



The ENABLE-AGE Project
Enabling Autonomy, Participation, and
Well-Being in Old Age:
The Home Environment as a Determinant
for Healthy Ageing
(QLRT-2001-00334)



ENABLE-AGE POLICY UPDATE REVIEW

European Level Report

(M12, based on WP7)

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ENABLE-AGE WP7 cross national report summary

The ENABLE-AGE up-date review involved collecting information on policy to create reports for each of the participating countries. Each national team filled in a common information template, covering: background information on health and welfare systems and older people; brief summaries of key reports on health, housing and older people; key policies on health, housing and older people; general policy on accessibility issues; role of NGOs; pilot schemes; key issues and dominant problems. A cross-national report was compiled based on the national reports, identifying five key themes and related policy recommendations:

Socio-Economic Context

While the level of old age poverty varies, it is a problem to some extent in all the countries reviewed. Policies need to be in place to ensure decent and appropriate housing that meets the needs of all individuals. Issues relating to housing need to be incorporated into other areas of social policy. Some fundamental structural changes have occurred in the transformational countries that have worked against the interest of older people at a time in their lives when they have become more vulnerable. Special efforts need to be given to the basic housing needs of older people who have been marginalized by the transformational process. A concerted effort at the EU level to develop guidelines and norms to ensure appropriate housing for all older people would be useful. Specific professional competence is needed in all countries relating to individual housing adaptations.

Housing Accessibility

In recent years there has been a drive to promote barrier-free environments and accessible buildings for people with functional limitations. Appropriate housing is an important factor in remaining healthy and independent in later life. Relocation or housing adaptations may be needed as the person becomes more frail or disabled. All countries need to introduce guidelines and regulations and improved professional competence to ensure more accessible housing, when new houses are being built or existing houses are being rebuilt/renovated. There is a need for better information for citizens on the issue of accessibility.

Home and Health in Very Old Age

As people grow older they spend more time at home and most daily activities are performed at home and in the immediate surroundings. The conditions in which people live and the appropriateness of the environment to the dweller's needs are likely to have a big impact on the quality of life and health. The preliminary results from the ENABLE-AGE project indicates the need to consider both objective and subjective aspects of housing and their implications for health and well-being in very old age. Housing and health and social care professionals and need to be sensitized to a holistic approach to housing solutions.

Supporting people at home

Recent years have seen a shift in policy towards supporting people in their own homes, rather than providing institutional care. Being able to live independently in your own home is a central component of "Ageing in Place" policy. However, there may be downsides to this and there has to be adequate support in place, not only to

help the person to live independently, but also ensure they have a good quality of life. There is a need to ensure provision of, and access to, basic assistive devices, such as mobility aids, hearing aids, spectacles etc., especially in the transformational countries. There is a need to provide better information for older people and their carers of what is available in terms of support services. Efforts to positively improve access to and take up of available grants/financial aid should be made.

Social participation and housing

Social participation refers to a person's involvement in community life, social roles and social relationships. As a person grows older it can become increasingly difficult to maintain previous levels of participation due to illness, disability or frailty and elderly people are most likely to experience social exclusion through a reduced social circle, poverty and fear of crime, to name but a few factors. The home environment may act as a platform for social participation as it may help to facilitate social involvement. The home, however, may also contribute to increasing social exclusion when a person becomes socially isolated, due to increasing incapacity and/or inappropriate infrastructure.

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PREFACE

This report is based on data collected within the ENABLE-AGE Project, conducted during the period 2002-01-01 to 2004-12-31. The project was sponsored by the European Commission within Framework Five (QLKG-CT-2001-00334) and involved six partner universities in five countries: Sweden, Germany, the United Kingdom, Hungary, and Latvia.

The ENABLE-AGE Project was very comprehensive, and during the project process high quality data collection and preliminary analyses were prioritised. Given the three-year time frame for the project, within this period it was only possible to present raw data material and basic analyses. This report comprises such preliminary results from the ENABLE-AGE Survey Study at the first measurement occasion, aiming at giving a first impression of the potential for further analyses and forthcoming scientific publication.

During several years to come, the ENABLE-AGE consortium will engage in scientific publication of the results, based on the ENABLE-AGE Survey Study, In-depth Study, and Update Review. Forthcoming publications will be listed at the ENABLE-AGE Project website, <http://www.enableage.arb.lu.se>.

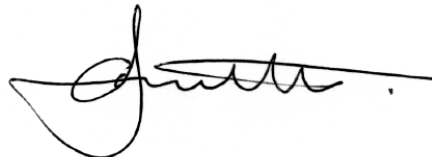
DISCLAIMER

Every effort has been made to ensure that the information contained in the present report is correct or is a reasonable interpretation of the current national situation. The reader is nevertheless reminded that legislation, policies and other relevant information are ever changing and evolving, and that the report may contain some errors. The time of finalising the writing is May 2004.

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0 AIMS AND OBJECTIVES

The aim of the Enable-Age (EA) project is to examine, in a European perspective, the home environment as a determinant for autonomy, participation and well-being in old age. The project counts seven specific objectives (appendix 1), and objective number 5, with which this report is primarily concerned, is to provide a macro level update of housing policies, relevant legislation, norms and regulations, type of housing and typical pathways of housing decisions in the participating countries, i.e. Hungary, Germany, Latvia, Sweden and the UK/England.

The project's partners have consequently produced a systematic review of policy and legislation in their respective country focusing on housing and older people in relation to the promotion of health and quality of life. The national policy reports highlight national gaps and deficiencies, as well as evidence of good practice and successful schemes on housing and the elderly-related matters, and have led to the identification of a series of topic issues centred on the relationship between housing and healthy ageing, which have subsequently been synthesised into five key themes explored later in the present report (section 4).

The EU level report aims to give an overview and to produce a comparative analysis of the current socio-political situation of the EU, Hungary, Germany, Latvia, Sweden and the UK/England with regards to housing and older people. The aim of this analysis is to establish a map highlighting older people's housing situations and living conditions in relation to their well-being, healthy ageing, participation and autonomy on a European level from the perspective of various welfare systems, including transformational mix, continental/corporatist, Nordic and neo-liberal approaches (section 4.4). This report forms part of a wider cross-national and integrated analysis, which includes qualitative and quantitative data generated by the EA project and which ultimately aims to produce a set of evidence-based policy recommendations for healthy housing solutions across the European Union.

The present report integrates two perspectives: a "top-down", review of the European Union policies in relation to social and housing issues; and a "bottom-up analysis", which is based on the project's findings. The later perspective is based on the national policy reviews, from which the EA team has identified policy issues discussed in sections 3 and 4 below. This involved considering policy directly concerned with the EA topic area of housing for older people, but also policy indirectly concerned with housing (e.g. the provision of services to aid independence at home, the co-ordination of various support services - such as finance, healthcare and housing; and policy concerned with other key issues within the EA project, such as health, quality of life and social participation. The importance of this second perspective is that the impact of housing on the quality of life of older people can only be understood in its wider socio-political context.

Section 1 of the report provides a contextual background on the European Union's general social policy framework and section 2 reviews its policies in relation to older people and housing in particular. Section 3 outlines the EA project's findings on the participating countries' national policy in relation to housing and the elderly; whilst section 4 proceeds to the cross-national analysis of the countries' situations based on five key themes: 1) housing, participation and quality of life; 2) housing barriers, accessibility and implications for building guidelines;); 3) socio-economic change; 4) housing and health; 5) societal supports for "ageing in place". Finally, section 5 concludes by drawing together the various themes discussed in the report.

1 THE EUROPEAN UNION SOCIAL POLICY FRAMEWORK

The aspiration for a united Europe, originally focused around economic considerations, has seen several developments in the area of social policy since the mid-1990s, culminating with the Treaty of Amsterdam introducing an Employment Title and a Social Chapter in the constitutional framework of the European Union (EU) in 1997.

Although social policy is traditionally a matter of national competence, it is now argued that a clear cut separation between market issues, which are the Union's competence, and social issues, which are essentially the Member States' responsibility, does not exist anymore as economic considerations and policies spill onto the social domain and affect social policies (Leibfried & Pierson 2000). Indeed, efforts for the establishment of a common market have required a shift in mentalities and national measures towards the opening of national frontiers and the free movement of goods, workers, services and capital, which has far-reaching implications for people in particular. In order to encourage and facilitate workers' mobility for the good of the EU and national economies, measures taken to ensure that workers, as well as their dependants (i.e. spouse, children), benefit from social security rights (e.g. pension rights). Education, for instance, is traditionally a matter of social policy; however, as it appeared essential for worker's mobility that their diplomas and other qualifications be recognised in other Member States, a provision on educational qualifications mutual recognition was introduced in the Treaty establishing the European Community (art. 47(1) ECT 1997). EU legislation and the European Court of Justice (ECJ) case law have subsequently further impacted on Member States' ability to set out policy for the organisation of their national systems (Arnall, *et al.* 2000).

The Union has recognised that ignoring social issues is not an option if the EU integration process is to be carried out effectively and successfully. In other words, there is a very close correlation between economic and social issues, as they support each other's (sound) development both at national and Union level. The EU has thus acknowledged that social policy cannot be excluded from its agenda. Consequently, social policy, once mainly seen as a branch of economic policy, has now become an important element in the furtherance of the EU's integration process and is progressively being incorporated within the EU's arena of competence. As the ambition for a strong economic European Union must be carried out along with providing protection and social welfare for its citizens, given the variety of Member States' welfare regimes and the resulting differences highlighting inequalities in people's economic and social situations, there is a growing need for the EU's input into social policy-making in order to promote and develop social cohesion across the Union.

The EU's specific social policy competences, established by the Treaty of Amsterdam, cover free movement of workers, gender equality in the workforce, working conditions (incl. health & safety issues), social security, workers' protection, and labour market inclusion of those susceptible to be excluded. The Union also has the power to orientate national social policies through the formulation its own social policy initiatives and programmes, or through the rulings of the European Court of Justice (ECJ), whose decisions may either affect national or create supranational social policies (Leibfried & Pierson 2000). Areas of social policy which are thus also covered by the EU's input include public health, poverty, social exclusion, social protection, transport, disabled and elderly people and education.

The Lisbon European Council, held in March 2000, formally recognised that economic and social considerations are two essential factors of the European integration process and must both be a priority on the European political agenda. The Council thus set out a *new strategic goal* for the EU "to become the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion". The three main objectives of what is coined the Lisbon Strategy are to

facilitate: the transition towards a knowledge-based economy and society; the modernisation of the European social model through the investment in the people and the fight against social exclusion; and the realisation of these objectives through the 'open method of coordination' (Europarl 2000).

In its ensuing communication (COM (2000) 379 final), the Commission of the European Communities outlined the Union's Social Policy Agenda, and its five main objectives, i.e. full employment and quality of work; quality of social policy; promoting quality in industrial relations; preparing for enlargement; and promoting international co-operation. This report is primarily concerned with the aim to develop 'quality social policy' which requires that action is taken across the Union towards the modernisation and improvement of social protection, social inclusion and gender equality, and towards the protection and promotion of fundamental social rights and anti-discrimination measures. The various orientations of this objective are especially relevant to the situation of the elderly in the EU as it touches on issues such as pension and health care systems, which are further explored in section 2.1 below.

The aim of the Social Policy Agenda is "to strengthen the role of social policy as a productive factor" (COM (2000) 379 final, p.5), not through the harmonisation of national social policies, but by promoting and encouraging the "co-ordination of social policies in the context of the internal market and the single currency" (COM (2000) 379 final, p.7). The method favoured by the Lisbon Strategy to address the implementation of the Social Policy Agenda is the Open Method of Coordination (OMC), which is characterised by a voluntary-based partnership between key social policy players, including the EU, Member States, regional and local authorities, social partners, non-governmental organisations and corporate businesses (Europarl 2000). The OMC, which came first as a response to the growing rise in unemployment rates across Europe in the 1990s, was introduced by the European Employment Strategy (EES) as an alternative model of governance in a bid to modernise the European economic institutions and tackle unemployment through soft laws, as opposed to 'hard laws' which "... rely primarily on top-down command and control-type regulation backed by sanctions..." (Trubek & Mosher 2001).

In brief, the EU's social policy-making and implementation tend to be influenced more by a cooperative partnership between the EU institutions, Member States and other social partners, rather than by imposing a direction and sanctioning any deviation from the EU's preferred mode of action. The OMC thus seems to be an essential tool for the development of social cohesion and integration in the Union.

2 THE EUROPEAN UNION ON AGEING AND HOUSING ISSUES

The Union, like the rest of the world, is experiencing a critical change in its demographic structure, as its population is rapidly ageing and the number of older people is increasing dramatically. Demographic ageing of that scale raises socio-economic and political concerns, as will be explored below, such as the viability of pension systems and the cost, quality and availability of healthcare for the elderly. Ageing implies that a person will have different needs in old age, whether it is related to health, income, or housing. The current state of national housing stock will have to undergo some adaptation to the physical, social and emotional needs of the older generation.

It is important to note, however, that although the EU has no direct competence over older people and/or housing-related issues, the ageing issue is nevertheless a priority issue on the EU's social agenda, and housing-relating matters (e.g. sustainable/social housing, fuel energy) are being addressed at various levels and degrees. Arguably, changes are to be expected with the Charter of Fundamental Rights of the European Union, currently not legally

binding, but as it is now included in the draft Constitution for the European Union, which will be a binding document, it is likely that the EU competence on elderly and housing matters will be extended, as can be inferred from the following articles:

Article 7 – Respect for private and family life: Everyone has the right to respect for his or her private and family life, *home* [added emphasis] and communications.

Article 25 – The rights of the elderly: *The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life* [added emphasis].

Article 34 – Social security and social assistance:

1. The Union recognises and respects the entitlement to social security benefits and social services providing protection in cases such as ... *dependency and old age* [added emphasis]...

3. In order to combat social exclusion and poverty, the Union recognises and respects the *right to social and housing assistance* [added emphasis] so as to ensure a decent existence for all those who lack sufficient resources...

Article 35 – Health care: everyone has the right of access to preventive health care and the right to benefit from medical treatment...

Policy makers would have to consider these (future) legal provisions and would have to ensure that they are not violated when formulating policy on elderly and housing related issues. Better still is that Member States' policy makers may be required to incorporate these principles, i.e. older people's independent living and dignity, elderly participation, entitlement to social and housing assistance, within any future health, social and housing policy document. This would, for instance, contribute to reinforcing the trend towards the promotion and development of preventive measures and rehabilitation services in healthcare, elderly autonomy, manageable homes, housing expenditure and conditions, etc.

The EU's current position, measures and/or policy on older people and housing related issues are now examined in the sections below.

2.1 THE AGEING CHALLENGE

The European Union's demographic profile, which shows a noticeable ageing of the population and a progressively growing number of older people within society, has resulted in the elderly becoming an important topic on the EU's political agenda, for both economic and social reasons.

The demographic ageing and increase in the number of older people in the EU can be explained by a combination of factors, including low birth rates, extended longevity (due to better health and improved living conditions) and the generation of 'baby-boomers' who are now reaching pensionable age. It is estimated that people aged 65+ represent 16% of the EU population of today and will reach 18% in 2010; in comparison, the percentage of those aged 15 and under will have decreased to 16% by then. The biggest change will occur in the 'fourth age' group, i.e. those aged 80+, as their number will increase by an overall 50% by 2020 (European Commission 2003). Trends also show a predicted decrease of almost 20% in the number of people in the 20-29 age group by 2020, whilst those in the 50-64 age group will increase by 25% (COM (2002) 143 final).

The implications of an ageing society are manifold and cover issues such as economic development, employment, discrimination, public expenditure and social protection. In its communication paper, "Towards a Europe for All Ages", the Commission of the European Communities refers to the ongoing structural changes of the Union's demographic design as the 'ageing challenge', and identified prime economic and social implications brought on by the ageing EU population, including a declining working age population and ageing labour force; tensions on pension systems and public finances; a growing demand for care and healthcare for the elderly; age-related social exclusion and poverty; and gender inequality affecting older women's pension rights (COM (1999) 221 final).

The Commission states that the ageing challenge cannot be dealt with as an isolated issue and must be part of an "overall strategy of mutually reinforcing policies" (COM (2002) 143 final), which cover economic, employment and social considerations, through close collaboration between the EU and its Member States, and the cooperation process (i.e. OMC) between the EU, Member States and social partners. It has indeed been commented that the implications of an ageing population "go beyond the realm of action of individual nations" and "concern about the possible impact of such changes on the funding and provision of benefits and pensions schemes, and thus on workers' mobility, public expenditure and international competition, helps to explain why the Union's institutions have identified ageing as an area for concerted action by member states" (Hantrais, 2000, p.141).

The position adopted by the EU, and confirmed as one of the priorities of the Lisbon Strategy for 2004 (see COM (2004) 29 final/2), is to promote 'active ageing policies and practices', which are substantially oriented towards encouraging older people's extended participation in the labour market in order to reduce dependency rates and associated pressures on the financing of pension, health and social care systems. However in the words of Geert de Cock (2003), active ageing also "... refers to continuing participation in social, economic, cultural and civic affairs, not just the capability to participate in the labour force" (p.5).

Therefore, the scope of active ageing is aimed at keeping older people within the work force for longer by curbing early retirement exits and favouring later gradual retirement instead, as well as offering career development and progression through life long learning programmes; and by promoting post-retirement 'capacity enhancing and health sustaining activities'. The Commission states, "such practices aim to raise the average quality of individual lives and at the same time, at societal level, contribute to larger growth, lower dependency burdens and substantial cost savings in pensions and health" (COM (2002) 143 final, p.6).

The Union's focus in relation to ageing is thus heavily directed towards establishing effective policies for the promotion and development of social protection (including pensions, health and long-term care of the elderly), anti-discrimination and social inclusion.

2.1.1 Pensions

2.1.1.1 EU Legislation relating to pensions

As stated before, the EU's policies are based on supporting the common market's development and economic growth, which is now closely linked to social issues. It thus appears that aims set out by the Treaty establishing the European Community (ECT) can only be carried out if social considerations are addressed. Table 1 below is an overview of measures relating to pensions, which have ensued in order to achieve and be in conformity with ECT articles towards the completion of the Internal Market and the Single Currency:

Table 1: Summary of EU Legislation relating to pensions

Art.42 ECT: Portability of pension rights

- **Council Regulation 1408/01** on coordinating social security in the EU (covers pension matters, including statutory and occupational schemes).
- **European Directive 98/49/EC** on safeguarding supplementary pension entitlements.

Art.43 ECT: Freedom of establishment / Art.49: Freedom to provide services

- **Council Directives 79/267/EEC** and **90/619/EEC**, both amended by Council Directive **92/96/EEC** on establishing a single market for direct life assurance.
- Proposal (COM (2000) 507 final) on defining the role, responsibilities and range of activities of institutions for occupational retirement provisions.
- Proposal (COM (2001) 214 final) on eradicating tax obstacles to cross-boarder provision of occupational pension scheme.

Art.99 ECT: Co-ordination of economic policies

- “Member States need to develop comprehensive strategies for addressing the economic and budgetary challenges posed by ageing populations. Strategy measures might include reform of pension and health care systems, and care for the elderly, increasing the effective retirement age, stimulating higher labour supply participation, especially for older workers, setting-up and increasing public pension fund reserves and possibly encouraging the expansion of supplementary privately-funded pension schemes...” (Broad Economic Policy Guidelines for member states and the European Union, adopted at the European Council of Gothenburg 2001)

Art.125 ECT: Achieve a high level of employment through a coordinated strategy

- This is an objective being addressed by the European Employment Strategy (EES), which aims to increase women and older workers’ employment rates.

Art.137 ECT: Promote high standards regarding worker’s rights

- Both **Council Directives 80/987/EEC** on protecting workers when employers are in insolvency and **2001/23/EC** on protecting employees in situations of undertakings or business transfers contribute to the protection of employee’s supplementary pension entitlements.

Art.140 ECT: Achieve a high level of social protection by encouraging cooperation between Member States and facilitating the coordination of their action

- The Open Method of Coordination (OMC) is being advocated by the Commission (COM (2001) 362 final).

Art.141 ECT: Promote the equal treatment of men and women

- **Council Directive 79/7/EEC** eradicating sex discrimination and promoting equal treatment of men and women in social security related matters, advocating for

discrimination on retirement age to be progressively eliminated.

- **Council Directive 86/378/EEC**, amended by council directive **96/97/EC**, on equal treatment between men and women in occupational social security schemes.

(Source: COM (2001) 362 final)

In addition, the **Council Recommendation 92/441/EEC** on social security schemes ensures a minimum income in old age; the **Council Resolution 95/C228** on the employment of older workers encourages access to an early retirement pension; and **Regulation 574/72** and **Regulation 1408/71** are concerned with the co-ordination of pension entitlements for workers who move between countries. However, they do not cover non-statutory occupational pension schemes (see <http://www.age-platform.org/EN/B-Policy/B-Pensions.htm>)

Finally, a new **European Directive (2003/41/EC)** on the Activities and Supervision of Institutions for Occupational Retirement Provision (IORPS directive) represents a first step towards occupational retirement provision organised on a European scale, the plan being that these pensions will complement the existing social security pensions systems, which are coming under increasing pressure. The directive enables institutions to operate across borders and encourages the redirection of savings into occupational retirement provisions. It also recommends that employers and employees consider the risk of increased longevity in setting up their pension schemes.

2.1.1.2 Pensions systems reforms

The reforms of pension systems are a central element of a strategy for modernising social protection with a view to creating an active welfare society, as well as for ensuring a high level of social cohesion. They also play a key role in ensuring fiscal consolidation, quality and sustainability of public finances. (Com (2001) 362 final, p.9)

A first consequence of demographic ageing is the demand it places on pension systems in terms of public funding and long-term sustainability, repartition and distribution of resources, economic development and workforce supplies. These demands can be exacerbated and proven more problematic according to the type of pension system in place in a given Member State. Despite the differences in pension systems, Member States have agreed that there is a need for collaboration and coordination when elaborating pension policies, and an essential goal of the EU Social Policy Agenda to render pension systems safe and sustainable (COM (2000) 379 final) is further amplified by three established strands for action, namely: pension adequacy; pension systems financial sustainability; and modernisation of pension systems in accordance with economical, social and individual changing needs (Council of the European Union 2003 – 7165/03 ECOFIN 76 SOC 115).

The EU favours an integrated approach to reforming pension systems, which is described as a “triangle’ of mutually reinforcing policies – employment, social protection, and economic and budgetary policy” (COM (2001) 362 final, p.9), and which covers economic policy coordination, OMC, and employment policy and practices. This coordinated structure is aimed at enabling and supporting Member States’ national policy to achieve safe and sustainable pensions, through the realisation of the following objectives:

Adequacy of pensions

The more adequate a pension system is, the better it caters for the basic needs of retired people. The objectives are thus to prevent and/or reduce the risks of poverty and social exclusion; enhance their ability to participate actively in all strands of societal life (e.g. public, social and cultural life); and enable them to maintain a decent standard of living, which can be supported better access to public/private pension schemes, and inter- and intra-generational solidarity (Council of the European Union 2001 – 14098/01 LIMITE SOC 469 ECOFIN 334).

Financial sustainability of pension systems

As stated above, demographic ageing is associated with serious financial considerations, in particular as regards the capability of public finances to cope with heavy structural changes brought on by a growing pensionable age band and a reducing and smaller labour force. The Commission has thus stated that promoting a rise in employment rates is crucial to attain pension sustainability, and factors contributing to this rise include: immigration; reduced early retirements; promotion and encouragement of older workers' extended labour market participation; and facilitation of gradual retirement. In addition, public finances sustainability may also be supported by fiscal policies, and a fair repartition of responsibility for sustainable pensions between active and pensioner groups (i.e. not one group should be disadvantaged or bear a heavier burden than the other). Also, there is clear need for the implementation of a sound regulatory framework and management, which will allow pensioners to receive efficient, affordable, portable and secure pensions, whether they are publicly or privately funded (Council of the European Union 2001 – 14098/01 LIMITE SOC 469 ECOFIN 334).

Modernising of pension systems in response to changing needs of the economy, society and individuals

Demographic ageing is an issue that has come on the EU political agenda only fairly recently, and as stated previously, was formerly a matter of national policy. However, as it is now included in the policy coordination model of the Union, it requires new thinking and new approaches. As current pension systems seem unable to operate successfully in tackling the ageing challenge, it is to be assumed that such systems need improvement and modernisation, which the EU advocates should be made "... to take account of changes in society and to make sure that they cater well for the needs of a more mobile and flexible workforce and of less stable families" (COM (2001) 362 final, p.7).

The objectives are thus to promote pension systems compatibility to the flexibility and security requirements of the labour market; to ensure that workers' pension entitlements are not penalised by cross-boarder mobility and that pension systems also cater for self-employment ventures. In addition, the modernisation process implies that reforms be in accordance with the gender equality principle (i.e. address sex discrimination in the current repartition and distribution of pension benefits), and that pension systems be transparent, predictable and adaptable to changing circumstances.

Other reforms which should accompany these objectives are the provision of reliable information on the developments of pension systems through the assessment and monitoring of factors impacting on the systems, including demographic, socio-economic and political evolution (Council of the European Union 2001 – 14098/01 LIMITE SOC 469 ECOFIN 334).

In the 2003 joint report on adequate and sustainable pensions (7165/03 ECOFIN 76 SOC 115), which assess the Member States' national pension systems and policies the Commission and the Council state:

"The national strategy reports present a wide range of positive developments with regard to the common objectives. While financial challenges have been the main driving force for reforms, Member States have respected the social objectives of their pension systems and

are making efforts to adapt their pension system to changing societal needs. This balance between social and financial reforms is key for the political success of pension reforms ...

Ageing will start to produce its effect on pension systems within the next 10 years in many Member States. It is therefore urgent to put in place credible and effective strategies and to give clear signals to citizens about what they can expect from their pension systems and what they have to do to achieve an adequate living standard in retirement" (p.8-9).

2.1.2 Healthcare, long-term care and care of the elderly

The modernisation and improvement of social protection also implies "high quality and sustainability of health care" (COM (2000) 379 final, p.20). Social protection encompasses pension, health care and long-term care related issues (European Commission 2003). The Commission advocates "there should be policies to curtail the growth in dependency through the promotion of healthy ageing, accident prevention and post-illness rehabilitation" (COM (1999) 221 final, p.4).

Demographic ageing raises challenges of a different nature regarding the health care systems, for instance: older patients have specific needs, which need to be addressed by specialised staff, this poses a problem if there is poor staff training and low staff supply; older patients are likely to spend more time in hospitals if their health and housing conditions would make it a risk for them to return home, which would be a problem if there are no sufficient hospital beds available; on the other hand, poor financial status would prevent an older person from accessing health care, and could seriously jeopardise their access to adequate long-term care and arrangements.

In its communication, *Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the "open method of coordination"* (COM (2004) 304 final), the Commission addresses the impacts of the ageing challenge on health care systems and provides a set of objectives dedicated to supporting Member States' policy in this field in order to achieve: accessibility of care, high quality care and financial sustainability.

The Commission also raises the issue of staff ageing and its impact on employment, as close to 30% of the healthcare staff in the EU in 2001 are in the 45-54 age group, "which could lead to a demographic time bomb in years to come" (COM (2004) 304 final, p.5). Indeed, these workers will reach retirement in this general demographic ageing situation, implying that there is likely to be (even further) staff shortages in health and social care services, which would have to compete with other sectors for staff recruitment. People must be satisfied and attracted to work in the health sector, therefore in order "to meet the challenges posed by demographic trends and technological progress, it is vital to have a sufficient number of trained professionals and to give them quality jobs" (COM (2004) 304 final, p.5).

A joint report from the Commission and the Council (Council of the European Union 2003) recognises that the need for long-term care is likely to increase as a result of various social and economic factors. Indeed one of the major effects of the demographic trend in ageing will be an increase in older people requiring long-term care, additionally age-related diseases are likely to increase in their prevalence. However, some theories propose that these effects may be mitigated by an improvement in the general health of elderly people and severe illness may be delayed until the end of life. The report encourages emphasis on preventative strategies particularly aimed towards younger and middle-aged people. A number of planned policy issues arose from this report and those relating specifically to the health needs of older people were as follows:

- The need to provide alternative geriatric or post-acute facilities for rehabilitation outside hospitals in order to free up space in hospitals and to enable active and independent living for the elderly as far as possible.
- The establishment or re-activation of local health centres in order to facilitate access to care and, through a multidisciplinary approach, to appropriate treatment.
- Improve access for certain categories of the population (self employed, elderly, people on low income);

Member States acknowledged that the ageing of the population would pose new challenges in relation to healthcare and access to health care. With regards to long-term care some countries are aiming towards integrated and continuous care that addresses the range of complex health needs. Systematic evaluation of the quality of care is only found in some Member States; however, in nearly all EU countries measures have been introduced in an attempt to safeguard the right of the patients.

2.1.3 Discrimination

Age discrimination exists within all the European Union Member States. The forced removals of older workers through retirement, or the focus of health care resources on younger populations, are both examples of age discrimination. Furthermore, such discriminatory practices result in serious economic and social costs. In the UK alone the cost of age discrimination is estimated at 25 to 30 billion Euros per annum.

Since 1997 the EU has taken steps towards combating age discrimination with the introduction of the Framework Directive on equal treatment (2000). It was stated that this Framework was to be implemented by all EU Member States by December 2003. However, the outcomes of this are not consistent across the Union. Although some Member States have employed a wide-ranging approach to tackle all age discrimination, other countries have only focused on employment. Thus although this framework is useful in the fight against age discrimination it still holds limitations, the most notable being:

- The focus on age discrimination in relation to employment issues
- A period of up to 3 years longer for Member States to address age-related discrimination compared to other forms of employment discrimination

The EU also aims to strengthen the fight against discrimination and promote the reinforcement of fundamental social rights, as well as tackle gender inequality by encouraging the "... full participation of women in economic, scientific, social, political and civic life as a key component of democracy" ((COM (2000) 379 final), p.21).

2.1.4 Social exclusion / inclusion

Article 137 of the Treaty of Amsterdam states:

"The Council, acting in accordance with the same procedure, may adopt measures designed to encourage co-operation between Member States through initiatives aimed at improving knowledge, developing exchanges of

information and best practices, promoting innovative approaches and evaluating experiences in order to combat social exclusion."

In March 2000 the European Council of Lisbon adopted an Open Method of Communication in a bid to address the problems of poverty and social exclusion by 2010. This method involves several key elements such as the development of Common Objectives and National Action Plans and encourages Member States to work together in tackling social exclusion. The Common Objectives as agreed by the Nice European Council 2000 still advocate that, "employment is the best safeguard against social exclusion". However, there is also recognition that access to pensions and healthcare is important in working towards social inclusion.

In tackling social exclusion, public policy has traditionally placed emphasis on the younger generations, teenage mothers and those who are unemployed for example. Moreover, much previous work in this domain has posited the engagement in paid work as its central focus. This is problematic when understanding social exclusion in relation to older adults due to the forced withdrawal from the labour market upon reaching the standard retirement age (Walker 2000). The joint report on social inclusion presented by the Council in March 2004 stated that tackling social exclusion is 'first and foremost' the responsibility of Member States; it also promoted action to tackle social exclusion in favour of a number of specific groups, in which the elderly are included. The provision of quality services, which are affordable and accessible, remains a challenge for some Member States. Indeed one key policy direction will be to ensure access to appropriate healthcare for all including in cases of dependency.

Another objective of the Social Policy Agenda is to promote social inclusion in order "to prevent and eradicate poverty and exclusion and promote the integration and participation of all into economic and social life" (COM (2000) 379 final, p.20).

2.2 HOUSING

2.2.1 EU Member States' Housing Ministers informal meeting

"Housing policy is the exclusive responsibility of the European Union Member States", as reiterated in the Final Communiqué of the 14th meeting of the Housing Ministers of the Member States of the European Union in June 2002; however, the EU Housing Ministers, who have been meeting annually since 1989 to discuss housing issues across the Union, recognise that "these meetings contribute to the formulation of measures to promote social cohesion, the environment and sustainable development, in line with the Charter of Fundamental Rights" (2002).

In 1999, the EU Member States Housing Ministers met in Kuopio to address issues relating to housing and the elderly. In their communiqué, the Ministers advocated the importance of choice for older people in relation to their accommodation and the support services they may use, and highlighted the need to give special consideration to older people whose health and finances put them in a vulnerable situation. From this perspective, it is arguable that there is a need for housing and care agencies to co-operate in providing good quality accommodation; and that living conditions and the involvement of older persons themselves in developing strategies should be encouraged.

The Ministers went on to propose that, in order to help alleviate the housing problems for older people, support should be provided to enable living at home for as long as possible. It is contented that if and when a person needs to move to alternative accommodation this should be a positive choice; it is thus essential that greater attention is given to ensuring

homes can be adapted to meet the needs of the individual and can continue to do so in the case of further age-related decline. Housing must be accessible, convenient and safe. The needs of elderly people should also be borne in mind in the building of new dwellings and funds should be used to adapt existing housing, as this is more cost effective than financing institutional care or service housing. A further element suggested to be of importance was the development of new technologies to aid independent living for older people. In cases where older people own their own homes, there is a need to enable these people to access the capital tied up in their houses to help fund for example, repairs or adaptations to the house or home support services. However, it must be noted that not all elderly people will retain the capacity to live in their own homes throughout their later life, particularly those in the oldest-old population. Thus Ministers recommended that 'an appropriate level' of institutional care should be provided and conditions of this care should be improved. Furthermore, alternative, non-traditional housing/care support should be considered to increase diversity and choice.

The scope of the Housing Ministers' proposals is to include all categories of older people, i.e. those living at home, in institutional care or alternative accommodations: "There is a particular need for appropriate policy measures to tackle social disadvantage and to ensure a good quality of living conditions, accommodation and services for all older people, including those who are not able to live independently" (Ministers of Housing 1999, para. 5). The Housing Ministers acknowledged that the issue of housing for the elderly is a complex matter due to the fact that it raises many questions: indeed, when considering older people's housing, older people's issues should be addressed first, such as health issues, including their mobility, level of (in)dependency, access to services and local amenities, their financial situation. These issues should also be considered in conjunction with the quality of housing available, accommodation options and accessibility/barrier-free environment. These considerations imply looking at the bigger picture with regards to older people's housing, and thus require various branches of expertise, ranging from housing services to social services and health services.

In terms of shaping future housing policies, the Ministers tend to favour a holistic approach by advocating inter-agency co-operation and co-ordination and including older people's consultation in the process, thus taking into consideration their expectations, views and requirements (Ministers of Housing 1999, para. 5). Paragraph 12 of the communiqué states: "Housing for older people is something far more than a question of housing policy, and therefore, it is important to ensure that solutions are part of integrated strategies, incorporating, as appropriate, housing, transport, health and other services. The Ministers emphasised that ensuring well-being of older people requires better cooperation between different agencies, including public, voluntary and private. This refers to housing policy, social and health care, and general social policy." The Ministers also make the link between housing and social inclusion and emphasised that future policies should recognise older adults as a valuable resource within communities and strive to create neighbourhoods with mixed age groups. In paragraph 13 of their communiqué, the Ministers state "Housing for older people should be developed alongside general housing to help ensure the social inclusion of older people".

In 2003, the Ministers met in Padua to discuss aspects of housing policies in relation to European Integration, and the link between housing and social exclusion/inclusion was further stressed. The European Ministers again noted that "although housing is not under the direct competence of the EU, it has complex links with many important issues with EU policies" and that "...housing policies under national competence are affected by several ever more binding European laws and other activities". It was also agreed that housing was paramount in fighting social exclusion due to the effects it can exert on health, safety and wellbeing. The principle of the right to housing, which is included in most EU countries' national legislation, can be interpreted as being part of the EU's constitution through the right to social and housing assistance stipulated in Title IV, Art.II-34-3: "...in the struggle against social alienation and poverty, the Union recognises and accepts the right to social assistance

and assistance in housing for the purpose of ensuring a dignified existence to all those who do not possess sufficient resources according to the methods established by European Union law and Member nation legislation and procedures". To which extent this article will be formulated in practice, through subsequent EU legislation and policies on housing, and Member States' implementation, remains to be seen once the constitution is ratified by the latter.

3 ENABLE-AGE NATIONAL POLICY OVERVIEWS

As explained in the introduction, one of the ENABLE-AGE project's objectives was to provide a systematic national policy review on housing and older people-related issues. The methodology for this has involved each national team filling in a common information template, e.g. information on: background information on health and welfare systems and older people; brief summaries of key reports on health housing and older people; key policies on health, housing and older people; general policy on accessibility issues; role of NGOs; pilot schemes; key issues and dominant problems. Below are overviews of these policy reviews for each of the project's participating countries.

3.1 HUNGARY

3.1.1 National background and healthcare & welfare systems

Hungary's older **population** is growing rapidly, both in terms of biological (longer life expectancy) and socio-economic (pensioners) ageing, with the over 60 year-olds forming close to 20% of the national population in 2000.

The Hungarian **welfare system** can be likened to the German/Austrian corporatist-etatist model and is described as 'a constantly changing welfare mix', with, for instance, social insurance and social help included within the social security system; the pension system differing according to the birth year, with the former system applying to those born before 1939 (men) and 1947 (women), and the current system, implemented in 1998, operating in a three-pillar form (compulsory pension funds; private pension funds; voluntary benefits funds) for those born thereafter. There is no basic pension for either of the pension systems.

Changes have also occurred for **healthcare services**, which used to be automatic for all citizens pre-1992, but have since been operating with the Health and Pension Insurance Funds, which finances health insurance services and reimburses treatment and medicines expenditure for those entitled to compulsory insurance. This, in effect, results in healthcare services being inaccessible to certain social groups. The Hungarian healthcare system is said to operate 'in a very distorted manner' and faces problems such as regional inequalities, the deterioration of citizens' health status, lack of system transparency, a semi-privatised state and medicine price increase due to full privatisation of pharmaceutical industry. Furthermore, the practice of 'gratitude money', which is an informal but substantial payment made to the doctor, the nurse or other health professional in addition to the normal charges (reimbursed by the social insurance), particularly disadvantages the elderly population as such a payment, made at each health visit, can amount to a high portion of their monthly income.

The provision of **social care services** is the responsibility of local authorities; although, non-governmental organisations (NGOs) play an important part in supporting local authorities to fulfil their duties, as well as in shaping welfare policies for the elderly and their carers. These organisations also often have better trained staff and provide a higher standard of services than that of the public sector.

In brief, Hungary's welfare system is in transition with multiple services providers, including central state government, local authorities, NGOs and the private sector, with the last two playing an increasingly important role in the provision of services, as the involvement of governmental bodies seems to recede.

3.1.2 Health, housing and older people

There appears to be a disproportionate number of health professional (i.e. doctors) practicing in the cities, compared to those in the rural areas, where very little **healthcare services** are available to the older inhabitants. Similarly, the Budapest older population seems to have better health indicators than its national counterparts, which is explained by a better financial and housing situation and healthcare services.

In general, there has also been a policy to cut down on the number of hospital beds available in internal medicine departments, where the elderly constituted 40% of the in-patients. Indeed, until recently, rather than adapting the home environment, Hungary's policy for older people, who are unable to remain in their own homes as a result of their deteriorating health and function/mobility conditions, has been to admit them to either welfare homes (now residential homes since 1986) or to chronic wards. The latter's cuts therefore have an impact on the elderly, their health, independence, quality of life and housing accommodations.

Indeed, the only alternative to living in poorly equipped homes is to move into residential housing, which remains in insufficient number compared to the growing demand. Besides, new residential homes maintained by NGOs or market actors are rather expensive, with older people not often able to meet the cost of admission fees.

In relation to **basic house facilities**, more than 90% (91.4%) of Hungarian household are owner-occupied and over 80% have water mains connection, sewerage and bathrooms facilities.

Housing policies vary according to the government in power, who will direct its policy based on its targeted electorate. Arguably, this can result in policy inconsistency, social instability and national uncertainty, as it appears that the housing policies will be aimed at a certain portion of the Hungarian society, to the detriment of the rest.

Although there is little or no policy as regards providing older people with **barrier-free homes**, Hungary, in a bid to reach EU standards, has set the governmental programme KINCS three main objectives: development, emphasis on welfare & health and supporting environment for the elderly. KINCS aims to improve the poor infrastructure and other housing related problems of elderly accommodation in order to enable them to stay put in later life.

3.1.3 Policies, legislations and schemes

Although there appears to be little **legislation relating to older people specifically**, some will impact on the elderly situation by assimilation, with, for instance, laws on housing construction imposing a requirement to build obstacle-free environments, in conformity with EU guidelines; or, a law regulating living conditions for 'disadvantaged' groups, which only applies to handicapped people, but which can be applied to handicapped elderly; or again, a legislation requiring that public building be made accessible to people with limited mobility (which does not apply to private homes).

A number of **policies addressing older people's needs** have also been implemented to promote rehabilitation, safe and independent living at home, reduction in long-term institutional care settings for the older generation, and specialist training for health professionals caring for the elderly.

Funding for housing improvements are quasi-inexistent, although governmental programmes may provide some kind of help through the implementation of housing schemes for adaptations and improvements (e.g. KINCS).

NGOs play an important role in the provision of Hungary's welfare, social and housing services by supporting local authorities in fulfilling their responsibilities including: emergency aid, information & social mapping, supplementary activities, creating models & launching institutionalisation and contracting out. In relation to housing, NGOs also run various programmes aimed at the elderly population, such as: building sheltered homes for elderly homeless people, building residential homes close to family settlements to encourage interaction, or launching home appliances repair services.

3.1.4 Key issues / problem areas

Despite a lack of clear governmental commitment to address older people's housing issues, policies and programmes are still being set up with the involvement of various actors such as sociologists, social workers/planners, architects and NGOs. Moreover, although some progress over the creation of barrier-free external environments has been noted, the concept 'obstacle-free' is still narrowly interpreted, resulting in practical implementation falling below the EU regulation and architectural standards for public institutions. In comparison, regulations for barrier-free homes are non-existent, and funding for home improvement/adaptation/alteration is available to disabled people only.

3.2 GERMANY

3.2.1 National economic background of older people

People aged 80+ form 4% of the German population, with a majority (70%) of this age group being female. Despite an **economic picture** described as satisfactory, gender inequality affects the distribution of income and assets and women are at a higher risk of poverty. In general, nearly 20% of the very old live in relative poverty, receiving less than half the national average income, with housing costs constituting up to 30% of their disposable income. 4% of those aged 80+ depend on state benefits for housing expenditure, social welfare and long-term care.

This small percentage may, however, not reflect the total number of older people who would need such benefits, as the latter are, in general, quite reluctant to exercise their rights to social or housing benefits due to complicated application procedures. Poverty is a factor for housing relocation in old age, which is particularly true for those who do not have a strong family net and support to allow them to stay put and remain independent.

3.2.2 Welfare & healthcare systems

Germany counts six leading welfare organisations and other not-for-profit organisations, whose role is to lobby for the interests of various groups, such as older people.

The **welfare system** is characterised by a collaboration of governmental and non-governmental organisation, and is based on employee insurance schemes, which include: pension, statutory health insurance, and long-term care insurance. The long-term care insurance favours home care against in-patient care. Important means-tested social benefits for economically disadvantaged citizens are social welfare, housing benefits and social assistance for special circumstances (i.e. old age, disability, illness). Recently, the system of social security has undergone several major changes: Since the pension reform in the year 2001, employees are encouraged to supplement their obligatory statutory pension insurance with a voluntary private pension insurance (Riesterrente). In the course of the comprehensive reform program of the welfare state of the Federal Government called "Agenda 2010" the pension system has undergone an important reform in the year 2003 in order to tackle poverty in old age: it abandons means-testing of pensioners' relatives and allows them to

receive basic benefits. Likewise in the course of the “Agenda 2010” the statutory health system has also seen some changes in relation to the principle of cost reimbursement of medical treatment, with patients now charged for most medical treatments. This has an adverse impact on the older population as they must collect vouchers and apply for exemption to be reimbursed; however, here again, the prospect of filling in application forms and going through complex administrative procedures may be daunting and act as a deterrent for those with visual/cognitive impairments and without appropriate assistance, thus effectively preventing them from receiving benefits and reimbursement to which they are entitled.

The **healthcare system** comprises of two branches: acute medical care and long-term care, but suffers from structural problems centred on the strict separation between ambulatory and in-patient care.

These problems include: budgetary issues; ineffective communication between health professionals; concentration on acute medical care; increasing cost pressure; deficits in prevention; rehabilitation and geriatrics; and deficiencies in the coordination of the various care service providers, which ultimately affect the organisation of adequate needs-based care arrangements.

The **care market** has experienced changes since the introduction of the long-term care insurance in the year 1995, when the leading non-statutory welfare organisations faced more competition with the introduction of private care providers on the market. Although the former provide a wider range of care services, and the latter provide mainly specialist and medical-oriented care, there still remains a gap in the provision of informal primary care, with 71% of long-term care insurance beneficiaries preferring to receive monthly cash benefits for familial care rather than flat rates for professional service providers. In comparison, the provision of formal home care is on the increase since 1995, although there seems to be a growing number of seasonal non-registered care providers from East European countries, who are favoured against the more expensive professional care providers. Seasonal care workers appear to solve issues of bureaucracy, lack of flexibility and continuity of personal care which ‘plague’ formal service providers; however, this situation can be problematic for quality assurance and consumer protection purposes. Nearly 20% of people aged 80-85 are in need of long-term care.

Health and social policy objectives are to promote quality assurance and cost efficiency in acute and long-term care.

3.2.3 Housing, policy and legislation

Most older old people live in **private households**, 17% live in nursing homes and only 2% live in ‘novel housing’ models (e.g. home communities). Over 50% of those aged 60+ are owner-occupiers, close to 50% live in rented accommodation, and less than 2% are sub-tenants. This relative low percentage of elderly owner-occupiers can be a problem for the development and installation of home adaptations and barrier-free environments, as people are less keen to make such investments in their rented accommodations, affecting women and ethnic minority elderly most. There has been an increase in both East & West Germany of people aged 65+ who now live in modern dwellings, which include a bathroom, inside toilet and central heating. However, there is also an increasing prevalence of older people living in substandard accommodation, which was higher in East Germany than in West Germany in 1993.

Despite a majority of elderly wanting to remain in their own homes in later life, they may often only do so if they can rely on a family member, other significant person or professional custodian to organise their home care; however, 20% of people aged 65-80 will be subject to **relocation** into a nursing home following a medical intervention and subsequent change in their needs, due to inadequate housing, lack of supportive home environment, loss of partner, or poor finances. However, it also appears that relocation tend to have a positive

impact on the individual's quality of life as it may result in similar or better housing conditions, adequate environment, stimulation, accessibility and social participation.

On a federal level, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth is the governmental body dealing with elderly housing issues, although federal states and municipalities are the main responsible bodies for implementing policies relating to elderly matters, which are established by the Federation. The main objective of the **national housing policy** in general is to promote real estate to constitute social security in old age, encourage housing stock modernisation and tackle social and spatial marginalisation. In relation to housing for the elderly, the policy is to promote ageing at home and quality assurance standards through funded programmes, which encourage barrier-free housing. Federal government reports on ageing recognise that interventions must consider a vast ray of factors to promote healthy ageing at home, including medical care, socio-economical and housing-related issues.

The **housing needs** of older people still have a long way to go before being satisfied, as there is a need for preventive and needs-based adaptations measures to be further developed and for specialist housing regulation in terms of barrier-free and service quality assurance. Nevertheless, since the 1990s, there has been an impetus to promote barrier-free private living environments, and since 2002, the Federal Government has committed itself to ensure barrier-free public buildings and public transportation and funds barrier-free modernisation of social housing units for economically disadvantaged older and disabled people. **Legislation on barrier-free environment** for public buildings, workplaces and private dwellings bases largely on the German Industrial Norm standards DIN 18024 and DIN 18025 which consider specific housing needs of disabled people and incidentally applies to the elderly.

Presently, the legislation on barrier-free environments differs in the individual Federal States. Due to the German Federalism, the Federal Government can only recommend the standard use of DIN 18024 and DIN 18025 in the legislation on barrier-free building. **Funding for housing adaptations** comes from a variety of sources, including private funding, long-term care/statutory health insurance, social welfare, or federal/community initiative on housing modernisation.

The latter specify which measures may be funded, but the limited and out-dated array of choices available does not encourage older people to apply for adaptations or use technical solutions, nor does it allow for the development of new and innovative products.

3.2.4 Neighbourhood / social participation / counselling

The situation of older people seems to receive a lot of public and governmental attention, as shown by the number of reports on ageing from the Federal government, with their care, welfare and housing needs being considered and recognised. However, despite a federal effort to promote barrier-free environment standards, these are not systematically applied on the housing market. It is argued that, for the needs of the older generation to be met, consideration must be given to neighbourhood-based support, as there appears to be a link between social/spatial marginalisation and disadvantaged neighbourhoods; indeed, the very old are most likely to experience some form of social isolation and be affected by substandard housing.

As the trend seems to go towards smaller housing and care units in the neighbourhood, it has been suggested that one-stop counselling services should be available to promote a new integrated care and service structure, which adopts a holistic approach to the needs of older people and considers the following simultaneously: supportive home environment design, professional care management, informal carers' support service, volunteers' motivation. The objective would also include maintaining elderly social and community participation to prevent isolation.

3.2.5 Key Issues / Problem areas

The complex implications of the demographic challenge for housing and urban planning have not yet been fully recognised. The regular housing stock needs to be modernised according to barrier-free standards, as defined in the DIN 18024 and DIN 18025. Since the latter DIN standards are criticized for being complex and user-unfriendly, the development of a more user-friendly and integrated set of barrier-free building standards in the future DIN 18030 is still in progress. To meet the needs of future older people housing options will have to be closely linked to neighbourhood-based support, care structures, new technologies, including accessible and safe public transportation. Presently the housing needs of people with dementia and immigrants are insufficiently considered. A nationwide centrally coordinated and dense network of housing counselling service needs sustainable funding and should be integrated in a complex model of on-stop counselling, comprising housing adaptations, assistive devices, case management, counselling and support of care persons, relocation management etc.

3.3 LATVIA

3.3.1.1 National background and health & welfare systems

The Latvian population is ageing and research seems to show that Latvia is progressively becoming an 'old' state as the number of very old people increases. In 2001, the older age group constituted 22.4% of the national population, with a majority being female. There is a large number of **pensioners** due to the fact that the pensionable age was set at 55 (women) and 60 (men) until 1996; however, this number is now decreasing following reforms to pension laws setting the retirement age at 62. Pensioners are described as a 'socially vulnerable' group, with limited economic resources, considering the low average pension income, which is below the national survival minimum.

It appears that, although there is a slight improvement in the general condition of the Latvian population, the state of its **health** and healthcare system has declined since the country gained its independence. In 2002, 80% of the deceased people were aged 65+, with a mortality ratio 1.7 times higher than for births. A survey has shown that people rate their health at 6.6 out of 10 (1 being the lowest rate).

Healthcare reforms started in 1992 to change and re-organise a former centralised and inflexible system based on the Soviet model. Healthcare services are provided by governmental agencies, including: the state, municipalities and private health institutions.

Compulsory **health insurance** is funded by both taxpayers and the state, which allows beneficiaries to receive certain health services; however, patients still have to cover some expenses (patient deposit), which amounts to nearly 40% of the total cost, which seems to be a source of concern for people who fear being unable to pay for services or receive quality treatment when needed. Furthermore, the 'custom' that the patient must give additional payments in exchange for medical services is widespread and contributes to the inequality of access to services for people with low income. Accessibility and quality of healthcare services are issues with a geographical dimension as well since there are differences from one region to the next. In addition, there is a shortage of doctors and medical nurses as their numbers are progressively decreasing each year due to a perceived low prestige of the medical profession and low wages, the consequence of which means that the supply does not meet the demand.

Since 2002, **social assistance** is oriented towards providing care services at home or as close to home as possible. Furthermore, the law on social services and social assistance encourages client's participation into the decision-making and issue-solving process. The provision of social care is the responsibility of both the state and municipalities, who provide

services based on the financial resources available to them, and include: state social benefits, social assistance, municipality social benefits (over 35% of which is spent onto housing benefits).

Home care, which was provided by 57% municipalities in 2001, is a favoured option whenever possible. Day care centres are also available and play an important in promoting elderly social participation. Although community-based **rehabilitation** services are uncommon in Latvia, there is a legislative drive to develop social rehabilitation in the home environment; however, in practice, such a rehabilitation care at home is very limited as there is both a lack of economic resources and available service in the municipalities.

On the other hand, only 20 to 24% of the demand for medical rehabilitation care was satisfied in 2000. Similarly, funding is also limited for the provision of technical aid to elderly people, with only 30% of the demand met in 2002.

3.3.1.2 Housing and older people

The Latvian **general housing condition** is characterised by poor quality compared to the rest of Europe, building deterioration, and low insulation cover, with 1/3rd of the buildings dating from WWII and the majority of housing in need of reconstruction and modernisation. Inner cities appear to have a better quality of home design and commodity compared to the rural areas.

75% of the Latvian population has expressed its dissatisfaction with the current housing condition and wish for its improvement.

Pensioners constitute 34% of the people living in social housing, with every 1/3rd household expressing the wish to move onto a cheaper dwelling. A portion of the elderly group is unable to cover housing expenditures and must either downsize, move into their children's house or relocate into an elderly home. Relocation to a social care centre is also an issue when elderly people lack family support for their home care. Latvia's social policy has encouraged the development of social housing, available for people with low income, where the costs of heating and water are substantially reduced. In 2003, there were over 1000 social dwellings in Latvia, with 34% of occupants being pensioners. Some of these accommodations are specifically designed to cater for the needs of people with mobility impairments.

3.3.1.3 Legislation, policy and NGOs

Latvia's **legislative and policy framework** cover equal opportunities for disabled people, standards regulations on environment accessibility; however none applies specifically to older people, whose group can be incidentally included within the legislation targeted population. Housing adaptations regulations considering the specific needs of the elderly are non-existent: the latter may either apply for self-care aids or for a bank loan.

NGOs provide a voice for socially vulnerable groups, such as disabled people and the elderly, and their role include: advising the state/municipalities, providing social care services and participate in social assistance projects. In relation to the elderly, the Latvian Pensioners Federation (1992) includes within its structure a vast array of organisations/associations dedicated to older people's issues at the local level. This network feeds the Federation with information, such as complaints and recommendations, which is then coordinated into summary documents presented to the Latvian's Parliament and government. The role of the Federation is essential as its work contributes considerably to resolving social issues and protecting the social interests of the elderly.

3.3.1.4 Key issues / problem areas

The overall socio-economic situation of Latvia is still in need of stabilisation, as successive legislative, structural and policy reforms have an impact on the effective development of a social/health care system and housing services.

The state also appears to be focusing on issues concerning the younger population. The problems affecting elderly in the Latvian state are threefold:

- **Pension** income is low; a growing black economy impacts on the full payment of social insurance to pensioners; and frequent legislative reforms adversely affect the social insurance budget and generate a lack of confidence in the social system.
- **Healthcare** services are under-funded, with a budget in deficit, which is often used for social issues purposes rather than healthcare issues; and growing waiting list for care services impact on emergency services expenditures.
- **Housing** provisions are below European standards, both qualitatively and quantitatively.

EU funding appears to provide the necessary impetus for improvement, both in boosting the country's economic situation and in improving the quality of life of its citizens in terms of housing, health and social care services.

3.4 SWEDEN

3.4.1 National background and health & welfare systems

People aged 65 and over formed 17% of the Swedish population in 2002, counting close to half a million people aged 80 and above. The older generation's general **health** has been improving in the last twenty years, although it has been noted that the prevalence of disease in later life is on the increase, with older people's health and functional capacity deteriorating. Women, in particular, seem to have poorer health, though longer life expectancy, than their male counterparts. Health indicators show that the quality of health will also vary according to individuals' socio-economic group, with employee having a better chance to live longer than workers. Half of those aged over 65 experience some sort of health problem (hearing, vision, mobility, psychological), with 1/4th reporting to have at least two concurrent health problems. Nevertheless, 86% of those aged 75 and above and 84% of those aged over 85 consider themselves to be in good health.

Health outcomes are related to the people's **income**, as the higher the income, the better the individual's health, and vice-versa, with as much as fifteen difference in life expectancy for those with a high income. Senior citizens' income will vary according to which type of pension sources they benefit from, ranging from public social insurance, which is of lower importance nowadays, to private premium pensions, occupation pensions and capital income. The Swedish pension system changed in 2000, with the old system (based on the individual's fifteen best working years) still applying to those born between 1938-1953, and the new system (based on the individual's lifetime earnings) applying to those born thereafter. A basic security pension is available for those who have either low-income related pensions or no pension rights at all.

County councils have prime **responsibility for health, medical and dental care** in their areas, with the provision of health services accounting for 89% of their activities, 71% of which were paid for by taxpayers in 2001, and the rest being financed by grants or other payments for services provided by central government.

In addition to county councils, local municipalities play a substantial role in the provision of healthcare (not medical treatment) for the elderly and disabled people living at home or in sheltered accommodations, and are under a duty to pay for patients' extended hospital's stay when, once their treatment over, they cannot be offered a place in local rehabilitation or sheltered housing. Since 1992, municipalities have full responsibility for long-term care services concerning the elderly and disabled people, which has resulted with a rise in

municipal housing capacity for older people needing social and care services, and a decrease in county council's hospitals beds.

In order to reach Sweden's objectives in relation to healthcare, which are good health and equal access to health services for all, a plan for development was introduced for the period 2001-2004, with the main priorities including better medical care for the elderly and a reduction in mental health problems for the children, young and older people.

3.4.2 Older people and housing: policy, legislation and schemes

92% of older people live in ordinary housing, with half of those aged 75-84 living alone. 8% of the over 65 and 19% of the 80+ age group live in sheltered housing. 20% of the 65-74 age group and 27% of those aged 75-84 live in homes inaccessible to wheelchairs. 8% of those aged 65+ and 19% of those aged 80+ living in ordinary housing require some kind of **home help**. A low percentage of the older population require help with managing P-ADL, although 19% of those aged 85+ will need some support for bathing themselves. Dependency increases in relation to I-ADL, with cleaning help being the most need in urban areas, and public transport for rural areas. In 2002, municipalities provided services to 42% of people aged 65+ who needed between 10-49 hours of home help; 37% needing less than 10 hours home help, and 21% needing more than 120 hours on a monthly basis.

The burden of care has nevertheless shifted to involve spouses and cohabiters more, with 36% of the older population reporting to receiving informal home help.

The Swedish **national policy on the elderly** aims to enable them to live an active life and have an input in the daily organisation of their life; to grow old in security and independently; to be treated with respect; and to have access to quality healthcare and social services. The main drive being this policy is that older people, including those needing extensive social and healthcare, must be given the opportunity to remain in their own home for as long as possible. A government bill, introduced in 2000, announced that changes and improvements should occur to promote social participation, personal development, building/transport accessibility and universal design for the elderly, and recognised ageing as being a dynamic process to be nurtured.

In relation to **housing requirements**, governmental regulations stipulate that homes, whether new-built or renovated, may be designed to fulfil the needs of people with functional impairments. Municipalities are responsible for housing planning and for the housing of older people. Their objective is to ensure that individuals have access to housing which meets their various needs; moreover, before reaching a planning decision, municipalities are under a duty to consult with those concerned. The numbers of **sheltered housing** are decrease due to a reduction in the municipalities' economy and to older people staying put in ordinary housing, which result in the demand being higher than the supply and people being on waiting lists.

Sheltered housing design must comply with certain criteria, including minimum room, facility and measurement requirements in order to provide staff with room to work safely and effectively, and sufficient living space for the use of a wheelchair.

Legislation addressing disability issues and the provision of social services to people with (functional) impairments will also cover the elderly. Municipalities also provide the elderly and disabled people with special transportation services (taxi or adapted vehicles) at an equivalent charge as that paid by community members for public transport. Private housing, public building and close surroundings must be designed to allow wide **accessibility** to people with impaired or limited mobility. In order to promote independent living, municipalities will cover the costs of **housing adaptations** for people with disabilities who live their home permanently and if the adaptations are of a preventative or rehabilitative nature, or on long-term care grounds. The granting of such help is assessed on the individual's functional needs, and not their revenue.

Despite an absence of **NGOs** specifically dealing with older people's issues, the latter are included within the framework of pensioners' organisations, which are political pressure groups involved in governmental committees and other consultation processes.

3.4.3 Key issues / problem areas

The decrease in sheltered housing implies a deteriorating quality of care and security housing for the elderly. The staying put policy imposes high demands on municipalities to ensure the accessibility of all, new and old, buildings. Despite an increase in the society's care resources, only a small portion of the elderly receives healthcare. There also appears to be a reduction in home help services in favour of informal help, putting a heavier burden on relatives. The provision of quality care and rehabilitation services is dependent on the municipalities' supply of skilled staff. Further co-operation between municipalities and county councils is needed to promote rehabilitation services, which are, as yet, not fully integrated within geriatric care services, thus resulting in a lack of trained rehabilitation personnel. Following reports on the situation of the elderly and their housing conditions, recommendations were made for better integration of older people's needs within policies relating to all areas and levels of societal life.

3.5 UK / ENGLAND

3.5.1 National background

The UK **population** is getting older, with close to 20 million people aged over 50 in 2002; 16% of the population aged 65+, 27% aged 80+ and 1.9% aged 85+. Furthermore, women have greater life expectancy, with 28% more women than men aged over 50 and 2.6 women for every one man over the age of 85 in 2002. On average, state benefits amounts to 51% of a **pensioner's** household income, rising up to 60% for those aged 75+. Pensioners on low income are entitled to income support through the Pension Credit Scheme and may apply for housing and council tax benefits, winter fuel payment, attendance allowance and disability living allowance.

3.5.2 Health & welfare systems

The National Health Service (NHS), local authority social services and independent **service providers** are the main providers of formal services for older adults. As people aged over 65 constitute 2/3rd of hospital patients and 40% of emergency admissions, the NHS, financed by taxpayers, aims to invest a substantial amount of funds for the improvement of care services and standards concerning older people; and currently also funds home based medical care and nursing care. Other services available to older people include home help, home care, meals on wheels, lunch clubs, social clubs and day centres. The more recent addition to care services is the Supporting People programme, which provides housing related assistance to vulnerable people in order to improve both their quality of life and independence.

3.5.3 Housing situation, policy and legislation

The UK offers a range of **different housing accommodations** to older people, from ordinary housing, to 'sheltered housing', 'very sheltered housing', 'close care housing' and care homes. As 80% of older people prefer to live independently in their own home, a majority of older people live in **ordinary housing**, with 67% of those aged 65+ being homeowners and just over 30% living in rented accommodation. However, 40% of the over 65 age group live in unfit housing, despite a decreasing number of unfit dwellings in recent years. Other housing options available include **sheltered housing**, a 'barrier-free', more manageable accommodation purposely designed for the over 65, promoting independent

living and providing added security; **very sheltered housing** or **extra care housing**, a similar concept which provides additional support and services. Approximately 5% of the older generation live in this type of housing and the Department of Health recently announced plans to create a further 1,500 extra care housing places; nevertheless, 87% of local authorities have 'difficult-to-let' sheltered units and there appears to be a lack of information available to consumers regarding sheltered housing. Other types of housing include **close care housing** and **care homes** (residential/nursing homes).

Housing policy objectives are to provide decent housing for all, social cohesion, well-being and independence. Although general policies address the needs of vulnerable people, within which group older people are to be included, there is only policy paper, which is specific to elderly housing matters and which aims are to ensure and promote older people's independent living in adequate housing conditions and personal choice through access to housing and advice services. Other housing-related provisions that are relevant to older people may be found in health/social/community care policies, for which elderly independent living in their own home as opposed to institutionalised care/housing is an underlying principle. **Healthcare policies** are oriented towards a better provision of rehabilitation services and long-term care at home with assistive devices or home adaptations. **Community care policies** emphasise on the ability to stay put and age in one place. As recent research observed a link between **health and housing**, suggesting that housing providers could contribute to improving the health of local communities and reducing health inequalities, as better housing promotes better health, this correlation has inspired a more integrated approach to the needs of older people, with policies and strategies, such as Health Improvement Programmes now bringing together health/social care, education, housing, transport and police services in order to meet the needs of older people.

It has thus been recognised that health, care and housing issues are inter-linked especially as regards matters relating to older people, therefore the trend is set towards enhancing and improving **inter-agencies collaboration** (i.e. joint-working & partnership), as the government's general policy aims to enable older people to live independently at home for longer, through the provision of home-based/long-term care.

Assistive technology has been mentioned in a number of essential policy frameworks dealing with elderly issues, as both governmental and non-governmental bodies acknowledge AT's potential to promote and encourage elderly care standards and choice, independence and well-being.

Legislation and regulation relating to accessibility do not specifically address the accessibility issue, but will rather focus on disability (accessibility for disabled people) or building issues. Building regulations have been up-dated over the last decade to ensure that public and non-domestic (existing and new) buildings are accessible to disabled people, within which group older people are to be included. Standards and regulations also apply for the design of accessible private houses; however, progress still remains to be done for the creation of regulations/standards, which specifically relate and consider the needs of older people. **Home improvements and adaptations** may be funded by the local authority through various grants; interests-only loans; and equity release, which is encouraged though it is in a developing stage and lacks in popularity amongst older people.

NGOs are also involved in the provision of housing, support, advice and care services for older people, through various initiatives, such as stay put programmes and schemes.

3.5.4 Key issues / problem areas

Although older people's situation in the UK has much improved over the last twenty years as many efforts have been made to improve their quality of life, some findings still demonstrate that the situation of older people is not optimal and key areas of concern remain, especially in relation to age discrimination and housing issues; moreover, the overall situation of older people in the UK appears to be better on paper than in reality. For instance, considering that the UK population is steadily ageing due to low birth rates and longer life span, despite a

growing number of elderly who own their homes, they are nonetheless increasingly 'property-rich' and 'cash-poor', which is the case for those who are on low income.

Other key issues in relation to older people in the UK include: poor/inappropriate housing; poverty; lack of consideration for special groups including ethnic minorities, women and those suffering from dementia; negative attitude of society; lack of information; social exclusion; fear of crime; insufficient transport; lack of speedy; convenient and specialized health care.

The involvement of older people in decision & policy-making is considered a positive way forward. However, although there have been attempts by charitable organizations and some governmental initiatives to include older peoples perspectives in policy making, it nevertheless seems that 'policy initiatives and service provision are shaped by the assumptive worlds of policy makers and service providers'.

4 CROSS-NATIONAL ANALYSIS OF THE ENABLE-AGE POLICY DATA

The WP7 national reports provide an important resource for cross-national analysis, looking at similarities and differences between the participating countries. The value of this is to highlight common issues, problems and policy approaches and to identify avenues for policy initiatives at the EU level. The analysis progressed through several stages:

Thematic analysis: the individual WP7 national reports were analysed thematically (see the protocol for WP4 for a broad overview of this kind of methodology) to identify their key themes.

Initial project workshop: The key themes were reduced to key words as the basis for a workshop held by the Liverpool WP7 team. The aim of this workshop was to assign the key themes to a smaller number of superordinate categories (e.g. by removing redundancies and grouping similar themes together). The results of this created an initial topic list (Table 2). A description of the topics is provided in Appendix 2. These were circulated to partners for feedback.

Full project workshop: a workshop was convened in Vienna during July 2004 prior to the IAPS conference. This allowed all the national WP7 teams to get together to review the preliminary cross-national analysis and determine the route for further working. The aim of this particular workshop was to identify a small set of issues for “targeted data analysis” (TDA), to bring together the policy analysis and the qualitative and quantitative data generated by ENABLE-AGE. This was to be the basis for evidence-based policy recommendations.

Validation: the report was circulated to the WP7 national team leaders to provide comment and amend inaccuracies.

Consultation: the draft report was distributed to experts within the ENABLE-AGE advisory group for feedback prior to finalisation.

Table 2: ENABLE-AGE Topic List

1A	National political reforms (e.g. transformational experience)	13	Community care / Home care / Assisted-living facilities
1B	National economic reforms (e.g. pensions)	14	Role of informal carers / Burden of care
1C	National social reforms (e.g. health/social care system)	15	Assistive technology
2	Healthcare system, structure & supply	16	Inter-agency collaboration
3	Role of NGOs	17	Preventive measures
4	Policy/Legislation orientation & applicability	18A	Housing stock / conditions
5	Demographic changes	18B	Home & Health
6	Dependency & Independence	18C	Housing alternatives (e.g. staying put / relocation)
7	Social participation / Inclusion	18D	Housing costs
8	Inequalities	18E	Barrier-free environment / Accessibility
9	Geographical differences	18F	Adaptations / Improvements

10	Age discrimination / Ageism	18G	Housing policy
11	Consultation / Participation	19	Poverty / Income
12	Information / Research	20	Funding / Access to funding / Benefits

In the Vienna workshop, the ENABLE-AGE team determined five main strands of political relevance based on their academic and/or political importance for the targeted analysis of policy issues relating to older people and housing, namely:

- 1) Housing, participation and quality of life
- 2) Housing barriers, accessibility and implications for building guidelines
- 3) Socio-economic change
- 4) Housing and health
- 5) Societal supports for “ageing in place”

In this report we have regrouped the topic issues from the list in Table 2 and five themes by creating a matrix (Table 3) that highlights the relationship between the twenty-eight topic issues and the five key themes. The selection of topic issues within each of the five key themes is not a definite one, as the ENABLE-AGE team recognises that they are all inter-related; however, to include all topic issues would require an in-depth and extensive analysis which the team cannot provide at this stage. However, this is a valuable starting point for further research. It also provides the framework for the policy discussion relating to the five themes for the TDAs. These are discussed in turn below.

Table 3: ENABLE-AGE Causality Matrix

	Key themes (objectives)	Housing, Participation & Quality of life	Housing barriers / Accessibility & Implications for building guidelines	Subjective experience of home & Implications for policy (incl. tensions within policy)	Socio-economic change	Housing & Health
	Topic issues (factors)					
1A	National political reforms (e.g. transformational experience)				✓	
1B	National economic reforms (e.g. pensions)			✓	✓	
1C	National social reforms (e.g. health/social care system)				✓	
2	Healthcare system, structure & supply					✓
3	Role of NGOs				✓	
4	Policy/Legislation orientation & applicability				✓	
5	Demographic changes				✓	
6	Dependency & Independence	✓	✓	✓		✓
7	Social participation / Inclusion	✓				
8	Inequalities	✓			✓	
9	Geographical differences	✓		✓	✓	
10	Age discrimination / Ageism			✓		
11	Consultation / Participation	✓				
12	Information / Research	✓				
13	Community care / Home care / Assisted-living facilities			✓	✓	✓
14	Role of informal carers / Burden of care	✓		✓		✓
15	Assistive technology	✓	✓	✓		
16	Inter-agency collaboration			✓		
17	Preventive measures			✓		✓
18A	Housing stock / conditions		✓		✓	✓

18B	Home & Health					
18C	Housing alternatives (e.g. staying put / relocation)		✓	✓		
18D	Housing costs				✓	
18E	Barrier-free environment / Accessibility		✓			
18F	Adaptations / Improvements		✓			
18G	Housing policy			✓		
19	Poverty / Income			✓	✓	
20	Funding / Access to funding / Benefits	✓	✓	✓		

4.1 HOUSING, PARTICIPATION AND QUALITY OF LIFE

The aim of the Enable Age project is to examine the relationship between the home environment and healthy ageing, which encompasses notions of autonomy, participation and well-being in later life. Following the bottom-up analysis of each of the five ENABLE-AGE national policy reviews, Housing, Participation and Quality of Life has emerged as a key theme, which considers the subjective element of well-being, as opposed to the medical outcomes, which are explored in section 2.5 below on housing and health. To facilitate the analysis and understanding of this theme, the ENABLE-AGE team has regrouped a number of topic policy issues (table 2), which serve as a platform for observing the dynamics between housing and participation as contributing factors to people’s quality of life in old age.

As shown in the schema below, the ENABLE-AGE project is mainly interested in the role played by housing both on older people’s participation within society and their quality of life; and on the relationship between the latter and social participation if and when supported by housing policies and the home environment. The idea of participation here is quite wide and includes a range of related issues and concepts, such as participation in activities (leisure, hobbies), participation within the community (both informally and within community organisations), social inclusion/exclusion, isolation, loneliness, and so on. The focus of the ENABLE-AGE project here is to understand the role of the home environment in facilitating or constraining participation amongst older home-dwellers. Participation is one of the four key areas identified by the ENABLE-AGE project, which relate the home environment to the quality of life of older people; the other three key areas include: physical (physical environment/infrastructure), psychological (fulfilment of older person’s home requirements/needs) and personal needs (support/care services for independent living).

Table 4: Dynamics in the relationship between housing, participation and quality of life in old age



In ‘Housing, Participation and Quality of life’, the notions of autonomy, independent living and well-being are paramount. The aim for this preliminary analysis is thus to identify whether and how the home environment favours social participation and supports independent living, and what this implies for the quality of life of older home-dwellers. The factors/topic issues considered for this primarily include: Dependency & Independence; Social participation / Inclusion; Inequalities; Geographical differences; Consultation / Participation; Information / Research; Role of informal carers / Burden of care; Assistive technology; and Funding / Access to funding / Benefits.

Participation (and integration) refers to involvement in community life, a person's social roles and social relationships. As a person grows older it can become increasingly difficult to maintain previous levels of participation due to illness, disability or frailty and elderly people are most likely to experience social exclusion through a reduced social circle, poverty and fear of crime, to name but a few factors. The home environment may thus act as a platform for social participation as it may help to facilitate social involvement through, for instance,

having friends and family over for dinner, or by being situated close to public amenities such as public transport.

Informal care provides us with a further example of how the home can encourage participation. Receiving help in one's home from friends, family and neighbours helps maintain social relationships and people who have difficulty getting out are able to centre their social activities around the home. An issue remains though with regards to the '**burden of care**', to what extent it is perceived as such, and the impact it exerts on the carer's life, relationships and financial situation. If the 'burden of care' becomes too great for the carer then this could negatively impact the social relationship with the individual being cared for and be of detriment to their quality of life. The 'burden of care' may be considered in terms of personal (informal/carer), economical (funding, benefits) and social (society's responsibility, policy).

The level of **independence** of a person may determine how fully that person is able to socially participate. Housing can promote or hinder independence depending on barriers, accessibility and services that can be received in the home. **Assistive technology** is one method used in the home to promote independence. There are various forms of the technology and it may be used for a wide range of purposes according to the individual's needs. In addition to the maintenance of independent living, it can encourage autonomy and quality of life at home or in assisted-living housing. The level of technology is constantly under advancement but its use may be influenced by consumers/users' attitude, funding for installation/affordability, availability, technical development and choice. **Funding** for housing maintenance, adaptations, improvements, assistive technology, housing expenditures, and so on, is accessed through various sources according to its purpose, the country, regional location/local authority. Monies may be raised through grants, self-financing, benefits, or loans. In relation to this point, there exist wide-ranging **inequalities** in the provision of services, access to grants and in housing conditions. These inequalities are partly due to **geographical differences**, as the quality and provision of housing, social and health care services will differ according to its geographical location and socio-economic situation. There is indeed a noted disparity between rural/urban, East/West and regional settings in all five partner-countries.

It is argued that social participation can exert a positive impact on quality of life and well-being. The need for a more holistic approach in the provision of services to older people is thus a new trend to be found in certain partner-countries' national policy strategies. There is a drive to see older people's needs considered and addressed within health/social care and housing policies; however, it is contented that this can only be effectively and adequately achieved if and when the elderly are involved in **consultation**. There is thus also a need to **inform older people** and their carer of what is available in terms of: types of housing accommodation, housing grants, housing adaptations, home care services, and so on. Furthermore, research is needed to identify the needs and views of older people in order for policies, legislation and programmes to be relevant, meaningful and adequate.

Overall, in examining housing, participation and quality of life, key questions to consider include:

- To what extent does remaining in one's home promote independent living, social participation/inclusion and healthy ageing?
- Is the issue of elderly social exclusion/inclusion/participation taken into consideration by policy-makers, legislative powers, and other service providers?
- What are the measures in place to promote elderly social participation, including funding for transport facilities, social clubs/centres, neighbourhood renewal?

4.2 Housing barriers and accessibility

The European **housing stock** has progressively changed in the last few decades, and now should include in-doors bath and toilet facilities, a kitchen, bedroom(s), living room(s) and heat insulation. However, there remain a large number of dwellings (even more so in some countries) that are still in need of modernisation to meet today's standard of decent housing conditions. In recent years there has been a drive to promote **barrier-free environments** and **accessible buildings** for people with mobility and functional impairments. Thus, in private dwellings especially adaptations are often needed to meet this end.

Housing adaptations can be technical or environmental, and serve to meet the needs of the elderly at home, in community accommodation or care settings, as a preventive or care measure. **Housing improvements** include measures to improve the living/housing conditions of the elderly, generally in terms of modernisation, repair and maintenance.

Assistive Technology is a type of adaptation in the form of technology that may be used for various purposes according to the individual's needs. It can aid in maintaining and promoting independent living, autonomy and quality of life at home or in assisted-living housing. Assistive technology remains an area under development and maybe influenced by a number of factors including, consumers/users' attitude, funding for accessibility, affordability, availability, technical development and choice.

These adaptations and improvements can help to promote **independent living** and enable a person to '**stay put**' in their own home for longer. However, they inevitably require **funding** which may be raised through various sources such as loans, self-financing and grants. Where exactly the funding comes from is often dependent on its purpose, the country and regional location.

Key issues to consider are:

- What is the difference between barrier free design and accessible environments?
- How are these included in housing policy if at all?
- How important is accessibility for independence and well-being

4.3 Impact of socio-economic change

Socio-economic change includes **national reforms, transformational experiences** and other broad socio-economic and political developments that have occurred over the last decades. **Political changes** are macro level changes concerned with broad social, political and institutional reforms which in/directly affect older people's housing and well-being status. **Economic changes** include, for example, reforms to the pension system. Pension systems are in a transitional state in some countries, with changes including: pensionable age, pension repartition/funding/income level, etc. **Social, welfare, health and housing services** have been or are going through extensive reforms in some countries, impacting on older people's quality of care, service availability, benefits accessibility, and overall well-being. This in turn, affecting their health, care and independent living status, and subsequently their housing/living conditions (i.e. ability to remain at home).

Legislation regulating such aspects as housing services, discrimination, accessibility and so on, tend to be oriented towards the betterment of 'disabled', 'vulnerable' or 'disadvantaged' people – no specific reference is made to older people, who are assumed to be included within these legislation. **Policies** set to improve the quality of life and independence of older people raise some questions as to their motives in terms of: interest of older people vs. interests of the state/government/political agenda.

Non-Governmental Organisations are present in all five partner-countries. In some, their role is intrinsically linked to the national welfare system; in others, they are prominent in research, lobbying and social/housing/health scheme activities. In other words, they are essential actors in the social field and as representatives or protectors of elderly interests.

Demographic changes are occurring all over Europe, with the general population getting older. **Community care services** promote staying put and independent living, and may include health & social services at home, home care, rehabilitation services at home, the provision and installation of sheltered housing, care homes, day care centres, etc.

The national **housing stock/conditions** has progressively changed in the last few decades, and now should include in-doors bath and toilet facilities, a kitchen, bedroom(s), living room(s) and heat insulation. However, there remain a large number of dwellings (even more so in some countries) that are still in need of modernisation to meet today's standard of decent housing conditions. **Housing costs** can take up a large portion of a household's income, leading people with low income to claim benefits, grants and other allowances to meet their expenses. Some older people will cut down on certain essential spending (e.g. heating) in order to 'make ends meet'. Indeed **low income** is a problem amongst the elderly, as many must rely solely on their pensions to cover the cost of their daily living expenses. However, pension systems are not necessarily effective in providing an adequate income, as the system can be confusing, disparate and irregular, and/or pension may be low and its financing difficult.

Inequalities are evident in housing conditions, provision of services and quality of life. These can be partly attributed to **geographical differences**. The quality and provision of housing, social and health care services will differ according to its geographical location and socio-economic situation. There is a disparity between rural/urban, East/West and regional settings.

Key issues to consider are:

- *How do these macro level issues impact on the housing and societal supports needed for older people to remain independent and "healthy"?*
- *How do these macro level issues impinge on individual well-being?*

4.4 Housing and health

Research has observed a link between **home and health** in terms of "better home results in better health", and vice versa. Poor housing conditions can cause a number of ailments, to which older people are particularly susceptible.

It is also important to consider other factors, which may influence this relationship between home and health, such as the **healthcare system** for example. In considering the healthcare system one must think about issues of funding, access to services, the structure of the healthcare system, and staff and service supply. The structure of the healthcare system refers to the efficiency of the internal / external organisation of the system in the delivery, repartition and management of services. The supply of staff and services is important in terms of quality, training, availability, specialist areas and whether the system can meet the level of demand. All these factors can contribute to older people being able to return and live at home after a medical intervention.

With regards to maintaining health within the home, community care services and **informal care** have a vital role to play. **Community care** services promote 'staying put' and **independent living**, and include a range of health & social services at home such as general home care, rehabilitation services, the provision and installation of sheltered housing, care homes and day care centres. Informal care from friends and family is another way in which health can be maintained within the home, for example informal carers may collect prescriptions, give reminders to take appropriate medicine. However, one must also bare in mind the notion of a burden of care and its potential impact on the carer.

Preventive measures such as assistive technology, housing adaptations and rehabilitation services may promote 'healthy ageing' as well as enabling older people to remain independent in their own home for longer.

Key questions to consider are:

- *What are relationships between housing situation and health outcomes?*
- *How do health care interventions impact on healthy ageing?*
- *Are health care interventions geared up to supporting people living independently at home?*

4.5 Societal supports for “ageing in place”

At the macro level current **policy** concerning older people's housing issues may be integrated within health and social care, urban planning or a community care perspective, for instance. **Legislation** regulating such aspects as housing services, discrimination, accessibility and so on, tend to be oriented towards the betterment of 'disabled', 'vulnerable' or 'disadvantaged' people – no specific reference is made to older people, who are assumed to be included within these legislation. Policies developed to improve the quality of life and independence of older people raise some questions as to their motives in terms of: interest of older people vs. interests of the state/government/political agenda. Policy recommendations more often pertain to addressing instrumental needs rather than considering more subjective and emotional wishes.

Despite a majority of older people wanting to **stay put** and 'grow old' in their own home, **relocation** occurs in some circumstances for instance in the case of a lack of (appropriate) structural support, poverty, lack of family support/net, poor housing conditions, little/no housing adaptations and so on. Thus it is vital that there exist appropriate **housing alternatives** but in order to provide appropriate housing alternatives older adults must be involved in **consultation**. There is a drive to see older people's needs considered and addressed within health/social care and housing policies, however, research is also needed to identify the needs and views of older people in order for policies, legislation and programmes to be relevant, meaningful and adequate. There is a need to **inform** older people and their carer of what is available in terms of: types of housing accommodation, housing grants, housing adaptations, home care services, and so on.

Moreover, when a person does decide to remain in private dwellings, how do current policies support this decision? It is important to consider whether the services a person receives are reflective of the type of services that person actually wants.

For example, the service of the **healthcare system** can impact on whether an older person is able to return and live at home after a medical intervention though it could be argued that this service only adequately addresses instrumental issues. **Community care services** do promote 'staying put' and independent living, and may include health & social services at home, home care, rehabilitation services at home, the provision and installation of sheltered housing, care homes, day care centres, etc. However, one must consider the effectiveness of these provisions and their ability to provide a holistic approach to care.

Thus **inter-agency collaboration** is vital in the provision of effective, appropriate services. Research has shown that independent living, healthy ageing and the home environment are all inter-linked, thus implying that in order to address one issue, the others must also be considered. This has prompted policy-makers and service providers to recognise and promote a holistic approach in dealing with older people's housing and health/social care needs, and to encourage joint-working, partnership and inter-agencies cooperation.

Informal care is increasingly being recognised as vital for many older people. Help from friends, family and neighbours can aid independence and 'healthy ageing' whilst delaying the

intervention of external organisations. However the 'burden of care', experience by carers must be taken into consideration. The 'burden of care' may be personal (informal/carer), economical (funding, benefits) and social (society's responsibility, policy).

Factors of **independence** can heavily influence a person's experience of home and exert influence on quality of life and well-being. Independence can be encouraged through family support, home care, transport facilities, adapted housing, accessible buildings, policy orientation promoting independence and local authority funding to provide appropriate care services. **Preventive measures** such as assistive technology, housing adaptations and rehabilitation services all help in promoting independence.

Funding for housing maintenance, adaptations, improvements, assistive technology, housing expenditures, and so on, may come from grants, self-financing, benefits, or loans. However, the provision of funding such changes to one's home through self-financing is not an option for many older people. **Poverty** and low income is a problem amongst the elderly, as many must rely solely on their pensions for their daily living expenses. The pension systems are not necessarily effective in providing an adequate income, as the system can be confusing, disparate and irregular, and/or pension may be low and their financing difficult. The likelihood of receiving a grant or benefits to cover such costs can depend on the country, regional location, local authority and personal financial situation

Ageism is a further factor which can negatively impact upon a person's care at home or otherwise. Ageism is caused by stereotypes and prejudices, stemming from society's tendency to focus on younger generations (leisure activities, consumer market, policies, media's portrayal). This is to the detriment and disadvantage of the elderly, who may be termed second-class citizens. Ageism may impact on older people's protection in relation to home care (abusive/unsafe carer; inappropriate care) and housing issues (cowboy builders), and in terms of their views being taken seriously by care providers and authorities. The expression of ageism in the form of age discrimination affects older people in a variety of ways, in all social sectors, including education, employment, and in particular health/social care, where discriminatory policies in the provision and delivery of adequate institutional and home care services have an adverse effect on older people's ability to remain in their own home and maintain independent living.

Two key policy themes have emerged in cross-national analysis: the emphasis on

- "Ageing in place", where a person is provided with community support to remain living at home
- Seeing the person as a "whole", where assessment and provision of support addresses their needs holistically

From these key ideas 'support' needs address:

- Is the assessment of a person based on a holistic evaluation of their personal needs and situation within which housing is contextualised?
- Are services aimed at supporting the person's holistic needs
- Are the different agencies 'joined up' (e.g. housing, health etc) or at least working together (e.g. UK single assessment) to provide client-centred care and support?
- Is support about quality of life as well as the instrumental aspects of living independently?

5 CONCLUSIONS

5.1 Scope of current report

The work carried out in ENABLE-AGE policy review has been very extensive and the report presented here represents only a very preliminary stage of an analysis that will extend beyond the contracted period of the project. However, the ENABLE-AGE team is in a strong position to carry out this work in the future:

- National reports represent an unique database of national policy material on housing
- Policy data can be linked into the quantitative and qualitative data generated by ENABLE-AGE

Further work on policy analysis is envisaged:

- Detailed cross national analysis of policy themes
- Comparative analysis between EU and national level policy on housing

5.2 Scope of ENABLE-AGE policy recommendations

The discussion emphasises the limitations of EU competence over national policy relating to housing. The implications of this for EMABLE-AGE is that the research carried out cannot be directly transposed into specific EU-level policy recommendations, as policy competence remains fragmented at the national level. In this context the role of project dissemination will be to inform the debate about housing for the elderly and to identify the key “messages” emerging from the research.

5.3 Targeted Data Analyses

The current report sets the scene for further policy analysis work within ENABLE-AGE. This work will focus carrying out the targeted data analyses on the five key themes identified in this report. The results of these explorations will provide the basis for developing the “messages” that will form the basis of the policy recommendations report.