

Criteria for Care: Assessing Eligibility for Long-Term Care Services in Europe

Diana Robbins, July 2008



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1. Introduction – the Data

- 1 This paper summarises the results of a very rapid review of selected literature relating to frameworks for establishing eligibility for long-term care services in other EU countries. The purpose is to help to illuminate the current British debate about eligibility for social care by reference to international and comparative data. In the time available, it has seemed sensible to focus on 'old' EU members, many of whom are working with contexts and issues similar to those currently experienced in England and Wales. Some information about the experience of Japan is also included, since this country offers an interesting case study of a rather 'traditional' society which responded to growing need by setting up an insurance-based system from scratch in 2000.
- 2 Relevant material was found, firstly, by reference to the Social Care Institute for Excellence (SCIE) initial search, completed in April 2008. Since standard database searching produced relatively little, the scope has been supplemented by hand-searching relevant journals, visiting the websites of key institutions, and approaching directly experts in the field in EU countries.
- 3 A great deal of EU-wide data is held by EU institutions, and they include some detail about systems of access to long-term care. Cross-national databases incorporating social protection include:
 - The Mutual Information System on Social Protection in the EU (MISSOC) – is managed by DG Employment and Social Affairs of the EU Commission. It collects information on the social protection systems of the Member States. National reports and analysis, comparative tables, *MISSOC-info* and other publications related to social protection are produced.
 - The European System of Integrated Social Protection Statistics (ESPROSS) carries information on social expenditure for the EU of 27.
 - EUROSTAT also manages a cross-EU Survey on Income and Living Conditions (SILC) using common methodology. Analysis of the first round of SILC surveys was under way in 2007.
 - European Observatories on Health Systems and Policies and on Social Situation and Demography touch on some relevant information.
- 4 Other important sources of international information include:
 - The Organisation for Economic Co-operation and Development (OECD), whose membership covers 21 of the EU 27 states – a long-term care study was completed in 2005. Data are collected on the number of people receiving long-term care at home and in institutions. This builds on a pilot data collection implemented as part of the 2005 study, which has now become part of the regular data collection of OECD health data. Future work is planned:
"Importantly, we are planning for in-depth country reviews on long-term care,

to take place starting from autumn this year, and involving examination of 10 to 12 countries overall".¹

- The European Centre in Vienna (the Vienna Centre), which has been working on two major cross-national projects relevant to care policies. One is concerned with 'social and health services of general interest' (SHSGI) – a concept which was introduced by the Commission in a 2003 Green Paper to describe services which are regarded as intrinsic to the 'European model', worthy of protection in a period of enlargement: *"They are a part of the values shared by all European societies and form an essential element of the European model of society. Their role is essential for increasing quality of life for all citizens and for overcoming social exclusion and isolation".*² The second, 'rescaling social welfare policies', involves eight European countries. *"The aim of this project is to improve the information and knowledge base for assessing intended and unintended consequences of policies concerning multi-level governance (centralisation or decentralisation) in social welfare domains...The project is to describe different strategies and solutions in European countries which are facing similar challenges..."*³
- The European Foundation for Living and Working Conditions, which conducted the first EU Quality of Life survey in 2004, and which regularly publishes research in the 27 on the implications of an ageing population for workforce policies and work/life balance.

Clearly, each of these studies has a particular orientation – the European Foundation, for example, is centrally concerned with the care workforces, and with supports offered to carers; the OECD work focuses on the economic viability of systems. But all of them offer valuable insights into the evolution of long-term care policies and current debates in other EU countries.

- 5 It goes without saying that each country's framework is embedded in a unique mix of ethics and politics, culture and tradition. Completed policy developments which appear very similar may be driven by very different priorities: the introduction of cash payments for elder care services was focused on employment priorities in France, for example; but in the Netherlands, they were intended to support dwindling inter-generational solidarity and the role of informal caring.⁴
- 6 It is difficult (and potentially misleading) to isolate 'long-term care' services from the bundle of related policies which impact on them: health, housing and pensions/income maintenance policies, for example. In some countries, debates about migration and the development of a 'grey' workforce (Austria, Italy, **7**⁵) are

1 Francesca Colombo, OECD – personal communication

2 http://eur-lex.europa.eu/LexUriServ/site/en/com/2003/com2003_0270en01.pdf

3 http://www.euro.centre.org/detail.php?xml_id=89

4 SCIE (2007) *Choice, control and individual budgets –emerging themes*, (Research Briefing 20), London: SCIE (<http://www.scie.org.uk/publications/briefings/briefing20/index.asp>)

5 **Numbers in bold** throughout the text refer to the Bibliography

linked to care; in others, ageism in the definition of benefits has been an important issue (Flanders, 4). Populations affected may be very different: Germany, for example, has only recently begun to confront the needs of older disabled people (as opposed to people who become disabled in old age) (37 p.26), while other EU states are noticing changes in the age profile of those with high care needs. Differences **within** countries may be as great as those between: recent developments in care in the north of Italy are in marked contrast to those in the much poorer south (22 p.13).

7 Nonetheless, as the Vienna Centre has noted, many countries in Europe are experiencing a range of problems which have features in common, and which suggest the opportunity for cross-national learning. Issues identified as 'important' or 'very important' in the development of services by the seven countries⁶ included in the SHSGI study included:

- demographic trends and other macro socio-economic development (seven countries)
- financial constraints on budgets of public territorial authorities (five)
- availability of a sufficient quantity of good quality services (six)
- need to adapt to the evolution of users' needs, or to better tailor the supply of services (six)
- structural reforms in view of organisation, regulation, financing (6)
- problems with low quality services (four)
- availability and qualification of personnel (four)
- co-existence of different types and status of service providers (four)
- concerns about financial sustainability of service provision (four).
- *Source: Study on SHSGI in the EU, 2007 (16 p.36) Figure 1.*

8 The final report of the SHSGI project has been published at:

http://ec.europa.eu/employment_social/spsi/ssgi_en.htm

The Vienna Centre is currently working on a compendium of facts and figures in relation to long-term care in the EU and in other selected countries, which it hopes to publish in 2009.

9 Finally, it should be said that systems in many countries are changing very rapidly, as experience of working with new needs develops.

6 Czech Republic, Germany, France, Italy, Netherlands, Sweden, UK

2. Definitions

- 10 Long-term care is defined in the OECD study (2005) as “a cross-cutting policy issue that brings together a range of services for persons who are dependent on help with basic activities of daily living”.⁷ Dependency and the need for support are therefore key factors in describing the population requiring services. For many countries these issues have been brought into sharp relief by the ageing of the population, and in some, systems specifically targeting the long-term care of the elderly were introduced (France). However, following an EU Recommendation (1998) many countries including Germany, the Netherlands and Sweden unified their systems (4 p.542).
- 11 It follows that definition of levels of dependency, sometimes described as combinations of risks and needs, is frequently the key that unlocks services. In many systems, access to services is controlled by formal assessments which attribute a specific level of need to the applicant, expressed either in terms of deficits in relation to ADLs and/or IADLs,⁸ or in terms of hours of care needed. Again, in many countries, the formal assessment is followed by the development of a care plan to meet the needs identified by, or sometimes with, a local care or case manager. The rest of this paper is concerned with a description of how these access frameworks are operated in selected countries, and with evidence of their effectiveness.

7 http://www.oecd.org/document/50/0,3343,en_2649_33933_35195570_1_1_1_1,00.html

8 Activities of daily living (**ADLs**) and instrumental activities of daily living (**IADLs**)

3. Systems

France⁹

- 12 A national system specifically targeting the care of elderly people was set up in 2001. This provides for the allocation of a personal allowance: allocation personnalisée d'autonomie (APA). Anyone over 60 domiciled in France and living at home or in a residential institution may make a written application to a defined range of local agencies for the payment. Assessment of the degree of needs and risks will be assessed during a home visit by at least one member of the local 'socio-medical' team; or by the institution's, or other doctor, in the case of residential care.
- 13 In either case, the national AGGIR scale Autonomie Gérontologique – Groupes Iso – Ressources, will be used to allocate the applicant to one of six groups, from the highest level of dependency to the lowest. These GIR (which refer to sub-divisions of the AGGIR scale and group broadly similar need levels) groups are listed at Annex A. The AGGIR scale comprises 10 'discriminating' factors related to loss of psychological (two) and/or physical (eight – similar to ADLs) independence; and seven 'illustrative' factors (capacity to manage budget, washing, etc).¹⁰ Only those allocated to the top four levels of need may receive the allowance. Unsuccessful applicants may appeal.
- 14 The allocation is made in relation to a **specific package** of support services, and – depending on local supply – the user can choose between providers. In 2007, the monthly value of the allowance was:
- GIR 4: up to 510 euros
 - GIR 3: up to 765 euros
 - GIR 2: up to 1,020 euros
 - GIR 1: up to 1,190 euros.
- The allowance is less for people in residential care (about 40% of beneficiaries) than for people living at home.
- 15 The APA is separate from the social security system, and is managed and largely financed by the 100 Departments of France. Above a certain level of income, a (gradually increasing) contribution to the cost of the package is expected from the individual concerned. Following the heatwave in 2003, a move towards an insurance-based principle was established with a fund for the frail elderly financed by an employers' contribution in 2005. The APA is explicitly linked to services, and geared to employment policy. Family members (except spouses) may be employed with it.
- 16 One retrospective study of the 858 people receiving the APA who died during the heatwave of 2003 throws some (sombre) light on the accuracy of the system in identifying vulnerable and needy people. Results suggested that death was strongly

9 Details provided here were mainly derived from **28iii** and **35**

10 http://www.cavimac.fr/pages_cavimac/aggir.pdf

associated with GIR dependency levels; and that the ratings could have been used effectively as a way of targeting elderly people most at risk (3 p 3).

- 17 The tight conditions governing the allocation of the allowance, and central planning for the Departments, are designed to prevent the growth of a 'grey market' in care services, and ensure equity across France. Nonetheless, debates continue about 'postcode lotteries'; about the low-paid and low-status jobs which have resulted; and about whether a long-term care insurance scheme would be preferable, as demand increases. The elaborate, centralised system for determining needs and risks, and the waiting lists associated with it, are seen by some as a means of deterring applications.

Sweden¹¹

- 18 Sweden operates a relatively very generous welfare system: 97% of services are publicly financed from compulsory insurance and high taxation, and seen as a right by citizens. The quality of long-term care services is regarded as high compared with the rest of Europe. Although health and social care are formally seen as separate systems, health and social care professionals have worked together for more than 25 years in care planning teams to ensure appropriate care for the individual. Local self-government is also a long tradition, and is seen as a very positive value by Swedish people. Long-term care services are the responsibility of each of the 286 municipalities (from 2005), based on the principle that it should be the community, not the family, who cares for vulnerable and/or elderly people. Surveys have shown that this principle is well supported by the general public.
- 19 The social security system provides for a system of personal allowances for people aged under 65 who are "*severely and permanently*" disabled (26), and need more than 20 hours support with ADLs per week. The application is made to the Social Insurance Agency, which assesses the applicant's needs "*in consultation*" with them. A flat rate per hour is set by the Agency annually (around £20 per hour in 2007).
- 20 Swedish arrangements for assessing the level of support required by the elderly are much less formalised than in France. The Social Services Act of 1982 articulated the right of the elderly to receive help at all stages of life, and responsibility for operationalising this commitment is devolved to local level. Municipalities organise assessments for services along lines recommended by the Ministry of Health and Social Affairs, but retain a very high level of autonomy to define and raise taxes for their own systems.
- 21 Obviously, this has led to great variation across the country. In general, the care manager will interview the applicant for services and assess their needs, making use **if necessary** of international scales linked to ADLs and IADLs, or medical advice (23 p.32). Benefits may be means-tested. From 2006, municipalities have been authorised to supply certain practical services to older people in their own homes "without any further needs assessment". Charges are set by the local agency, but

11 Details provided here were mainly derived from 11 and 28xxviii

cannot exceed cost (27). Home care services and other support to living at home are offered by all municipalities, and some provide vouchers which allow users freedom to purchase chosen services.

- 22 According to the Swedish Social Report 2006,¹² "Most of the care of older people still living in their homes is provided by relatives. Around 9% of the population aged 65 and above received home-help services, a fifth of which received extensive measures, 50 hours or more per month. The proportion of older people receiving home-help services or living in special accommodation has fallen to an extent that cannot be explained solely by reduced care needs among the older population. The number of people receiving home-help services has, however, increased in recent years as a result of the increased proportion of elderly in the population."
- 23 The downward trend in home help services has been noted over some years, and – combined with the known variation in provision between municipalities – has given rise to concern about the adequacy of local services. However, recent research has established that the system remains equitable overall, and that levels of unmet need remain low despite shrinking service levels (36 p.49). There appears to have been an increased emphasis on targeting people in greatest need, with a shift from help with instrumental to personal ADLs. This study argues that local systems are adapting appropriately to local needs and resources, although the question remains of how far the family is able to absorb further shrinkage in home care services.
- 24 Debates about equity and service quality continue, and the development of national standards has been proposed, as well as closer collaboration between the municipalities and the National Board of Health and Welfare. The latter has developed a range of quality indicators for social services, while the municipalities have begun to work in 'comparative quality networks'.

Germany¹³

- 25 The 'headline news' about the German arrangements for providing long-term care is that there is a comprehensive, national long-term care insurance system, introduced in two stages from 1995 in response to the decline in family care and to support informal caring. Public insurance covers most people, with mandatory private insurance covering most of the rest (97% in all). This scheme is primarily to provide assistance in the home, and relatives can be employed with the allocation.
- 26 Individuals must apply to local agencies, who will arrange a standard assessment using a national scale of risks and needs. The assessment will be done by a doctor. The scale includes ADLs and IADLs, but the final 'score' must include both, or only ADLs, for the application to be successful. They must need help with at least two ADLs, for more than 90 minutes a day, over a period of six months. Successful applicants are then **entitled** to benefits, which they may take in kind, as a care package; or in cash, equivalent to roughly half of the package; or a mixture of the

12 <http://www.socialstyrelsen.se/en/showpub.htm?GUID={695BC0F2-70EA-483D-86D6-91A1E6C573C1}>

13 Details provided here were mainly derived from 28iv and 37

two. Three levels of dependency are identified above this rather high initial threshold, including nursing at home.¹⁴

- 27 The social services element in the package will be assessed by a local case manager, making use of the completed medical assessment. Benefits are not means-tested. Unsuccessful applicants have recourse to means-tested social assistance benefits, to insurance-based health services, and to local (means-tested) services accessed through social services agencies. Local authorities are of increasing importance in implementing care systems, and this is seen as supportive to the development of more user choice and consultation (37).
- 28 Cash benefits have proved extremely popular in Germany, and (because of their lower-than-services value) have been an important factor in controlling the costs of the scheme (34). At the beginning, in 1995, 84% of successful applicants for long-term care insurance chose cash only: this figure has declined, but only gradually. Equally striking is the fact that a high proportion of people with even the highest level of care needs preferred cash only – 64% in 1998. When asked in a survey, people explained their choice in terms of preferring to be cared for by a family member (25). However, the continuing (if declining) high preference for cash has given rise to debates in Germany about the impact on women's employment and carers' rights, about the adequacy of the smaller cash sum, and about the impact on the development of a market for high quality professional services (34).
- 29 Other debates about the future of the system concern the assessment scale, which gives little consideration to mental health problems or dementia; and the provision of preventive or rehabilitative care which – although talked about – is underdeveloped.

The Netherlands¹⁵

- 30 A statutory insurance scheme has covered the risks of long-term care in the Netherlands since 1968 (the Exceptional Medical Expenses Act – AWBZ). Fundamental to the Dutch approach is that the family is the carer of first resort, and policies are developed to support this principle. The other guiding principles are that all citizens should be able to participate fully in society, and that – as far as possible – people with care needs should be supported in their own homes. The system is also characterised by being relatively 'generous', and highly regulated. Since the insurance is compulsory for everyone paying payroll tax, benefits are seen as a right.
- 31 Until 2007, the AWBZ covered all services for people with chronic conditions: patients in long-term hospital care, elderly people, and people with disabilities or mental health problems. Benefits are offered in the form of a package of services; or – except for treatment or residential care – they may be taken in cash as a personal budget (worth rather less than the equivalent package).

14 A table of benefits appears in 28iv, p.3

15 Details provided here were mainly derived from 28xx1 and 43, and from an interview with Marcel de Krosse, Manager, Centre of Expertise CIZ Netherlands.

- 32 The Act deals with the need for seven broad categories of support: domestic help, personal care, nursing, supportive guidance, activating guidance, treatment and accommodation.¹⁶ Assessing eligibility for each kind of support is the responsibility of the national, independent assessment agency, the CIZ. For the purposes of assessment, the Netherlands is divided into six districts, and each has one head and several local CIZ offices.
- 33 The person applying for support or their carer will first ring the national call centre, which transfers the call to the nearest CIZ office. In some cases, where the applicant is already known to the agency, the assessment of the person's needs may be completed by phone. More usually, the method of assessment is decided on the basis of the call, and will often involve a home visit. These are undertaken by a team of trained assessors, who normally have a nursing or social work qualification. In complex cases, the applicant may be asked to attend a meeting with a multi-disciplinary team at the CIZ office.
- 34 Each method of assessment is related to a checklist of more than 100 items, based on the World Health Organisation International Classification of Functioning, Disability and Health (ICF), which is published on the CIZ website. The extent to which the checklist is completed is left to the discretion of the assessors. The aim of the visits is to build a general picture of the applicant in their own surroundings, and to establish the extent to which members of the household can contribute to the support. In 2005, protocols were adopted which established the responsibilities of co-resident family members (**42**). All household members over the age of 15 are expected to make a contribution.
- 35 'Indications' of eligibility are issued to successful applicants together with a determination of the appropriate hours and types of care. This ticket to care can be taken by the applicant to any local provider, all of which are part of the vigorous private care market. The indication is valid for a specified period (up to five years), after which a new application must be made. The applicant may ask for a second opinion, or take the CIZ to court, if they are dissatisfied with the indication. But how these thresholds translate into actual payments depends on political decisions, in which the CIZ acts only as an adviser to the Ministry of Health. At the time of writing, revision of access boundaries is being hotly debated in the Dutch Parliament.
- 36 Responsibility for funding (with an adjustment to their block grant), developing and allocating home care was decentralised to the municipalities in 2007. The Ministry of Health sets the overall standards for care; but each local authority (467 in all) is able to develop its own criteria. The Act (WMO) was specifically directed at making services more responsive to local needs; but also – importantly – to controlling the growth of the AWBZ budget. Local authorities are also obliged by the WMO to develop carer support.
- 37 These changes were greeted with some alarm by the powerful service user lobby – the network of organisations of clients and patients – but the effects are not yet clear. People have less legal certainty about their entitlements, and expenditure has gone down; but evidence that services are fewer or worse has not yet materialised.

16 For an explanation of these terms, see **43**, p.16

Inevitably, unacceptable variations in service and difficulties for users in dealing with multiple agencies have been predicted, as has the possible inflation of administrative costs (**43** p.19). Sustainable quality of care in the residential sector is another source of debate.

- 38 An important feature of the Dutch system is its transparency. Citizens are readily able to find out how the system works, and the service user lobby is fully involved in the operation of the CIZ. It is also engaged in the current debate about thresholds.

Japan¹⁷

- 39 A compulsory insurance-based long-term care system was implemented in Japan in 2000, following urgent public debate about the future of the ageing population. People aged 40 and over pay 50% of the premium, and the remainder is paid by national and regional governments. Contributions rise with income. Benefits are paid to companies that provide services, but recipients have to contribute 10% of the cost. The scheme mainly targets people aged 65 and above. Applicants refer themselves to regional public health offices, and are assessed according to a national format, by a doctor. The screening process covers physical and mental health. On the basis of the assessment, the applicant will be allocated (by a computer programme) to one of seven categories (or none), ranging from two categories 'in need of support', up to 'in need of nursing care assistance'. Neither the availability of informal help nor income is taken into account in the determination.
- 40 The government did not accurately predict the uptake of the new scheme, which has proved very popular, or the cost, which is now predicted to exceed £79.1 billion by 2025. In response to this, some revisions were made to the eligibility framework in 2006, including the introduction of the second (lower) level of the lowest category, 'in need of support', in order to control costs. People reallocated to this category lost some benefits (such as cooking or cleaning services). A new package of preventive services was introduced at the same time. These changes have not been welcomed by users or providers, and questions still remain about the financial viability of the scheme.

17 Details provided here were mainly derived from **12** and **21**.

4. Discussion

Virtually all countries in the European Union assess eligibility for long-term care services by reference to internationally validated scales involving ADLs and IADLs, related – in many cases – to the Katz scale.

- 41 A general statement along these lines is probably true, but not very helpful. In most countries, it is not the scale itself, but how it is located in the political system and used which determines its effects. In Italy, many scales are available, but ultimately, decisions may be determined by what **services** are available (**16**). In relation to home care services, no explicit criteria may be used, and allocation may be left absolutely to social workers' discretion (**22**). At first sight, this situation may resemble that of the Swedish social worker, who sits with an applicant and discusses loss of autonomy, with reference to scales "if necessary". But this happens in the context of citizens' rights and relative plenty: plenty of services, plenty of funding, and plenty of experience in running a service which is embedded in Swedish traditions.
- 42 Where service allocation is tightly linked to centrally determined eligibility criteria - in France or Flanders for example – there is confidence about equity. But there are complaints of rationing by bureaucracy, delay and waiting lists. Locally determined criteria, reasonably enough, raise the postcode lottery spectre. There is a call in Sweden for national guidelines and standards, just as the Netherlands has devolved responsibility for criteria in allocating home care to the municipalities.
- 43 Criteria can be and are used to contain costs and depress demand. Insurance-based systems appear equitable and may 'cover' most of the population, but the extent to which they fully cover the needs of an ageing population is more problematic, and depends on eligibility criteria. The German threshold was set relatively high from the start; the Japanese authorities rapidly adapted their framework. One of the aims of the Japanese insurance scheme is to transfer responsibility for older people from the family to the state; the reverse is arguably true of the German system, mainly through the mechanism of cash payments.
- 44 Of course EU and other countries have in common the prospect of ageing populations, declining family support and rising demand for long-term care services. One international study has modelled the German principle of entitlement to long-term care on the UK, Italy and Spain, and included formal home care (rather than cash payments) in the equation. The impact on costs to 2050 is very big in all countries, although less in the UK than in countries still very dependent on informal care (**34**).
- 45 The discussion paper on SHSGI raises many common problems: service quality, particularly in residential care, but also in relation to care assistants; devolution versus equity; the mismatch between budgets and expectations; poor integration between health and social care (**16**). Common trends include interest and (in most cases) first steps towards user empowerment and involvement; and a trend towards reducing the funding of low cost/high-volume services at the same time as promoting or at least exploring the notion of preventive programmes.

- 46 Few cross-national studies or reports considered here have evaluated access frameworks in terms of the outcomes for service users. Only two – Le Bihan and Martin (**23**) and the SHSGI country studies (**11, 22, 35, 37, 43**) – make use of vignettes to capture the multiple factors involved in any comparison. The first of these demonstrates how apparently similar ‘scientific’ scales can produce markedly different determinations.
- 47 In the time available, it has proved difficult to access many national evaluations (in English or French) which might provide more outcome data. What is clear from the material covered here is that as cost pressures increase, there is a trend towards targeting help on those most in need. In some countries - the Netherlands, Sweden and Japan, for example - this is going alongside the development of a programme of preventive services.
- 48 What we can say, on the basis of the limited evidence presented here, is that most frameworks use combinations of scales of needs and risks, multi-disciplinary teams and local care management to establish the service user’s allocation of time, money or services. These allocations are seen as rights in insurance-based systems, in Nordic welfare states and – until the WMO – in the Netherlands. Access thresholds, expressed as needs/risks or time entitlements, have been explicitly linked to cost containment. However, more subtle adjustments – for example, the Swedish drift away from providing home help – are harder to pin down.
- 49 Where responsibility for assessment is fully devolved to local authorities, it is very difficult indeed to have a clear, national picture of access to social services. This a cause of concern to service users and carers, as well as to governments. The trend towards greater standardisation is beginning in Sweden; it much further advanced in Denmark (**40**). Talk about ‘user sovereignty’ is just beginning in some countries which have traditionally made use of rather paternalistic frameworks driven primarily by medical opinion (**37**). However, in Nordic countries, the service user does indeed appear to occupy a central place in decisions about resource allocation, as a citizen with a clear claim on the local community’s assistance.

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Annex A

France: Six GIR Groups

Iso-Resources Group 1: people who are bedridden or chair-ridden, having lost their mental, physical, locomotive and social independence, and who require the essential and continuous presence of carers.

Iso-Resources Group 2: people who are bedridden or chair-ridden, whose mental capacity is not completely affected and who require assistance for the majority of everyday activities, or those people whose mental capacity is affected but who are still able-bodied.

Iso-Resources Group 3: people who are still mentally autonomous, have partial locomotive autonomy, but who require assistance for their physical autonomy, daily and several times per day.

Iso-Resources Group 4: people who cannot ensure their transfer alone, but who, after rising, can move around inside the accommodation. They require help for washing and dressing themselves.

Iso-Resources Groups 5 and 6: people who are very slightly or not at all dependent.

Bibliography

1. Aidukaite, J (2006) 'The formation of social insurance institutions of the Baltic States in the post-socialist era', *Journal of European Social Policy*, 16, 3, pp 259-270.
2. Bannink, D and Hoogenboom, M (2007) 'Hidden change: disaggregation of welfare state regimes for greater insight into welfare state change', *Journal of European Social Policy*, 17, 1, pp 19-32.
3. Belmin, J, Auffray, J-C, Berbezier, C, Boirin, P, Mercier, S, de Reviere, B and Golmard, J-L (2007) 'Level of dependency: a simple marker associated with mortality during the 2003 heatwave among French dependent elderly people living in the community or in institutions', *Age and Ageing*, Advance Acces, March 24.
4. Breda, J and Schoenmaekers, D (2006) 'Age: a dubious criterion in legislation', *Ageing & Society*, 26, pp 529-547.
5. Clasen, J, Davidson, J, Ganssmann, H and Mauer, A (2006) 'Non-employment and the welfare state: the United Kingdom and Germany compared', *Journal of European Social Policy*, 16, 2, pp 134-154.
6. Comas-Herrera, A, Wittenberg, R, Costa-Font, J, Gori, C, di Maio, A, Patxot, C, Pickard, L, Pozzi, A and Rothgang, H (2006) 'Future long-term care expenditure in Germany, Spain, Italy and the United Kingdom', *Ageing & Society*, 26, pp 285-302.
7. Da Roit, B, Le Bihan, B and Osterle, A (2007) 'Long-term care policies in Italy, Austria and France: variations in cash-for-care schemes', *Social Policy and Administration*, 41, 6, pp 653-671.
8. Daly, M and Rose, R (2007) *First European quality of life survey: key findings from a policy perspective*. Dublin: European Foundation for the Improvement of Living and Working Conditions.
9. European Foundation for the Improvement of Living and Working Conditions (2008) *Working longer, living better – Europe's coming of age*. Dublin: European Foundation for the Improvement of Living and Working Conditions.
10. Forder, J (2007) *Self-funded social care for older people: an analysis of eligibility, variations and future projections* (PSSRU Discussion Paper 2505). London: Commission for Social Care Inspection.
11. Fröbel, L, Jönsson, P-O and Sundén, E (2007) *Sweden, SHSGI Country Studies, No. 7*. DG Employment, Social Affairs and Equal Opportunities, European Commission – unpublished.
12. Fuyuno, I (2007) *Ageing society in Japan – Part I*. Tokyo: The British Embassy.
13. Glasby, J (2005) *Health and Social Care in the Community*, 13, 2, pp 187-199, review of:
 - Glendinning, C, Davies, B, Pickard, L and Comas-Herrera, A (eds) (2004) *Funding long-term care for older people*. York: Joseph Rowntree Foundation.

- Alaszewski, A M and Leichsenring, K (eds) (2004) *Providing integrated health and social care for older persons: a European overview of issues at stake*. Aldershot: Ashgate.
 - Wittenberg, R, Comas-Herrera, A, Pickard, L and Hancock, R (eds) (2004) *Future demand for long-term care in the UK*. York: Joseph Rowntree Foundation.
14. Glendinning, C, Schunk, M and McLaughlin, E (1997) 'Paying for long-term domiciliary care: a comparative perspective', *Ageing & Society*, 17, pp 123-140.
 15. Henwood, M and Hudson, B (2008) *Lost to the system? The impact of fair access to care*. London: Commission for Social Care Inspection.
 16. Huber, M (2007) *Long-term care for older people: the future of social services of general interest in the European Union. Discussion Paper*. Location: Publisher.
 17. Huber, M (2007) *Long-term care for older people: the future of social services of general interest in the European Union. Draft thematic background paper*. Location: Publisher.
 18. Huber, M (2007) *The future of social services of general interest. Synthesis report*. Brussels: DG Employment, Social Affairs and Equal Opportunities, European Commission.
 19. Huxley, P, Evans, S, Munroe, M and Cestari, L (2006) *Fair access to care services in integrated mental health and social care teams, final report*. London: Health Services Research Department, Institute of Psychiatry, King's College, London.
 20. Ikegami, N and Cambell, J C (2002) 'Choices, policy logics and problems in the design of long-term care systems', *Social Policy & Administration*, 36, 7, pp 719-734.
 21. Ikegami, N (2005) 'Design and impact of public long-term care insurance in Japan', AARP International, available online through <http://aarpinternational.org/>
 22. Kazepov, Y with Arlotti, M, Barberis, E, da Roit, B and Sabatinelli, S (2007) *Italy, SHSGI Country Studies, No. 4*. DG Employment, Social Affairs and Equal Opportunities, European Commission – unpublished.
 23. Le Bihan, B and Martin, C (Year) 'A comparative case study of care systems for frail elderly people: Germany, Spain, France, France, Italy, UK and Sweden', *Social Policy & Administration* 40, 1, pp 26-46.
 24. Leppo, K (2006) 'Health care and long-term care – a view from Finland', AARP International, available online through <http://aarpinternational.org/>
 25. Lundsgaard, J (2005) *Health working paper 20*. Paris: OECD.
 26. Ministry of Health and Social Affairs, Sweden (2007) *Assistance allowance. Factsheet*.
 27. Ministry of Health and Social Affairs, Sweden (2007) *Care of the elderly in Sweden. Factsheet no. 18*.
 28. MISSOC Info2 (2006) *Social protection for long-term care*,
 - i. Spain
 - ii. Estonia
 - iii. France
 - iv. Germany
 - v. Denmark
 - vi. Czech Republic

- vii.** Belgium
- viii.** Cyprus
- ix.** Ireland
- x.** Italy
- xi.** Lithuania
- xii.** Latvia
- xiii.** Luxembourg
- xiv.** Hungary
- xv.** Malta
- xvi.** Austria
- xvii.** Poland
- xviii.** Portugal
- xix.** Slovenia
- xx.** Slovakia
- xxi.** The Netherlands
- xxii.** Finland
- xxiii.** United Kingdom
- xxiv.** Iceland
- xxv.** Liechtenstein
- xxvi.** Norway
- xxvii.** Switzerland
- xxviii.** Sweden
- xxix.** Greece

29. MISSOC Info/1 (2007) *Evolution of social protection in 2006*.
30. Morel, N (2007) 'From subsidiarity to 'free choice': child- and elder-care policy reforms in France, Belgium, Germany and the Netherlands', *Social Policy & Administration*, 41, 6, pp 618-637.
31. OECD (2005) *Ensuring quality long-term care for older people – policy brief*. Paris: OECD.
32. OECD (2007) *Society at a glance: OECD social indicators – 2006 Edition*. Paris: OECD.
33. Ogg, J and Renaut, S (2006) 'The support of parents in old age by those born during 1945-1954: a European perspective', *Ageing & Society*, 26, pp 723-743.
34. Pickard, L, Comas-Herrera, A, Costa-Font, J, Gori, C, di Maio, A, Patxot, C, Pozzi, A, Rothgang, H and Wittenberg, R (2007) 'Modelling an entitlement to long-term care services for older people in Europe: projections for long-term care expenditure to 2050', *Journal of European Social Policy*, 17, 1, pp 33-48.
35. Richez-Battesti, N, Priou, J and Petrella, F (2007) *France, SHSGI Country Studies, No. 2*. DG Employment, Social Affairs and Equal Opportunities, European Commission - unpublished.
36. Savla, J, Davey, A, Sundström, Initial, Zarit, S H and Malmberg, (2008) 'Home help services in Sweden: responsiveness to changing demographics and needs'. *European Journal of Ageing*, 5, pp 47-55.
37. Schulz-Nieswandt, F, and Sesselmeier, W, Wölbart, S, Maier-Rigaud, R, Nätke, J F and Toellner-Bauer, U (2007) *Germany, SHSGI Country Studies, No. 3*. Brussels: DG Employment, Social Affairs and Equal Opportunities, European Commission.

38. SCIE (2007) Research briefing 20: *Choice, control and individual budgets – emerging themes*. London: SCIE.
39. Sundström, G and Tortosa, M A (1999) 'The effects of rationing home-help services in Spain and Sweden: a comparative analysis'. *Ageing & Society*, 19, pp 343-361.
40. Thorgaard, C and Vinther, H (2007) *Rescaling social welfare policies in Denmark. National report*. Social Policy and Welfare Services, Working Paper 10, The Danish National Institute of Social Research.
41. Threlfall, M (2007) 'The social dimension of the European Union: innovative methods for advancing integration'. *Global Social Policy*, 7, 3, pp 271-293.
42. Timonen, V, Convery, J and Cahill, S (2006) 'Care revolutions in the making? A comparison of cash-for-care programmes in four European countries', *Ageing & Society*, 26, pp 455-474.
43. Tjadens, F and Meinema, T (2007) *Netherlands, SHSGI Country Studies, No. 5*. DG Employment, Social Affairs and Equal Opportunities, European Commission – unpublished.
44. Van Campen, C and van Gameren, E (2005) 'Eligibility for long-term care in The Netherlands: development of a decision support system'. *Health and Social Care in the Community*, 13, 4, pp 287-296.
45. Waterplas, L and Samoy, E (2005) 'L'allocation personnalisée: le cas de la Suède, du Royaume-Uni, des Pays-Bas et de la Belgique', *Revue Française des Affaires Sociales*, 2, pp 61-101.