



**New European Member States and
the dependent elderly
by
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Abstract

The ten new Member States who joined the European Union in May 2004 have increased the population of EU-15 by 20% and they together account for almost 16.4% of the total EU-25 population. The current ageing of the population of EU-15 has highlighted other challenges besides the well-known problems of financing pension and health systems. It has also highlighted the risk of dependency. Given the emergence of this new risk, one may wonder about the situation of the aforementioned new members. The present study shows that they do not appear to face the problem of elderly dependency on the same scale as the countries of EU-15, although in the coming decades it is likely they will have to contend with it to a much greater degree. The study also indicates that provision for dependent elderly care in the ten countries does not seem to be fully established as yet. However, Malta and Slovenia, countries which will have a considerable proportion of oldest people among their populations in the near future, are distinguishable from the others in that they appear better prepared in terms of dependent elderly care. Although Poland is considered to be far from prosperous as regards economic and social development, in terms of ageing – particularly provision for the dependent elderly- it appears better placed than most of the other new Member States, who appear to be less generous as regards assistance provided to the dependent elderly. The three Baltic states are distinguishable from the others in that the share of GDP allocated to this category is lowest, even though they are expected to have the oldest population in the coming decades.

Key words: ageing, dependent elderly, new Member States, welfare system.

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1. Introduction

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

As the EU-15 confronts one of the major ageing-related problems, namely, the emergence of dependency risk, one can wonder as to the demographic evolution of the ten new Member States in the years to come. One characteristic of relatively poor countries which have experienced considerable growth is the improvement of the health of the population, at least when said growth is invested by the authorities in the social and health sectors (Sen, 1999). Growth allows a better coverage of health. In transition countries, growth has effectively provided the means to introduce social health insurance and increase private financing. Consequently, spending on health in these countries increased at the beginning of the nineties (Busse and Reinhard, 2002).

Moreover, health improvement is generally accompanied by an increase in life expectancy, i.e. ageing of the population. Among the ten new members, in the Czech Republic the percentage of GDP spent on sickness/health care rose from 6.3% in 1995 to 7% in 2002, while life expectancy at age 65 increased by at least one year during the same period both for men and women (from 12.7 to 14 for men and from 16 to 17.4 for women). However, as western countries well know, population ageing is not without repercussions on the economy. The resulting imbalance between the proportion of elderly people and the proportion

¹ Data from Eurostat online data base.

of the working population entails problems for pension financing. In EU-15 the elderly dependency ratio - the ratio of the total number of elderly persons of an age when they are generally economically inactive (65+) and the number of people of working age (from 15 to 64) - has increased from 23 to 25.9 between 1995 and 2005. Population ageing implies also an increase in the proportion of elderly who need assistance to carry out daily life activities. In France for instance, according to a mainstream hypothesis, the number of dependent elderly is expected to rise by 25% between 2000 and 2020 (Bontout et Al., 2002). Because of changing family structures and the growing proportion of working women, the number of potential care providers has already fallen and is expected to continue to do so.

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

Section 2 looks at the demographic challenges which the systems face at present and will face in future. Specifically, it highlights the loss of self-sufficiency on the part of the elderly which will be a major characteristic of the future scenario and assesses whether new EU Member States need to anticipate this social risk. Section 3, on institutional provision for elderly dependency, describes public provision and the conditions governing public interventions.

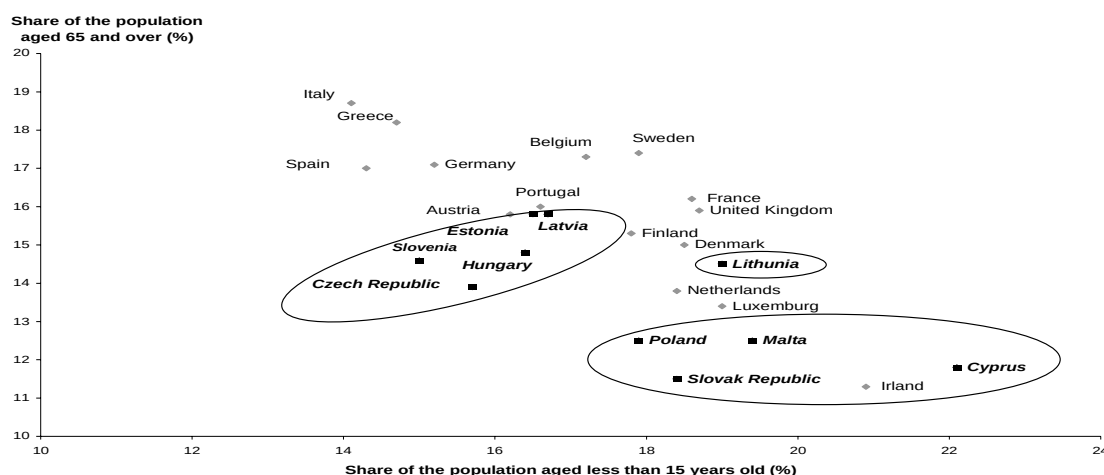
The availability of informal and formal help is discussed in Section 4. Finally, Section 5 offers some concluding remarks

2. Population ageing

2.1. Demographic developments

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

- Firstly, the group with the youngest population, which comprises Cyprus, Malta, Poland and the Slovak Republic. Here, young people represent a large proportion of the population (over 18%), while the proportion of older people is lower than in the other countries (less than 13%). This group is quite similar to Ireland in terms of ageing.
- Secondly, the group with the oldest populations among the ten: Latvia, Estonia, Slovenia, Hungary and the Czech Republic. The proportion of young people is below 16.6% while that of the 65+ category exceeds 14%. In terms of ageing the characteristics of these five countries are similar to Austria or Portugal.
- Thirdly and lastly, Lithuania appears somewhat isolated from the other new Member States, given that its proportion of young people is above 18% and the elderly represent more than 13% of the population. Among the EU-15, Lithuania's ageing characteristics resemble those of Denmark and the Netherlands.

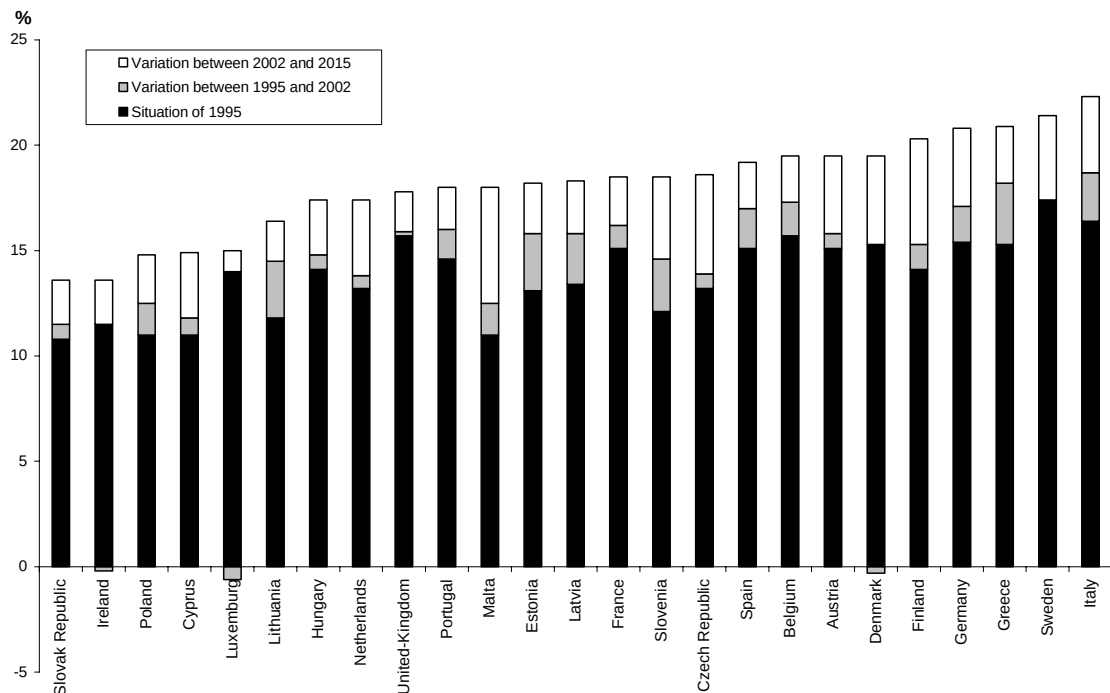
Figure 1: Demographic situation of European countries in 2002

Source: United Nations Development Program (2004).

Although the ten new Member States appear to be younger than the EU-15 countries, like the latter their populations have already aged and will continue to do so in the coming years (Figure 2). UNDP figures show that since 1995 the proportion of elderly has increased and will continue to rise for each country until 2015.

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

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

Figure 2: Evolution of the share of elderly people (65 and over) between 1995 and 2015

Sources: United Nations Development Program (2004) for 2002 data and projections for 2015. European Commission for 1995 data.

Other UN projections estimate the distribution of world population by age for the longer-term future. The median age - which divides the population into two equal parts - gives some indication of population ageing. In 2050, the median age of the population is expected to increase in much of the world. However, whereas in 2005 only three central European countries are listed among the twenty oldest nations, six are likely to figure in the classification in 2050 (Table 1).

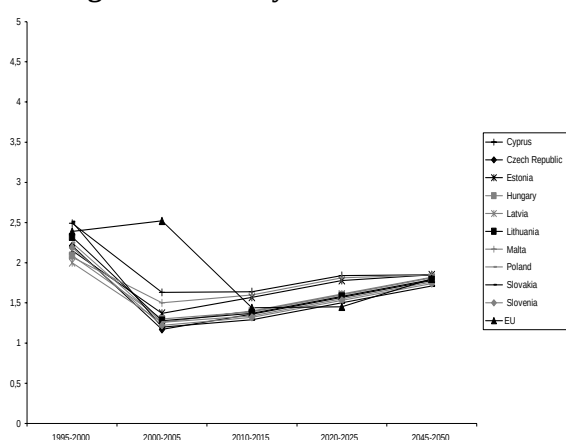
Table 1: Countries from Europe ranked in the twenty oldest countries in the world, 2005 and 2050.

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

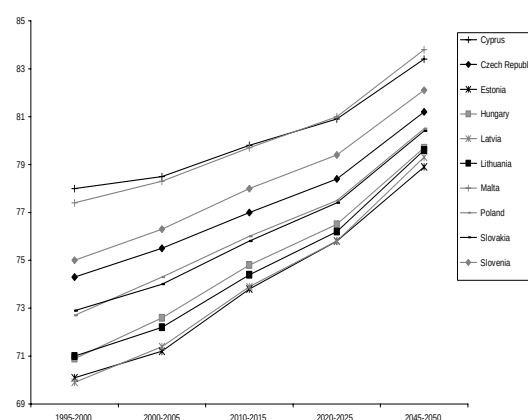
Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2005).

Hypothesis retained for projections are the median variant with moderate recovery of fertility.

According to demographic indicators, the new Member States are also confronted by the problem of population ageing. Although their populations are currently younger than those of EU-15, the magnitude and pace of their evolution should eventually result in an ageing exceeding that of EU-15. As in other countries, in the ten new members ageing is the product of the cumulative effects of a lower fertility rate up to 2005 and the very slight increase in the rate anticipated after 2005 (Figure 3), together with a constant increase in life expectancy up to 2050, which is to a large extent attributable to improved health conditions and public health (Figure 4).

Figure 3: Fertility rate: 1950-2050.

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2005).

Figure 4: Life expectancy at birth: 1950-2050.

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2005).

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

Overall since 1980, net migration rates have decreased in 5 of the 8 countries of Central Europe. Table 2 shows a positive net migration rate for the Czech Republic and Slovenia only. In these two countries, inflows are positive due particularly to the population influx from countries in transition. Between 1990 and 1999, for example, 84% of inflows to the Czech Republic were from the other countries in transition.

Migration has a significant impact on the population trends in these countries. During the 1990s, the Czech Republic gained 44,000 migrants although its population declined by 30,000.

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

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

Table 2: Net international migration in the 8 transition economy countries which joined the EU in May 2004

Country	Net migration rate	
	1990-1995	1995- 1998
Czech Republic	0.6	0.7
Estonia	-7.4	-2.5
Hungary	-0.6	-0.0
Latvia	-10.0	-4.7
Lithuania	-3.9	-1.1
Poland	-2.0	-0.9
Slovakia	0.0	0.0
Slovenia	0.1	0.3

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2002).

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

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

Table 3: Countries from Central Europe ranked by ascending order of dependency rate among the EU-25 countries, 2005 and 2050.

2005			2050		
Rank	Country	Median age	Rank	Country	Median age
12	Latvia	2,16	3	Slovenia	0,28
15	Lithuania	2,30	4	Czech Republic	0,31
17	Estonia	2,48	8	Slovakia	0,44
18	Hungary	2,50	9	Poland	0,46
19	Slovenia	2,64	11	Latvia	0,49
20	Malta	2,75	12	Hungary	0,49
21	Cyprus	2,94	13	Malta	0,51
22	Czech Republic	2,95	16	Lithuania	0,56
23	Poland	3,28	20	Estonia	0,70
25	Slovakia	3,53	24	Cyprus	0,97

Source: data from UN online database.

Hypothesis retained for projections are the median variant with moderate recovery of fertility.

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

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

2.2. Dependency status

Little information is available on the dependency status of the elderly. WHO and national statistics services provide some pointers as to the proportion of disabled persons, but the data do not allow comparison between countries. The reference years are not the same, for example: the data for Cyprus are from 1992 and for Lithuania from 2001. The underlying definitions are also very different and thus result in very disparate figures as regards the proportion of dependent persons. While the proportion of Cypriots aged 60 and over with a disability is put at approximately 12%, the figure for Hungary is almost 36% (Table 4).

Lastly, not all definitions correspond to the exact definition of dependency, which includes any intervention by another person for the performance of daily activities.

Table 4: Share of disabled persons by country

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

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

In view of the shortage of precise data concerning the dependent status of the elderly population, the proportion of persons aged 80+ appears a more appropriate approach to help identify the number of dependent elderly. The prevalence of dependency increases greatly with age and with a growth between 80-85 years, at least in countries from Western Europe.

Figure 5 presents, for 2005 and 2050, the proportion of persons aged 80 and over plotted against that of the over 65s, according to the proportion of the latter group in the population overall. Plotting in this way allows us to avoid effects of ageing due essentially to a fall in the birth rate by observing only the age structure of the elderly population. The first result to be noted is the lower proportion of oldest persons in the new Member States compared to the other European Union countries, both for 2005 as well as for 2050. However, the new Member States will see an increase in their oldest populations. In all cases, the

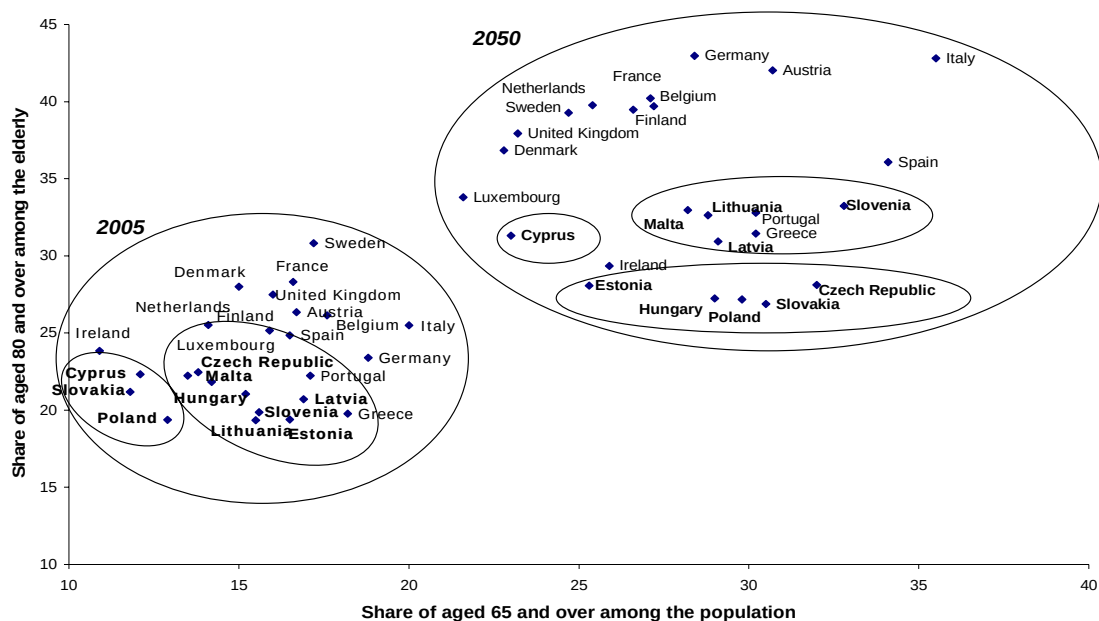
share of this category among the over 65s is forecast to be between 26% and 33% in 2050, compared to 19% and 22% in 2005.

In the case of 2005, two groups of countries can be distinguished.

The first comprises Cyprus, Slovakia and Poland, where the share of oldest people is similar to the other countries, but the share of elderly among the population as a whole is somewhat lower. The other countries' share of oldest people is similar to this first group, but they have a higher proportion of over 65s. Thus, in 2005 the difference in terms of ageing between the new members depends not so much on the oldest but on the youngest segment within the elderly category. In 2050, the ten countries will be distinguishable on the basis of the proportion of the oldest segment, with three distinct groups:

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

Figure 5: Share of persons aged 80 and over among the population aged 65 and over according to the share of 65 and over among the population as a whole



Sources :UN Projections.

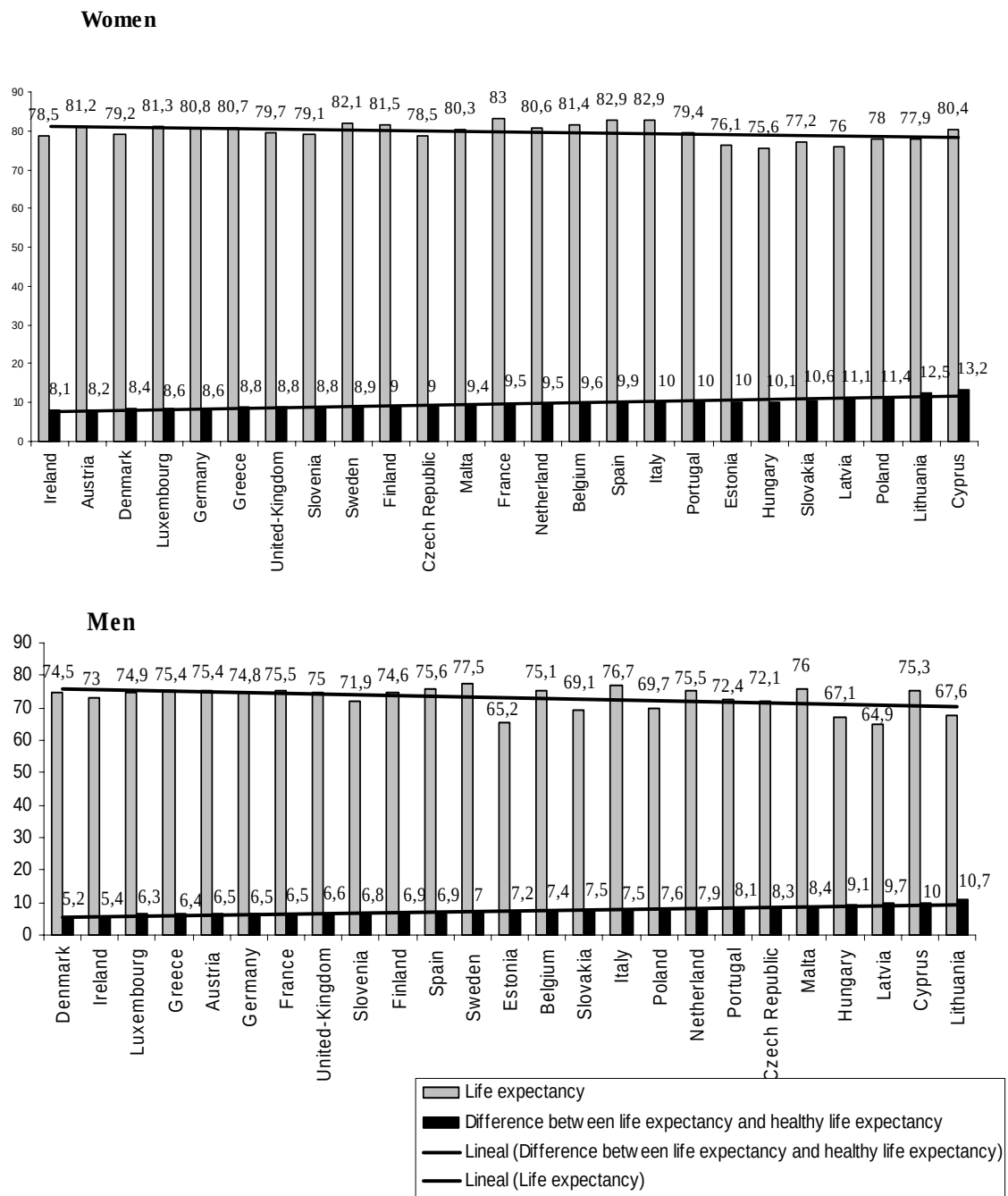
Hypothesis retained for projections are the median variant with moderate recovery of fertility.

Therefore, although as was seen in the previous section the populations of new Member States will experience more extensive ageing than the overall European Union population in 2050, this should not affect the share of oldest people to the same extent that it affects the share of elderly among the population overall. In other words, the proportion of oldest persons is not expected to increase as heavily as that of the elderly among the population as a whole.

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

Another point to be noted from Figure 6 is the relation between life expectancy at birth and healthy life expectancy for European countries. In the case of both men and women, the lower the life expectancy is, the longer the life expectancy with bad health is. The age of prevalence of dependency appears slightly lower in central European countries, although the elderly in these countries are likely to require help for a longer period of time.

Figure 6: Life expectancy at birth and difference between life expectancy at birth and health life expectancy



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

Finally, although the new members are not as old yet as their counterparts from western and northern Europe, they are expected to age more quickly. Notwithstanding the lack of data on the proportion of elderly who have lost their self-sufficiency, and even though their life expectancy is lower than the EU-15 countries, the data from UNECE show that the end-of-life period in poor health is longer in the new members. The recent setting up of health insurance systems should be accompanied in decades to come by an improvement in the health status of the population and, consequently, by an increase in life expectancy and

a higher proportion of elderly people who lose their self-sufficiency. Therefore, although new Member States are not yet confronted to the same degree as EU-15 countries by the problem of elderly dependency, they can be expected to experience a similar problem in the coming decades. However, this situation prevails only if the elements taken into account are assumed to remain constant. Let us imagine, for example, that citizens from central Europe decide to retire in Cyprus or Malta. The situation would be reversed for the central European countries and would worsen in Malta and Cyprus.

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

3. Institutional provision

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

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

In central and eastern European countries, the moves towards decentralization of welfare systems that followed the fall of the Soviet Union have led to regional organization of long term care in the majority of cases. However, whereas long-term care is organized at regional level in Estonia and Poland, it is jointly insured by the State and the regions or by local government in the Czech Republic, Latvia, Lithuania, Hungary and Slovenia. Among

countries of central Europe, only Slovakia centralizes at State level its long-term care services. Lastly, in Cyprus and Malta long term care is organized at State level.

Given that in the majority of the ten countries long term care provision is covered by legislation for other contingencies, it is difficult to obtain data concerning precise expenditure on the dependent elderly. However, in its online database Eurostat offers details of social protection expenditure on the aged. As can be seen in Table 5, the GDP share of social security benefit allocated to the elderly is lower in the new Member States than elsewhere in Europe. Only Slovenia and Malta's spending on social benefits for the elderly is close to the average spent, in GDP terms, by European countries (1% and 0.9% respectively, compared to 0.9%, in 2001)². The three Baltic states spent a very low share of GDP on social benefits for the elderly (0.3 % or less). Other countries allocated between 0.6 % and 0.7 % of GDP to paying for social benefits for the elderly.

Table 5: GDP share of social security benefits allocated to the ageing (excluding pensions) (2001)

	% GDP
EU 25	0.9 ^{e3}
EU 15	0.9 ^e
Czech Republic	0.6 ^p
Estonia	0.2 ^p
Latvia	0.3 ^p
Lithuania	0.2 ^p
Hungary	0.7
Malta	0.9
Poland	0.7 ^p
Slovenia	1
Slovakia	0.6

(^p) Temporary value

(^e) Estimated value

Data for Cyprus missing

Sources: Eurostat.

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

³ Social security benefits dedicated by EU-15 equal those dedicated by EU-25, even though the percentages for the ten new members states are substantially lower, generally-speaking, than for the 15. This indicates only that the global GDP of the 10 new Member States represents a very low proportion of the global GDP of the EU-25. Indeed, the volume index of GDP per capita in Purchasing Power Standards (PPS), expressed in relation to EU-25, is 110.2 for the EU-15 and below 90 for the ten new Member States (Czech Republic 65.5; Estonia 44.4; Cyprus 88.5; Latvia 37.1; Lithuania 40.5; Hungary 55.9; Malta 72.9; Poland 45.4; Slovenia 74.6 and Slovakia 48.5).

3.1. Types of institutional provision

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

As in most EU-15 countries, services for persons living at home vary. Basic services relate to assistance for daily life activities, such as home help, meals on wheels and incontinence care. Day centers have been created to provide care during the day for such elderly persons. Other more specific services –e.g. support centers providing vocational training- have also been established (Estonia, Latvia).

The most widespread service is help in the home for dressing, personal hygiene, or doctor's visits. Providers of such care also look after housework and, for example, monitoring. The Czech Republic, Hungary, Malta and Slovenia allocate the largest share of their GDP to daily life assistance (0.1 %) (Table 6). Their expenditure on these social security benefits is close to that estimated for European countries overall. Except for Cyprus, help with daily life activities is often the responsibility of local government or municipalities.

Table 6: GDP share of social security benefits allocated to assisting elderly daily life activities (2001)

	% GDP
EU 25	0.1 ^{e4}
EU 15	0.1 ^e
Czech Republic	0.1 ^p
Estonia	0.0 ^p
Latvia	0.0 ^p
Lithuania	0.0 ^p
Hungary	0.1
Malta	0.1
Slovenia	0.0
Slovakia	0.1

^(p)Temporary value

^(e)Estimated value

Data for Cyprus and Poland missing

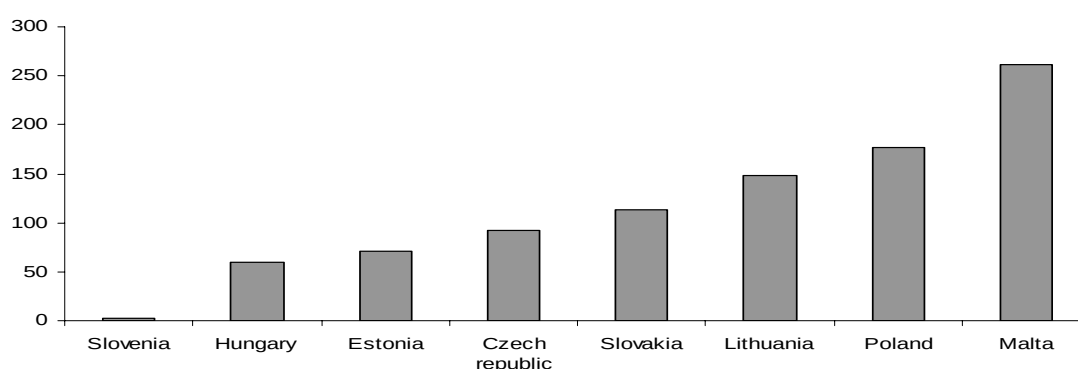
Sources: Eurostat.

Residential homes are generally organized at local level, although provision also exists in the form of non-governmental organizations in Lithuania

⁴ The very low proportion of the EU-25's global GDP which is represented by the global GDP of the 10 new Member States explains the minimal impact of these ten countries' share of social security benefits allocated to assisting elderly daily life activities in the GDP share of EU-25.

for instance. Institutions caring for the dependent elderly can be of various types: rest homes, old people's homes, long term care institutions, specialized institutions, geriatric units in hospital. In Malta the number of long term care beds is proportionally higher than in the other countries (over 200 per 100,000 inhabitants) (Figure 7). The figure for Poland and Lithuania is lower than for Malta but higher than the other countries (100-200 per 100,000 inhabitants). Slovenia is distinguishable by the extremely low number of long term care beds (less than 5/100,000).

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



Missing Cyprus and Latvia.

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

The proportion of elderly people in institutional care appears lower than in Western Europe. The proportion of elderly aged 65+ in institutions does not exceed 3.6%, compared to an average of 4.8% in OECD countries (2000) (Table7).

Table 7: Proportion of elderly living in institutions

	65 and over	80 and over
Cyprus	3.6	11.4
Estonia⁽¹⁾	5	8
Latvia		2.5
Lithuania	1	2
Slovenia	3	10

⁽¹⁾ Share of elderly in institutions among disabled elderly.

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

Other services provided to the elderly include home improvements, technical assistance, help with heating or rent, among others. Social security benefits granted for housing are on a par, in GDP terms, with the figure

allocated by countries from Western Europe to housing assistance for their elderly (Table 8). Countries from EU-15, like the EU-25, spend 0.2% of GDP on housing benefits for the aged. Malta, with 0.4% of GDP, and the Czech Republic and Latvia (0.3%), exceed the European average. Hungary and Slovakia's spending is similar to that of European countries as a whole, while Estonia, Lithuania and Slovenia devote just 0.1% of GDP to housing assistance for the elderly.

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

	% GDP
EU 25	0.2 ^{e5}
EU 15	0.2 ^e
Czech Republic	0.3 ^p
Estonia	0.1 ^p
Latvia	0.3 ^p
Lithuania	0.1 ^p
Hungary	0.2
Malta	0.4
Slovenia	0.1
Slovakia	0.2

^(p)Temporary value,

^(e)Estimated value,

Data for Cyprus and Poland missing.

Sources: Eurostat.

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

3.2. Form of allocation

Form of help provided

Institutional help can be allocated in the form of benefits in kind or in cash. In the case of home care services, the help can take the form of a range of services made available to the elderly and which are often rendered by communities. Public authorities employ home nurses to look after domestic maintenance and to provide personal care for the beneficiary, for instance.

⁵The very low proportion of EU-25 global GDP represented by the GDP of the 10 new Member States explains the low impact of the ten countries' share of social security benefits allocated to housing for the elderly on the GDP of EU-25.

However, dependent elderly persons can also access these services through cash allowances designed to pay someone to provide care to the needy elderly. As regards residential care, help in kind is characterized by the setting up of care institutions where the accommodation is subsidized by the authorities. Where help is given in cash to elderly persons living in an institution, the authorities pay a monthly allocation to cover costs. Data from Eurostat's online database enable us to distinguish benefit in cash from benefit in kind allocated by each country to the aged. On the whole, benefits in cash are less widespread than benefits in kind (Table 9). This can be explained by the fact that assistance for daily life activities, in the majority of the ten countries, is provided through social assistance, which tends to take the form of community services.

Table 9 : Share of benefits allocated to the aged in cash and in kind (2001)

	% benefits in kind	% benefits in cash
EU 25	44	56
EU 15	44	56
Czech Republic	83	17
Estonia	100	0
Latvia	100	0
Lithuania	100	0
Hungary	71	29
Malta	56	44
Slovenia	10	90
Slovakia	67	33

Data for Cyprus and Poland missing.

Source: Eurostat's online data

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

Elderly participation

In most cases contributions by the elderly are a feature of dependency benefits, with means-testing a commonly-used approach. Even though benefits are already awarded on the basis of income, the beneficiaries tend to have to contribute. Beneficiaries of services in kind -such as technical help, home care, day centres or meals on wheels- pay a sum proportional to their income in Hungary, Slovenia and Slovakia, although some variants exist. In Slovenia services are free of charge for those whose only source of income are their social benefits. In Poland, elderly persons with an income below 96 € per month are

exempted from making a contribution. In some cases, a ceiling on the amount of participation is set (Missoc, 2005). In Lithuania, for example, a beneficiary cannot contribute more than 50% of his/her income, pensions for the most part, to the cost of a day centre. In Estonia, participation in the cost of technical assistance can vary from 10 to 50% of income.

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

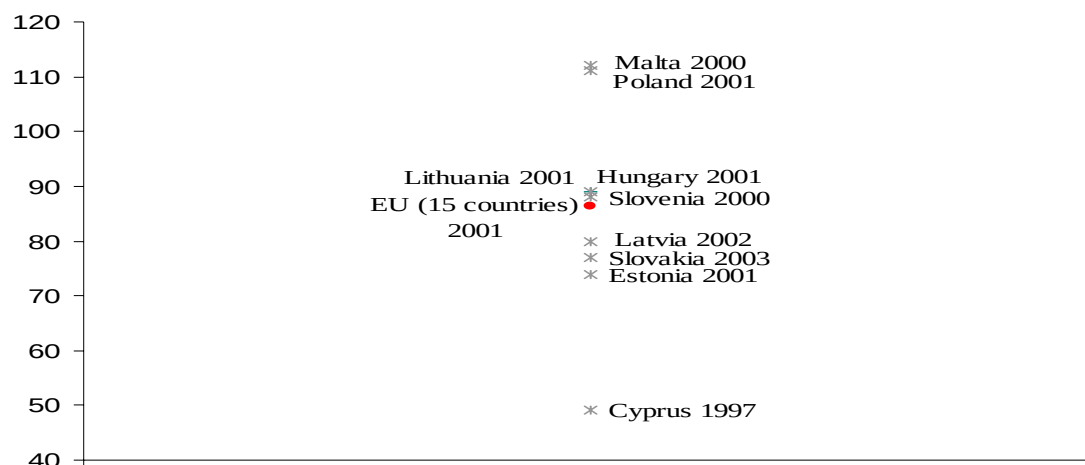
Elderly persons living in institutions must pay accommodation and cutlery costs in Estonia. In the other countries participation in residential institution costs is means-tested. However, some countries have set up a maximum contribution threshold for those receiving social assistance. In Cyprus the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

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

Along with their counterparts in Poland, elderly people in Malta are the only ones to have an income higher than that of the under-65 population in their country (Table 9). The elderly in Latvia, Slovakia, Estonia and Cyprus appear to have a considerably lower level of income than the rest of population.

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

Figure 8: Relative ratio of median incomes between persons aged 65 and over and those below 65



Ratio for Czech Republic not given.

Source: Eurostat database

4. Availability of care providers

4.1. Informal care providers

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

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

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

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

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

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

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

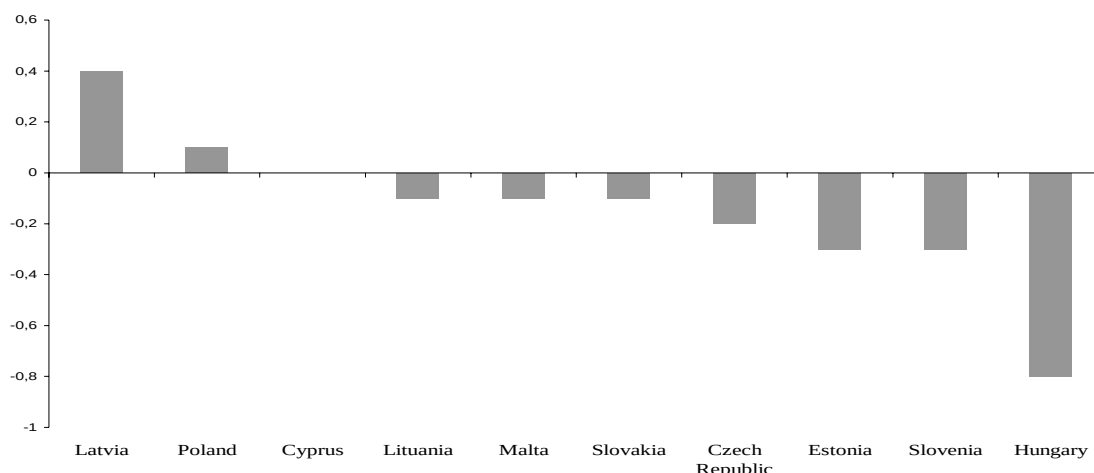
Table 11: Average number of persons per household (2003)

	Average number
Czech Republic	2.5
Estonia	2.6
Hungary	2.6
Slovenia	2.6
Latvia	2.8
Lithuania	2.9
Cyprus	3.0
Malta	3.0
Poland	3.1
Slovakia	3.1
UE 25	2.4 ^{(e) 6}
UE 15	2.4 ^(e)

^(e) Estimate

Sources: Eurostat.

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

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

Sources: Eurostat.

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

In tandem with changes in family structures, the increase in the numbers of women in employment also contributes to the drop in the number of potential providers of care to the dependent elderly. Among the ten new countries, only in Poland, the Czech Republic and Lithuania did the proportion of women in

⁶ The low proportion of the new Member States' population in the Europe of 25 (16.4 %) explains the low impact of these ten countries on the average number of persons per household in the latter.

employment decrease between 1999 and 2003, albeit on a much smaller scale (-1.7 points for Poland and -0.4 points for Czech Republic and Lithuania) (Table 12). The proportion increased by less than 1 point in Slovenia, Malta and Slovenia, more than 2 points in the other countries, and by as much as 12 points in Cyprus.

Table 12: Proportion of women in employment

	1999	2003
Czech Republic	54.30	53.90
Estonia	55.50	56.40
Hungary	43.00	45.10
Slovenia	53.60	53.70
Latvia	52.60	54.50
Lithuania	58.50	58.10
Cyprus	44.80	56.50
Malta	24.90*	25.40
Poland	53.20	51.50
Slovakia	54.30	56.80
EU 10 new Member States	51.70*	51.80
EU 15	48.30*	48.80
EU 25	48.80* ⁷	49.30

*data from 2002.

Source: Eurostat

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

4.2. Formal care providers

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

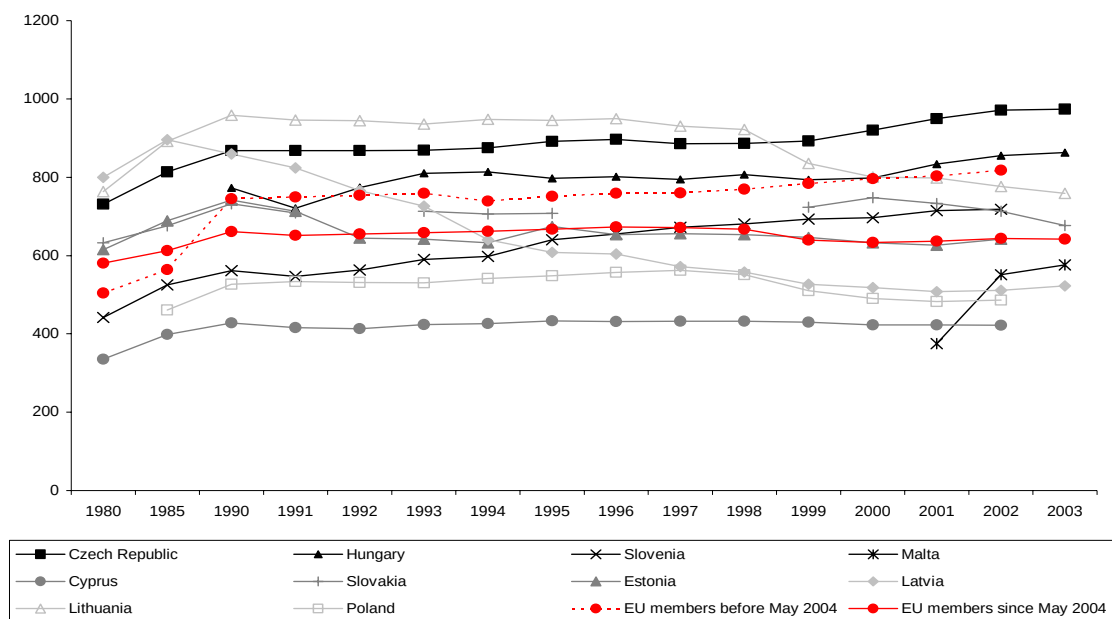
⁷ The low share of the new Member States' population in the Europe of 25 (16.4 %) explains the low impact of these ten countries on the female employment rate in the latter.

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

In some countries, governments have made efforts to enhance the attractiveness of the profession. In Hungary, the level of education of nurses has been raised to post-secondary, for instance. In Malta, Estonia and Slovakia nurse training has been developed.

Figure 10 shows that in the Czech Republic, Hungary, Slovenia and Malta, the number of nurses per 10,000 inhabitants has increased in recent years. In Cyprus, Slovenia and Estonia it has remained stable, whereas it has fallen in Latvia, Lithuania and Poland. For the most part, the poor wages on offer explain the low number of nurses in these countries.

Figure 10: Number of nurses per 10,000 inhabitants



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

5. Concluding remarks

Given the emergence of a new risk of dependency in EU-15 countries and its consequences on the sustainability of welfare systems, it was considered important to examine the situation of the ten new Member States with respect to loss of self sufficiency and the role currently played by the State in addressing said loss. We felt it important to identify, in terms of demographic evolution, the extent to which these countries will face a similar risk and, if so, whether their welfare systems are equipped to respond accordingly.

As the first part shows, the new Member States are not confronted yet by the problem of elderly dependency on the same scale as countries from EU-15. However, according to UN projections, the dependency rate between generations is expected to be lower in the new Member States than in the rest of Europe over the next five decades and potential family support is expected to decrease also in most of the ten countries. Hence the new members would be faced with the problem, on an even greater scale.

From the data presented in the second and third sections, provision for caring for elderly persons who lose their self-sufficiency does not appear fully established in the ten countries as yet. The data are imperfect of course, particularly due to the lack of availability, but at least they give an outline of the current situation regarding help for aged persons who lose their self-sufficiency. The lack of available data is indicative of the weakness of institutional provision for such care.

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

allocated to the dependent elderly is low despite the fact that they are expected to be among the oldest countries in the coming decades.

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

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