centres employ about 2,200 persons. It is estimated that about 2% of the 65 years olds or over receive meals on wheels (Alber & Schölkopf, 1998 p. 107).

Stationary meals

Also stationary centres where the older people may have meals served are managed by the associations. In 1996 there were 638 such centres in Germany employing 848 persons. The number has decreased during recent years.

Other services

Other services comprise counselling and advice centres (1,366 in 1996), emergency telephone centres 523 in 1996), and other services which are established by the welfare associations. All in all there were in 1996 3,489 such different services across Germany employing around 5,200 persons.

Self-help and help groups

The German tradition for voluntary work also manifest itself in an increasing number of self-help groups and visiting groups etc. There were almost 10,000 such groups across Germany in 1996 under the auspices of the welfare associations.

Appliances and aids in the home

Payment for Care benefits may be supplemented with coverage of expenses to required appliances and aids, if they are not covered by health insurances or other schemes. This may be alterations of the home up to a maximum of 5,000 DM for each alteration.

9.7.6. Institutional care

In Germany, there are traditionally three different types of institutional care for old people: Most places have been available in old age homes *(Altenheim),* where residents typically have their own room or maybe a little apartment and cleaning and meals are provided. Sheltered housing or service flats *(Altenwohnheim)* offer own apartments with own housekeeping, but usually a possibility for having dinner in common. Nursing homes *(Pflegeheim)* offer nursing and care in one-bed rooms or rooms with more than one bed. However, an increasing number of institutions offer a mix of places with possibilities for more or less help or nursing attached. They are not easy to classify in the traditional types of residential institutions, but are usually referred to as mixed institutions *(Mehrgliedrigen Alteneinrichtungen).*

Entitlement

In principle everyone can enter a residential institution, if a place is available and the person is able to pay the cost. Benefits for payment of the care at a residential institution may be applied for at the Social Care Insurance Funds by insured persons if they fulfill the requirements of time insured.

Persons in need of care may choose between care in the home and residential care, but if the person choose residential care even though the care as well might be carried out in the home, benefits granted will only be the amounts for home help/care. If the need is assessed to be at Care-level III, it involves a right to benefits for residential placement. At the other Care-levels *(Pflegestufe)* the medical services have to decide whether a residential placement is necessary because of need for care and missing possibilities for proper home care. The need for care is assessed by the medical advisors of the Health Insurance Funds *(Krankenkassen)*, which are also the carriers of the Social Care Service Insurance Funds *(Pflegekassen).*

Provision

The number of residential care institutions and the number of places available have steadily increased from a provision of about 430,000 places in 1982 in the West to about 560,000 places in 1995. The number of places in pure old age home types of institutions - *Altenheime* and *Altenwohnheime* have steadily decreased, whereas the number of places in nursing homes and in mixed type of institutions have increased. The number of places in pure nursing homes more than doubled from 85,000 places in 1982 to 219,000 places in 1995. Also the number of places in mixed institutions has increased from 168,000 in 1982 to 278,000 places in 1995. In addition to the places in residential care institutions, it can be mentioned, that there are about 8,700 places for geriatric patients in 109 specialised departments at hospitals in Germany.

In the new Länder a large majority of places in residential institutions is in nursing homes but the number of places all together has decreased a little since the unification. In 1995 it was about 100,000 places in the new Länder - excluding the former East-Berlin.

As in most other countries the trend in type of places reflects that more and more of the residents in old age institutions are in need of more comprehensive nursing and care. In 1970 about 70% of all residents were old age home type of residents and 30% were nursing home type residents. In 1990 this relation had reversed: 70% of all residents in the residential institutions were nursing home type of residents. This trend most likely has continued since then, as it corresponds with the policy of prioritising care in the home over residential care. Most of the residential institutions are managed by the associations of welfare services.

Table 9.11. Number of places in residential care institutions 1982-1995.

	In all	Mixed institutions	*Altenwohnheime*	*Altenheime*	Nursing homes	Other
West Germany						
1982	429,577	168,116	81,077	201,273	85,498	6,682
1983	436,224	175,367	82,400	201,919	88,914	7,936
1984	464,479	177,307	71,937	255,689	123,707	7,342
1985	476,269	194,947	74,404	253,727	135,854	6,023
1986	485,873	194,938	77,963	251,615	143,265	6,923
1987	489,365	184,114	78,154	258,252	146,594	4
1988	507,480	243,808	71,593	180,586	204,498	..
1989	511,447	250,797	72,542	178,207	209,895	..
1990	516,819	249,698	70,706	176,181	219,486	..
1991	538,522	263,794	70,304	172,763	183,449	..
1992	551,353	271,240	72,657	169,701	196,610	..
1993	567,611	270,608	78,254	168,539	219,284	..
1994	577,036	266,648	78,430	170,600	226,140	..
1995	556,854	278,387	65,593	177,293	219,759	..
East Germany						
1991	114,434	62,078	333	27,957	86,144	..
1992	108,695	58,756	128	26,716	81,851	..
1993	106,402	67,861	1,959	23,519	80,924	..
1994	105,184	64,655	1,934	20,838	82,414	..
1995	100,734	62,232	98	18,434	82,202	..
All Germany						
1991	652,956	325,872	70,637	200,720	269,593	..
1992	660,048	329,996	72,785	196,417	278,461	..
1993	674,013	338,469	80,213	192,058	300,208	..
1994	682,220	331,303	80,364	191,436	308,554	..
1995	657,588	340,619	65,691	195,727	301,961	..

Source: Statistisches Bundesamt VII D - P.

According to the principle of subsidiarity local authorities are obliged to support the use of non-public sector institutions if it is possible, and the large associations have maintained and enlarged their dominating position in this area. During the recent decades an increasing number of private institutions run on a commercial basis has been established, whereas the number of public sector institutions has decreased.

In 1994 the associations managed a little more than half of all institutions covering almost two thirds of all places in residential institutions in Germany. Institutions belonging to the public sector accounted for 14% of all institutions and 18% of all places, whereas a little less than one third of all institutions and 18% of the places were in private institutions. In average private institutions are only half the size of other institutions in number of places. In publicly owned institutions the average number of places is 102, in the institutions belonging to the associations it is 96 and in private institutions 46 places.

Coverage

The increasing number of places in residential institutions has been followed by an increase in the proportion of older people living in residential institutions. In 1984 there were 114 places for every 1,000 persons aged 75 or more. In 1994 it was 130 places (Alber & Schölkopf, 1998).

Care in residential homes constitutes a rather significant and often underestimated part of care provision in Germany (Alber & Schölkopf, 1998 p. 100). About 5% of the population aged 65 or more are living in residential homes at a given time, and the percentage of persons, who once during their lifetime will live in a residential home amounts to 40% of the men and 70% of the women.
Average age for residents was in 1994 81 years of age (Schneekloth und Müller, 1997). Not all residents in the old age institutions are in need of care or assistance. 63% are in need of personal care and assistance. Another 28% need some help with domestic tasks, but the remaining 9% have no need for care or assistance. The average duration of stays in residential homes are about 6 years.

Waiting lists

The new social care insurance legislation has improved the possibilities for care in ones own home considerably. The pressure on residential institutions has as a consequence been relieved and waiting lists have in general disappeared (Deutscher Bundestag, 1997).

Table 9.12.
Residential homes, number and per cent of older people (65+) 1982-1996.

Year	Number of residents (65+)	%
1982	366,408	3.99
1983	372,003	4.14
1984	416,280	4.64
1985	425,605	4.66
1986	427,047	4.61
1987	428,463	4.55
1988	374,083	3.93
1989	376,148	3.91
1990	371,736	3.82
1991	434,293	3.61
1992	434,200	3.57
1993	441,506	3.57
1994	437,452	3.49
1995	431,728	3.39

Source: Deutscher Bundestag: Drucksache 12/5897.

Table 9.13.
Nursing homes, number and per cent of older people (65+) 1982-1996.

Year	Number of residents (65+)	%
1982	169,556	1.85
1983	176,598	1.97
1984	212,361	2.36
1985	233,328	2.56
1986	240,734	2.60
1987	238,651	2.53
1988	326,402	3.43
1989	335,294	3.49
1990	344,335	3.53
1991	432,529	3.59
1992	443,459	3.64
1993	469,443	3.80
1994	474,206	3.78
1995	472,271	3.71

Source: Deutscher Bundestag: Drucksache 12/5897.

Fees

The price of a residential place vary (in 1994) between 3,200 DM and 4,600 DM a month at nursing homes in West Germany and between 2,200 DM and 3,200 DM a month in East. At old age homes the price was in average 2,600 DM in West and 2,000 DM in East (Schneekloth & Müller, 1997). These amounts exceed what most older people are able to pay. Before the introduction of benefits from the new social care insurance scheme in 1996 the only possibility was to apply for social assistance. In 1994 in West Germany 59% of residents in all types of homes received social assistance. Of the residents in need of care the proportion was 69%. The corresponding percentages in East were 87% and 88%.

Contributions to residential care for the elderly have been granted by the Social Care Insurance Funds since 1. July 1996 according to the three Care-levels of need for care and assistance. Residents are supposed to pay by other means for board and lodging and must bear at least 25% of the total nursing home charges.

During the initial period of the new scheme until 31 December 1997 the benefit was a flat rate benefit of 2,000 DM a month at Care-level I, 2,500 DM a month at Care-level II and 2,800 DM a month at Care-level III. In special hardship cases the amount could be up to a maximum of 3,300 DM a month. From 1 January 1998 benefits are laid down depending on the actual price at the individual residential institution of the personal and social care and nursing. The Care Insurance Funds may cover up to 2,800 DM a month and in special severe cases up to 3,300 DM a month. The individual Care Insurance Fund is obliged to ensure that the recipients in average are not granted more than 30,000 DM a year.

In 1997 416,000 persons living in residential institutions received a social care insurance benefits. Compared to the number of places in residential institutions for old people this indicates that maybe about 60% of the residents receive an insurance benefit for care/assistance. Statistics are not available on type of benefit. As mentioned earlier it may be cash payment for care or a benefit in kind.

Staff

There are not any comprehensive national statistics available on number of staff and their qualifications in residential institutions. According to the latest survey carried out in 1994, 360,000 persons were employed including trainees and *Zivildienstleistende*. In full-time persons, the number was 290,000 which gives a rate of 47.6 full-time employed for each 100 residents (Schneekloth und Müller, 1997). The rate of persons working with care was 30.4 and a little higher in West than in East. Of the care personnel about one fourth are nurses, one fourth are

AltenpflegerIn, 8% are *AltenpflegehelferIn*, almost 10% are under education and 37% are without special education. In East Germany, however, almost half of the staff are nurses but also there 36% are without special qualifications.

The rate of employed in relation to number of residents vary across types of institutions. The number of residents for every care person in nursing home oriented institutions was 2.8 in 1994. In mixed institutions the rate was 4.0 and in old age home oriented institutions it was 6.5. In average, for all residential institutions the rate was 4.2.

Standards

Standards in residential institutions have greatly improved during the last 30 years. The number of one bed rooms has increased considerably and sanitary installations are greatly improved. In 1960 only 6% of the nursing home type places were in one-bed rooms. This proportion had increased to 40% in 1994 (Alber & Schölkopf, 1998 p. 114). 57% of all residents in West had one-bed rooms, whereas the percentage in East Germany was 36. Most of the other residents are living in two-bed rooms.

Most of the residential institutions are offering some kind of activities for the residents to do exercises and gymnastics.

Administration

Residential institutions are regulated by an act for residential homes which first of all aims at protecting residents. The act sets standards for buildings, rooms, services and fees, and hold a provision for participation of the residents in decision-making. The regional authorities *Landkreise* and the *kreisfreie* towns are responsible for implementation of the legislation. This takes place directly towards the private institutions whereas the institutions owned by the associations are the responsibility of the Länder-associations. Regional authorities have to approve establishment of private institutions but not institutions established by local authorities or independent welfare associations.

9.8.
Development and changes 1982-1995

Since the Second World War childcare policies in West Germany have aimed at enabling mothers to stay at home to take care of their children rather than providing day care services which may facilitate a combination of work and family duties. The number of infant children cared for outside the home in West Germany is still very low. Increasingly children aged 3-5 years attend kindergartens but the purpose of kindergartens is as much development of the child as it is to

sustain labour market participation of parents. Most kindergarten places are part-time.

In East Germany, before unification the situation was quite different as the high female employment rate was supported by a very high provision of day care places not only for kindergarten children but also for children under 3. The rate of children in day care is still higher in East than in West Germany. But the number of children in day care outside the home has decreased considerably since unification because of decreasing birth rates, high unemployment and abolishment of the old system of company based day care facilities.

In West Germany, the number of creches and places for children under 3 years of age has always been and still is very small. In East Germany, however, before unification there were places for the majority of the children aged 0-2 years old. In 1994 it was in all 151,000 places in publicly funded creches in Germany. 68% of these in East Germany. In 1990 there were 38,153 places in West Germany. This constituted a coverage of less than 2% of the age group. In the former East Germany there were places for 3/4 of the age group and still in 1991 the number of publicly funded places covered 54% of all children aged 0-2 years. The proportion of 0-2 year old attending creches in East decreased to 33% in 1996. In all this meant that 7.5% of all children in Germany 0-2 years old were attending a creche in 1996.

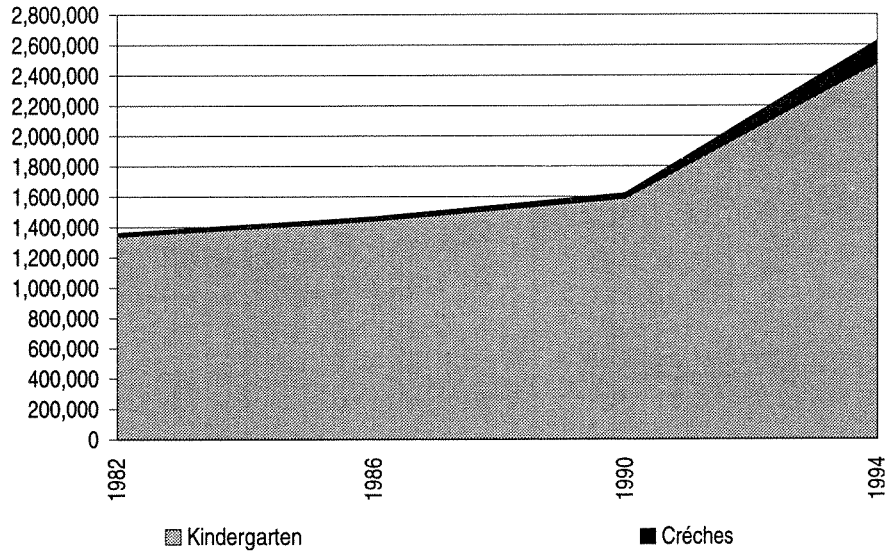
Increasing labour market activity of women, however, put pressure on day care facilities in Germany as in other European Countries. Particularly kindergarten places are in demand. The federal government issued in 1994 a guarantee coming into effect 1 January 1996. For the first 3 years it will be applied flexibly, but from 1999 every child will have the right to be admitted to a kindergarten from the age of 3.

Survey data indicate that the proportion of children attending a kindergarten in 1994 was 59% in West and 89% in East. In all Germany this makes a proportion of 65% of the 3-5 year old. In East the vast majority attend a kindergarten from the age of 3 years (82%), but in West only 29% of the 3 year old children were in kindergartens. Among the 4 year olds the proportion was 70% and among the 5 year olds 82% in. Most children in West Germany start in kindergarten when they are 4 years old.

Parents staying at home to take care of the child may receive a child-raising benefit which was introduced in 1986. The benefit is available to either parent and can be split between them or for alternative periods until the child is 2. It is

almost exclusively women receiving this benefit. The benefit is a flat rate benefit of 600 DM a month. The amount of 600 DM has not been raised since it was introduced in 1986, and so has lost some of its value. In 1986 it almost matched a half-time wage in low paid female jobs. It is possible to work up to 19 hours a week without reduction in the allowance. Almost all families with newborn children receive the benefit for the first 6 months. In 1992 15% of all families with small children received the full child-raising benefit after the seventh month, 73% received a reduced benefit and 12% were not entitled at all because of too high family income.

Figure 9.11.
Development in the number of places available for children (0-6) in publicly funded day care facilities, 1982-1994.



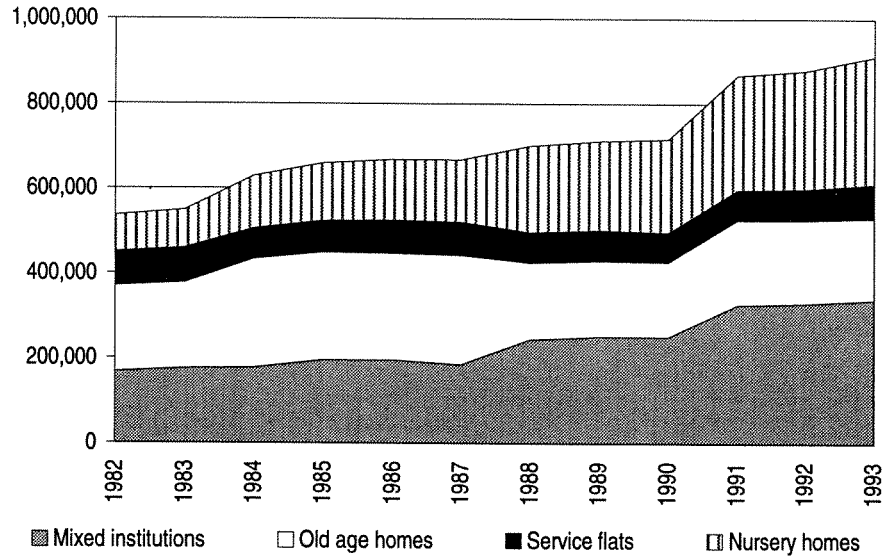
Source: Deutscher Bundestag: Drucksache 12/5897.
Note: 1982-1990: West Germany. 1994: All Germany.

Policies for long term care of frail elderly people also reflect belief in family solidarity. Public initiatives to support the provision of professional care have developed slowly, and policies have aimed equally at reinforcing family care. Benefits in kind for professional domestic care in Germany have been developed along-side development of cash benefits if family members provide the care.

Home help and home care services have developed since the 1970s but the provision of services is still at a modest level. The number of people making use

of a professional domestic service is only vaguely known. It is estimated that about 3% of the population aged 65 or over receive professional home care and about 2% receive help with domestic work from the domestic service agencies.

Figure 9.12.
Development in the number of recipients (65+) of the main social services for older people (65+), 1982-1993.



Source: Deutscher Bundestag: Drucksache 12/5897.

In April 1994 the German parliament passed a legislation introducing a new long term social care insurance system *(Die Soziale Pflegeversicherung)*. This is financed on a 'pay-as-you-go' basis, and has to be self-financing. The care insurance scheme allows a choice between home care in kind *(Sachleistung)* and a cash payment for care by a family member or other care person *(Geldleistung)* or a combination of both. The amount granted in cash payments for care is about half the total amount granted for benefits in kind which is a service provided by a professional agency. By far the most receive the payment for care. In first half of 1997 an estimated 6.5% of all aged 65 or over received payment for care benefits, about 1.5% received home care in kind and about 2.5% received help to pay for residential care. In all about 9% of the population aged 65 or over received some kind of benefit from the social care insurance scheme.

Between 5% and 6% of the population aged 65 or more live in a residential homes. The number of institutions and places have steadily increased, and as in other countries more and more places are occupied by residents dependent on nursing and care. The traditional distinction between different types of institutions such as old age homes (*Altenheime* and *Altenwohnheime*) and nursing institutions (*Pflegeheime*) has increasingly been superseded by institutions offering different types of places. Currently about two thirds of residents need personal care and assistance.

Box 9.2.
Aachen, Germany

1. Introduction
Aachen is situated in the land of Nordrhein-Westfalen. It serves as a cultural and occupational centre for the Euro region Maas-Rhein (Holland, Belgium and Germany), as it is the largest city of the region with 254,383 citizens. A large proportion of the labour force is therefore also from Holland and Belgium. In Aachen there are 38,079 senior citizens above the age of 65, thus the older people population constitutes 15%. The number of children is low. Children in the age group 0-6 constitute 6% of the total population and the number is expected to decrease further.

Aachen is a *Kreisfreie Stadt* which means that it is both a municipality and an administrative district, a county. Since the city also constitutes a county, it also implements and administrates the constituent state legislation in the area of senior citizens and children.

The fundamental principle of subsidiarity of the German welfare state is reflected in the provision and organisation of social services in Aachen. According to the principle of subsidiarity family, neighbours and voluntary organisations have responsibilities and rights to provide welfare. In Aachen a major part of the older people and children are taken care of by a female member of the family. In situations were the family care is not sufficient the voluntary organisations take over the care of children and the older people. The welfare organisations, Diakonisches Werk, Deutscher Caritasverband, Arbeiterwohlfahrt, Deutsches RoteKreuz and Paritätische Wohlfahrtsverband therefore play a major role in the provision of social services in Aachen.

2. Children
Child care policies are governed according to the constituent state legislation on this area and according to the federal legislation on place provision guarantee for the age group 3-6 years. For children under the age of 3 it is expected that the parents take responsibility for the care, as they are offered parental leave and child-raising benefit. According to legislation, the municipality is obligated to offer a sufficient supply of day care arrangements in the individual neighbourhoods. The constituent state aims at 90% coverage before 1995. Areas which are socially and economic deprived are given high priority together with areas with a high number of both parents in paid employment.

At the end of 1995 there were 7,651 children aged 3-6. All in all there were 6,148 places available in public and private kindergartens corresponding to a coverage of 89%. For children under 3 there are 197 places which corresponds to a coverage of 3%. The supply of day care is provided mainly by the municipality and welfare organisations. All facilities are open five days a week. The parental fee is paid to the Department of Youth and depends on the income, number of children and whether the child receives lunch in the kindergarten.

Visit to Kindertagesstätte Alfonsstrasse
The kindergarten is located in a very rough neighbourhood with many immigrants. The kindergarten was originally evangelical but 15 years ago it became public. The opening hours are from 7.30 until 4 in the afternoon. However, not all children are in kindergarten over lunch and the kindergarten is therefore half empty between 12:00 and 14:00.

The kindergarten is in a three-floor building with an asphalted yard in front of the building. There is no fence or door surrounding the play ground. Therefore the pedagogues have to be very attentive of the children. The first two floors are used for the kindergarten and third floor is reserved for a youth centre, which is part of the kindergarten arrangement. Every group consist of 20 children and has a combined living room and play room on 30 square metres. There are 125 children in the kindergarten hereof 73 aged 3-6 years. Half the children are children of immigrants. There are 15 kindergarten teachers, 3

pedagogues and an assistant during lunch hours. The kindergarten emphasises inter-cultural upbringing as many of the children are immigrants. There is only a limited number of toys, as the philosophy is to reduce the number of toys. Alternatively the children can work with clay or build some things themselves out of different materials.

The Kindergarten opens at 7:30 in the morning. As the kindergarten does not serve breakfast the children bring their own breakfast. After breakfast the children are divided into groups and then they play. Dependent on the weather the children play outside or stay indoor painting, reading books etc. Furthermore the children can play sports in a nearby sport hall accompanied by a pedagogue. At 12:00 most children are picked up by their mothers to go home for lunch. Some children stay and have a hot meal, provided by a restaurant. After lunch the children relax and read books. At 14:00 some of the children having been at home return to the kindergarten. At 15:00 there are a number of activities, dependent of the weekday. Mondays there are sports for the children aged 4-6 year while Tuesday is music day. This is a parental initiative and the costs for music teaching are extra. Wednesday is for language therapy, and Thursday the kindergarten teachers have music practices for everybody. On Friday there are brunch organised by the children and parents. The parents play a substantial role in the organisation and provision of activities in the kindergarten.

3. Older people

The city council of Aachen administer senior policies according to the policies of Nordrhein-Westfalens. The goal of the constituent state policies is to sustain that senior citizens should be able to stay in their home as long as possible. All organisations in the municipality are obliged to co-operate in achieving this goal. Aachen aims at developing three areas: support and assistance to relatives, mobile domestic care facilities and an information centre for older people.

The services for older people are not organised or regulated by the municipality. The municipality only have a consulting function. Therefore the municipality aims at informing older people and their relatives on the offers available in Aachen. For this purpose a centre *Leistelle Älter werden* in Aachen has been established in order to advise/inform the older people and their relatives. Most of the older people with a care need are taken care of by a relative. The guidance centre procures a number of offers on courses, seminars, self-help groups assisting the relatives etc. As elsewhere in Germany the extent of informal care in Aachen is considerable. One of the purposes of the new care insurance system is to grant informal care givers some status. The care insurance offer training courses in care taking, advise and support to the carer.

In order to receive a payment for care benefit the older people have to apply a *pflegekasse*. The allocation is decided by the *pflegekasse* and the need for help of the applicant is assessed by the medical service. The carer has to work a minimum of 14 hours per week and can not have own business. The benefit wage is between 1,100-3,300 D-mark per month in West and between 933-2,800 in East.

The major part of the institutional care is offered by voluntary organisations (83,5%). The remaining number (16.5%) are run by private companies. In Aachen there are 1,996 places in 24 old people's homes. It is mainly the older people over 80 who are in nursing homes. The price is set by the individual nursing home as the standards differ. Nursing homes are competing for residents and at the same time they have to fulfill the requirements of the state in order to receive subsidies. A place in a typical nursing home costs 150-250 D-mark a month.

Within the area of home care there are two types of organisations offering care of older people; *Sozialstationen* offer both sickness and domestic care. *Mobilen Sozialen Hilfdienste* offer household assistance, assistance in personal care and home nursing. When assessment of need takes place the applicant, a relative and a doctor from *medizinschen dienst* are present. The need will be estimated on basis of the somatic condition. In Aachen there are 32 social stations and their work is partly divided according to territory. The latest statement made by the municipality shows that 915 persons receive help from a social station in Aachen and 5.9% in the age group 80+ receive help from a social station.

Visit to the social station Caritas Hubertusplatz
Caritas is located in the western part of Aachen. The social station offers three kinds of assistance to older people: household assistance *(Hauswirtshaftliche Hilfe)*, domestic care *(Grundpflege)* and home nursing *(Behandlungspflege)*. The Social station offers home care to 160 people who receive all the three kinds of assistance according to need. The station has 11 full-time staff. All employees are trained as older people care nurses *(Altenpfleger)* or nurses *(Krankenschwester)*. Furthermore, there are six part-time employees. The opening hours are from 7 in the morning to 7 in the evening, and during weekends there is a call service.

The social station is financed through church tax, Caritas' own means, the care payment from the *pflegekasse* and through user payments from the older people.

The Mobile Social Services (Mobile Sociale Dienst)
This organisation offers a number of services for older people such as household services, cleaning, cooking, clothes washing etc. Additionally, the organisation offers the so-called *Betreuungsdienste*, which is conversation/support during crises, assistance in writing letters or contacting public administration. There are 10 mobile service organisations offering services to 400 people in Aachen. At present the price for the mobile social assistance is 15 DM per hour.

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APPENDIX A

Tables

Appendix table A1 (Denmark)

Current prices (m DKK)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	464,467	512,541	565,284	615,072	666,496	699,908	732,054	767,251	799,109	827,868	856,031	874,394	925,632	967,723	1,013,928
Maternity, paternity and parental leave	1,265	1,396	1,721	2,392	2,802	3,070	3,334	3,612	3,963	4,077	4,402	4,515	4,503	4,686	4,595
Child care leave	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	425	3,347	4,001	2,803
Nursery education	61,478	59,335	..	..	56,237	52,129	51,814	50,959	51,583	53,693	53,102	..	58,765	61,234	63,377
Day nursery	865	899	945	983	1,048	1,147	1,240	1,298	1,363	1,467	1,475	1,462	1,487	1,437	1,437
Kindergarten	2,158	2,167	2,195	2,233	2,306	2,390	2,487	2,500	2,544	2,705	2,882	3,207	3,467	3,546	3,858
Age-integrated day care	704	775	837	927	1,008	1,167	1,343	1,549	1,776	2,063	2,379	2,748	3,150	3,484	3,894
Family day care	1,116	1,132	1,195	1,306	1,469	1,740	1,900	1,996	2,073	2,283	2,658	2,945	2,740	2,877	3,323
Nursing home	8,119	8,606	9,173	9,798	10,034	10,791	10,791	10,880	10,418	10,001	9,283	8,306	7,627	..	..
Day home	84	92	104	119	121	167	167	173	164	157	139	131	135	..	..
Day centre	225	242	263	290	318	333	385	401	438	467	487	482	492	..	..
Sheltered accomodation	191	206	214	251	265	271	259	157	218	181	154	123	114	..	..
Home help	3,351	3,625	3,542	4,066	4,369	4,742	5,077	5,509	6,036	6,174	6,292	8,134	9,869	..	..
Integrated care institutions	727	810	848	893	982	1,089	1,218	1,342	1,549	2,326	3,308	2,651	2,664	7,867	7,239
Home help and welfare measures	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	14,278	16,112
Home care allowance	..	..	..	..	..	..	..	..	..	..	..	..	70	69	86

Fixed 1990-prices (m DKK)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	667,523	684,334	714,374	745,014	772,152	774,423	783,444	787,859	799,109	809,848	811,683	824,189	859,212	881,712	905,139
Maternity, paternity and parental leave	1,818	1,864	2,175	2,897	3,246	3,397	3,568	3,709	3,963	3,988	4,174	4,256	4,180	4,270	4,102
Child care leave	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	401	3,107	3,645	2,502
Nursery education	88,355	79,223	..	..	65,152	57,679	55,451	52,328	51,583	52,524	50,351	..	54,548	55,792	56,577
Day nursery	1,243	1,200	1,194	1,191	1,214	1,269	1,327	1,333	1,363	1,435	1,399	1,378	1,380	1,309	1,283
Kindergarten	3,101	2,893	2,774	2,705	2,672	2,644	2,662	2,567	2,544	2,646	2,733	3,023	3,218	3,231	3,444
Age-integrated day care	1,012	1,035	1,058	1,123	1,168	1,291	1,437	1,591	1,776	2,018	2,256	2,590	2,924	3,174	3,476
Family day care	1,604	1,511	1,510	1,582	1,702	1,925	2,033	2,050	2,073	2,233	2,520	2,776	2,543	2,621	2,966

Appendix table A1 (Denmark) continued

Nursing home	11,668	11,491	11,592	11,868	11,625	11,940	11,549	11,172	10,418	9,783	8,802	7,829	7,080	..	..
Day home	121	123	131	144	140	185	179	178	164	154	132	123	125	..	..
Day centre	323	323	332	351	368	368	412	412	438	457	462	454	457	..	..
Sheltered accomodation	275	275	270	304	307	300	277	161	218	177	146	116	106	..	..
Home help	4,816	4,840	4,476	4,925	5,062	5,247	5,433	5,657	6,036	6,040	5,966	7,667	9,161	..	..
Integrated care institutions	1,045	1,081	1,072	1,082	1,138	1,205	1,304	1,378	1,549	2,275	3,137	2,499	2,473	7,168	6,462
Home help and welfare measures	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	13,009	14,383
Home care allowance	..	..	..	..	..	..	..	..	..	..	..	..	65	63	77
Number of receipients/ residents	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
Maternity, paternity and parental leave	..	..	100,268	130,056	141,057	146,934	152,798	158,078	166,714	170,378	181,991	180,112	182,665	187,315	179,310
Child care leave	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	33,606	42,135	30,579
Nursery education	61,478	59,335	..	..	56,237	52,129	51,814	50,959	51,583	53,693	53,102	..	58,765	61,234	63,377
Day nursery	21,337	21,484	21,557	21,730	21,810	22,260	23,040	23,675	24,420	24,653	23,687	23,389	22,751	21,661	21,142
Kindergarten	101,770	96,634	95,158	93,803	91,654	91,197	89,661	89,325	88,851	91,531	91,606	97,125	101,966	105,089	109,866
Age-integrated day care	30,784	34,226	37,497	38,346	40,727	43,434	46,249	49,872	56,382	59,869	67,043	69,889	85,942	88,689	97,377
Family day care	58,409	55,845	52,864	54,276	57,964	58,246	65,759	65,512	64,871	65,618	70,968	76,289	75,778	68,276	74,822
Nursing home	49,588	49,755	49,812	49,736	49,487	49,088	48,011	47,065	44,847	42,285	40,449	39,190	37,683	36,485	36,444
Day home	2,520	2,642	2,836	3,132	3,174	3,298	3,339	3,513	3,952	3,864	4,244	4,132	4,091	3,948	4,070
Day centre	25,905	20,740	18,580	20,201	21,104	23,748	23,424	26,924	25,756	30,060	32,957	43,169	46,875	43,088	46,796
Sheltered accomodation	5,813	5,621	5,817	6,791	7,150	7,300	7,486	7,253	6,852	6,196	6,116	5,786	5,515	5,332	5,310
Service housing flats	..	..	..	..	..	..	..	5,660	7,789	11,807	13,040	17,204	18,771	22,125	23,914
Home help	118,634	122,764	124,504	128,278	133,525	134,809	133,905	141,962	147,661	148,784	151,977	157,765	160,685	159,692	169,095
Home care allowance	..	..	..	..	..	..	..	..	..	981	1,037	1,183	1,442	1,385	1,434
Growth (%) in	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP in fixed 1990-prices	3.02	2.52	4.39	4.29	3.64	0.29	1.16	0.56	1.43	1.34	0.23	1.54	4.25	2.62	2.66
GDP-deflator	10.56	7.64	5.65	4.33	4.55	4.71	3.39	4.22	2.69	2.23	3.17	0.60	1.54	1.88	2.06

Appendix table A2 (Sweden)

Current prices (m SEK)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	636,015	712,310	797,333	866,601	947,263	1,023,602	1,114,502	1,232,602	1,359,879	1,447,327	1,441,723	1,446,212	1,531,102	1,644,983	1,678,111
Parental leave	4,562	4,734	5,173	6,144	7,215	8,294	10,730	12,145	15,758	17,950	18,917	19,093	..	14,563	11,338
Temporary leave	685	790	884	1,050	1,192	1,359	2,538	2,830	3,238	3,269	3,190	3,251	3,131	2,496	2,221
Daddy days	..	..	..	..	..	..	..	..	..	..	..	..	..	437	385
Day care centre	7,574	9,434	10,876	11,360	13,136	14,239	16,031	18,473	22,043	24,441	26,212	25,515	25,661	26,800	29,477
Family day care	2,567	3,257	3,707	4,079	4,703	4,640	4,927	5,310	6,175	6,346	6,264	5,589	6,101	6,432	6,283
Residential home	3,542	3,542	4,149	4,320	4,405	4,585	4,860	4,791	5,459	5,611	<>	<>	<>	<>	<>
Service housing	..	..	6,064	6,271	6,299	6,509	6,848	7,041	8,012	8,322	..	..	..	..	..
Special need housing	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	30,155	31,476	33,006	..	..
Home help	3,806	4,460	5,199	6,238	7,133	8,550	9,831	11,705	13,585	14,392	15,065	12,294	13,261	..	..
Leave of absence for informal care	<>	<>	<>	<>	<>	<>	<>	6	11	9	10	15	24	33	33
Transport service	..	..	448	491	569	704	780	893	1,228	1,166	1,328	1,152	1,250	..	..

Fixed 1990-prices (m SEK)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	1,125,589	1,145,312	1,191,666	1,214,657	1,242,523	1,281,602	1,310,453	1,341,595	1,359,879	1,344,697	1,325,579	1,296,142	1,339,383	1,392,185	1,409,831
Parental leave	8,074	7,612	7,731	8,612	9,464	10,385	12,617	13,219	15,758	16,677	17,393	17,112	..	12,325	9,525
Temporary leave	1,212	1,270	1,321	1,472	1,564	1,702	2,984	3,080	3,238	3,037	2,933	2,914	2,739	2,112	1,866
Daddy days	..	..	..	..	..	..	..	..	..	..	..	..	..	370	323
Day care centre	13,404	15,169	16,255	15,923	17,230	17,828	18,850	20,106	22,043	22,708	24,100	22,867	22,448	22,681	24,765
Family day care	4,543	5,237	5,540	5,717	6,169	5,810	5,793	5,780	6,175	5,896	5,759	5,009	5,337	5,444	5,279
Residential home	6,268	5,695	6,201	6,055	5,778	5,741	5,714	5,215	5,459	5,213	<>	<>	<>	<>	<>
Service housing	..	..	9,063	8,790	8,262	8,150	8,052	7,664	8,012	7,732	..	..	..	..	..
Special need housing	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	27,726	28,210	28,873	..	..
Home help	6,736	7,171	7,770	8,743	9,356	10,705	11,559	12,740	13,585	13,371	13,851	11,018	11,601	..	..
Leave of absence for informal care	..	..	..	..	..	..	..	7	11	8	9	13	21	28	28
Transport service	..	..	670	688	746	881	917	972	1,228	1,083	1,221	1,032	1,093	..	..

Appendix table A2 (Sweden) continued

Number of recipients/residents	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Parental leave	..	..	..	..	..	421,116	343,924	358,667	399,436	436,652	458,647	474,957	518,770	471,552	471,712
Temporary leave	..	..	..	..	..	673,298	737,401	724,784	761,995	742,722	711,965	721,984	675,868	705,133	684,214
Daddy days	..	..	..	..	..	86,645	94,401	99,804	106,930	104,793	100,583	92,287	87,076	77,522	69,939
Day care centre	151,123	161,350	173,246	184,392	191,924	204,228	217,372	233,058	256,349	283,367	306,869	313,207	331,803	356,116	362,169
Family day care	97,004	103,177	108,808	112,845	116,000	118,677	119,995	117,825	110,356	105,353	100,678	98,235	101,345	99,730	92,262
Part-time group	88,496	82,793	78,619	78,025	76,009	73,223	69,339	67,317	63,111	65,509	60,808	65,300	65,924	66,641	74,614
Residential home	53,723	52,675	51,182	48,308	43,892	42,773	40,268	38,628	36,863	34,224	<>	<>	<>	<>	<>
Service housing	21,000	18,500	31,100	33,500	36,600	41,600	45,500	37,700	39,800	38,900	38,900	36,086	38,811	46,544	43,766
Special need housing	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	75,412	85,254	89,742	83,299	83,246
Group accomodation	<>	<>	<>	<>	<>	<>	<>	<>	<>	4,760	..	..	..	..	..
Nursing home	42,300	43,200	44,700	46,100	45,700	44,400	43,400	42,100	40,979	39,931	11,388	8,357	4,269	4,320	..
Home help	..	290,524	..	274,201	..	273,005	278,352	270,079	265,789	252,627	200,700	149,650	145,034	137,572	129,543
Leave of absence for informal care	<>	<>	<>	<>	<>	<>	<>	..	2,574	1,972	2,769	4,094	5,450	6,431	6,545
Home care allowance	..	..	21,000	..	..	..	..	..	..	..	..	8,678	7,194	7,080	5,816
Transport service	249,955	262,305	279,404	299,835	321,983	336,036	353,754	362,293	353,483	339,275	..	..	369,408	360,665	355,545
Meals-on-wheels	..	..	..	..	..	25,475	29,631	11,430	9,942	8,883	8,221	..	..	..	..
Day care service	..	..	..	..	..	..	..	..	..	..	..	..	..	45,000	..
Growth (%) in	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP in fixed prices	1.00	1.75	4.05	1.93	2.29	3.15	2.25	2.38	1.36	-1.12	-1.42	-2.22	3.34	3.94	1.27
GDP-deflator	8.25	10.07	7.58	6.63	6.86	4.76	6.48	8.03	8.84	7.63	1.05	2.59	2.45	3.36	0.74

Appendix table A3 (Finland)

Current prices (m FIM)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	243,585	271,607	304,597	331,628	354,994	386,855	434,341	486,998	515,430	490,868	476,778	482,397	510,992	549,863	574780
Maternity allowance	1,222	1,467	1,603	1,097	791	877	1,001	1,107	1,266	1,404	1,417	1,251	1,193	1,713	1,034
Paternity allowance	27	37	41	39	58	43	53	63	79	115	105	102	102	122	121
Parental allowance	..	..	..	758	1,173	1,270	1,398	1,565	1,286	2,066	2,252	2,062	1,834	1,182	1,619
Day care centre and family day care	2,074	2,479	2,781	3,449	3,862	4,276	4,840	5,704	6,610	7,140	6,847	6,488	6,593	6,973	7,771
Home care allowance	102	170	180	191	438	812	1,019	1,392	2,234	2,650	3,213	3,229	3,274	3,053	2,042
Home help for families with children	111	129	143	180	171	187	199	211	226	233	231	212	196	189	201
Old-age homes	1,379	1,549	1,649	1,953	1,998	2,149	2,324	2,608	3,005	3,228	3,222	3,352	3,341	3,586	3,601
Home help and auxiliary services	349	413	495	647	821	936	1,056	1,111	1,296	1,476	1,519	1,554	1,603	1,790	2,104
Informal carers' allowance	..	..	36	76	127	168	197	236	276	328	270	270	292	321	333
Pensioners' care allowance	308	351	394	435	472	516	572	631	703	854	988	1,023	1,028	1,033	1,034
Fixed 1990-prices (m FIM)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	398,907	409,690	422,048	436,258	446,606	464,917	487,719	515,364	515,430	479,011	462,003	456,571	477,340	501,490	517,942
Maternity allowance	2,001	2,213	2,221	1,443	995	1,054	1,124	1,171	1,266	1,370	1,373	1,184	1,114	1,562	932
Paternity allowance	44	56	57	51	73	52	60	67	79	112	102	97	95	111	109
Parental allowance	..	..	..	997	1,476	1,526	1,570	1,656	1,286	2,016	2,182	1,952	1,713	1,078	1,459
Day care centre and family day care	3,396	3,739	3,853	4,537	4,859	5,139	5,435	6,036	6,610	6,968	6,635	6,141	6,159	6,360	7,003
Home care allowance	167	256	249	251	551	976	1,144	1,473	2,234	2,586	3,113	3,056	3,058	2,784	1,840
Home help for families with children	182	195	198	237	215	225	223	223	226	227	224	201	183	172	181

Appendix table A3 (Finland) continued

Old-age homes	2,258	2,337	2,285	2,569	2,514	2,583	2,610	2,760	3,005	3,150	3,122	3,173	3,121	3,271	3,245
Home help and auxiliary services	572	623	686	851	1,033	1,125	1,186	1,176	1,296	1,440	1,472	1,471	1,497	1,633	1,896
Informal carers' allowance	0	0	50	100	160	202	221	250	276	320	262	256	273	293	300
Pensioners care allowance	504	529	546	572	594	620	642	668	703	833	957	968	960	942	932
Residents/ recipients	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
Maternity, paternity and parental allowance	119,800	130,600	129,300	127,000	124,300	123,300	128,200	131,700	137,800	151,000	158,000	150,800	149,600	148,700	143,973
Public day care centre	..	..	..	96,263	97,452	100,935	103,000	106,876	101,658	104,331	104,398	105,738	111,366	117,897	134,542
Private day care centre	..	..	..	..	..	..	..	..	..	..	..	..	..	7,607	8,121
Family day care	..	..	..	..	..	..	..	..	78,922	72,042	61,343	53,688	54,899	58,065	68,396
Home care allowance	..	..	..	42,790	76,320	86,890	96,030	110,710	129,430	138,290	145,420	159,740	156,650	155,030	131,600
Home help for families with children	..	..	..	65,554	60,494	61,052	60,070	57,896	51,433	48,017	41,670	34,469	30,796	29,859	28,959
Guided play	..	..	..	53,156	..	..	..	..	44,694	39,832	30,237	30,338	24,011	24,315	26,029
Old-age homes	25,780	25,616	..	25,377	25,185	25,302	25,034	26,943	25,659	25,048	24,492	23,461	22,593	22,546	22,684
Home help	91,921	..	..	116,950	118,350	121,479	125,237	127,499	125,571	123,817	106,220	98,842	88,266	86,466	87,189
Auxiliary services	..	..	..	..	..	..	..	..	200,169	113,912	127,999	109,720	97,216	98,703	99,350
Informal carers' allowance	..	..	..	9,793	13,878	19,206	18,144	20,139	21,032	20,418	18,860	16,822	17,249	18,271	19,337
Pensioners' care allowance	100,845	104,392	109,461	113,615	118,430	124,159	128,079	131,786	131,504	134,912	137,670	140,030	141,864	140,754	141,674
Service housing	..	..	..	..	..	..	..	..	..	..	..	..	12,752	14,661	16,595
Growth in (%)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP (fixed 1990-prices)	3.25	2.70	3.02	3.37	2.37	4.10	4.90	5.67	0.01	-7.07	-3.55	-1.18	4.55	5.06	3.28
GDP-deflator	8.89	8.57	8.86	5.33	4.57	4.68	7.03	6.11	5.82	2.48	0.71	2.38	1.32	2.42	1.21

Appendix table A4 (The Netherlands)

Current prices (m NLG)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	373,060	387,350	405,700	425,540	437,860	440,840	457,680	484,950	516,550	542,570	566,100	581,460	614,270	638,380	667,640
Maternity leave	..	..	..	..	..	..	..	..	..	..	..	..	899	985	958
Maternity and parental leave	171	186	172	185	217	234	242	270	..	..	..	..	..	..	..
Day care centre	..	..	..	..	..	..	106	126	167	173	287	340	392	396	..
Playgroup	..	..	..	..	..	..	96	98	100	118	120	135	138	139	..
Age-integrated day care	..	..	..	..	..	..	17	24	114	251	320	429	499	564	..
Nursery education*	1,735	1,643	1,550	1,713	1,770	1,650	1,686	1,632	1,671	1,787	1,865	1,899	1,997	2,144	..
Home help	1,580	1,560	1,565	1,600	1,645	1,675	1,679	1,715	1,848	1,943	2,018	2,111	2,204	2,206	1,991
Residential home	4,018	4,208	4,158	4,498	4,523	4,545	4,638	4,706	4,690	5,037	5,100	5,203	5,253	5,323	5,381
Nursing home	3,255	3,403	3,454	3,565	3,702	3,774	3,854	3,968	4,243	4,531	4,829	5,180	5,394	5,644	5,866
Individual care budget	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	..	85

Fixed 1990-prices (m NLG)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	409,320	416,320	430,010	443,250	455,460	461,900	473,980	496,160	516,550	528,280	538,980	543,090	560,590	573,260	591,970
Maternity leave	..	..	..	..	..	..	..	..	..	..	..	..	820	885	849
Maternity and parental leave	188	200	182	193	226	245	251	276	..	..	..	..	..	..	..
Day care centre	..	..	..	..	..	..	110	129	167	168	273	318	358	356	..
Playgroup	..	..	..	..	..	..	99	100	100	115	114	126	126	125	..
Age-integrated day care	..	..	..	..	..	..	18	25	114	244	305	401	455	506	..
Nursery education*	1,903	1,766	1,643	1,785	1,841	1,729	1,746	1,670	1,671	1,739	1,776	1,774	1,822	1,926	..
Home help	1,734	1,677	1,659	1,667	1,711	1,755	1,739	1,755	1,848	1,892	1,921	1,972	2,011	1,981	1,765
Residential home	4,409	4,523	4,407	4,685	4,705	4,762	4,803	4,815	4,690	4,904	4,856	4,860	4,794	4,780	..
Nursing home	3,571	3,658	3,661	3,713	3,851	3,954	3,991	4,060	4,243	4,412	4,598	4,838	4,923	5,068	5,201
Individual care budget	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	..	75

Appendix table A4 (The Netherlands) continued

Number of receipients/ residents	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Maternity leave	38,500	43,200	45,900	45,500	45,800	43,300	50,900	52,200	53,200	58,500	70,600	76,500	77,900	85,600	..
Parental leave	..	..	..	..	..	..	..	..	..	..	14,000	18,000	20,000	21,000	22,000
Maternity care	114,000	116,900	123,200	127,800	133,800	136,600	138,800	143,700	151,700	153,600	157,600	152,000	152,200	152,000	..
Day care centre	6,535	..	9,444	..	11,799	..	16,790	25,200	40,754	48,165	51,214	59,890	65,828	70,044	73,510
Age-integrated day care	..	..	..	..	..	..	..	..	6,056	11,455	12,751	19,421	21,995	26,460	30,565
Half day care centre	..	..	..	..	434	..	..	2,400	2,500	3,500	3,600	3,900	4,200	4,000	..
Workplace day care	..	..	..	..	..	..	..	4,600	4,600	3,500	4,600	4,800	5,100	5,000	..
Family day care	..	..	..	..	..	..	..	1,200	2,400	4,900	9,300	11,400	12,191	13,925	15,200
Playgroup	125,125	..	134,507	..	132,520	..	137,680	164,000	173,800	196,000	191,000	197,500	200,633	198,331	..
Nursery education	171,048	168,437	173,164	179,792	174,714	167,865	172,486	176,864	182,958	184,175	183,379	185,372	194,112	196,669	194,831
Meals-on-wheels	..	..	..	16,499	20,354	22,952	33,212	33,001	36,545	42,187	43,860	44,338	49,969	48,432	51,652
Day care	..	..	..	..	..	..	..	..	..	..	..	..	..	5,529	..
Home help and care	..	130,000	..	133,200	..	..	141,200	149,300	160,700	168,100	185,800	..	..	185,479	195,561
Residential homes	133,092	133,350	132,562	136,238	..	..	135,119	130,406	129,379	127,886	126,386	123,569	120,606	117,035	112,581
Nursing homes	46,600	47,300	46,300	48,173	48,649	48,526	49,292	49,177	49,801	50,590	51,636	52,460	53,539	54,020	56,900
Sheltered housing	..	..	..	..	..	..	..	..	..	..	..	..	228,911	..	..
Individual care budget	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	1,500	3278*
Growth (%) in	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP in fixed 1990-prices	-1.41	1.71	3.29	3.08	2.75	1.41	2.62	4.68	4.11	2.27	2.03	0.76	3.22	2.26	3.26
GDP-deflator	6.03	2.08	1.40	1.76	0.14	-0.72	1.17	1.22	2.31	2.71	2.27	1.94	2.34	1.63	1.28

* Nursery education: based on average cost per child in the education system and multiplied by the number of children in nursery education.

Appendix table A5 (England)

Current prices (m GBP)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	189,790	207,985	221,002	245,940	271,797	298,719	335,907	370,749	401,465	416,128	434,037	458,575	483,353	504,893	
GDP (United Kingdom)	278,241	303,519	324,842	356,172	383,632	421,891	469,760	514,241	549,386	573,909	597,010	628,675	666,430	701,496	739,260
Statutory Maternity Pay (GB)	<>	<>	<>	<>	<>	193	250	289	314	408	434	416	443	453	472
Maternity Allowance (GB)	..	152	..	164	168	51	27	30	34	31	32	33	27	32	34
LA day nurseries	..	83	88	88	101	107	114	115	130	138	139	126	127	132	..
LA play-groups	..	6	6	6	9	11	10	11	12	12	11	10	36	35	..
Family day care	..	3	3	4	5	6	7	8	9	10	13	12	..	..	..
Nursery education*	323	367	417	446	471	531	604	678	761	884	..	1,176	1,251	1,342	1,382
LA home help	..	273	290	320	361	439	493	549	596	651	684	730	838	897	..
LA meals-on-wheels	..	35	39	42	46	51	53	55	61	68	68	76	92	89	..
LA day centres	..	36	40	42	48	41	44	75	88	117	127	141	138	149	..
Independent nursing home	..	..	..	..	..	..	..	..	..	..	..	120	371	566	..
LA residential care home	..	586	621	649	690	761	810	874	929	935	874	851	824	818	..
Independent residential care home	..	..	..	..	..	..	..	..	..	24	74	235	507	672	..
Attendance allowance (GB)	403	..	..	686	779	897	1,003	1,159	1,382	1,706	1,553	1,795	1,963	2,194	2,421
Mobility Allowance and Disability Living Allowance (GB)	236	..	..	422	514	596	675	769	883	1,062	1,973	2,772	3,125	3,802	..
Income Support (GB)	941	..	..	..	1,457	..	..	..	2,305	2,758	3,728	3,939	3,959	3,877	3,739
Invalid Care Allowance (GB)	8	..	..	13	104	184	173	184	208	285	345	442	526	617	..
Fixed 1990-prices (m GBP)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	1996
GDP	289,546	301,208	306,523	322,084	345,005	361,208	382,959	394,535	401,465	390,711	390,530	399,663	412,588	421,636	..
GDP (United Kingdom)	424,488	439,562	450,546	466,444	486,963	510,147	535,562	547,233	549,386	538,524	535,660	546,684	570,277	585,967	599,540

Appendix table A5 (England) continued

Statutory Maternity Pay (GB)	..	..	..	..	..	233	285	308	314	383	390	363	378	378	..
Maternity Allowance (GB)	..	220	..	215	213	62	31	32	34	29	29	29	23	27	..
LA day nurseries	..	120	122	115	128	129	130	122	130	130	125	110	108	110	..
LA play-groups	..	9	8	8	11	13	11	12	12	11	10	9	31	29	..
Family day care	..	4	4	5	6	7	8	9	9	9	12	11	..	..	..
Nursery education*	494	532	579	584	598	642	689	722	761	830	..	1,025	1,068	1,121	..
LA home help	..	395	402	419	458	531	562	584	596	611	615	636	715	749	..
LA meals-on-wheels	..	51	54	55	58	62	60	59	61	64	61	66	79	74	..
LA day centres	..	52	55	55	61	50	50	80	88	110	114	123	118	124	..
Independent nursing home	..	..	..	..	..	..	..	..	..	..	..	105	317	473	..
LA residential care home	..	849	861	850	876	920	923	930	929	878	786	742	703	683	..
Independent residential care home	..	..	..	..	..	..	..	..	..	23	67	205	433	561	..
Attendance allowance (GB)	615	..	..	898	989	1,085	1,143	1,233	1,382	1,602	1,397	1,564	1,676	1,832	..
Mobility Allowance and Disability Living Allowance (GB)	360	..	..	553	652	721	770	818	883	997	1,775	2,416	2,667	3,175	..
Income Support (GB)	1,436	..	..	..	1,849	..	..	..	2,305	2,590	3,354	3,433	3,379	3,238	..
Invalid Care Allowance (GB)	12	..	..	17	132	222	197	196	208	268	310	385	449	515	..
Number of recipients/ residents	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
Statutory Maternity Pay (GB)	<>	<>	<>	<>	<>	80,000	80,000	90,000	95,000	95,000	95,000	95,000	..	..	..
Maternity Allowance (GB)	115,000	..	..	115,000	110,000	30,000	15,000	20,000	20,000	20,000	20,000	20,000	11,000	12,000	13,000
LA day nurseries	33,261	33,733	35,187	34,478	36,705	36,534	36,482	34,408	34,201	32,272	30,400	28,800	31,800	29,800	25,700
Independent day nurseries	21,906	22,625	23,929	25,986	28,739	31,853	37,286	46,589	59,473	79,029	92,900	112,400	125,300	140,700	158,400
LA play groups	7,897	10,157	12,100	12,922	14,663	15,543	15,181	13,824	14,081	13,997	12,700	13,800	15,900	11,600	11,500
Independent play groups	371,620	384,871	391,148	406,568	409,750	411,366	406,491	404,605	414,336	426,502	413,100	395,400	409,700	408,900	397,000

Appendix table A5 (England) continued

Places with LA childminders	2,376	2,183	2,240	1,197	1,544	1,798	1,659	1,947	1,889	1,813	2,200	4,700	2,100	1,900	2,300
Places with registered childminders	96,119	104,246	114,091	125,650	136,188	148,845	162,041	184,409	203,678	231,445	252,100	296,100	355,400	371,700	373,900
LEA nursey schools	49,341	49,875	49,627	49,842	49,696	49,745	50,003	50,440	51,818	52,376	52,453	53,307	52,614	52,768	52,177
LEA nursery classes	186,413	198,274	209,195	217,323	223,097	226,672	234,756	245,414	255,449	265,810	..	286,926	294,331	303,462	318,100
LEA reception classes	201,162	210,249	236,326	245,520	236,143	240,376	248,173	251,980	270,247	285,682	..	316,279	328,003	343,824	344,222
Independent reception classes	..	..	..	..	41,789	43,550	46,639	50,417	53,063	55,111	56,435	57,599	58,190	60,875	51,844
LA home help	..	..	..	..	..	..	..	..	..	..	466,700	447,100	429,000	373,600	330,000
Independent home help	..	..	..	..	..	..	..	..	..	..	9,700	15,800	50,800	78,700	97,800
LA meals-on-wheels	..	..	..	..	..	..	..	..	..	..	156,000	155,100	152,000	126,000	143,526
Independent meals-on-wheels	..	..	..	..	..	..	..	..	..	..	117,800	129,200	146,200	139,100	110,792
LA day centres	..	..	21,464	21,806	21,630	21,879	23,264	24,490	27,000	25,920	..	..	124,100	129,000	125,600
Independent day centres	..	..	..	..	..	..	..	..	..	..	..	..	52,200	63,700	69,100
Independent nursing home	..	..	..	33,869	41,570	..	57,007	73,601	89,616	108,979	113,839	144,325	148,459	155,412	159,217
LA residential care home	103,720	103,598	101,996	101,526	101,704	99,750	97,380	95,335	89,340	80,836	70,000	61,842	57,000	52,791	50,735
Voloutary residential care home	26,116	26,468	26,005	25,818	25,121	25,105	25,633	25,858	26,633	26,888	30,474	32,702	35,138	35,683	35,592
Private residential care home	35,839	42,142	52,675	66,143	77,557	84,945	96,161	111,391	119,883	127,510	130,386	132,661	136,128	137,150	140,002
Attendance allowance (GB)	202,000	..	..	555,000	605,000	670,000	730,000	795,000	890,000	975,000	660,000	700,000	952,000	1,051,000	1,142,000
Income Support (GB)	..	..	..	1,805,000	1,930,000	1,950,000	1,815,000	1,780,000	1,705,000	1,575,000	1,643,000	1,736,000	1,765,000	1,781,000	1,588,000
Invalid Care Allowance (GB)	..	..	..	10,000	25,000	80,000	100,000	115,000	136,000	167,000	199,000	240,000	285,000	339,000	361,000
Growth in (%)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP in 1990-prices	1.89	4.03	1.76	5.08	7.12	4.70	6.02	3.02	1.76	-2.68	-0.05	2.34	3.23	2.19	..
GDP-deflator	7.39	5.34	4.42	5.91	3.17	4.98	6.06	7.13	6.42	6.51	4.35	3.24	2.10	2.21	..

* Nursery education: based on average cost per child in the education system and multiplied by the number of children in nursery education.
GB: Figures are for Great Britain.

Appendix table A6 (France)

Current prices (m FFR)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	3,626,021	4,006,498	4,361,913	4,700,143	5,069,296	5,336,652	5,735,092	6,159,680	6,509,488	6,776,231	6,999,546	7,077,087	7,389,654	7,662,391	7,860,517
Maternity and parental leave	11,966	11,664	12,565	12,037	11,858	16,520	21,210	19,341	21,875	22,701	23,288	22,968	23,398	26,769	..
Family services	12,645	15,064	16,974	17,228	17,540	18,042	19,185	22,048	21,942	21,745	22,978	26,471	26,903	28,046	..
Nursery education	..	..	..	..	..	..	16,800	23,100	26,300	40,000	40,700	46,000	51,700	54,100	55,700
Residential care homes	3,546	4,036	4,159	4,271	4,055	4,203	4,144	4,273	35,613	36,910	37,442	41,065	43,578	47,808	..
Home help	2,058	2,378	2,646	2,862	2,781	2,795	2,632	2,714	6,921	7,384	7,730	8,083	8,277	8,728	..
Fixed 1990-prices (m FFR)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
GDP	5,393,637	5,436,162	5,507,012	5,607,484	5,740,954	5,870,008	6,118,831	6,357,346	6,509,488	6,560,175	6,629,435	6,543,901	6,718,850	6,862,938	6,949,073
Maternity and parental leave	17,799	15,826	15,864	14,361	13,429	18,171	22,629	19,962	21,875	21,977	22,057	21,238	21,274	23,976	..
Family services	18,809	20,439	21,430	20,554	19,864	19,845	20,469	22,756	21,942	21,052	21,763	24,477	24,461	25,120	..
Nursery education	..	..	..	..	..	..	17,924	23,841	26,300	38,725	38,548	42,534	47,007	48,455	49,241
Residential care homes	5,275	5,476	5,251	5,095	4,592	4,623	4,421	4,410	35,613	35,733	35,462	37,971	39,622	42,820	..
Home help	3,061	3,227	3,341	3,414	3,149	3,074	2,808	2,801	6,921	7,149	7,321	7,474	7,526	7,817	..

Appendix table A6 (France) continued

Number of receipients/ residents	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Congé de naissance	343,000	337,000	310,000	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>	<>
APE	<>	<>	<>	2,000	567,000	1,087,000	1,387,000	1,367,000	1,375,000	1,371,000	1,364,000	1,346,000	1,292,000	1,167,000	1,069,000
AGED	<>	<>	<>	<>	<>	2,000	9,000	11,000	13,000	12,000	15,000	21,000	25,000	47,000	67,000
AFEAMA	<>	<>	<>	<>	<>	<>	<>	<>	<>	110,000	163,000	222,000	273,000	326,000	384,000
Crèches collectives	..	78,704	82,914	..	84,300	90,900	95,700	99,728	107,070	112,354	115,851	122,200	126,900	127,132	133,859
Crèche familiales	..	40,270	43,317	..	46,400	49,500	53,200	57,150	58,921	61,500	66,033	65,900	65,300	64,930	63,030
Jardins d'enfants	..	12,778	13,186	..	13,300	12,800	12,100	12,242	12,083	12,299	12,019	11,700	11,800	12,164	11,651
Halte-garderies	..	..	..	..	..	41,400	42,800	47,111	50,568	52,859	55,750	58,400	60,100	63,278	64,650
Assistantes maternelles agréées	..	..	..	..	248,400	..	..	..	..	246,000	257,000	340,000	411,000	488,700	248,400
École maternelle	1,801,595	1,843,700	1,889,906	1,920,777	1,911,708	1,906,717	1,901,027	1,926,200	1,940,000	1,942,200	1,932,300	1,925,846	1,908,035	..	1,878,104
Maisons de retraite	..	..	..	..	324,925	..	329,124	..	352,481	..	376,153	..	392,335	..	406,753
Logements-foyer	..	..	..	..	120,928	..	128,978	..	142,478	..	148,805	..	153,397	..	155,703
Allocation pour aide ménagère	131,165	148,058	143,997	134,348	125,996	115,266	110,352	112,522	..	107,700	106,910	100,600	96,020	..	..
Service de soins à domicile	..	19,634	23,338	26,573	28,228	30,382	34,870	38,322	42,761	42,388	47,468	51,809	54,470	55,379	56,650

Growth (%) in	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
GDP-deflator	10.79	8.78	6.95	5.50	5.08	2.87	3.00	3.26	3.11	3.19	2.17	2.37	1.67	1.49	1.30
GDP in fixed 1990-prices	2.22	0.79	1.30	1.82	2.38	2.25	4.24	3.90	2.39	0.78	1.06	-1.29	2.67	2.14	1.26

Appendix table A7 (Germany)

Current prices (m DEM)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**
GDP (West Germany)	1,588,090	1,668,540	1,750,890	1,823,180	1,925,290	1,990,480	2,095,980	2,224,440	2,426,000	2,647,960	2,813,000	2,844,100	2,965,900	..
GDP (Germany)	..	..	..	..	..	..	..	..	..	2,853,600	3,078,600	3,163,700	3,328,200	3,459,600
Maternity and parental leave	1,783	1,678	1,340	1,337	2,703	4,150	4,511	5,169	5,807	7,361	8,689	8,350	8,113	8,672
parental leave benefits (Child raising allowance)	..	..	..	..	1,654	3,121	3,322	4,042	4,590	5,906	7,222	6,823	6,669	7,231
parental leave benefits (Social assistance)	..	..	..	..	..	150	240	221	199	200	200	240	210	200
income maintenance (Health insurance)	1,731	1,628	1,292	1,287	996	824	891	862	980	1,217	1,231	1,253	1,203	1,210
private mandatory: Income maintenance	850	840	830	870	1,000	1,100	1,280	1,360	1,647	1,983	2,268	2,559	2,633	2,757
Formal day care (Child day care - Youth Assistance)	4,101	4,056	4,320	4,500	4,736	5,068	5,452	5,518	6,554	10,627	11,780	13,902	13,686	13,465
Care allowance	673	670	635	668	708	789	860	900	956	1,137	859	936	947	5,379
Residential care	3,795	4,054	4,237	4,601	4,789	5,063	5,345	5,604	6,325	8,809	10,542	11,666	12,638	11,746
Home help (Long term Care Insureance, since 1995)	..	..	..	..	..	..	..	..	..	..	..	..	..	1,772
Home help and care	..	..	..	6,296	..	..	..	7,904	..	11,359	13,273	14,924	..	16,405
Day care and rehabilitation services	1,261	1,274	1,263	1,342	1,368	1,530	1,637	1,637	1,728	1,963	2,219	2,467	2,631	3,115
Assistance in carrying out daily tasks	784	889	802	765	1,147	977	1,133	1,043	1,283	3,121	3,825	4,178	4,635	2,480
Fixed 1990-prices (m DEM)	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**
GDP (West Germany)	1,926,054	1,959,935	2,015,089	2,055,997	2,104,221	2,135,311	2,214,817	2,295,094	2,426,000	2,548,782	2,593,387	2,542,853	2,599,354	..
GDP (Germany)	..	..	..	..	..	..	..	..	..	2725173	2785146	2752199	2826975	2878163

Appendix table A7 (Germany) continued

Maternity and parental leave	2,162	1,971	1,542	1,508	2,954	4,452	4,767	5,333	5,807	7,085	8,011	7,466	7,110	7,215
parental leave benefits (Child raising allowance)	..	..	..	..	1,808	3,348	3,510	4,170	4,590	5,685	6,658	6,100	5,845	6,016
parental leave benefits (Social assistance)	..	..	..	..	..	161	254	228	199	193	184	215	184	166
income maintenance (Health insurance)	2,099	1,912	1,487	1,451	1,089	884	942	889	980	1,171	1,135	1,120	1,054	1,007
private mandatory: Income maintenance	1,031	987	955	981	1,093	1,180	1,353	1,403	1,647	1,909	2,091	2,288	2,308	2,294
Formal day care (Child day care - Youth Assistance)	4,974	4,764	4,972	5,075	5,176	5,437	5,761	5,693	6,554	10,229	10,860	12,430	11,995	11,202
Care allowance	817	787	731	753	773	847	909	929	956	1,095	792	837	830	4,475
Residential care	4,603	4,762	4,876	5,188	5,234	5,431	5,648	5,782	6,325	8,479	9,719	10,430	11,076	9,772
Home help (Long term Care Insurance, since 1995)	..	..	..	..	..	..	..	..	..	..	..	..	..	1,474
Home help and care	..	..	..	7,100	..	..	..	8,155	..	10,934	12,237	13,343	..	13,648
Day care and rehabilitation services	1,529	1,496	1,453	1,514	1,495	1,642	1,730	1,689	1,728	1,889	2,046	2,206	2,306	2,592
Assistance in carrying out daily tasks	3,480	2,889	1,655	1,573	3,648	1,837	1,723	2,520	4,074	12,143	16,851	13,013	9,344	13,258

Appendix table A7 (Germany) continued

Number of residents/ receipients	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Public nursery	19,138	..	..	..	20,601	..	..	..	15,206	..	..	..	109,420	..
Private nursery	6,633	..	..	..	7,332	..	..	..	12,313	..	..	..	41,333	..
Public kindergarten	410,727	..	..	..	442,013	..	..	..	455,957	..	..	..	1,093,073	..
Private kindergarten	916,306	..	..	..	990,041	..	..	..	1,034,203	..	..	..	1,378,615	..
Public age-integrated institutions	..	..	..	..	..	..	..	..	27,885	..	..	..	140,527	..
Private age-integrated insitutions	..	..	..	..	..	..	..	..	52,598	..	..	..	74,347	..
Public comprehensive groups	..	..	..	..	..	..	..	..	..	..	..	..	339,738	..
Private comprehensive groups	..	..	..	..	..	..	..	..	..	..	..	..	122,105	..
Home help and care	..	..	..	251,875	..	..	..	271,000	..	377,500	398,500	394,100	..	364,800
Mixed institutions	168,116	175,367	177,307	194,947	194,938	184,114	243,808	250,797	249,698	325,872	329,996	338,469	331,303	340,619
Old-age homes	201,273	201,919	255,689	253,727	251,615	258,252	180,586	178,207	176,181	200,720	196,417	192,058	191,436	195,727
Service flats	81,077	82,400	71,937	74,404	77,963	78,154	71,593	72,542	70,706	70,637	72,785	80,213	80,364	65,691
Nursery homes	85,498	88,914	123,707	135,854	143,265	146,594	204,498	209,895	219,486	269,593	278,461	300,208	308,554	301,961
Growth (%) in	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**
GDP-deflator	4.44	3.25	2.06	2.06	3.18	1.88	1.52	2.42	3.18	3.89	4.41	3.11	2.02	5.35
GDP in fixed 1990-prices	-0.94	1.76	2.81	2.03	2.35	1.48	3.72	3.62	5.70	5.06	1.75	-1.95	2.22	-100.00

APPENDIX B

Leave Schemes

Maternity leave

	Denmark	Sweden	Finland	The Netherlands
Scope of application	Employees, self-employed, and assisting spouses	See parental leave	All mothers	All wage earners and salaried employees
Eligibility criteria	Must have been affiliated to labour market for 13 weeks and must have worked minimum 120 hours during this period. Further premised on paying income taxes and residing in Denmark	<>	Mother must have resided in Finland for six months prior to the expected date of birth	Employees working part- or full-time. Self-employed and housewives not covered
Total number of weeks	18 weeks	<>	17.5 weeks	16 weeks
Of which after birth	14 weeks	<>	12.5 weeks	10-12 weeks
Amount	DKK 2,688 weekly	<>	Earnings related	Full compensation of previous earnings
Compensation rate, for APW woman working part-time	55.2% of previous wage	<>	69.5% of previous wage	100%
Financing	State (54%), employers (1.25), insured (45%)	<>	Employers (38%), insured (71%)	Health insurance
Taxable	Treated as income	<>	Treated as income	Treated as income

Note: Compensation rates are calculated as effect on gross income of utilizing the maximum possible duration of leave after birth. APW wage from Hansen, 1997. APW for men calculated as the income of an average male industrial worker in full-time work; APW for women calculated as APW man X 0.5, presuming that the woman is working part-time. Compensation rates do not take into account the taxes paid of the benefit.

(to be continued)

(**Maternity leave** – continued)

	England	France	Germany
Scope of application	Employees	Insured women	Insured women or spouse or daughter of insured person
Eligibility criteria	Employees who pay Class 1 contributions to national Insurance, and dependent on a minimum of 26 weeks employment with same employer prior to the 15th week before birth	Insured for at least 10 months for 1,200 hours of work previous year	Insured for 12 months between 10th and 14th month before confinement
Total number of weeks	40 weeks, only 18 with benefit	16 weeks, 10 extra weeks available for birth of the 3rd and subsequent children	14 weeks
Of which after birth	29 weeks	10 weeks	8 weeks
Amount	First 6 weeks: 90% of average wage. The following 12 weeks: Flat-rate benefit	A maximum of FRF 357,46 is paid daily	Employers are obliged to top up the maternity benefit of 31.6% compensation rate to former income. Maternity benefit is supplemented by a one-time confinement grant
Compensation rate, for APW woman working part-time	33.1% of previous wage*	100%	100%
Financing	National Insurance	Sickness insurance funds	Sickness insurance funds
Taxable	Treated as income	No	Maternity benefit taxed in principle but in general not because of progression. Confinement grant non-taxed

Note: Compensation rates are calculated as effect on gross income of utilizing the maximum possible duration of leave after birth. APW wage from Hansen, 1997. APW for men calculated as the income of an average male industrial worker in full-time work; APW for women calculated as APW man X 0.5, presuming that the woman is working part-time. Compensation rates do not take into account the taxes paid of the benefit.

* Compensation rate calculated according to the full leave period, if only calculated on basis of the 18 weeks with benefit, the compensation rate would be somewhat higher, at 53, 7%.

Paternity leave

	Denmark	Sweden	Finland	The Netherlands
Scope of application	Employees, self-employed, and assisting spouses	See parental leave	All fathers	No statutory paternity scheme, but an emergency leave (Calamiteitenverlof) offers short-term leave
Eligibility criteria	Must have been affiliated to the labour market for 13 weeks and must have worked minimum 120 hours during this period. Further premised on paying income taxes and residing in Denmark	<>	Fathers who have been insured under the national health insurance scheme for at least 180 days prior to birth. Only payable if the father is caring for the child, lives with the mother and if she gives her consent	Employees
Length of leave	28 days	<>	6-12 days	Must be negotiated with employer
Amount	DKK 2,688 weekly	<>	Earnings related	Must be negotiated with employer
Compensation rate, for APW male worker working full-time	55.8% of previous wage	<>	69.2% of previous wage	..
Financing	State (54%), employers (1.25%), insured (45%)	<>	Employers (38%), insured (71%)	Employer
Taxable	Treated as income	<>	Treated as income	Treated as income

Note: Compensation rates are calculated as effect on gross income of utilizing the maximum possible duration of leave after birth. APW wage from Hansen, 1997. APW for men calculated as the income of an average male industrial worker in full-time work. Compensation rates do not into take account the taxes paid of the benefit.

(to be continued)

(**Paternity leave** – continued)

	England	France	Germany
Scope of application	No statutory scheme	Employees	No statutory scheme
Eligibility criteria	<>	..	<>
Length of leave	<>	3 days to be taken within 15 days before or after confinement	<>
Amount	<>	Full salary	<>
Compensation rate, for APW male worker working full-time	<>	100%	<>
Financing	<>	Employer	<>
Taxable	<>	Treated as income	<>

Note: Compensation rates are calculated as effect on gross income of utilizing the maximum possible duration of leave after birth. APW wage from Hansen, 1997. APW for men calculated as the income of an average male industrial worker in full-time work. Compensation rates do not take into account the taxes paid of the benefit.

Parental leave

	Denmark	Sweden	Finland	The Netherlands
Scheme	*Fødselsorlov* *Børnepasningsorlov*	*Föräldrepenning*	*Vanhempainraha* *Lasten kotihoiden tuki*	*Ouderschapsverlof* *Loopbaanonderbreking*
Scope of application	Employees, self-employed and assisting spouses *Børnepasningsorlov:* Also unemployed and recipients of social assistance	Employees, self-employed and unemployed	All parents, including housewives and students	Employees
Eligibility criteria	*Fødselsorlov:* Must have been affiliated to labour market for 13 weeks and must have worked minimum 120 hours during this period. Further premised on paying income taxes and residing in Denmark. *Børnepasningsorlov:* Parents with custody of a child aged 0-8 years. If the child is 0-2 years the child must be taken out of child care institution.	Parents with custody of a child aged 0-8 years. Only parents who have been in paid employment for a minimum of 34 weeks prior to birth receive full benefit.	*Vanhempainraha:* All parents who have been insured under the national health insurance scheme for at least 180 days prior to birth. Only payable to the father if he is caring for the child, lives with the mother and if she gives her consent. Only payable to the mother if she has had a post-natal examination by a doctor *Lasten kotihoiden tuki:* Parents with custody of a child 0-3 years. Child cannot use local day care facilities	*Ouderschapsverlof:* Parents of children under 4 years can reduce working hours. *Loopbaanonderbreking:* Employees working for more than 12 hours a week and who have been working for 1 year are entitled to a benefit, but not to leave which must be negotiated with employer
Length of leave	*Fødselsorlov:* 10 weeks per family *Børnepasningsorlov:* 13 consecutive weeks per parent for every child 0-9 years. If the child is 0-1 year or adopted the right to leave is extended to 26 weeks, and with employer's permission extension up to 52 weeks	64 weeks. Parents can share leave, but 30 days are reserved for the other parent By multiple birth extra 6 months for each additional child	*Vanhempainraha:* 26.3 weeks. Multiple births entitle parents to further 60 days *Lasten kotihoiden tuki:* The right to leave and benefit are separate schemes. Leave must be negotiated with the employer. One leave per child 0-2 and another per child 2-3 years. Parents must take leave separately	*Ouderschapsverlof:* Reduction of working hours to 20 weekly hours for 13.5 weeks *Loopbaanonderbreking:* 9-27 weeks with full time or reduced working hours

(to be continued)

(**Parental leave** - continued)

	Denmark	Sweden	Finland	The Netherlands
Minimum length	*Børnepasningsorlov:* 13 weeks	..	*Vanhempainraha:* 12 days *Lasten kotihoiden tuki:* 2 months	*Ouderschapsverlof:*13.5 weeks *Loopbaanonderbreking:* 9 weeks
Amount	*Fødselsorlov:* DKK 2,688 weekly *Børnepasningsorlov:* 60 % of maximum unemployment benefit rate, DKK 1,614 weekly. Municipal supplement allowed up to DKK 35, 000 yearly. Must not exceed 80% of previous income	80% of previous earnings. Last 90 days covered by a minimum benefit of SEK 60 per day. If no earned income SEK 60 per day.	*Vanhempainraha:* Bases on taxable income *Lasten kotihoiden tuki:* FIM 1,500 per month and FIM 3-500 in siblings-increase and an earnings related addition. Deducted from unemployment benefit. A partial benefit can be paid for part-time employees. Average allowance for family with two children: FIM 2,800 monthly. Municipal supplement may be available	*Ouderschapsverlof:* Unpaid, only public employees receive 75% of previous earnings *Loopbaanonderbreking:* Earnings related, with maximum of NLG 960 monthly.
Compensation rate	*Fødselsorlov:* 55.7% *Børnepasningsorlov:* 26.85%	71.9% (1)	*Vanhempainraha:* 69.5% of previous wage. *Lasten kotihoiden tuki:* 30.2% of previous wage	*Loopbaanonderbreking:* 40%
Flexibility	*Fødselsorlov:* Possibility to work part-time with reduced benefit *Børnepasningsorlov:* Possibility to participate in educational activities up to 20 weekly hours	Leave can be taken as 25%, 50%, 75% or full-time leave. Minimum 5 weeks vacation included	Parents working full time can reduce hours and receive the partial leave benefit under the *Lasten kotihoiden tuki* scheme	..
Financing	*Fødselsorlov:* State (54%), employers (1.25%), insured (45%) *Børnepasningsorlov:* State (9%), insured (91%)	State (14%), employer contribution (86%)	State (31%), LA (69%) *Lasten kotihoiden tuki:* State (31%), local authority (69%)	*Ouderschapsverlof:* Employer and employee *Loopbaanonderbreking:* Unemployment fund

(to be continued)

(**Parental leave** - cntinued)

	Denmark	Sweden	Finland	The Netherlands
Taxable	Treated as regular income	Treated as regular income	Treated as regular income	*Loopbaanonderbreking:* Treated as income, but exempt of social security premiums.
Tax (or other) reductions	*Børnepasningsorlov:* If the replacement is registered as unemployed the employer can receive a wage supplement from the Job placement services	No	No	If the employer hires a low skilled employee, a tax reduction is available

Note: Compensation rates are calculated as effect on gross income of utilizing the maximum possible duration of leave after birth. APW wage from Hansen, 1997. APW for men calculated as the income of an average male industrial worker in full-time work; APW for women calculated as APW man X 0.5, presuming that the woman is working part-time. Compensation rates do not take into account the taxes paid of the benefit.

(1) Compensation rate calculated for the mother on basis of using the full leave period of 420 days; if the woman only uses the 330 days the compensation rate is 80%.

(to be continued)

(**Parental leave** - continued)

	England	France	Germany
Scheme	No statutory scheme. A 3-month leave, unpaid leave period may be implemented in 1999.	Allocation Parentale d'Education	Erziehungsgeld
Scope of application	<>	All interrupting working activity totally or partly	All
Eligibility criteria	<>	Parents of children aged 0-3 years. Parental allowance for the second and subsequent child, if the recipient has been economically active in two of the preceding five years. For the third and subsequent children two years within the last ten years.	Parents of children aged 0-3 years. If one parent is at home, unemployed or in education
Length	<>	146 weeks, shared or alternated. A family with two part-time leaves.	3 years. Can be shared
Minimum length	<>	<>	<>
Amount	<>	Unpaid. For second and subsequent child: FFR 2,964 for full-time leave and FFR 1,960 part-time. FFR 1,480 if working hours are between 50% and 80% full-time hours	Benefit during the first 24 months. Can work up to 19 hours a week without reduction in benefit. Flat rate benefit: DM 600 a month. First 6 months irrespective of income. Hereafter income dependant.
Compensation rate, % of APW	<>	59% of previous wage	16.9% of previous wage
Flexibility	<>	Parents can take the leave as part-time and receive a reduced benefit.	They may work up to 19 hours without reduction in benefit
Financing	<>	Mainly employers	100% tax financed
Taxable	<>	No	No

Note: Compensation rates are calculated as effect on gross income of utilizing the maximum possible duration of leave after birth. APW wage from Hansen, 1997. APW for men calculated as the income of an average male industrial worker in full-time work; APW for women calculated as APW man X 0.5, presuming that the woman is working part-time. Compensation rates do not take into account the taxes paid of the benefit.

Appendix

Main institutional day care for children

	Denmark	Sweden	Finland	The Netherlands
Schemes	*Vuggestue* *Børnehave* *Aldersintegreret*	*Daghem*	*Pälväkoti*	*Kinderdagverblijven*
Scope of application	0-2 years *(vuggestue)* 2-7 years old *(børnehave)* 0-7 years *(aldersintegreret)*	0-6 years	Children 0-7 years old	Children aged 0-4 (13) years
Eligibility criteria	Age and availability of places	Parents in employment, education or children with special needs	Age and availability of places	Local authority (LA): parents in employment, single parents or social needs. Private: ability to pay and sometimes employee position
Responsibility	Municipality	Municipality	Municipality	LA
Assessment	Municipality	Municipality	Municipality	LA
Provision, % of places	Municipality and independent institutions under contract.	Municipal (88%), private (12%)	Municipal (94%), private (6%)	For and non-profit
Opening hours	7 a.m. to 6 p.m all year	6:30 a.m. to 6 p.m. all year	7 a.m. to 5 p.m. all year	7.00 a.m. to 6.00 p.m. all year
Average attendance hours	3-6 years: 7-8 hours per day	31.3 hours a week	4-10 hours per day	17.9 per week
Coverage in FTE places	0-2 years: 17.5% 3-6 years: 64.5%	0-2 years: 31% 3-6 years: 54%	0-2 years: 10% 3-6 years: 38%	0-4 years: 6%
Group size	0-2 years: 10 children 3-6 years: 15-20 children	16.9 children	30-50 children in the whole centre	LA: Group size: 9-10 children dependent on age
Staff qualifications	0-2 years: trained (3½ years of training) (50% of staff) and untrained 3-6 years: 60% trained staff	Pre-school teachers (3 years of training), child care attendants (3 years). 98% of staff hold qualifications	Kindergarten teachers (university), nursery school teacher (3 ½ years) and day care nurse (2 ½ years)	95% have training or hold qualifications
Staff ratio (staff per children)	0-2 years: 1: 2.60 3-6 years: 1: 5.27	1:5.41	1:3.8	1:6.7, not including volunteers and trainees

(to be continued)

(**Main institutional day care for children** – continued)

	Denmark	Sweden	Finland	The Netherlands
Financing	Municipality and client fees 0-2 years: Clients 29% 3-6 years: 30%	State (2%), LA (85%), client (13%)	State (27%), LA (54%), client (20%)	Public (33%), employer (25%), clients (42%)
Formula of fees	Fees related to income for low income parents, and number of children. Average monthly fee for 0-2-year-olds DKK 2,075. 3-6 years: DKK 1,159	Based on income and number of children and hours of day care	Income-dependent, hours of attendance and number of children. Average monthly fee FIM 450	Parental fees for 0-4 years from NLG 97 to NLG 1,176 monthly depending on income
Tax-relief	No	No	No	No
Regulation	Social welfare board	National Agency for Education	Social board	Local Health services and local Fire department

(to be continuec

(**Main institutional day care for children** – continued)

	England	France	Germany
Scheme	*Day nursery*	*Crèche* *École maternelle*	*Krippe* *Kindergarten*
Scope of application	Children aged 0-4 years *(Day nursery)*	Children 0-2 *(crèche)* and 3-6 years *(école maternelle)*	0-36 months *(Krippe)* 3-6 years *(Kindergarten)*
Eligibility criteria	Local authority (LA) day nursery: children in need Private: ability to pay	0-2 years: by age and need 3-6 years: all children	0-2 years: need 3-6 years: all
Responsibility	LA	0-2 years: municipality 3-6 years: Ministry of Education	Municipality
Provision (% places)	LA (11%), Independent (89%)	0-2 years: voluntary non-profit, municipality 3-5 years: municipality	1-2 years: Welfare Associations
Opening hours	LA: 7:30 a.m. to 6:00 p.m. all year	8:30 a.m. to 4:30 p.m. during term -time. Wednesday afternoon closed	50% places in West, 'morning and afternoon places' without care during lunch break
Average attendance hours	60% attend full-time on weekdays	3-6 years: 26 hours per week	..
Coverage in FTE places	6%	3-6 years: 98%	0-2 years: 4.5 % in West, 33% 3-5 years: 65% (1994)
Group size	No more than 26 per group. Average size is 19	3-6 years: 20-28	..
Staff qualifications	LA: mainly nursery nurses (2 years training) Independent: 50% are nursery nurses	0-2 years: nurse (4 years), assistant nurse (1 year work experience), pedagogue (2 years) 3-6 years: teacher (5 years), teacher assistant (1 work experience)	Social teachers (3-4 years), nursery-school teachers (3-5 years) and nursery nurses (3 years).
Staff ratio (staff per children)	LA: 1:4 children	Crèche: 1:5 children who cannot yet walk 1:8 children otherwise École maternelle: 1:27	No national standards, but regional. Average: 0-2 years 5-7.5 3-6 years: 10 or 14 (West), 18 (East).
Financing	LA nurseries: LA 94%, clients (6%). Independent: clients (100%)	0-2 years Local insurance office, municipality and user fees. 3-6 years Ministry of Education	Municipality and Länder

(to be continued)

(Main institutional day care for children – continued)

	England	France	Germany
Fees	LA day nurseries: means-tested but often waived.Independent: £55-£160 per week. Average hourly cost is £1.30	Crèche: 28% of costs École maternelle: free	16-20% of costs 0-2 years: 0-300 DM 3-6 years: 0-240 DM
Tax relief	If day care arrangement is approved an income related Working Parent FamiliesTax Credit cover some child care costs	No	No
Regulation	Children Act Inspectors under the Social Service Department or OFSTED, the inspection unit under the Department of Education for the 4-year-olds.	Local social centre	Local youth Welfare Centre

Family day care

	Denmark	Sweden	Finland	The Netherlands
Scope of application	Children aged 0-14 years	Children aged 0-12 years	0-7	Children aged 0-12 years
Eligibility criteria	Age and availability of places	Parental employment and educational activities or special need	Age and availability of places	Availability of places and ability to pay
Responsibility	Municipality	Municipality	Municipality	Non-profit agency
Provision, % of places	Childminder schemes organised by municipality	Municipal childminder or self-employed day carers (1.5%)	Childminder scheme organised by the municipality	Local non-profit agencies, and a few independent family day carers
Opening hours	5:30 a.m.–6:00 p.m. all year round	All year round	8-10 hours full-time, 4-5 hours part-time, all year round	Arranged with parents, but mainly all year round
Average attendance hours	7.25 hours per day	28.2 hours per week	..	14.6 hours per week
Coverage in FTE places	0-2 years: 27% 3-6: 4%	0-2 years: 9% 3-6 years: 13%	0-2 years: 11.5% 3-6 years: 18%	0-4 years: 1%
Group size	0-10 children	3-8 children	4 under school-age and a fifth school aged child- attending part-time or 12 in group care	No requirements
Staff ratio per children	1: 5 children, including own children	1:4.8 children	1:3.7 children	1:4, including own children
Staff qualifications	No requirements. Voluntary 38 hour introductory course, followed by a 74 hour course after 6 months	No requirements. Voluntary 50-100 hours training. In addition, 30 hours annual training recommended	250 hours of minimum training	No requirements. Training offered by local agencies
Financing	Municipality, and clients (30%)	Municipality, and clients (18%)	Municipality, and clients (15%)	Clients
Formula of fees	Dependant on income and attendance. Average DKK 1,580 monthly for a full-time place	Depending on income, number of children and attendance	Income-dependent, hours of attendance and number of children. Average monthly fee FIM 450	Individually arranged between childminder and parents. Average hourly pay: NLG 3-5 per hour.
Regulation	Family day care supervisor	Supervisor at local family day care centre	Local supervisors	Local family day care agencies themselves

(to be continued)

(**Family day care** – continued)

	England	France	Germany
Admission	Children aged 0-5 (8) years	Children 0-3 years full-time and older children after school	All children
Eligibility criteria	Parental ability to pay	Parental ability to pay	Parental ability to pay
Responsibility	Private	Municipality	Private
Provision (% places)	Independent (99%) and Local authority (LA) (1%)	Public authority (crèche familiale) or independent (assistante maternelle)	Independent approved or not approved
Opening hours	8:00 a.m. to 6:00 p.m. or part-time. Except public holiday and 2 weeks summer holiday.	Negotiated between parents and child minder	..
Average attendance hours	..	..	..
Coverage	0-4 years: 12 %	0-2 years: 12.2%	0-2 years: 4%
Group size	3 children under the age of 5 including own children. 6 children, if 3 children are school age	Maximum 3 including own children	Maximum 3 children apart from own children
Staff ratio per children	1:3.7	1:3	..
Staff qualifications	No formal requirements. Training provided by LA or child minder may have a National Vocational Qualification in Child Care and Education (NVQ)	Compulsory training of minimum 60 hours during the first 5 years, of which 20 hours are during the first two years	Federal organisation of family day carers organised training
Financing	Clients	Crèche familiale: LA (35%), Département (7%) and regional family allowance funds (CAF) (22%), parents (34%) Assistant maternelle: parents	Income families may obtain subsidy from LA. Others: parental financing.
Formula of fees	Private arrangement between child minder and parents. Average payment £1.30 an hour.	Income related	In some municipalities: minimum and maximum payment of DM 250-950 per month
Tax relief	If family day carer is approved, an income related Working Parent FamiliesTax Credit covers some child care costs	AFEAMA: FR 800 if child under 3 and FR 400 if child is 3-6 years to cover social security contributions for the employed day carer	No
Inspection and regulation	LA register child minders	Local public authority	Local authorities approve the carers

Appendix

Nursery education

	Denmark	Sweden	Finland	The Netherlands
Scheme	*Børnehaveklasse*	*Deltidsgruppe/Förskoleklass (6-year-olds)*	*Peruskoulu*	*Basisschool*
Scope of application	Children aged 5-7 years	Children aged 4-6 years	6-year-olds	Children aged 4-6 years
Eligibility criteria	None	Mainly for families with one parent neither gainfully employed nor studying and for children in family day care.	None	None
Responsibility	Municipality	Municipality	Municipality	Local authorities
Provision, % of places	Municipal	Municipal, and private providers (12%)	Municipality: separate reception classes or combined with primary school	Public (32%), private (68%)
Opening hours	20 weekly hours, 5 hours per day, during school-term	30 weekly hours, 6 per day	25 weekly hours, 5 hours per day during school term	8:30-12 a.m. and 1:15-3:15 p.m., except wednesdays: 8:30-12.00 a.m., during term-time
Coverage in FTE places	0-6 years: 9%	0-6 years: 5%	0-6 years: 1%	0-4 years: 11%
Average attendance hours	5 hours per day	3 hours a day	19-21 weekly hours or 12-21 hours	Minimum 4.4 and maximum 5.5 per day
Group size	Maximum class size 28 children. Average 18.9 children	20 children	No legislation on maximum number of children	22-40 children. Average: 22 children
Staff qualifications	Kindergarten teacher	Mainly pre-school teacher and child care assistants	Kindergarten teacher or primary school teacher	Primary teacher: 4 year post-18 education
Staff ratio (FTE staff members per children)	1: 10.4	1:18	No legislation	1:22 or more
Financing	Public	Deltidsgrupper: public and parents Förskoleklass: public	Public	Public
Fees	No fees	According to income and attendance, but mainly waived for children aged 6	According to income, family size and attendance	No fees, but for day care during lunch break NLG 1-3 a day
Regulation	Municipal board	National Agency for Education	Local authorities	Education inspectorate

(to be continued)

(**Nursery education** - coninued)

	England	France	Germany
Scheme	*Nursery school* *Nursery class* *Reception class*	École Maternelle	No arrangement
Scope of application	2-4 years (Nursery school and classes) 4-5 years (Reception classes)	Children aged 2-5 years	
Eligibility criteria	Nursery school and classes: child's educational and phychological needs, catchment area, and siblings attending same school or class. Reception classes: Vary	Available classes for all 3-year-olds Increased number of classes for 2-year-olds	
Responsibility	Local Education Authority (LEA)	State, *Département* and local authorities	
Provision, % of places	Nursery school and class: LEA (45%), Independent (55%). Reception: LEA (89%), Independent (11%)	3-5 years (98%) 2 years (33%)	
Opening hours	Nursery school and class: Five days a week from 9.00-11.00 and 1.30-3.00. during term-time Reception: Five days a week 9.00-15.30 during term-time	8:30 a.m. to 4:30 p.m. on weekdays except for Wednesdays (only mornings)	
Coverage in FTE places, % 0-4 year olds	Nursery schools: 1% Nursery class: 5% Reception: 12%	98% of the age group 3-6 years. 10% of the 2-year-olds.	
Average attendance hours	Nursery school: 30% attend full-time Nursery class: 10% full-timers	..	
Group size	Nursery school: 27 children in public and 17 in private Nursery classes: 26 children Reception: 26 children in public and 17 in private	Average size is 27	
Staff qualifications	Qualified teacher and qualified nursery assistant	Teacher (5 year higher education) and assistant with some training	
Staff ratio (FTE staff member per children)	Nursery schools: 1: 16.03 children Reception: 1: 20-30 children	1:27 (2:27)	
Financing	Central and local government	Central and local government	
Fees	LEA provision: Only for meals. Independent reception-classes: £400-800 a term	No fees	

(to be continued)

(**Nursery education** – continued)

	England	France	Germany
Daily administration	Governing body including parents in nursery classes		
Regulation	OFSTED under the Department of Education and Employment. Registered Nursery Inspectors inspect private and voluntary providers	The Ministry of Education	

Home help for older people

	Denmark	Sweden	Finland	The Netherlands
Scope of application	All citizens	All citizens	All citizens	All citizens
Eligibility criteria	Old persons, need-based	Old persons, need-based	Old persons, need-based	Old people, need-based
Assessment	Nurse, home help or home help manager assesses need	Home help supervisor	Leading home helper	Regional assessment teams (insurers, representative of the older people and GP)
Coverage, % 65+	24%	17%	12%	9.5%
Provision	Mainly municipality, some provider-purchasing split with use of for-profit providers	Municipality (96%) Contract with public or private providers, mainly on housekeeping (3%)	Municipal (90%) and for-profit and voluntary non-profit org. provision (10%)	Mainly from non-profit home help organisations, some for-profit
Content of services	Housekeeping and personal care. Priority to personal care	Housekeeping and personal care. Priority to personal care	Housekeeping and personal care. Priority to personal care	Housekeeping and personal care. Priority to personal care. Help strictly divided into specialised care and domestic care
Standards for staff	21 FTE staff members per 100 recipients (1992). 48% of staff have received 1 year of training	12 FTE staff members per 100 recipients (1989) with basic school education, nurse aides or nurses attendants training	16 FTE staff members per 100 recipients (1996) mainly with 3 months of training	28 FTE staff members per 100 recipients (1995), mainly without formal qualifications. Staff divided according to tasks
Average weekly hours	5 hours (1996)	6 hours (1996)	1.5 hours (1990)	3.8 hours (1994)
Financing	Municipality	Municipality (93), clients (6%), state (1%)	Municipality (58%), state (28%), clients (14%)	AWBZ insurance (90%) and user fees (10%)
Formula of user fees	No fees for permanent provision of services	Based on number of hours and taxable income. Progressively increasing fee with income in most municipalities. Average fee SEK 500 monthly	According to household size and income and quality and quantity of services. No national maximum	Based on household income and composition. From NLG 5-250 weekly. Recipients of Alpha help service (domiciliary care) pay NLG 14.60 per hour
Regulation	Municipal board	Municipality	Local social welfare board	Home help associations
Daily administration	Manager of the home help scheme	Home help supervisor or care manager	Leading home helper	Staff members of home help association

(to be continued)

(**Home help for older people** – continued)

	England	France	Germany
Scope of application	All citizens	Means-tested	Means tested and contribution based
Eligibility criteria	Older people with need for care, subject to means-testing	Older people with need for care	Older people with need for care
Assessment	Local authority (LA): Social worker and GP, or hospital staff	Medico-social team: GP and social worker. National scale of decency with 6 categories	Medical advisory board of the Social Care Service Insurance Funds. Granted according to three levels of need
Coverage, % 65+	5.52%	Domiciliary care: 6.2%	Personal care: 3% Domiciliary care: 2%
Provision, % of providers	Public (77%) or contract with private for-profit services (19%) or voluntary organisations (4%)	Non-profit agencies or persons part of the employment scheme. Some public (CCAS)	Non-profit voluntary organisations and for-profit
Content of services	Personal and domestic care and support	Housework. Home nurses provide personal care	..
Average weekly hours	5 hours (1996)	2.88 (1992). Maximum 30 weekly hours for a single person	..
Number of staff	13 FTE staff members per 100 recipients, normally with limited training	No statutory requirements for training. Some internal training programmes	Home helpers with short training and educated community care nurses
Financing	LA (92%) and clients (8%)	Department or fees: PSD allowance is financed by the *département*	Statutory health insurance. 1.7 % of total income
Formula of user fees	Differs, some use flat-rate, others means-tested fees, and in few LA no fees are charged. Average weekly fee £24,70	Old person as employer: FF 50-60 per hour. Regular home help: FF 80 per hour	Non-eligible persons must pay
Regulation	LA inspects public care. No inspection of private providers who are not under contract with the LA	Approvement and inspection of organisations by the prefect of the *département*	Inspection by the welfare associations

Appendix

Institutional care for older people

	Denmark	Sweden*	Finland	The Netherlands
Scope of application	All citizens	All citizens	All citizens	All citizens
Eligibility criteria	Older people unable to manage on their own	Older people unable to manage on their own	Older people unable to manage on their own	Older people unable to manage on their own
Responsibility	Municipality	Municipality	Municipality	Municipality
Assessment	Municipal admission board in conjunction with GP, nurse, home help and family	Municipal home service unit	Working group of welfare and health care professionals and the director of old people's home	Regional assessment team
Coverage, % 65+	4.55% (67+)	8.23%	3.05%	Residential homes: 5.46% Nursing homes: 2.76%
Provision, % of places	Public (73%), and contract with private provider (27%)	Public (84%) and private (16%)	Public (81%), private non-profit (19%)	Nursing homes: non-profit organisations (95%), public (5%). Residential homes: non-profit housing corporations (40%), public (60%)
Standards	Staff ratio on average 1:1; in 1992, 131 FTE-staff members per 100 residents. 75% have own bath	In 1994, 125 FTE staff members per 100 residents. 75% of residents have room with own toilet and 40% with kitchen. 10% share rooms.	In 1996, 80 FTE staff members per 100 residents	Mainly single rooms in residential homes. In nursing homes 27% share rooms, 35 % with 2-3 people and 19% with 4 or more
Financing	Municipality (95%) from local taxation and block grants, and clients (5%)	State (2%), municipality (89%), client (9%)	State (26%), municipality (54%), client (20%)	Residential homes: public (61%), clients (39%). Nursing homes: public (4%), insurance (86%), clients (10%)
Formula of user fees	10% of estimated current expenses and 10% of individual income. 20% is paid if income is above DKK 139,099	Residential home: pensioner with basic pension pay 57% of gross income and a pensioner with occupational pension pay 36%	Progressive of income. The older person must have 20% left a month	Nursing homes: means-tested fee. Residential homes: means-tested fee. Must not exceed NLG 2,200 for an unmarried person and NLG 1,100 for a married person. Average fee: NLG 900 per month

(to be continued)

(**Institutional care for older people** – continued)

	Denmark	Sweden	Finland	The Netherlands
Daily administration	Manager of the nursing home and residents' council	Head nurse or director	Director of old people's home	..
Regulation and inspection	Municipality and residents' council	Municipality	Municipality	Provincial Home-for the Elderly Inspectorates and Health Care Inspectorate, org. by the insurance

* Special needs housing including sheltered housing.

(to be continued)

(**Institutional care for older people** – continued)

	England	France	Germany
Scope of application	All citizens	All citizens	All citizens, after means- and income-testing
Eligibility criteria	Local authority (LA) homes: older people unable to live in own home. Independent homes: ability to pay	Needs based	Needs-based: old persons assessed to be at Care level III
Responsibility	LA	*Département*	Social Care Insurance Funds
Assessment	LA homes: multi-disciplinary admission teams. Independent homes: only public assessment if resident applies for public support to cover fees	Medical-social board: GP and social worker	*Medizinischer Dienst* (assessors from the social care insurance fund)
Coverage, % 65+	Residential homes: 2.86% Nursing homes: 1.72%	Residential homes: 4.6% Nursing homes: 1.5%	Old age homes and nursing homes: 5%
Provision, % of places	Residential homes: private for-profit (63%), public (22%), and voluntary sector (15%) Nursing homes: mainly the independent sector	Nursing and residential homes: public (57%), non-profit associations (29%) and for-profit (14%)	Welfare associations (64%), for-profit (18%) and public 18%)
Standards	In 1995, FTE staff ratio 73 per 100 residents. Single rooms (75%) and double rooms (23%), 2% share a room with a non-relative	Residential homes, single rooms: 66% in public sector, 81% in private non-profit and 60% in for-profit sector	Single, double or triple rooms. Nursing homes: 40% in single rooms. Old age homes: 57% in single rooms (West Germany)
Financing	Independent nursing homes: clients 31%. Independent residential homes: clients 38%. LA residential homes: clients 29%	Private funding, may be supplemented by social assistance. Care is financed by care insurance	Insurance based and private funding (25 % by older person or family). Others pay privately
Formula of user fees	Client fees subsidized by Income support, funding from LA (means-tested and principle of liable relatives) or private financing. Average weekly costs in independent nursing homes £337, in residential homes £242	Up to 90% of old person's income	Residential homes: DM 3,200-4,600 per month in West Germany. Old age homes: DM 2,600 (per month) in West Germany
Regulation	Registration officers under the health authorities	Regional authority	Local authorities and welfare organisations

Main support schemes for informal carers

	Denmark	Sweden	Finland	The Netherlands
Benefit	Allowance for care in the home *(Plejevederlag)*	Leave of absence for informal care *(Närståendepenning)*	Informal carers' allowance *(Omaisloidon tuki)*	Career leave *(Loopbaanonderbreking)*
Scope of application	Employees	All citizens	All citizens	Employees
Recipient	Care giver	Care giver	Care giver	Care giver
Eligibility criteria	Persons caring for a terminally ill relative or friend, who must give consent to the care arrangement. Dependent on employer's acceptance	Persons caring for a terminally ill family member or friend, who must give consent to the care arrangement. A doctor must establish the need for care	Need for daily care and support	Employees who work for more than 12 hours a week, and who have been working for 1 year can receive a benefit during leave. The period of leave must be negotiated with the employer
Assessment	Municipal board	Home help supervisor or care manager	Health or welfare professionals	..
Length	Average period of receipt of benefit 10 weeks	60 days, or prolonged if taken as part-time leave	Contract with care giver	2-6 months
Amount	1.5 times the sickness benefit, DKK 4,032 weekly	Maximum sickness allowance, SEK 2,436 (1996), average benefit SEK 495	Average monthly allowance FIM 1,496 (1994). Variation between municipalities and according to the need of the older person	Maximum NLG 960
Other conditions/ entitlements	State employees maintain seniority and earn pension credits. Also paid during hospitalisation of care recipient. 12.5% of benefit paid after end of care arrangement until the care giver returns to employment, and full benefit paid for 14 days if care recipient dies	Compensation when older person is hospitalised	Some municipalities first suspend allowance after 7 days of hospitalisation of care recipient. Two days paid vacation a month. Pension credits	Disability and survivors' credits are mostly maintained. Some times right to pension credits. Position must be replaced by a recipient of a welfare allowance, a disabled or by women re-entering the labour market
Taxable	Treated as income	Treated as income	Treated as income	Treated as income with the exemption of social security premiums
Tax reductions	No	No	No	Available for the employer if a low-skilled replacement is hired
Financing	State	Health Insurance Scheme	Municipal home care budget	Unemployment Fund and government subsidies

(to be continued ...)

(**Main support schemes for informal carers** – continued)

	England	France	Germany
Benefit	Invalid Care Allowance	No statutory scheme	Pflegegeld
Scope of application	People in working age (16-65 years)	<>	All
Recipient	Care giver	<>	Care giver
Eligibility criteria	Care recipient must receive Attendance Allowance; carer must be 16-65 years; must earn less than £50 a week; not be in full-time education and must spend a minimum of 35 hours caring per week	<>	Non-professional carers. Minimum 14 hours caring per week. Maximum 30 hours on the labour market
Assessment	Municipal Benefit office	<>	Professional care provider every 6 month for level 1 need and 3 months for level 3 need
Length	No minimum nor maximum	<>	Depending on assessment of need
Amount	£37.35 weekly. Higher if carer has dependants and lower if other benefit is received. Carers on Income Support are awarded a means-tested Carers' Premium of £13.35 weekly.	<>	400 DM, 800 DM, 1,200 DM a month depending on assessment of need
Other conditions/ entitlements	Compensation is also paid during hospitalisation of care recipient and during vacation. Premium paid up to 8 weeks after the care arrangement has ceased	<>	Compensation is also paid during hospitalisation of care recipient and during vacation up to 4 weeks. Accident insurance paid by the municipality
Taxable	Treated as income	<>	No
Tax reductions	No	<>	No
Financing	Social insurance	<>	Social care insurance

Appendix

APPENDIX C

Methods of Comparability

Model families

To relate the level of cash benefits and user fees to income, these have been compared to average income for certain groups in the population. For six of the countries, the incomes of a family with two children, a pensioner and a pensioner couple have been calculated (H. Hansen, 1997; 1998) using the 'Average Production Worker' (APW) derived from the OECD's 'Tax/Benefit Position of Employees' concept. The APW is based on the assumption that the family wage consists of the total income of an average male industrial worker and his wife, who is working part-time. Likewise, a pensioner APW is based on the income of a male industrial worker, who has a former working period (Box 1). For the compensation rates of the parental leave schemes, gross wage is used as we do not have adequate information on the various tax rates.

Box 1.
APW model families, annual net income 1996.

	Family with 2 children[1)]	Single pensioner	Pensioner couple
Denmark	DKK 230,288	DKK 75,219	DKK 152,904
England	GBP 19,152	GBP 6,602	GBP 10,673
Finland	FIM 149,846	FIM 57,208	FIM 96,370
France	Gross income for single, male APW, 1996: FRF 121,000		
Germany	DEM 58,823	DEM 25,094	DEM 37,641
The Netherlands	NLG 56,888	NLG 16,293	NLG 23,368
Sweden	SEK 218,261	SEK 87,172	SEK 136,555

Source: Hansen, H. (1997) *Elements of Social Security in 6 European Countries*, Copenhagen: The Danish National Institute of Social Research. 97:8, and Hansen, H. (1998) *Elements of Social Security*, Copenhagen: The Danish National Institute of Social Research. 98:4.

[1)] Including family allowances.

Purchasing Power Parity rates

Furthermore, a Purchasing Power Parity (PPP) has been calculated for the data on expenditure in order to arrive at more comparable data. The PPP shows the

actual value of a currency in terms of purchasing power against a standardised basket of goods and services. It does not illustrate, however, how resources are divided in society. The PPP currency used in this report is the Danish PPP (Box 2).

Box 2.
Purchasing Power Parities for GDP per DKK (Danish kroner), 1982 and 1996.

	1982	1996
Denmark	1	1
Sweden	0.808	1.145
Finland	0.597	0.691
The Netherlands	0.302	0.24
Germany	0.267	0.237
France	0.68	0.763
United Kingdom	0.06	0.078

Source: OECD (1998) National accounts – main aggregates, Vol. 1. OECD, Paris.

Conversion from part- to full-time day care

Provision of day care is often difficult to compare because of the inherent structural differences in opening hours. Day care within the social system is often full-time provided year round, whereas day care within the education system tends to be part-time and during the school year only. Measuring the coverage rate for day care as the number of children attending therefore gives a wrong indication of the actual provision. In this report it has been attempted to convert provision into full-time places, based on national experts' advice and on official documents. This is undoubtedly a procedure where some details are lost. The number of hours are often estimations only, and the calculations into full-time coverage rates may suffer from this. A full-time place has been estimated to be 30 weekly hours and above. In Appendix A, the absolute number of children enrolled is included for each country. For the conversion, the following rates have been used (Box 3):

Appendix

Box 3.
Conversion for day care into full-time equivalents (FTE).

		Weekly opening hours*	FTE conversion factor
Denmark	Vuggestue	50-55	1
	Børnehave	50-55	1
	Familiedagpleje	50-55	1
	Børnehaveklasse	20	0.67
England	Day nursery	50	0.77
	Playgroup	30	0.55
	Family day care	50	1
	Nursery school	25	0.83 (part-timers: 0.42)
	Nursery class	25	0.83 (part-timers: 0.42)
	Reception class	32.5	1 (part-timers: 0.50)
Finland	Day care centre	..	1 (part-timers: 0.50)
	Family day care	..	1 (part-timers: 0.50)
	Playground activities	..	0.2
France	Creche	50	1
	Halte-garderie	10	0.33
	Jardin d'enfant	50	1
	Assistante maternelle	50	1
	École maternelle	26	0.87
Germany	Krippe	..	1 (part-timers: 0.50)
	Kindergarten	..	1 (part-timers: 0.50)
The Netherlands	Day care centre	55	0.60
	Part-time day care centre	27.5	0.30
	Workplace day care centre	..	0.60
	Playgroup	6-12	0.40
	Family day care	..	0.80
	Nursery education	22	0.55
Sweden	Daghem	50-55	1
	Familjedaghem	30-45	1
	Deltidsgrupper	30	0.50

* Children may only attend part of the time.